A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy

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A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy was prepared by **Jamieson, Beals, Lalonde and Associates, Inc.** for the Family Violence Prevention Unit, Health Canada.

Également disponible en français sous le titre ***Guide à l'intention des professionnnels de la santé et des services sociaux réagissant face à la violence pendant la grossesse.***

This publication may be provided in alternate formats upon request.

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Cat. H72-21/165-1998E
ISBN 0-662-27295-1

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FOREWORD

Purpose of this handbook

The purpose of this handbook is to provide an educational resource for health and social service professionals who are providing services to women who are abused during pregnancy. The information contained in this handbook will help professionals to identify and appropriately respond to the needs of women who are abused during pregnancy. Health and social service professionals are not alone in their effort to provide care and support for abused women. In many communities, there are other resources and sources of support that, together, can make a difference.

Prevalence

It is clear that violence against women is a serious problem in Canada. The 1993 Violence Against Women Survey conducted by Statistics Canada found that 29% of women who had ever been married or lived in a common-law relationship had been abused by a male partner (Rodgers, 1994). More than half (56%) of women who reported experiencing wife assault in the 12 months prior to the survey were between the ages of 18 and 34 (Rodgers, 1994)—a period that coincides with the main childbearing years (moreover, the survey found that the rate of wife assault among young women aged 18 to 24 years is four times the national average (Rodgers, 1994)). According to the survey, *21% of the women who reported experiencing violence by a marital partner—approximately 560,000 women—reported that they had been assaulted during pregnancy* (Statistics Canada, 1993a).

Further estimates of abuse during pregnancy vary. For example, a recent clinical-based study in Ontario found that 6.6% of pregnant women are abused during pregnancy (Stewart and Cecutti, 1993). According to estimates cited by the Society of Obstetricians and Gynaecologists of Canada, the incidence of violence in pregnancy may range from 4% to 17% (SOGC, 1996). A 1996 review article in the *Journal of the American Medical Association* found that the prevalence of violence during pregnancy reported in the literature ranges from 0.9% to 20.1%, with the majority of studies reporting prevalences of between 3.9% and 8.3% (Gazmararian et al., 1996). These figures may significantly underestimate the problem, as many women do not report their experiences of violence (SOGC, 1996).

The problems associated with violence are confounded for women who live in disadvantaged or isolated circumstances (e.g., women who live in rural or remote locations, recent immigrant and refugee women, and women with disabilities) because they face additional obstacles to seeking assistance (Day, 1995).

Family violence in Aboriginal communities is of widespread concern. Although there are no national-level statistics on the extent of violence that Aboriginal women experience in their personal relationships, the Report of the Royal Commission on Aboriginal Peoples (RCAP) noted that two studies conducted in Ontario and one study conducted in Alberta in the early 1990s reported that 48% to 91% of Aboriginal women have experienced violence within their personal relationships (Royal Commission on Aboriginal Peoples, 1996a). A 1993 study of Aboriginal people living in urban centres found that 70% of the women in the study had been victims of violence—primarily inflicted by spouses, partners or boyfriends (La Prairie, 1995).

Abuse during pregnancy—an under-recognized problem

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 (Stewart and Cecutti, 1993). Paradoxically, pregnant women have a higher risk of experiencing violence during pregnancy than they do of

experiencing problems such as pre-eclampsia, placenta previa or gestational diabetes—health concerns for which they are routinely screened (Modeland, Bolaria, and McKenna, 1995; Petersen et al., 1997).

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 believe 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 (Ferris, 1994).

Health and social service professionals—a critical source of care and assistance

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 (Searle, n.d.). 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 (Walker-Hooper, 1981).

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 stopping the abuse.

The literature concerning abuse during pregnancy has increased in the past decade, and the knowledge base about this complex problem is growing, but there are still many important avenues for future research (Petersen et al., 1997; Gazmararian et al., 1996). Research on abuse during pregnancy is particularly limited in terms of exploring the diverse circumstances, experiences and needs of women who are abused during pregnancy. Nonetheless, there are some general approaches and practical strategies that can be considered.

The dynamics around abuse are particularly complex during pregnancy. For some abused women, pregnancy may motivate them to ask for help (Searle, n.d.). Even women who do not see their own suffering as a priority may seek help because of the baby (American College of Obstetricians and Gynecologists, 1993). Pregnancy may be the only time when women who are being abused have frequent, ongoing contact with professionals who can help them (Bohn and Parker, 1993). Most pregnant women routinely see physicians and nurses for prenatal care—and may not otherwise; therefore, it is an important time for intervention. At the same time, however, a woman's fear for her own safety and her emotional connection to the abuser may preclude her from disclosing abuse. To health and social service professionals, the signs of abuse may be diverse and conflicting. Other issues—such as whether there are other children involved—must also be considered.

Consequently, it is vital that health and social service professionals are as well equipped as possible to provide assistance and to refer women to other sources of support. For many reasons, professionals should not expect to address this issue on their own. In most communities across Canada, a combination of community agencies, and hospital and government health services now offer services for abused women (Hanvey and Kinnon, 1993). Increasingly, health and social service professionals are working together across disciplines to coordinate services and improve the response to abused women in their community.

A handbook of this type is not intended to function as a set of guidelines for practice. Rather, it is intended to demonstrate the scope of the problem and to point to some potential strategies for developing an effective response. Professionals are encouraged to consider the material in this handbook as a set of suggestions and examples for developing the specific tools they need. It is hoped that this handbook will add insight to the problem of abuse during pregnancy and serve as a starting point for further discussion, collaboration and action.

Where to get more information

More information on issues related to abuse is available from the National Clearinghouse on Family Violence, Health Canada.

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ACKNOWLEDGMENTS

A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy was prepared by Jamieson, Beals, Lalonde and Associates, Inc., under contract to the Family Violence Prevention Unit, Health Issues Division, Health Promotion and Programs Branch, Health Canada.

An Expert Advisory Group, consisting of health and social service professionals with expertise and practical experience working in the field of women's health and well-being—particularly around issues of abuse during pregnancy—helped to guide and shape the handbook. The members of the Advisory Group are listed in the right-hand column on this page.

We would like to thank the members of the Advisory Group for their generous and insightful contribution to this handbook.

In addition, we would like to thank Dr. Lorraine Ferris and Deana Midmer with whom we shared ideas, information and research during the process of creating this handbook. Thanks also to Dr. Patricia Morris who provided us with some practical insights into the experience of family physicians who are addressing this problem.

At Health Canada, we would like to thank Katalin Kennedy, Program Consultant, Family Violence Prevention Unit, who oversaw this project. Thanks also to Gaby Vieira and Leah Sims at the National Clearinghouse on Family Violence, and Lynn Austin at the Health Canada Library for their dedicated efforts to help us locate research and other materials.

Many other individuals also provided information and assistance, including: Becky Skidmore, Canadian Medical Association; Carolyn Brown, Editor, *Canadian Medical Association Journal*; Danielle Bown, Society of

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Several organizations in the United States provided review copies of their publications. We would like to thank the following individuals: Pat Paluzzi, American College of Nurse-Midwives; Linda Chamberlain, Alaska Domestic Violence Training Project; Jeanne-Marie Quevedo, Physicians for a Violence-free Society; and Anara Guard, Children's Safety Network.

We are also grateful for the many excellent summary and overview documents (e.g., book chapters, manuals, guidelines, protocols, literature reviews, articles and fact sheets) that we were able to use as sources for this handbook. Although not all of the primary sources from these documents are included in our selected bibliography, we encourage the reader to review those materials. Some sources have been particularly useful. For example, this handbook benefited significantly from the comprehensive material provided in *Improving the Health Care Response to Domestic Violence*, written by Carole Warshaw, Anne L. Ganley and Patricia R. Salber, and produced by the Family Violence Prevention Fund; and "Domestic violence and pregnancy: health effects and implications for nursing practice" by Diane K. Bohn and Barbara Parker (Chapter 6 in: Campbell, J. and Humphreys, J. (eds.), *Nursing Care of Survivors of Family Violence*).

We would also like to thank the following individuals for their input and assistance: Carole Morency, Department of Justice; Rosemary Sloan, Health Canada; Louise Hanvey, Consultant; and Jessica Harrington, Research Assistant.

Finally, we would like to acknowledge The Toronto Hospital Abuse Task Force for sharing its Policy on Spousal Abuse.

Liz Hart Wanda Jamieson

PRINCIPLES UNDERLYING THIS HANDBOOK

There are many reasons—moral, ethical and legal—to try to identify and assist abused women and their children.

- **Legally**, it is important to identify and address abuse experienced by women during pregnancy for two reasons: certain forms of abuse such as physical abuse, sexual abuse, criminal harassment and threats of violence are all criminal offences under Canada's *Criminal Code*. Moreover, there are certain legal obligations[1] to report all alleged or suspected cases of child abuse or neglect.
- **Ethically**, responding to abuse helps to prevent further abuse. It also saves women's and children's lives and reduces the health and social service system costs associated with abuse.
- **Morally**, abuse is wrong. No woman deserves to be abused.

Failing to identify and respond to abused women means:

- not developing a clear understanding of the scope of this problem;
- failing to address the root causes of many health and psychosocial problems;
- continuing to mislabel and misdiagnose women who are seeking help, further reducing their credibility and potentially exhausting their energy and strength;
- failing to prevent more women from dying as the result of serious injury, homicide or suicide;
- allowing children to remain at risk of developmental problems, injury, illness and death;
- providing less than optimal medical or social services.

Consequently, this handbook is based on the following principles:

- Women and children have the right to live violence-free lives.
- Abuse is related to the misuse of power and control.
- Abuse occurs in many different forms.
- Women have the right to make choices to disclose abuse and/or accept help and this must be respected.
- There is no excuse for violence against women in any culture; at the same time, understanding and respecting different social and cultural perspectives and contexts is essential to creating an effective response.
- Pregnant women who are abused face a number of unique circumstances that need to be considered.

A great deal of coordinated support is needed in order to help abused women address their situation, including any decisions and plans they may need to make to end the abusive relationship. Health and social services professionals are a vital source of support and assistance throughout this process.

[1] Reporting child abuse and neglect is not mandatory in the Yukon (Federal-Provincial Working Group on Child and Family Information, 1994).

PART 1:
UNDERSTANDING ABUSE DURING PREGNANCY

OVERVIEW

What is abuse?

Whenever someone uses power over another person to try to harm that person, or to exert control that will harm that person either immediately, or eventually if repeated over time, it is abuse.

There are many different terms—*family violence, domestic violence, woman abuse, wife abuse, wife assault, spouse abuse*—used to describe the abuse of a woman by her partner, family members, caregivers, or others with whom she has intimate, familial or romantic relationships. A woman may experience abuse in many forms, including physical, emotional/psychological, verbal, environmental, social, financial, sexual, religious/spiritual or ritual abuse. **Physical abuse** can include slapping, punching, kicking, biting, shoving, choking or using a weapon to threaten or injure a woman. It can include any unwanted physical contact or physical neglect, and it may result in death. **Emotional** or **psychological abuse** includes various forms of intimidation, harassment, excessive jealousy, control, isolation and threats. **Verbal abuse** includes constant criticism, blaming, false accusations, name calling and threats of violence toward a woman or people or things she cares about. **Environmental abuse** includes making a woman feel afraid in her home or environment by destroying property and possessions as a form of intimidation. **Social abuse** includes isolating the woman from her friends and family. **Financial abuse** includes preventing a woman from having financial independence, economically exploiting her, or preventing her from having any control over the family's money and expenditure decisions. **Sexual abuse** includes any forced sexual activity. It can also include infecting a woman with a sexually transmitted disease by engaging in unsafe sexual practices. **Religious** or **spiritual abuse** involves ridiculing a woman's beliefs, using her beliefs to manipulate her, or denying her or her children's involvement in her spiritual or religious practise. Professionals should also be aware that **ritual abuse**, which targets women and children, also occurs and should be carefully explored (Martin and Younger-Lewis, 1997; Health Canada, 1995a).

Typically, abuse is a pattern of assaultive and coercive behaviour used against a woman that involves:

- her intimate partner in a current or former dating, married or cohabiting relationship;
- the repeated use (sometimes daily) of many different abusive tactics that, without intervention, may increase in frequency and severity over time;
- a combination of physical violence and psychological attacks and other controlling behaviours that create fear and compliance and inflict harm;
- patterned behaviour aimed at controlling her and making her obey the abuser;
- her increasing entrapment and isolation.

(Salber and Taliaferro, 1995)

Woman abuse is linked to a web of attitudinal, structural and systemic inequalities that are gender-related (Status of Women Canada, 1995). It affects women in many different social relationships and contexts. Woman abuse happens regardless of age, race, ethnicity, education, cultural identity, socio-economic status, occupation, religion, sexual orientation or personality. Abuse has serious consequences for women, their children, their families, their communities and their abusers.

Abuse of women in their childbearing years

A woman may be abused by someone she may know, trust, respect and love at virtually any point in her life (Wilson et al., 1996): from childhood, through adolescence, through womanhood and in old age. There is, however, increasing evidence that a woman in her

childbearing years is at higher risk. The Violence Against Women Survey found that more than half (56%) of women who had experienced wife assault in the year prior to the survey were 18 to 34 years of age, a period that coincides with the main childbearing years (Rodgers, 1994).

Abuse can affect a woman's reproductive health and choices. For example, her choices around conception may be affected by:

- sexual coercion or control by her abuser,
- unwanted pregnancy (as a result of coercion), and
- becoming pregnant to try to stop the abuse.

Female genital mutilation (related to the practise of female circumcision in certain cultures)—another form of violence against women—may also have an impact on her reproductive health and choice.

Becoming pregnant can trigger abuse (Rodgers, 1994) or escalate ongoing abuse (Stewart and Cecutti, 1993). Being abused during pregnancy can seriously affect a woman's health and well-being and that of her baby and other children she is caring for.

Costs of abuse

The costs of abuse are very high. 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 and developmental effects on the fetus and newborn baby. Children living in violent homes are also 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 (Health Canada, 1996).

There are significant health care costs for treating the injuries and chronic health problems caused by abuse (resources that 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, recent Canadian studies have estimated that:

- **violence against women may cost more than $4.2 billion dollars a year** (in social services/ education, health/medicine, criminal justice and labour/ employment costs) (Greaves et al., 1995).
- **health-related costs alone of violence against women amounted to more than $1.5 billion a year** (a figure that is only the "tip of the iceberg," according to the author of the study) (Day, 1995).

UNDERSTANDING THE DYNAMICS OF ABUSE

Sequence and pattern of abuse

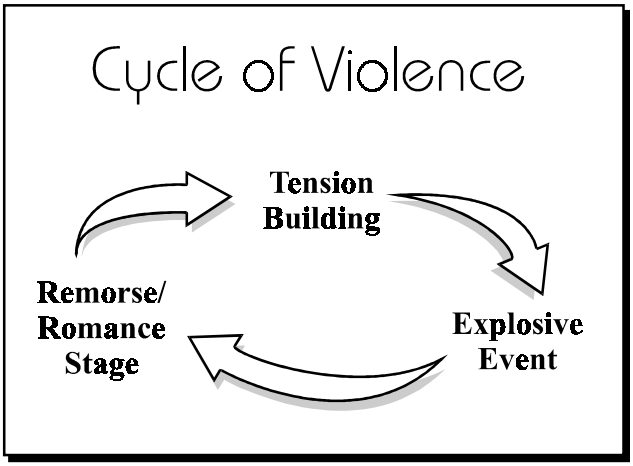
To understand the dynamics of abuse, it is necessary to recognize that:

- **Abuse is based on power and control.** An abuser uses a range of control and intimidation tactics to hold the balance of power in the relationship and to maintain control over the woman.
- **Abuse involves the abuser isolating the woman from her family, friends and community.** Along with losing contact with family and friends, a woman often cannot make contact with health or social service professionals, either because the abuser fears being discovered and will not let her make the contact, or because she does not have the financial resources, means of transportation or freedom of movement to make contact.
- **Abuse is a systematic pattern of behaviour.** In most cases, abuse happens in a repetitive sequence, often referred to as the "cycle of violence" (Walker, 1979). **In the tension-building phase**, the abuser experiences a period of increasing stress and tension. This may build over a matter of hours, days or weeks during which time a woman will try to avoid an outburst by accommodating the demands of the abuser. She may feel that she is "walking on eggshells." **When the pressure peaks**, the abuser explodes, unleashing anger and rage and trying to control the situation

through partner abuse. After the abusive incident, there is **a period of relief** when the abuser offers apologies and promises to change. This pattern occurs again and again over time. Often, the incidents of abuse start to become more frequent and severe, with shorter periods of relative calm.

- **The cycle of abuse follows a distinct sequence and pattern.** Abused women often go through phases of:
  - increasing fear,
  - isolation,
  - developing more and more complex adaptations (psychological and psychosocial), and
  - alternating periods of hope (that things will improve or change, that the violence will end, that she will escape) and increasing fear for herself and her children and their survival.

(Modeland, Bolaria and McKenna, 1995; Stark, 1994)



(Walker, 1979)

Characteristics of violence during pregnancy

The 1993 Violence Against Women Survey found that in Canada:

- 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.

(Statistics Canada, 1993a; Rodgers, 1994; Johnson, 1996)

A Canadian study 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.

(Stewart and Cecutti, 1993)

A subsequent Canadian 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 (Stewart, 1994).

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 (Rodgers, 1994), 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 (Wadhera and Millar, 1997). Consequently, the risk of abuse during pregnancy is an issue to consider for this population.

In summary, there is an increasing amount of evidence about the characteristics of violence during pregnancy. This evidence indicates that, in some cases, the abuse is initiated when the woman becomes pregnant. But **in most cases, it is a continuation of abuse that began before pregnancy** (Bohn and Parker, 1993). 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.

Dynamics of abuse during a woman's 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).

Before pregnancy the 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 not allowing 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.

(Martin and Younger-Lewis, 1997; Madsen, 1996)

Once a woman is pregnant, the 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.

(Martin and Younger-Lewis, 1997)

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 (Bohn and Parker, 1993; Saskatchewan Institute on Prevention of Handicaps, 1997). 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 (Stewart and Cecutti, 1993; Searle, n.d.). The reality is that pregnant women are at risk of being abused. Pregnancy is also a dangerous period for the children of abused women (Saskatchewan Institute on Prevention of Handicaps, 1997).

During pregnancy, the 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.

(Ferris et al., n.d.; Lent, B., 1991; Bohn and Parker, 1993; Modeland, Bolaria and McKenna, 1995; Salber and Taliaferro, 1995; Martin and Younger-Lewis, 1997)

During labour and birth, the 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, the 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.

(Stewart, 1994; Martin and Younger-Lewis, 1997)

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

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

(Martin and Younger-Lewis, 1997)

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 practise;
- 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 the woman and her baby.

(Townsend, n.d.)

Who are the abusers?

Women who are pregnant may be abused by their current or ex-husbands, partners, lovers or boyfriends (Stewart and Cecutti, 1993), or by their caregivers (Health Canada, 1993), parents, siblings, children or other relatives.[2]

General causes of abuse

There is no one simple cause of abuse against women. Abuse against women happens because:

- abusers have learned to be abusive by watching others in the family and society;
- abusers have found that it is an effective way of establishing or regaining control;
- societal attitudes and norms support the use of violence to control others;
- powerful gender-based inequalities in society support the notion that woman abuse is a private matter and permit people to look the other way when it happens.

[2] There are no Canadian data, but American research suggests that pregnant teens may be at particular risk of being abused by a member of their family of origin (Guard, 1997).

Sometimes, the consequences of abuse and the factors associated with it are misinterpreted as "causes." For example, although abuse may be correlated with the following factors, **it is not caused by:**

- the use of alcohol or other drugs,
- anger,
- stress,
- something the woman said or did, or
- relationship problems.

(as summarized in Warshaw, Ganley and Salber, 1993)

Causes of abuse during pregnancy

Pregnancy does not cause abuse, but it is clearly a risk period associated with abuse (Statistics Canada, 1993b; Stewart and Cecutti, 1993). There has been a lot of speculation about the link between pregnancy and abuse. Experts and abuse survivors have suggested a wide variety of explanations, including the examples listed below, but many experts now believe that **abuse is prompted by the abusers' desire for power and control and their belief in using violence and coercion to achieve this end** (Bohn and Parker, 1993).

Some theories about why men abuse women during pregnancy

The abuse may be:

- a form of prenatal child abuse;
- an attempt (conscious or unconscious) to terminate the woman's pregnancy or kill the fetus;
- an attempt to induce an abortion.

The abuser is jealous and:

- sees the fetus as competition for his partner's love and attention;
- considers the fetus an "intruder" in the relationship;
- feels loss of power and control over a woman as she begins to focus her attention on her own health and that of the developing fetus;
- resents a woman's increased contact with, and attention from, family and health care providers during pregnancy.

The abuse during pregnancy is caused by stress related to:

- an unwanted or unplanned pregnancy;
- marriage because of the pregnancy;
- pregnancy/another pregnancy perceived as a financial and emotional burden;
- conflict about the pregnancy (e.g., between the woman and her partner).

The abuser may feel:

- a loss of control over the woman;
- anger at his partner's decreased energy and ability to care for the abuser;
- ambivalent about the pregnancy;
- resentment because of increased responsibilities associated with a child/another child;
- angry because the pregnancy makes her less attractive to him;
- frustrated because the pregnancy may change her sexual behaviour toward him (e.g., decreased sexual availability);
- anger about her need to reduce her workload or take maternity leave.

(Searle, n.d.; Bohn and Parker, 1993; Stewart and Cecutti, 1993)

Stressors after the baby is born

Stressful situations (e.g., the baby is crying, has colic) may also influence the dynamics of abuse.

> "The postpartum period is known to be stressful. The couple must cope with the demands of a new baby, role adjustments to parenthood in their own relationship and in interactions with others (e.g., parents), sleep deprivation, increased financial responsibility, reduced sexual activity and the physical and hormonal changes experienced by the mother" (Stewart, 1994).

Risk factors

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); an unhealthy lifestyle (including poor diet, alcohol use, illicit drug use and emotional problems); physical and psychological health problems (including prescription drug use)[3] (Stewart and Cecutti, 1993).

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** (Stewart, 1994). 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 (Action on Women's Addictions—Research & Education, 1996), including the majority of teen pregnancies (Guard, 1997), 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 (Wilson et al., 1996).

The following groups of women may also be at high risk for abuse: women who are pregnant (Stewart and Cecutti, 1993); women whose pregnancies are unwanted or mistimed (increases by four times the risk of being physically abused) (Donovan, 1995; Gazmararian et al., 1995); pregnant adolescent women (Guard, 1997); and women in the postpartum period (Stewart, 1994).

Reasons why women stay in abusive relationships

It is important to recognize how the cycle of abuse traps women. An abused woman frequently stays in or returns to an abusive relationship. She may minimize or deny that the abuse is happening. She may feel it is her fault. She may feel she does not have any easy or effective ways of either leaving or staying away from the abuser. If he has threatened to harm or kill her if she leaves, she may feel that staying in the relationship is indeed safer for her than leaving. She may love the abuser and be ever hopeful that he will change his behaviour. Although not an exhaustive list, some of the common reasons why a woman may stay in an abusive relationship are that she:

- fears not being believed;
- hopes the relationship will improve because the abuser is often contrite;
- feels she has created the problem and that she is the one who should change her behaviour;
- is isolated from her support system by her abusive partner;
- is unable to escape her abuser's control (including control of her finances);
- does not have another source of income;
- lacks educational qualifications and/or employment skills;
- has nowhere to go with her children;
- fears being stalked or killed by her abusive partner;
- fears he may kill himself if she leaves;
- has grown up watching her mother being abused;
- has grown up being abused and thinks it is normal;
- is pressured by family or community members to stay with the abuser;
- believes that religious faith and doctrine (e.g., prescriptions against divorce) prevent her from leaving;
- does not want to deny her children their father;
- is fatigued or depressed from the constant high stress;
- has lowered self-esteem;
- feels powerless and lacking in control over her life;
- needs to be loved.

(Townsend, n.d.; Stark, 1994; Hotch et al., 1995; Saskatchewan Institute on Prevention of Handicaps, 1997)

[3] As the authors state, some of these factors may in fact be the **result** of living with abuse.

A woman who is a recent immigrant may have additional fears, such as the fear of authority and deportation (for herself or her family) if she leaves her partner and/or her sponsorship relationship breaks down (Department of Justice Canada, 1995). She may experience intense family and community pressure to endure the abuse. She may feel marginalized from support systems available in her community. She may lack economic means to support herself. Language is often a common barrier experienced by immigrant women seeking help.

Women living in rural or remote communities may feel that they would have to leave their communities—and everything familiar—to be safe. This isolation and lack of access to resources creates added barriers.

Disabled women may be dependent on their abusers for care (including affection, communication and financial, physical and medical support), may lack access to transportation, and may not be able to access information, services and support systems in the community (Health Canada, 1993).

A woman who has other children may:

- be unable to escape with them;
- not want to change the lifestyle to which her children are accustomed;
- fear that if she leaves, she or her children will experience more violence, or possibly be killed;
- want her children to have their father;
- lack confidence in her ability to care for her children alone;
- be worried that her children will be taken away by child welfare authorities if she seeks help;
- fear her partner will gain custody of her children.

(Hotch et al., 1995; Department of Justice Canada, 1995; Saskatchewan Institute on Prevention of Handicaps, 1997)

For women, the status of her dependents (including children, parents, other relatives and extended family members) may influence her decision making. For example, she may find it difficult to leave with a dependent who is ill or disabled.

Clearly, there are also many structural barriers—finances, lack of affordable housing, etc.—that keep women from leaving abusive situations. These problems may be compounded during and after pregnancy. During pregnancy, women are increasingly vulnerable and this can be a further barrier to leaving. For example, she may need money and she may find it harder physically to do things, particularly if she is experiencing medical complications as a result of being pregnant.

If she does not have access to transportation, her options are even more limited. As a result, she becomes even further isolated. Attitudes may also be a barrier. Many people assume that everything is fine in a relationship if there is a pregnancy. Given the evidence on abuse during pregnancy, this is a myth that must be challenged.

A woman may not leave abusive situations because she fears being killed. This fear should be taken seriously. When an abuser threatens to kill, she knows she is safer not leaving the relationship at this point. In fact, for abused women, separation is a high-risk period for death.

Despite all the ways in which a woman can be trapped by abuse, **the fact that she remains in, or returns to, an abusive relationship does not mean she accepts being abused**. Rather, it is indicative of the stage of the abusive relationship she is currently experiencing. Usually, she tries many different strategies to stop or cope with the abuse (Stark, 1994) and makes attempts to protect herself and her children. Often, she tries to escape (sometimes repeatedly) (Saskatchewan Institute on Prevention of Handicaps, 1997). Her strategies will depend on her circumstances and options.

UNDERSTANDING THE IMPACTS OF ABUSE

Overview

Much has been written about the serious physical and psychological effects of abuse on victims. Clearly, women who are abused during pregnancy (and their children) can suffer any or all of the known impacts of abuse, including serious physical and/or psychological trauma and death.

According to the literature, abuse during pregnancy can have direct and indirect effects. 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 (Bohn and Parker, 1993).

Impacts on the pregnant woman, fetus and infant

Effects of violence

In recent years, researchers have attempted to learn more about the specific impacts of violence during pregnancy on pregnancy outcomes. However, according to a recent review of the literature, these studies have not been conclusive for a variety of reasons. Nevertheless, because violence is linked to physical trauma and stress, it is important to consider the available evidence on the impacts of physical trauma and stress during pregnancy (Petersen et al., 1997).

Effects of 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 [Stewart and Cecutti, 1993])* 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 hemorrhage and bone fractures;
- fetomaternal hemorrhage;
- maternal shock (e.g., because of blood loss);
- rupture of the uterus, spleen, diaphragm and liver;
- neonatal death.

(Petersen et al., 1997)

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.

(Petersen et al., 1997)

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 (Petersen et al., 1997; Bohn and Parker, 1993). 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.

(National Council of Welfare, 1997; Hanvey et al., 1994)

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" (Meredith, 1996).

Abused women have been found to have increased rates of drug and alcohol use, substance abuse and tobacco use during pregnancy (Bohn and Parker, 1993).[4] Because the use of 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 (Stewart and Cecutti, 1993).

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 (Stewart and Cecutti, 1993).

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.

(Bohn and Parker, 1993)

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.

(Bohn and Parker, 1993)

[4] 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 (Addiction Research Foundation, 1995).

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.

(Bohn and Parker, 1993)

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 (Bohn and Parker, 1993). Abused women may have shorter intervals between pregnancies (Modeland, Bolaria and McKenna, 1995).

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.

(Bohn and Parker, 1993)

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.

(Bohn and Parker, 1993)

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 (Bohn and Parker, 1993).

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 (Bohn and Parker, 1993).

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).

(Bohn and Parker, 1993)

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.

(Bohn and Parker, 1993)

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 (Bohn and Parker, 1993).

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).

(Bohn and Parker, 1993)

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.

(Bohn and Parker, 1993)

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.

(Bohn and Parker, 1993)

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 (Health Canada, forthcoming [b]).

Other effects
There are anecdotal reports or case studies showing evidence of:

- fetal bruising,
- intraventricular hemorrhage,
- neonatal death,
- newborn gastric ulceration and hemorrhage,
- 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" (Bohn and Parker, 1993). 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 (Bohn and Parker, 1993).

Impacts on other children in the family

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).

(Health Canada, 1996)

Children who are exposed to the abuse of their mother
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 the 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).

(Health Canada, 1996)

Transgenerational abuse

Above all, being exposed to the 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.

Resiliency (protective factors)

There may be factors that help protect women and children from the impacts of abuse. Some researchers, for example, have suggested that the ways in which women and children cope with abuse-related trauma and stress may depend on individual and social factors, including physiological mechanisms, psychological state, personal disposition, social support, social networks and health behaviours (Petersen et al., 1997).

Other factors—such as access to economic resources, and the level and severity of the abuse—may also affect a woman's ability to cope. In some situations, it does not matter what kind of coping strategies she has or how well she copes, the abuse is just too severe and debilitating.

PART 2:
RESPONDING TO ABUSE DURING PREGNANCY

POINTS OF INTERVENTION

Given the prevalence of abuse, it is safe to assume that many women who have contact with health and social service professionals are being abused, even if they do not say so. Because many abused women are socially isolated and may not have networks of friends and family to turn to, it is important to recognize that this contact with professionals may be one of the only opportunities a woman has to get help.

Professionals may encounter abused women at different points throughout their reproductive years:

Before pregnancy, abused women may have contact with:

- family physicians or general practitioners;
- nurse-practitioners;
- nurses working in hospitals, mental health agencies, occupational health settings, home care and outpost nursing stations;
- obstetricians, gynaecologists or other medical specialists;
- dentists;
- chiropractors;
- ophthalmologists and other eye care professionals;
- psychiatrists, psychologists, therapists and/or counsellors;
- social service providers and social workers in hospitals, community/public health agencies, private counselling, mental health agencies and social service agencies;
- traditional healers;
- physiotherapists;
- pharmacists;
- community health representatives;
- occupational health professionals;
- community or school-based health clinics;
- family planning clinics;
- women's health clinics;
- hospital wards;
- emergency departments;
- ambulance services;
- fire department emergency services;
- police victim services;
- social service agencies (including welfare);
- wellness/healing services;
- support groups;
- substance abuse programs;
- shelters;
- places of worship;
- community centres;
- social welfare offices or social service agencies;
- addiction programs;

- mental health clinics or agencies;
- various other health care settings, including clinics, hospitals and emergency rooms, doctors' offices (e.g., family physicians, general practitioners, nurse practitioners);
- employee assistance programs.

During pregnancy, abused women may have contact with any of the places already listed, plus:

- fetal assessment units;
- labour and delivery units;
- prenatal checkups or visits with family doctors, obstetricians, midwives, doulas or public health nurses;
- birth preparation or prenatal education classes;
- ultrasound and other laboratories;
- genetic counselling services;
- at-risk pregnancy hospital units;
- nutrition programs;
- abortion clinics.

During birth and immediately afterward, abused women may have contact with:

- birthing centres/clinics,
- maternity/postpartum units,
- public health/CLSC nurse visits/calls (postpartum),
- home care nurse visits/postpartum home visiting programs,
- well-baby clinics,
- follow-up visits with obstetricians, pediatricians, family doctors, midwives, and doulas.

During the early parenting years, in addition to many of the places already listed, abused women who are mothers of young children may have contact with:

- immunization clinics,
- support groups,
- parenting classes,
- family resource centres,
- child care centres,
- schools,
- pediatricians.

Depending on their work setting, professionals' contact with abused women may relate directly to the consequences of abuse (e.g., the treatment of injuries and illnesses) or it could be for an unrelated reason, such as immunizing young children. Consequently, it is important to think about what signs of abuse may be likely to surface in specific work settings (e.g., women with serious injuries are most likely to appear in emergency departments; abused pregnant women may be most likely to present to labour and delivery units with, for example, unexplained abdominal pain or premature labour).

Professionals should assess their work settings to determine what advantages or disadvantages they present for abused women in terms of safety, accessibility and confidentiality. For example, emergency departments are open to everyone 24 hours a day, are a frequent point of contact for injured women, and offer a link to the social service system (Hotch et al., 1995). At the same time, emergency departments are often lacking in privacy and may not have any domestic violence protocols in place. The woman's partner may accompany her and prevent disclosure (American College of Obstetricians and Gynecologists, 1995). Furthermore, most visits take place at night or in the early morning when social workers are not on duty. Often, a woman goes to the emergency room only once she has already been seriously harmed (Guard, 1997).

Professionals should remember that they are not alone in encountering abuse in health and social service settings. They are part of a larger team of health and social service professionals serving the community who can share experiences and knowledge. Professionals should coordinate their efforts and work with others in the community to develop a stronger, more effective response to the needs of abused women.

OVERVIEW OF THE PROCESS

The process of responding to abuse during pregnancy includes the following steps:

- becoming aware of potential signs of abuse;
- making individual and institutional preparations to address the issue of abuse;
- identifying cases of abuse by universally screening all women for abuse;
- when abuse is disclosed, assessing the extent and scope of abuse;
- providing appropriate intervention and support;
- understanding and complying with confidentiality and reporting requirements;
- fully documenting the abuse.

Subsequent sections discuss each of these steps.

POTENTIAL SIGNS OF ABUSE

Looking for signs of abuse

Without being familiar with the signs and symptoms of abuse, it is difficult to feel confident about recognizing when a woman may be experiencing abuse. There are many reasons why women may not tell professionals they are being abused. Nonetheless, professionals can learn more about what to look for and be alert to the many signs and symptoms that suggest a woman is being abused. *(Note: information about risk factors for abuse during pregnancy and after the baby is born may also be useful. Risk factors for abuse during pregnancy and postpartum are discussed in Part I of this handbook.)*

The research literature describes numerous, and often interrelated, complications and adverse outcomes associated with abuse during pregnancy. Consequently, for professionals there are many potential "signs" of abuse. Professionals should keep in mind, however, that no single indicator may be definitive on its own. Most importantly, they should simply be open to the possibility that abuse may be occurring. A list of some of the potential signs of abuse during pregnancy is presented below, based on the evidence of the impacts of abuse. Professionals should also consult resources produced by professional organizations, e.g., policy statements and guidelines produced by the Society of Obstetricians and Gynaecologists of Canada (1996) and the Canadian Nurses Association (1992) for information on indicators of abuse.

Physical signs of abuse

- **Unwanted or mistimed pregnancies.**
- **Termination of pregnancy** (including multiple abortions, miscarriages, spontaneous abortions) (Warshaw, Ganley and Salber, 1993).
- **Any injuries or complications during pregnancy, labour and birth (especially unexplained symptoms)** (see previous section *Understanding the Impacts of Abuse*).
- **Low birth weight and preterm births.**
- **Sexually transmitted diseases.**

Behavioural signs of abuse

- **Smoking or substance abuse during pregnancy.** *(Note: this may be a mechanism for coping with the stress of abuse.)*
- **Suicide attempts during pregnancy.**
- **Inadequate or delayed prenatal care.**
- **Frequent visits to hospitals, clinics, doctors' offices** (with a wide range of—often unexplained—injuries or symptoms).
- **Poor nutrition and diet.**
- **Parenting difficulties.**

Emotional signs of abuse

- **Depression (including postpartum), anxiety disorders and fear** (Warshaw, Ganley and Salber, 1993).

Past history, attitudinal and behavioural signs of the abusers

There may be an opportunity to gather information on, or observe the attitudes and behaviour of, the woman's partner or other family members who may be abusing her. For example, if the woman's partner or another family member accompanies her to health care or social service appointments, this situation may provide such an opportunity. Or, the woman's partner may also be a patient or client.

* Handling dual care situations

*Professionals whose patients or clients include the woman and her abusive partner should **not** challenge her partner about the abuse. This could endanger her further.*

The abuser may have a history of:

- being abused as a child or having been exposed to his father abusing his mother;
- poor impulse control and anger management;
- violent behaviour (e.g., criminal convictions);
- low self-esteem;
- alcohol, drugs, or substance abuse and dependencies;
- poor conflict resolution skills.

(Correctional Service of Canada, 1993; Hotch et al., 1995)

The abuser may believe that:

- violence is an acceptable way of solving problems;
- men have the right to dominate women in relationships;
- he has the right to control his partner's actions.

(Health Canada, 1995a)

Abusers may behave in specific ways in the presence of health and social service professionals. Sometimes, the behaviour is intended to cover up the abuse. Other times, it is intended to intimidate or control the professional or his partner.

It is also important to note that the abuser may deny, delay or interfere with a woman's access to needed services, including medical treatment, prenatal care or admission to hospital. He may forbid her to see any professionals, cancel her appointments, or interfere with her ability to make or go to appointments by refusing to provide child care or transportation. In some cases, he may stalk her to and from appointments.

There are specific characteristic behaviours of abusers to watch for. For example:

- accompanying her to all appointments and not allowing her to speak privately with a professional;
- hovering around the woman, appearing over-solicitous;
- speaking for her (*she thinks, she feels, she does),* answering questions directed at her, or even trying to eavesdrop on a private interview;
- taking charge of her medication;
- appearing "over-protective" and not wanting her to be alone with anyone else;
- sending her "looks";
- making inappropriate, disparaging or belittling remarks about her;
- appearing to be emotionally absent or out of touch with the woman.

In the presence of the abuser, the woman may seem intimidated, afraid, compliant or unable to speak or to disagree. An abuser may claim that his presence is necessary to translate for the woman or because she is afraid of dealing with professionals alone (Bohn and Parker, 1993; Warshaw, Ganley and Salber, 1993).

* A key warning sign

Professionals should be particularly alert to situations in which a partner appears overly solicitous, answers questions on behalf of the woman and is unwilling to allow the woman privacy.

PREPARING TO RESPOND

Some key considerations

Before responding to pregnant women who are being abused, there are important institutional and personal considerations. For example, professionals should consider their own:

- values and attitudes about woman abuse;
- personal experience with abuse (Canadian Nurses Association, 1992);
- comfort level in discussing abuse;
- understanding of the issue, the barriers pregnant women face and the needs they have.

There are also challenges at the institutional level. The process of developing and implementing protocols and tools requires sufficient time, resources and support systems. It includes training, networking and providing professional support programs. It represents a significant commitment of energy on the part of professionals and administrators alike.

Personal values and attitudes about abuse

Professionals' personal values and attitudes about abuse can affect their response to abused women. Being judgemental, biased or insensitive can end up doing more harm than good. Sensitivity and good communication skills are essential in helping women who are being abused.

Personal experience with abuse

Often, ideas and attitudes about abuse are influenced by the media and the culture. Sometimes, they are also flavoured by personal experiences with abuse.

- Professionals who are themselves in an abusive relationship should consider how their experience may affect their ability to help others, and take appropriate steps, such as seeking help.
- Professionals who have been abused in the past should ensure that they have resolved this issue, or seek help to resolve personal issues before trying to help others. While there are many common patterns in abusive relationships, each person's experience is unique. Professionals should not project their personal experience with abuse (and how they or others did or did not handle it) onto others.
- Professionals who are abusers must get help to stop abusing.
- Professionals who need to seek help with their own abuse issues should refer women who are being abused to someone else who can help them.

Personal comfort level in discussing abuse

Professionals who feel uncomfortable talking about abuse cannot offer support to others. They should try to recognize their feelings of discomfort and figure out what is necessary to feel more at ease. For example, it may help to get more information about the issue, or get training in how to communicate effectively with women who have been abused or deal with gender issues effectively.

It may also be useful to identify other individuals working in the field (e.g., other physicians, shelter workers) who have had experience in responding to abuse, and talk about the issue with them.

* Refer her to someone who can help

If professionals do not feel they are in a position to respond appropriately, it is important that they refer women to others who can help (Modeland, Bolaria and McKenna, 1995; BCRCP, 1997).

Understanding the issue and the barriers abused pregnant women face and their needs

Understanding abuse means looking beyond the specific experiences or circumstances of individual women. It means making the connection between abuse and the social and economic situation of women in society. To understand how abuse affects pregnant women, it is also necessary to understand how pregnancy and childbirth affect women in society. Among other issues, the following points are important considerations:

- Paradoxically, pregnancy can increase a woman's vulnerability (e.g., physical considerations such as increased fatigue, morning sickness, less capacity to defend herself) and it can also increase a woman's strength (e.g., motivation to change the situation, hope for the future).
- Women who have been sexually abused may re-experience this trauma as part of their experience of pregnancy and giving birth.

- Some pregnancies may be the result of sexual abuse, a situation that may impact on a woman's experience of pregnancy and childbirth.
- Invasive interventions (e.g., vaginal examinations, use of forceps) may have even more profound impacts on women who have been or are being abused.
- Being abused can compound the social isolation that affects many women with newborns and young children—a situation that can further increase their vulnerability (Johnson, 1996).
- Societal expectations of women/mothers affect how pregnant women are dealt with (e.g., prenatal care tends to emphasize women's health behaviours and lifestyles in terms of their personal responsibilities for protecting and nurturing their unborn children, rather than emphasizing their own needs).
- Women who are pregnant or who have just given birth may be economically dependent on the father of the child, either temporarily or for a longer period during the early parenting years (Johnson, 1996).
- Women who have been abused may fear giving birth to a child of the same sex—either for fear that a female child will also be abused or because her partner wants or expects a child of a preferred gender.
- Women who are abused during pregnancy may need help coping with feelings about any number of fundamental experiences and issues, including birth, abortion, loss of a child (miscarriage/stillbirth), birth of a child with injuries/defects and single parenthood.
- Abused pregnant women may require additional support related to pregnancy and birth (e.g., labour support, early parenting support).
- Community resources for abused women may not have the capacity to meet the needs of abused women who are pregnant or who have newborn babies and/or young children (e.g., shelters may not have the capacity to accommodate women who are pregnant or who have newborns).

Recognizing and respecting the change process

For professionals involved in responding to abused women, it is important to understand the following characteristics of the change process.

- Change occurs in **stages**.
- Change is a **dynamic** (not linear) process.
- **Relapse** is part of the process.
- **Interventions** should be geared to the stages of change.

Rather than tell a woman what she should do (e.g., leave her partner), professionals should try to understand a woman's specific needs, her particular life circumstances and her current stage of change. It is important to understand and respect this process, and ask her what she needs (American College of Obstetricians and Gynecologists, 1997; Brown, 1997).

Anticipating abusers' behaviour toward health and social service professionals

Abusers may use many different tactics to persuade professionals not to take the situation seriously, or to make professionals feel too intimidated to take action. They may be charming or threatening. They may pretend that they are the "good patient." They may try to use flattery or praise. On the other hand, they could make false accusations against professionals or harass them with phone calls. They may want to have access to their partner's medical records. They may insist that she leave care prematurely (e.g., premature discharge from hospital). They may solicit their family or friends to help them intimidate professionals. They may try to divide professional teams by making accusations against individual team members (Warshaw, Ganley and Salber, 1993).

Professionals' role in responding to abuse—being part of the community's response

Before asking a woman about abuse, professionals need to be adequately prepared to deal with her disclosure. This means thinking about the advantages and disadvantages specific work settings offer to a pregnant woman who is being abused. It means thinking about how these settings fit into the larger network of services in the community. It also means assessing their own level of preparation to deal with this issue and when/to whom they will refer. Some key steps in preparing to address the needs of pregnant women who are abused include:

- hosting discussions and seminars around the issue of abuse during pregnancy;
- developing a team approach to responding to abuse;

- selecting and developing appropriate tools to identify, screen, assess, intervene and follow up;
- getting trained in how to use tools;
- ensuring there are ways to make sure everyone is aware of the tools, and is using them properly and consistently;
- ensuring that professionals monitor and evaluate their own progress;
- connecting with others to develop an effective, coordinated interdisciplinary response in the community (e.g., social workers may be able to play a valuable role in facilitating the process of preparing to respond);
- involving community leaders in addressing issues of abuse (this will be particularly important in rural or small communities where there may be few or no other resources or collaborators to draw on for an interdisciplinary approach);
- linking with others who are working on related issues (e.g., substance abuse and fetal alcohol syndrome);
- working to make the issue a standard part of professional curriculum for knowledge and skill development;
- becoming involved in preventing abuse.

The subsequent sections of this manual can help in assessing the steps that are needed. Each section discusses the important issues that should be considered. The extent to which these issues are applicable for individual professionals will depend on the specific role they play as team members in their work environments.

Creating a safe environment

* Do not add to the danger

Any efforts to help an abused woman should not put her or her children in further danger.

Before offering assistance, it is important to create a safe environment for her to talk about the abuse (Warshaw, Ganley and Salber, 1993). This is particularly important in dealing with pregnant women because of the cultural norms that surround and celebrate motherhood and birth. For example, family-centred maternity and newborn care can mean that partners are significantly involved in all stages of pregnancy, birth and infant care. It may be useful to review policies and procedures (e.g., hospital security procedures around access to newborns) to ensure that abused women have a safe and private opportunity to disclose abuse without putting themselves or their children in danger. In addition, many professionals have a relationship with the woman and with her partner, children or other family members, and their focus is on maintaining and supporting the family as a unit. When a woman is abused, **it is essential to hold her personal safety as the paramount consideration**. Remember that she is the best judge and decision maker regarding her personal safety.

Some practical ways to foster a safe environment include ensuring that:

- there is a private space for interviewing and/or examining women and being prepared to offer "safe" reasons why it is necessary to see a woman in private (e.g., collection of a fresh urine specimen);
- there is access to appropriate translators or signers (who are not family members or someone she knows personally[5]) if the woman speaks another language than the service provider, or if the woman has a hearing disability;
- women are informed about reporting requirements for child abuse and neglect **at the outset** (so they can assess the implications for safety and confidentiality) (See section on *Reporting and Confidentiality* below);
- there is a plan to enhance the safety of all staff involved in treating abused women.

[5] Ideally, women should have access to cultural interpreters who are trained in family violence.

IDENTIFICATION AND SCREENING

Importance of asking about abuse

Although professionals may discover in any number of ways that a woman has been abused—as a result of recognizing the signs and symptoms, being told by police or social service providers, reading medical records, hearing about it in the community or even witnessing it directly (Warshaw, Ganley and Salber, 1993)—asking women directly if they have been harmed remains the most important tool for identifying abuse.

Asking about abuse increases detection:

- "Experience in office practices has shown that a single direct question asked routinely and non-judgementally in the course of the social history, can significantly increase the detection of abuse" (Searle, n.d.).
- "...women are more likely to reveal abuse when asked by their primary care providers" (Modeland et al., 1995).
- "...in a study of 691 pregnant women, 8% self-reported abuse on an intake form, but 29% reported abuse when asked directly" (Modeland, Bolaria and McKenna, 1995).

Asking women about abuse also increases the chance of preventing further abuse. At the very least, it shows abused women that their suffering is taken seriously and that help is available if required.

Asking about abuse is an important signal of support. It tells an abused woman that:

- she is believed,
- she is respected,
- she is not alone,
- the professional is willing to hear about this topic,
- abuse happens to a lot of women,
- abuse has been encountered before,
- the issue is being taken seriously,
- she can get help.

(Warshaw, Ganley and Salber, 1993; Modeland, Bolaria and McKenna, 1995)

On the other hand, if professionals overlook abuse, they become part of the problem. Abused women are allowed to remain isolated and possibly receive inappropriate or ineffective treatment or advice. Any opportunity to prevent further injury, illness or death is missed. The problem continues and the costs—individual and social—continue to mount.

Routinely asking about abuse around and during pregnancy

* Ask every woman about abuse

*Universal screening means asking **every woman** about abuse, not just asking women whose situations raise suspicions of abuse. Pregnant women should be asked about abuse as early as possible in their pregnancies.*

Pregnant women are at higher risk for abuse than for many other medical problems— pre-eclampsia, gestational diabetes and placenta previa—for which they are routinely screened (Modeland, Bolaria and McKenna, 1995; Petersen et al., 1997). With so many women experiencing abuse during pregnancy, screening for abuse during pregnancy must be **a routine part of prenatal care**. The American Medical Association recommends routine screening for all woman patients in emergency, surgical, primary care, pediatric, prenatal and mental health settings (American Medical Association, 1992).

Furthermore, it is necessary to ask about abuse **in early pregnancy and again throughout the pregnancy and after the baby is born** because abuse may begin again after the "protection" provided by pregnancy is over (Guard, 1997). After the baby is born, **include questions about the safety of the infant and other children**. **Repeat the questions when a woman starts a new relationship** (Guard, 1997).

How to ask about abuse

How questions are asked is just as important as what questions are asked. Questions should be:

- **always asked in private;**
- direct and specific (although indirect questions may sometimes precede direct questions);
- non-threatening;
- non-blaming;

- open ended;
- neutral;
- preceded by supportive statements of concern.

When asking questions, professionals should:

- be empathetic, respectful and non-judgemental;
- use a non-threatening tone and body language (e.g., sit at or below the woman's level);
- use active and supportive listening techniques;
- make it clear that violence against women is a crime;
- encourage a woman to tell her own story and make her own choices and decisions.

(Searle, n.d.; Canadian Nurses Association, 1992; Warshaw, Ganley and Salber, 1993; Hotch et al., 1995; Modeland, Bolaria and McKenna, 1995; British Columbia Reproductive Care Program, 1997)

Keep in mind that there are already significant pressures on pregnant women (and mothers) in this society, focused on their roles as primary caregivers and nurturers of children. Any attempts to address abuse during pregnancy should be supportive and helpful. Do not:

- add to this pressure (e.g., feed into a "blame the victim" ideology);
- ask questions that disempower women or imply that they are responsible for abuse;
- ask questions about abuse on forms that are completed publicly (e.g., in a waiting room);
- try to take responsibility for fixing or solving the problem;
- repeat questions unnecessarily (e.g., if a nurse or social worker conducts the interview, they should brief the physician rather than have the questions asked again).

Sample questions

There are many abuse screening tools available. Professionals will need to select (or develop) the tool that is most appropriate for their work setting. Using appropriate screening tools, however, is only the first step. Appropriate information on options, resources and potential solutions must also be provided. Three sample tools are included below.

The "SAFE" Tool

Screening does not have to involve a long list of questions that may be inappropriate or difficult to use in some situations. The SAFE tool was designed to be memorized easily and used quickly:

S How would she describe her **spousal** relationship?

A What happens when she and her partner **argue**?

F Do **fights** result in her being hit, shoved or hurt?

E Does she have an **emergency** plan?

(SAFE tool, n.d.)

The "ALPHA" Tool

The ALPHA form is an antenatal psychosocial health assessment tool that contains the following questions about woman abuse:

- How do you and your partner solve arguments?
- Do you ever feel frightened by what your partner says or does?
- Have you ever been hit/pushed/shoved/slapped by your partner?
- Has your partner ever humiliated you or psychologically abused you in other ways?
- Have you ever been forced to have sex against your will?

(Midmer et al., 1996)

Domestic Violence Intervention by Emergency Department Staff

The Vancouver Hospital and Health Sciences Centre developed the following questions as part of its *Domestic Violence Intervention by Emergency Department Staff* protocol (Hotch et al., 1995):

Ways to ask about abuse

- From my experience here in the emergency department, I know that abuse and violence at home is a problem for many women. Is it a problem for you in any way?
- We know that abuse and violence in the home affect many women and that this directly affects their health. I wonder if you ever experience abuse or violence at home?
- Have you ever felt unsafe or threatened in your own home?

Physical abuse

- Has anyone hurt you?
- The injuries you have suggest to me that someone hit you. Is that possible?
- Who hit you?
- In my experience, women often get these kinds of injuries when someone hits them in some way. Did someone hit you?
- Is seems that the injuries you have could have been caused by someone hurting or abusing you. Did someone hurt you?

Emotional abuse

- Does anyone call you names? Or try to control what you do?
- Does anyone you are close to criticize your friends or family?

Sexual abuse (Note: it is usually best to establish a rapport before asking the following questions.)

- Have you ever been forced to have sex with your partner when you did not want to?
- Has your partner ever forced you to take part in sexual acts that you didn't feel good about?

Handling difficult situations

These are some of the situations that may prevent professionals from asking about abuse (Hotch et al., 1995):

Situation	Approach
Woman is in active labour	Provide support and safety, plus necessary care; minimize intrusion; after birth allow her condition to stabilize before asking about abuse.
Woman is intoxicated or is hallucinating	Minimize talk; provide support and allow woman to sober up or her condition to stabilize before discussing abuse; then provide assessment and referral as usual.
Woman is hostile/ abusive	Acknowledge her anger; offer support/services; don't pressure or insist.
Woman cannot communicate because of a language barrier or hearing disability	Do not use relatives, children or abusers as translators or signers; make sure staff translators or signers do not know the woman; if possible, use a translator or signer from a community agency; use a telephone translation service (e.g., AT&T which is available on a subscription basis).
Woman is seriously ill or is in serious danger to her life or health	Provide support; let her condition stabilize before asking about abuse.
During home visits, health/social service provider perceives an immediate threat to personal safety (e.g., of the woman, children or the provider)	Develop a team policy to prevent, handle and report dangerous situations; providers should always notify team of their whereabouts; leave the situation and call for appropriate help; document the situation.
The woman's partner is hostile or abusive, or appears dangerous	Develop a team policy to prevent, handle and report dangerous situations; stay calm and do not provoke or antagonize abuser; call for appropriate help.

Knowing what to do if the woman does not acknowledge she is being abused

If it appears that a woman is being harmed, but she does not admit it, professionals can:

- tell her they are concerned about her;
- try to ask her about abuse a second time (in a non-threatening manner) before she leaves;
- ask her if she would like more information and help;
- give her written, discreetly packaged information with phone numbers and information about available resources, and encourage her to contact them;
- tell her she is welcome to come back again;
- write down their concerns in her records.

Remember that **just making an attempt to help is important, even if a woman does not admit to abuse or does not want to make changes in her life**. In fact, knowing that someone is concerned may motivate her to make changes, when she is ready, in the future. For many abused women, **it takes a lot of time and support to leave an abusive relationship** (Saskatchewan Institute for Prevention of Handicaps, 1996). Often, a woman makes several attempts before she leaves for good. Some women choose to remain in an abusive relationship. Women know themselves and their abusers better than anyone else does. Their decisions must be respected. **Continue to offer consistent, ongoing support.**

ASSESSMENT

The importance of assessment

Once a woman has acknowledged that she is being abused, it is important to:

- validate her experience,
- find out how the abuse has affected her,
- assess the ongoing risk to her personal safety.

This information will help in supporting her to make decisions and choices. Professionals' involvement in assessment will depend on their role on the team within their work setting.

Validation

Disclosing abuse is not easy. When a woman has told someone that she is being abused, it is essential to continue supporting her. Responding to her story is very important. It is important to listen to her and believe her. She needs to know she can trust someone. Professionals can offer the following supportive messages:

- I am concerned about you and your safety.
- Some forms of abuse are crimes.
- Abuse is not your fault.
- Only the abuser can stop the abusive behaviour.
- No one deserves to be abused.
- There is no excuse for violence.
- You deserve better.
- It is good to confide in me/us.
- You are not alone.
- I understand that it is very difficult to make changes.
- It is okay to be angry or afraid.
- There are options and resources available to help you feel safer and more in control.

(British Columbia Reproductive Care Program, 1997; Warshaw, Ganley and Salber, 1993)

Keep in mind that the quality of the interaction with a professional is a key factor for a woman in the process of getting help. Do not:

- ask her questions about abuse in front of her abuser;
- minimize, deny or trivialize what she says;
- show more concern for her unborn baby than for her;
- confront the abuser;
- refer her and her partner to marital or joint counselling.

Safety considerations

Professionals should **ask the woman what she needs in order to be safe** and **inform her about their obligation to report cases of alleged or suspected child abuse or neglect** so she can make decisions about protecting the safety and confidentiality of both herself and her children. It is also important to **inform her that all provinces and territories have affirmed that wife abuse is a crime and have directed police to lay charges where there are reasonable and probable grounds to believe that an assault has occurred** (Ferris, McMain-Klein and Silver, 1997) so she understands the consequences of involving police. (See *Reporting and Confidentiality* below.)

History taking

Once a woman has disclosed abuse, professionals will need to ask her for more detailed information in order to determine the extent and impact of the abuse, what level of help she needs, and the urgency of the situation.

Sample History Questions

The Vancouver Hospital and Health Sciences Centre protocol, *Domestic Violence Intervention by Emergency Department Staff* (Hotch et al., 1995), suggests the following questions:

- When was the last time you were abused? What happened? What did he do/say?
- How often does the abuse occur?
- What seems to trigger the abuse?
- Is the abuse getting worse? More frequent?
- Has (your partner) ever threatened you? Has he ever used a weapon?
- Are you afraid of your partner? Are you afraid for your life or for the lives of your children?

Remember to **record this information clearly and accurately** in the woman's medical or other records. (See *Documenting Abuse* below.)

Physical examinations

Professionals who examine a woman who has been abused should ensure that they **do not further traumatize her**. Before an examination, explain the examination process to her. Discuss the collection of evidence and its process. Use a compassionate and respectful manner that is culturally appropriate (e.g., in some Aboriginal populations, people are not comfortable with direct eye contact).

It is very important to **conduct a thorough examination**. Injuries to the breasts, abdomen and genitals may be hidden by clothing. Injured tissue may be tender rather than obviously bruised. It is also necessary to evaluate her neurologic and mental status as well as any physical signs of injury or illness (Warshaw, Ganley and Salber, 1993).

Fully document any observable injuries. This includes:

- using the appropriate sexual assault evidence collection protocol, if required;
- consulting with the attending police officer regarding labelling and handling of forensic evidence (if she has decided to involve the police);
- including a detailed description of her injuries and any other relevant information in her medical record. (See *Documenting Abuse* below.)

Risk assessment

To understand how the abuse has affected the woman, it will be necessary to take a complete social history. In doing so, it is important to **explain what is being done**. Taking a woman's social history means **asking her to tell her story**. It is important to ask her about her past experiences of abuse, her current situation, how it is affecting her and her children, how she is coping, what she has tried to do to protect herself and what she wants to see happen.

It is important to ask about her concerns for her immediate personal safety. Of particular concern is whether she is at risk of serious injury or being killed. If a woman has been abused during pregnancy, it is very likely that she is already at high risk for serious injury or death. Assess whether she is suicidal. Assess the risk of domestic homicide. Advise her of the dangers and provide information on resources that can help her. Help her develop a safety plan. (See *Intervention* below.) Follow-up is essential.

Assessing the Risk of Domestic Homicide

The following "checklist" covers many identified risk factors for domestic homicide. Professionals should use appropriate language when asking risk assessment questions.

- Have weapons been used or has there been a threat with weapons?
- Is there access to, or ownership of, guns?
- Have there been threats to kill?
- Does the violence appear to be escalating or occurring more frequently?
- Has there been destruction of property?
- Has there been forced sex?
- Has there been a threat to, injury of, or killing of a pet?
- Is there a history of psychological problems?
- Is there an obsessiveness to the partner?
- Does he manifest extreme jealousy?
- Is there alcohol or drug abuse?
- Has the marital situation changed recently? For example, has there been a separation (or threat of a separation), a job loss, a pregnancy or a change in finances?

(Ferris et al., 1997a)

INTERVENTION

The importance of intervention

Professionals can provide an abused woman with information about abuse and the options that are available to her. They must also **provide, or guide her to, the appropriate source for support** as she makes her own decisions and choices about what is best for her and her children. Continuity of service and follow-up are essential. Professionals should compile a list of resources for referral and assistance. (See *Appendix A: Community Resource List.*)

Education, information and referral

The kinds of information that an abused woman needs to know include:

- the sequence and pattern of abuse;
- the impact of abuse on pregnant women and fetuses;
- the impact of abuse on newborns and their development;
- the impact of abuse on children who are exposed to violence in their homes.

(See previous section *Understanding the Impacts of Abuse.*)

Professionals should look at ways of providing information that are best suited to their work setting. This may include providing written information, discussing this information with the woman, and/or providing referrals to other services in the community.

Although each woman's options will depend on her situation, her priorities and what she thinks will be best for her and her children, it may be possible to help her "problem solve" her concerns (Hotch, et al., 1995), including determining:

- whether to leave the situation;
- where she will stay if she leaves;
- how to protect herself and her children if she returns home;
- how she will protect herself if the abuser is removed from the home. (See *Safety planning* below.)

Encourage her to consider her options, which may include:

- going immediately to a shelter;
- going to stay with family or friends;
- taking home hidden information about resources that she could use later;
- getting a referral to counselling;
- going home, having arranged for a follow-up appointment;
- going home, having asked someone to stay with her;
- being referred to police, a lawyer or victim's services (Modeland et al., 1995; Warshaw, Ganley and Salber, 1993);
- making application for a peace bond (under recent changes to the *Criminal Code* police and others—including health and social service professionals—can apply, on behalf of persons at risk of harm, for a peace bond, which is a court order that may, for example, require the abuser not to contact the victim and her children).

Providing written information

Be prepared to **provide up-to-date information about resources in the community**. This includes offering her an up-to-date list of agencies and community resources (including shelter, crisis centres, hotlines, children's services, counselling and legal options) **printed on a card small enough to be hidden in a wallet or shoe** (e.g., business card). These cards should be available in washrooms, examination rooms and any other private spaces.

These information cards should also indicate that:

- most services are free;
- some shelters can provide protection and legal information;
- services are available for women with special needs;
- help may be available outside the community, if necessary.

Because it may be too dangerous for her to take written information, mention that resources to help abused women are listed in the phone book. She could also memorize numbers or leave a message at a friend's or at work (Hotch et al., 1995; Warshaw, Ganley and Salber, 1993).

While it is not recommended that professionals directly confront a male client if abuse is suspected, they should look at ways of making information about local treatment programs for batterers available (National Clearinghouse on Family Violence, 1997). This could include displaying information (such as posters, pamphlets on local programs, etc.) in examination or counselling rooms.

Safety planning

Some women will decide that returning home is their safest option. Each woman's decision should be respected. It may be helpful, however, to discuss the strategies she has used to protect herself and her children and **help her develop a safety plan**[6]. Do not:

- insist that the woman leave her abusive partner;
- endanger her by providing information in an unsafe way (e.g., mailing it to her house or providing discharge instructions that an abuser may read);
- force her to do what anyone else thinks is best for her or for her unborn child.

*** Women who leave their abuser are at high risk**

If she is planning to leave the situation, ***warn her not to tell her abuser****. "Women are at greater risk of severe violence or even of being murdered* ***just after they leave*** *their husbands or partners. A large majority of murders occur when a woman attempts to leave the relationship in order to escape her partner's attempts to control her" (Health Canada,1995a).* ***Assure her that the abuser will not be informed that she is thinking about leaving.***

[6]The London Battered Women's Advocacy Centre has developed a Safety Resource Kit for Abused Women, which includes a personalized "take-home" safety plan.

Packing a "safety bag"

Many different resources suggest that women who return home should be advised to prepare a hidden safety bag in case they decide to leave. The bag should include important items and cash. Suggestions include:

- a change of clothing for herself and her children;
- medications;
- extra keys for the house and car;
- cash, chequebook, savings account book, debit or credit cards;
- her birthing kit or other items needed for her hospital stay;
- food, clothing, blankets and diapers for her newborn, if necessary.

When she leaves, she should try to take:

- identification papers for herself and her children, including health cards, birth certificates, passports, social insurance cards, driver's licence, mortgage papers, rent receipts, automobile title, diplomas;
- an item of special interest to each child (e.g., teddy bear).

She should have a plan that details exactly where to go, regardless of time of day. This may be a friend's or a relative's home, or a shelter for women and children (Hotch et al., 1995; British Columbia Reproductive Care Program, 1997).

Follow-up

Linking an abused woman and her children to other professionals can help ensure their future safety. Follow-up care may include:

- referring her to a social worker or a public health nurse;
- booking a follow-up appointment (or telling a woman she is welcome to return if she wants to);
- referring her to mental health professionals, substance abuse programs, or individual or peer counselling (these professionals should be trained in abuse issues);
- scheduling extra well-baby visits;
- referring her to parenting classes and/or new parents support groups;
- referring her to child welfare agencies, if appropriate;
- referring her to a community outreach worker (e.g., to a shelter or transition house).

(Midmer et al., 1996)

Communication is an important part of follow-up. For example, when a woman discloses abuse, there should be appropriate information sharing between hospital units and prenatal clinics and the home care or public health agencies that will conduct postnatal follow-up visits.

REPORTING AND CONFIDENTIALITY

What must be reported

Child abuse

In Canada, it is required by child protection law in all jurisdictions except the Yukon that persons must report cases of **alleged or suspected child abuse or neglect** to a child and family services authority.[7] For example, child abuse must be reported in the following situations, among others:

- An abused pregnant woman indicates that her children are also at risk (e.g., they are being, have been or may be abused).
- An examination or interview with a child indicates that he/she is being abused.
- An adolescent pregnant woman is being abused.[8]

Professionals need to have contact with provincial or territorial child and family services authorities and learn about the relevant legislation and regulations on child abuse and neglect in their jurisdiction. It is important to have this information at hand.

It is important to inform an abused woman up front about the mandatory legal obligation to report child abuse and neglect. Telling her **before you ask her about child abuse** means the reporting process and potential consequences can be discussed. Be honest with her about what could happen to her and her children. She also needs to know about how her children can be harmed by staying in an abusive situation and that help is available.

* Exposure to abuse is considered child abuse in some provinces

In some jurisdictions, when a woman reports that she has been abused, there may be a requirement to investigate any related child abuse. For example:

"Child welfare legislation in the Atlantic provinces and Saskatchewan have responded to these allegations about the negative effects of exposure to violence by including 'children living in situations of severe domestic violence' under the criteria of children in need of state protection. Children who are exposed to domestic violence, like those who are battered, sexually abused, or neglected, are considered children at risk and may be removed from their home and taken under the care of child welfare authorities" (Johnson, 1996).

Woman abuse

Woman abuse is a crime in Canada (e.g., various types of abuse are crimes under the *Criminal Code*, including assault and sexual assault—see list below). But this does **not** mean professionals have a legal obligation to report woman abuse to the police or any other person or authority. In fact, it is a breach of confidentiality to do so without the woman's consent.

All provinces and territories have recognized that woman abuse is a crime and that all jurisdictions have mandatory policies for the police to lay charges when there are reasonable and probable grounds to believe that an assault has occurred (Ferris, McMain-Klein and Silver, 1997). This means that abused women have a choice about whether to report abuse to law enforcement agencies, but once it is reported the police do not have a choice about laying charges. These policies are intended to reduce the incidence of violence by removing from women the onus to lay charges and by serving as a deterrent in sending the message that wife assault is a crime. It is not the professional's decision to call the police—it is the woman's.

[7] In the Yukon, cases may be reported but it is not mandatory (Federal-Provincial Working Group on Child and Family Services Information, 1994).

[8] Legislation in each jurisdiction specifies the maximum age up to which the child and family services authorities must investigate a report and provide services. The age varies from 16 to 19 years depending on the jurisdiction (Federal-Provincial Working Group on Child and Family Services Information, 1994).

Abusers can be charged under Canada's *Criminal Code* for various forms of assault. Criminal charges can include:

- abduction in contravention of a custody order,
- aggravated assault,
- aggravated sexual assault,
- assault,
- assault causing bodily harm,
- attempted murder,
- forcible confinement,
- hostage taking,
- intimidation,
- murder,
- sexual assault,
- sexual assault causing bodily harm,
- sexual assault with a weapon,
- criminal harassment (stalking), and
- uttering threats.

Other charges may include:

- violation of a court order,
- breach of a bail or probation condition, and
- breach of a peace bond.

The sentencing provisions of the *Criminal Code* were also amended (effective September 4, 1996) to allow for restitution (or reimbursement) of actual and reasonable expenses (e.g., temporary housing, food, child care and transportation where the amount is readily ascertainable) incurred by the victim in leaving the abuser's home because of bodily harm or threatened bodily harm.

Confidentiality

Professionals must protect each woman's right to confidentiality. They must not release information about her to anyone without her **written, informed voluntary consent**. Do not:

- **tell an abusive partner that the woman has revealed abuse;**
- pressure her to report to police;
- call the police without her consent;
- delay telling her about the legal obligation to report child abuse and/or disclose information until she has already discussed the abuse.

Generally speaking, never release information unless required to do so via a search warrant, a subpoena, a summons or other court order. **Keep a copy** of any information that is released. Keep in mind that information released to Crown attorneys, for example, can be read by the abuser and the abuser's lawyer. This could endanger or harm the woman. The rules governing the release of information are a matter of provincial or territorial jurisdiction and professional obligation. Professionals should inform themselves of their provincial/territorial and professional obligations in this regard. If there is any doubt, it is important to seek legal advice.

Those working in small, rural or remote communities need to make a special effort to ensure patient safety and confidentiality.

DOCUMENTING ABUSE

The importance of documentation

How abuse is documented can help prove that a woman was abused. She may need this documentation (now or in the future) if charges are laid, or if she is involved in child custody or other legal proceedings. Depending on their roles, professionals may be responsible for documenting abuse or explaining the documentation process to the woman. Professionals should consult with police investigative units and legal experts regarding requirements and procedures around documentation and preservation of evidence.

Medical records

Professionals who know or suspect that a woman has been abused should note this in her medical record.

*** Make sure information is recorded safely**

Do not record information about abuse in prenatal records that a woman may take home with her. This could put her in danger if it is discovered by her abuser. Instead, record this information on a separate piece of paper.

When a woman has been injured, it is important to make note of the following:

- individuals present during the interview and/or examination;
- description of the presenting problem and a detailed description, in the woman's own words, of how the injuries occurred;
- descriptions of all injuries (including type, location, length, width, shape, colour, depth, level of healing, etc.) and a notation if sexual assault is confirmed or suspected;
- descriptions of the woman's demeanour, including her gestures or expressions, etc.;
- any suspected or confirmed child abuse, and when authorities were contacted;
- completed Injury Location Diagram (a.k.a. Body Map) (see below);
- results of laboratory or diagnostic tests;
- treatment required;
- details of hospital admission, stay and discharge condition;
- the information (written or verbal) given to the patient;
- any collection and storage of physical evidence;
- any photographs, including the woman's written consent;
- referrals and follow-up plans made.

(Ferris, McMain-Klein and Silver, 1997)

Photographs

If the woman consents to have her injuries photographed (written consent is advised), this can be an important documentation tool that can complement good written descriptions in the medical record. Explain that photographs can be used as evidence, if necessary (now or in future). Ideally, photos should be taken before treating the injuries. It may also be useful to take a second set once the bruising has become clearly visible.

Use colour film.[9] Indicate the size of the injuries using a comparison object (e.g., a coin or a ruler) in the photo. Make sure the woman's face appears in at least one of the photos. Take photos from several different angles, including close-up and distance shots. Take two photos of each injury or trauma area (offer one set to the woman).

Store undeveloped film in a sealed envelope labelled with the date and the location of the injuries, and include the names and signatures of the woman, the photographer, the attending physician and any witnesses. Note in the medical record that photos were taken and attach the consent form (Searle, n.d.; Warshaw, Ganley and Salber, 1993; Hotch et al., 1995; British Columbia Reproductive Care Guidelines, 1997).

Injury location diagrams

Injury location diagrams (sometimes referred to as "body maps") can be used to mark the location of injuries that will not show up in photographs or can be used when photographs are not readily available. (These diagrams can be either a hand-drawn sketch of the body or a prepared form, as in Appendix B.) Either the professional or the woman can mark the location of current and past injuries on the diagram. When adding a description of the injuries, try to use the woman's own words if possible. Completed diagrams should be attached to her medical record (Alaska Network on Domestic Violence and Sexual Assault, 1987; Canadian Nurses Association, 1992; Warshaw, Ganley and Salber, 1993).

[9] Some sources (Warshaw, Ganley and Salber, 1993; Hotch et al., 1995) suggest using Poloroid film because photographs can be immediately attached to the medical record with less chance of being lost, and the quality of the photographs can be assessed immediately before the woman is discharged. If Polaroids are taken, the information should be recorded on each photograph and the photographs should be attached to the medical record.

Other records

X-rays showing old injuries are a useful tool to document a history of abuse. In some situations, CT (computerized tomography) scans, or magnetic resonance imaging (MRI) can also provide evidence of abuse (Warshaw, Ganley and Salber, 1993).

Preserving evidence of abuse

Professionals have a responsibility to ensure that any evidence collected is properly labelled and stored in an appropriate container. If any samples are taken (e.g., blood), this should be noted in the woman's medical record. Label containers with the following: the woman's name, hospital ID number (if appropriate), date of collection, a description of the contents and the initials or signature of the person who collected the evidence. Seal, tape and initial the container to make it tamper-proof and note its location in her medical record.

Professionals are advised to consult with local police regarding proper collection and handling of evidence (Hotch et al., 1995).

PART 3:
PREVENTING ABUSE DURING PREGNANCY

OVERCOMING BARRIERS AND FINDING SOLUTIONS

Structural or systemic barriers

Some of the major frustrations in responding to abuse issues are the systemic and structural obstacles in the health and social service sectors. It is easy to get discouraged. Health and social service professionals encounter many challenges as they try new approaches to deliver effective services. For example, many women have short postpartum hospital stays and return to their homes and communities earlier than in the past. As a result, during hospitalization, opportunities for screening women who are either at risk for abuse or who have been abused are more limited. Health and social service professionals are continually challenged in their efforts to address and follow up on myriad problems that people experience. For example, shelters and other sources of support are not always available or able to provide culturally accessible or otherwise appropriate accommodation and support. Despite some innovations in legislation (e.g., criminal harassment [anti-stalking] provisions), law enforcement (e.g., mandatory domestic violence charging policies) and the court process (e.g., in some jurisdictions, domestic violence courts), too often there are dismaying reports that the "systems" with which women have interacted have failed them—and sometimes these women have died.

What can be done, at a practical level, to ensure that the health and social service systems are more effective in their ability to respond to the needs of abused women? While there are many challenges, it is important to not give up hope. Systems can and do change. In fact, a recent report on the progress toward stopping woman abuse noted that "improvement to health services represents the greatest achievement in addressing health determinants and creating new knowledge" (MacLeod and Kinnon, 1996).

Potential obstacle	What professionals can do
Woman abuse not seen as a health priority	Become active in policy and program development. Involve women and men in developing a response to the issue.
Systems working in isolation	Encourage the development of interagency protocols. Support better integration and coordination of services. Support community development activities that strengthen linkages.
Abuse of women during their reproductive years not acknowledged within the practice or organization	Support research that helps define the problems and solutions. Support in-service awareness training for management and staff. Encourage internal and interagency policies and protocols to address abuse of women. Acknowledge that violence occurs. Listen to women who have been abused. Speak out about the issues.
Abuse of women during their reproductive years not well understood within the profession	Contribute to research and information sharing. Help to create policies on this issue.

Barriers for health and social service professionals

Currently, many cases of abuse during pregnancy are being overlooked. This happens for many reasons, but it is often linked to difficulties professionals have in dealing with the issue of abuse and knowing how best to respond. The table below lists some of the obstacles faced by professionals and suggests some possible solutions.

Potential obstacle	What professionals can do
Lack of resources for referral	Develop knowledge of community and any resources. Draw on resources at hand (including local Community Health Representatives, Elders, etc.). Establish temporary "safe" houses for women to stay in. Provide assistance to leave community if necessary.
Lack of time	Recognize that identifying the problem is an important "first step." Develop a good list of resources (social services, social worker, etc.) for referrals. Reconsider and reorganize priorities in prenatal care. Recognize that the process may **not** be particularly time consuming, particularly if an appropriate protocol is in place.
Lack of education/information about abuse *Lack of skill in assessing/dealing with abuse* *Lack of comfort in assessing/dealing with abuse*	Seek training and learn how to best manage situations. Develop an understanding of how abuse impacts women. Seek exposure to interdisciplinary models.
Personal issues with abuse surface	Acknowledge their feelings. Get counselling/seek help.
Reluctance to become involved	Learn more about the moral, ethical, legal issues associated with abuse. Seek training in interdisciplinary approaches to abuse.
Feeling isolated	Network with and learn from others working in this area. Learn about community resources to help abused women. Learn about where to fit in. Increase contacts within professional organizations.
Unclear about what to do, what not to do	Establish learning connections, policies and protocols for responding within the community. Follow through on professional responsibilities. Continually evaluate approach.
Language or cultural barriers	Use trained translators. Ensure they and their staff develop the capacity and necessary linkages to understand the cultural communities served by the practice or organization. Foster links to women's/advocacy cultural organizations.
Service challenges posed by disability	Use signers. Work with disability advocates. Ensure staff develops linkages with accessible services.

Barriers abused women face

Women who are being abused often face many obstacles to getting help. For some women, pregnancy may create an even greater sense of vulnerability, powerlessness and dependency. For others, pregnancy may be a source of strength and motivation to make change. For some groups of women—including Aboriginal women, immigrant and visible minority women, and women with differing abilities—abuse magnifies the impact of the discrimination and inequality they face in society. Systemic barriers—such as institutional racism and sexism, cultural stereotypes and negative attitudes—can make it more difficult for these women to access services and support.

Potential obstacle	What professionals can do
Lack of access to (or use of) appropriate services	Understand that infrequent patient visits may be related to abuse. Implement widespread, accessible screening in a variety of settings in the community. Provide more information made available in safe locations throughout communities. Make information available in as many languages as possible in the community.
Reluctance to disclose or discuss the abuse	Understand the dynamics of abuse and the reasons why she may be reluctant to disclose or discuss it. Routinely, privately and sensitively ask about abuse issues. Use supportive, empathic language. Undertake routine, repeated screening. Provide information on resources in the community that offer information and support.
Difficulty leaving an abusive partner for reasons including fear	Understand that her safety may be at greatest risk if she leaves. Do not judge or pressure her. Provide ongoing, consistent support. Provide information on resources in the community that offer safe intervention and help. Help her plan for her safety.

PREVENTION STRATEGIES

What's being done

There is a lot of work under way across Canada to help professionals learn more about abuse during pregnancy and how to support women who are abused.[10] To date, most of the focus is on education about abuse, and the development and dissemination of tools, including screening tools and guidelines. Some recent examples of initiatives that address violence during pregnancy include:

- The Society of Obstetricians and Gynaecologists of Canada (SOGC) Policy Statement on Violence Against Women also includes questions to ask about violence (SOGC, 1996).
- SOGC has produced *Healthy Beginnings: Guidelines for Care During Pregnancy and Childbirth*, which includes a section on "Abuse in the Obstetrical Population" (SOGC, 1995).
- There are revised Family-Centred Maternity and Newborn Care: National Guidelines being developed (Health Canada, forthcoming).
- The University of Toronto Department of Family and Community Medicine has developed the ALPHA (Antenatal Psychosocial Health Assessment) form and reference guide to help health care providers assess psychosocial issues during pregnancy (Midmer et al., 1996).
- Many provinces have revised (or are planning to revise) their prenatal record to incorporate questions about violence during pregnancy (e.g., Saskatchewan, Ontario, British Columbia, Newfoundland/Labrador).
- Health care providers in Prince Edward Island are currently piloting the use of the ALPHA form (Midmer, et al., 1996) to be used with the provincial prenatal record.
- A kit for health care providers on abuse during pregnancy (*Domestic Violence during Pregnancy*) has been produced by the Saskatchewan Institute on the Prevention of Handicaps.
- The British Columbia Reproductive Care Program has revised its Domestic Violence in Pregnancy and Postpartum guidelines.
- In Alberta, the Women's Health Program (Capital Health Authority, Edmonton) has started training nurses, social workers and physicians to ask all women about abuse (e.g., those presenting in Emergency and Obstetrics and Gynaecology departments in hospitals, and in the postpartum home care program of Community [public] Health).
- IWK Grace Health Centre in Nova Scotia is developing a woman abuse screening program for use in the Women's Health and Maternal Newborn programs.
- The Toronto Hospital has implemented model hospital woman abuse screening and referral protocols, which have been shared with other facilities (see Appendix C). Resource pamphlets have been placed in all hospital public women's washrooms since 1996.
- In Quebec City, pregnancy clinics in hospitals now screen all pregnant women for specific risk factors (including those for abuse) at 12 and 28 weeks. Those with specific risk factors are referred to the local health centre (CLSC), and prenatal follow-up includes home visits by a nurse and referral to social services when necessary. The OLO program, a prenatal nutrition program for low-income pregnant mothers, also allows nurses and nutritionists to identify risk factors for abuse during bi-weekly or monthly visits.

What professionals can do

Professionals in all health and social service disciplines have a responsibility for:

- role modelling non-violent behaviour in personal and professional lives;
- understanding violence issues;
- supporting activities and services that can prevent violence within their communities;
- educating health and social service professionals about the detection and best practices of dealing with violence against women;
- being alert for the signs of violence in order to effectively detect, intervene, treat and/or refer abused women.

[10] For more information about abuse issues, contact the National Clearinghouse on Family Violence. For contact information, see the *Foreword.*

The first step for professionals is to **understand their own experience and its impact**. Men and women should look at their own skill level for resolving conflict in their relationships. They need to ask themselves what they have learned about violence and how this has affected their lives. They must be prepared to learn more about the issue of violence against women. Professional schools and professional associations should be able to help individual professionals find whatever programs and resources are available. (As well, the interest expressed by individuals may help stimulate the development of such programs.)

Beyond building their own knowledge, skills and comfort level, professionals need to ensure that the issue is valued and becomes a priority. For example, it is very important for professionals to **get connected with others in the community who are responding to the issue of abuse against women**. This means finding and working with others in the community who want to develop or improve the response and try to prevent abuse during pregnancy. Professionals should 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 support educational campaigns in the community (including speaking out on the issue, and integrating the subject of abuse into prenatal classes).

For example, community-based solutions are particularly important in Aboriginal communities. Health and social service professionals should not try to "professionalize" the problem, but rather work with other members of the community to develop innovative approaches. This takes time and an understanding of the developmental process (Durst, 1991).

In 1996, the Report of the Royal Commission on Aboriginal Peoples set out some "ground rules for action," which include:

- Do not stereotype all Aboriginal people as violent.
- Make sure that assistance is readily available to those at risk.
- Do not make social or cultural excuses for violent actions.
- Attend to the safety and human rights of the vulnerable.
- Do not imagine that family violence can be addressed as a single problem.
- Root out the inequality and racism that feed violence in its many forms.

(Royal Commission on Aboriginal Peoples, 1996[b])

Professionals can also **foster professional education**. Some of the ways they can do this include:

- inviting people working in this area to give education sessions in their work setting;
- attending educational programs or workshops available in the community;
- encouraging their professional association to develop educational resources, policies, programs and training around this issue.

Finally, professionals may want to get involved in **developing and implementing programs, protocols and tools** (e.g., follow-up programs for abused pregnant women) in their work setting. (This step may flow

naturally from linking with others who have experience and expertise.) This can include:

- allotting time for dealing with abuse issues in prenatal care;
- developing staff training on abuse issues and assessment;
- developing (or adapting/adopting) screening questions and incorporating them into practise, perhaps as part of standard screening procedures;
- developing (and sharing) hospital (and other facility) protocols for the detection and response to violence against women, including national-level models *(Note: in the United States, hospitals are now required to develop protocols for screening and referral of abused women as part of hospital accreditation)*;
- developing domestic violence follow-up programs (see Hotch et al., 1995);
- developing (or adapting) lists of potential resources in the community for distribution;
- posting educational information on abuse in safe, accessible locations in their work setting (e.g., waiting rooms, examination rooms, washrooms). Telephone numbers for local shelters, help lines and other resources should be clearly displayed.

(Rattray, T. and Famularo, B., n.d.; Canadian Nurses Association, 1992; Hotch et al., 1995; Saskatchewan Institute on Prevention of Handicaps, 1996; British Columbia Reproductive Care Program, 1997)

APPENDIX A:
COMMUNITY RESOURCE LIST

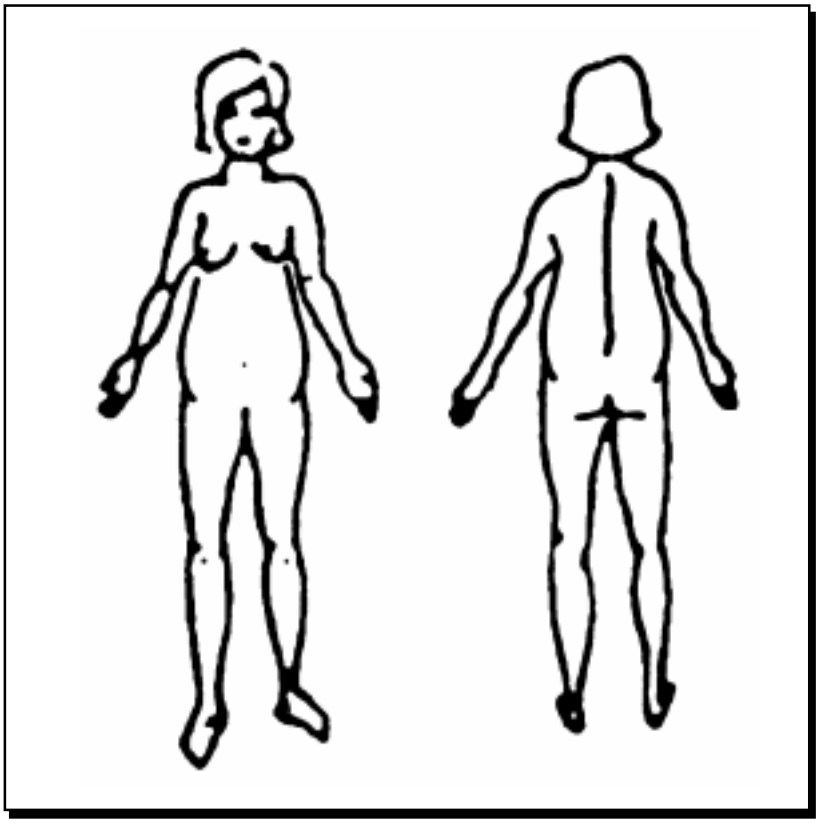
Professionals should keep an up-to-date list of the referral resources that are available in their communities to assist abused women. Here is a sample form that they could use.

RESOURCE	CONTACT	TELEPHONE/ADDRESS	COMMENTS
POLICE			
SHELTERS			
■			
■			
■			
VICTIM ASSISTANCE/SERVICES			
Police-based			
Court-based			
Other			
SEXUAL ASSAULT SUPPORT			
■			
■			
WOMEN'S CENTRES			
■			
CRISIS TELEPHONE LINES			
■			
■			
MEDICAL SERVICES/HEALTH CARE			
■			
■			
WOMEN-CENTRED COUNSELLING			
■			
LEGAL ASSISTANCE			
Legal Aid			
Lawyer Referral Service			
Other			
ABORIGINAL SERVICES			
■			
■			
IMMIGRANT/REFUGEE SERVICE			
■			
ETHNOCULTURAL ORGANIZATIONS THAT ADDRESS ABUSE ISSUES			
■			
CHILD WELFARE AUTHORITY			
■			
PROGRAMS FOR MEN WHO ABUSE WOMEN			
CLEARINGHOUSES/NETWORKS			
OTHER			

APPENDIX B:
SAMPLE INJURY LOCATION DIAGRAM

INJURY LOCATION DIAGRAM

If you have been physically abused (hit, punched, slapped, kicked or physically hurt in other ways) during this pregnancy, please mark with an X the places on the diagram below where you were hurt.



APPENDIX C:
SAMPLE SPOUSAL ABUSE PROTOCOL

The Toronto Hospital Policy and Procedure Manual **ADMINISTRATIVE**	
Section: **PATIENT CARE** **Patient Management**	Subject Title: **Policy #2.1.314 Spousal Abuse**
Issued by: **Abuse Task Force**	Date: 01/96 (o)
Approved by: **Operations Committee**	Review Date:

POLICY ON SPOUSAL ABUSE

The Toronto Hospital has a responsibility to identify and respond effectively to spousal abuse and, where possible, prevent further abuse, regardless of ethnicity, cultural values, age, sex, race, socio-economic status, sexual orientation, ability, psychological state and psychiatric history.

The Toronto Hospital defines spousal abuse as the intent of the partner to intimidate, either by threat or physical force, the person or property of the other partner. The purpose of the abuse is to control behaviour by inducement of fear. Forms of abuse include physical, sexual, or psychological abuse to the individual, threat to a third party (e.g., child) and/or destruction of property (e.g., family pet, cherished item).

Spousal abuse is a criminal act and an abuse of power. The abused spouse is not responsible for the abuse. The abuse should never be excused or condoned. Alcohol or drugs, cultural differences, and mental stress or disorder do not make this behaviour acceptable. Indicators have been established to assist in the identification of spousal abuse.

PROCEDURE IN THE CASE OF SUSPECTED, WITNESSED OR REPORTED SPOUSAL ABUSE

1. When possible, interview the patient alone in a private setting. Use a non-judgemental approach and open-ended questions.

2. Use a non-family member if an interpreter is required to conduct the interview.

3. Convey to the patient that she or he is believed, is not responsible for the abuse, and has the right to be safe; include in the interview questions about:

    a) level of immediate danger,
    b) type(s) and frequency of abuse,
    c) family/living situation, and
    d) personal and financial resources.

4. Advise the patient that although the information remains confidential, it will be documented in the medical record.

5. Because this may be your only contact, explore options with the patient and provide information on appropriate resources in a manner and form that does not increase the risk of abuse for the patient. This may include a referral to Social Work: TGD - ext. 3616, TWD - ext. 5929.

6. Ensure that the decision on which options to choose, if any, rests with the patient and that the patient is not denied services should she or he remain in an abusive situation.

7. Document on the patient's medical record the interview, physical injuries, and emotional, behavioural and psychological responses, details of the abuse, response to the interview, the treatment or care provided and follow-up (see indicators attached).

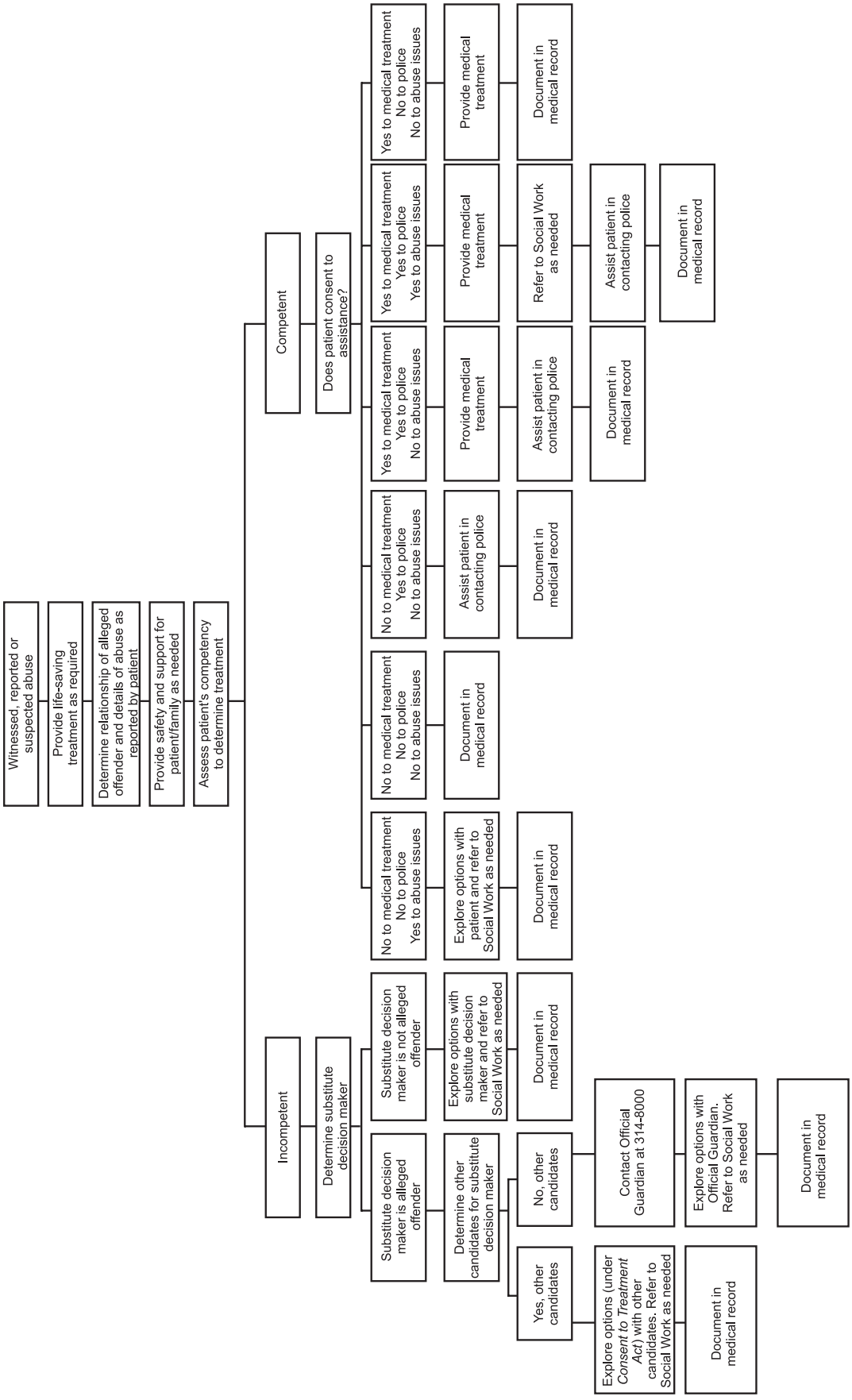
SPOUSAL ABUSE INDICATORS

PHYSICAL

1. Injuries to bone or soft tissues:
   - lacerations to head or face
   - broken teeth
   - fractured or dislocated jaw
   - contusions, abrasions
   - hair loss
   - black eyes
   - perforated eardrums
2. Retinal hemorrhage
3. Abdominal, breast or perineal bruising, especially if pregnant
4. Bite marks
5. Unusual burns caused by:
   - cigarettes
   - hot grease
   - top of stove
   - acids
6. Injuries sustained do not fit the history given
7. Client may show evidence of previous injuries
8. Increased hospital visits

PSYCHOLOGICAL/BEHAVIOURAL

1. Fear or anger toward perpetrator
2. Tearfulness
3. Shock
4. Dissociation
5. Flashbacks
6. Feels isolated
7. Treatment of injuries for self or child may be minimized
8. Investigation or intervention with self or child may be delayed or refused
9. Self-blame
10. Fears reprisal
11. May show detachment or hostility toward children
12. May have unrealistic expectations of children's development and capabilities
13. Depression
    - low self-esteem
    - unkempt appearance
    - may discuss or attempt suicide
    - anorexic or bulimic behaviour
    - alcohol or drug abuse
    - feelings of helplessness
    - psychosomatic illness
    - withdrawn
    - insomnia
    - anxiety attacks
    - cries frequently
    - indecisive behaviour
    - avoids eye contact


The Toronto Hospital
Spousal Abuse Flow Chart
Witnessed, reported or suspected abuse
Provide life-saving treatment as required
Determine relationship of alleged offender and details of abuse as reported by patient
Provide safety and support for patient/family as needed
Assess patient's competency to determine treatment
Incompetent
Determine substitute decision maker
Substitute decision maker is alleged offender
Substitute decision maker is not alleged offender
Determine other candidates for substitute decision maker
Explore options with substitute decision maker and refer to Social Work as needed
Yes, other candidates
No, other candidates
Document in medical record
Explore options (under Consent to Treatment Act) with other candidates. Refer to Social Work as needed
Contact Official Guardian at 314-8000
Document in medical record
Explore options with Official Guardian. Refer to Social Work as needed
Document in medical record
Competent
Does patient consent to assistance?
No to medical treatment No to police Yes to abuse issues
Explore options with patient and refer to Social Work as needed
Document in medical record
No to medical treatment No to police No to abuse issues
Document in medical record
No to medical treatment Yes to police No to abuse issues
Assist patient in contacting police
Document in medical record
Yes to medical treatment Yes to police No to abuse issues
Provide medical treatment
Document in medical record
Yes to medical treatment Yes to police Yes to abuse issues
Provide medical treatment
Refer to Social Work as needed
Document in medical record
Yes to medical treatment No to police No to abuse issues
Provide medical treatment
Document in medical record

APPENDIX D:
SAMPLE ALLEGED OFFENDER PROTOCOL

The Toronto Hospital Policy and Procedure Manual **ADMINISTRATIVE**	
Section: **PATIENT CARE** **Patient Management**	Subject Title: **Policy #2.1.315 The Alleged Offender**
Issued by: **Abuse Task Force**	Date: 01/96 (o)
Approved by: **Operations Committee**	Review Date:

POLICY ON THE ALLEGED OFFENDER

The Toronto Hospital has a responsibility to respond effectively to the perpetrators of abuse and assault for the purpose of, where possible, preventing further abuse, regardless of ethnicity, cultural values, age, sex, race, socio-economic status, sexual orientation, ability, psychological state and psychiatric history.

PROCEDURE IN THE CASE OF SUSPECTED, WITNESSED OR REPORTED ABUSE

1. When possible, interview the alleged offender in a private setting.

2. An assessment should be made regarding physical and emotional health. Document on the patient's medical record the interview, physical injuries, relevant information and follow-up (see attached indicators). A non-judgemental, reality-based approach is recommended.

3. Bear in mind that once the alleged offender is identified, he or she may or may not request treatment.

4. When appropriate, the alleged offender should be encouraged to accept referral services.

TGD - 3616
TWD - 5929

INDICATORS FOR ABUSERS

PHYSICAL

1. May show signs of victim fighting back:
   - facial scratches
   - injuries to hands
2. May display rough handling of children.
3. May display unrealistic expectations of children's abilities and behaviours.

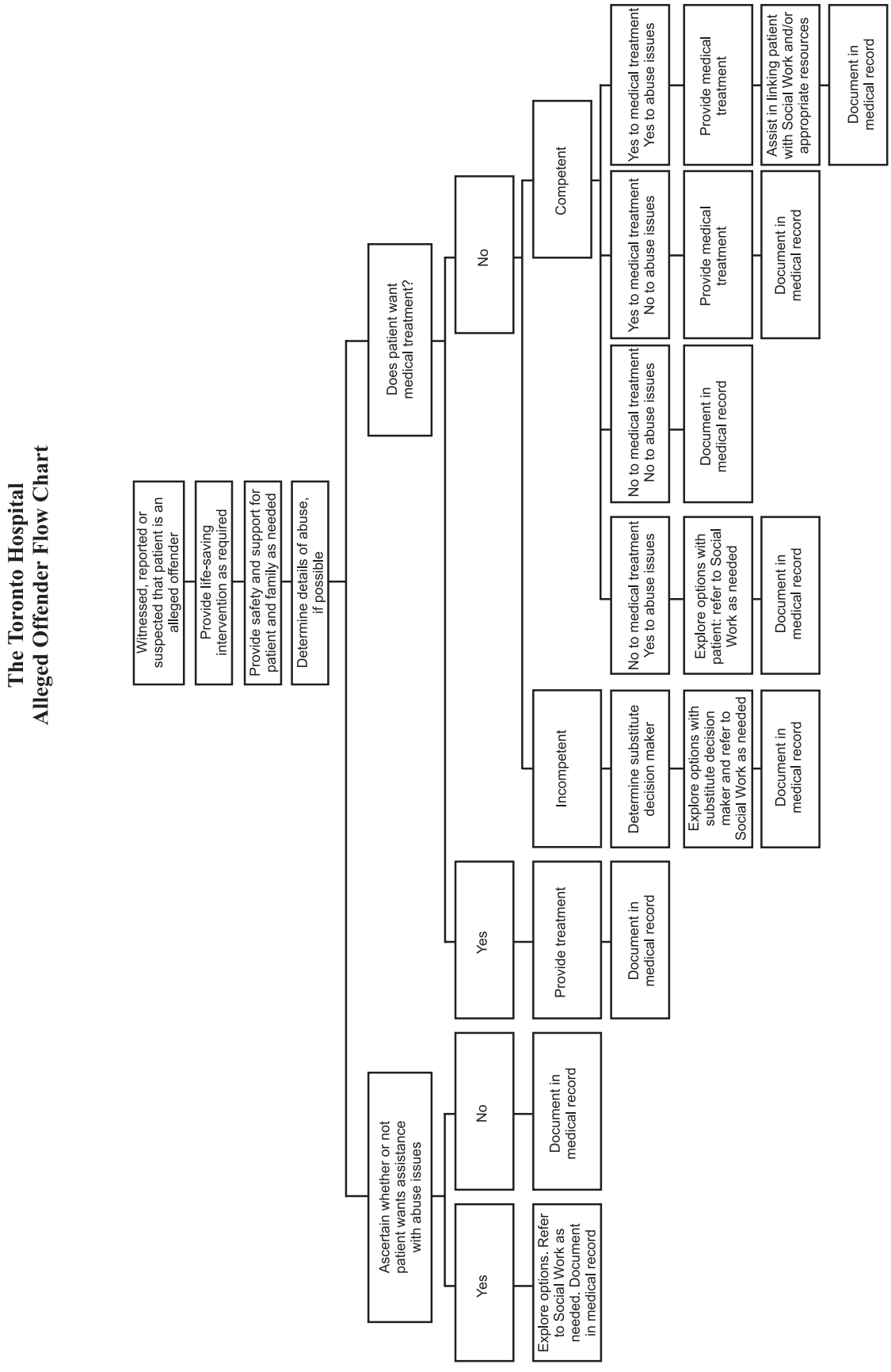
PSYCHOLOGICAL/BEHAVIOURAL

1. When in emergency room with injured partner, hovers and is unwilling to allow a private interview.
2. May minimize injuries.
3. Feels injuries were "asked for" and that he or she was provoked.
4. Family tension may be evident between spouses/children.
5. Tends to be jealous of partner: "Can't trust him/her or anyone else."
6. *Has rigid ideas about male and female roles.
7. *Feels women and children need to be "kept in line."
8. *Shows varying degrees of contempt for women.
9. May be verbally abusive to others.
10. Views partner and/or children as property.
11. May have been raised in a dysfunctional or abusive family.
12. Wants to be seen as the victim.
13. Blames alcohol or drugs for behaviour.
14. Tends to be unable to control angry outbursts.
15. May give appearance of being a "really nice person."
16. May be manipulative:
    - shows up with flowers/gifts for abused partner
    - threatens or attempts suicide
    - threatens to kill partner/children if partner attempts to leave
17. Vague or evasive when asked about injuries of partner or child.
18. Delays or refuses further treatment.

SEXUAL

1. *Shows little respect for women's rights or sexual needs (e.g., "No woman can be raped if she doesn't want it").
2. *May engage in polygamous relationships.
3. May feel "seduced" by children/adolescents.

* (Where abuser is male)


The Toronto Hospital
Alleged Offender Flow Chart
Witnessed, reported or suspected that patient is an alleged offender
Provide life-saving intervention as required
Provide safety and support for patient and family as needed
Determine details of abuse, if possible
Ascertain whether or not patient wants assistance with abuse issues
Yes
Explore options. Refer to Social Work as needed. Document in medical record
No
Document in medical record
Does patient want medical treatment?
Yes
Provide treatment
Document in medical record
Incompetent
Determine substitute decision maker
Explore options with substitute decision maker and refer to Social Work as needed
Document in medical record
No
Competent
No to medical treatment Yes to abuse issues
Explore options with patient: refer to Social Work as needed
Document in medical record
No to medical treatment No to abuse issues
Document in medical record
Yes to medical treatment Yes to abuse issues
Provide medical treatment
Assist in linking patient with Social Work and/or appropriate resources
Document in medical record
Yes to medical treatment No to abuse issues
Provide medical treatment
Document in medical record

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A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy

Feedback Form

We would very much appreciate your feedback on this resource material. If you can find a few minutes in your busy schedule to complete and return this feedback form, we will use your valuable input to improve future family violence resource materials. Please mail or fax this form to:

National Clearinghouse on Family Violence
Health Promotion and Programs Branch, Health Canada
Jeanne Mance Bldg., 7th Floor, Address Locator: 1907D1
Ottawa, Ontario K1A 1B4
FAX: 613–941–8930

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1. Your province/territory:

   ☐ Nunavut ☐ Northwest Territories ☐ Yukon ☐ British Columbia ☐ Alberta
   ☐ Saskatchewan ☐ Manitoba ☐ Ontario ☐ Quebec ☐ New Brunswick
   ☐ Nova Scotia ☐ Prince Edward Island ☐ Newfoundland ☐ Other:_____

2. Category of your organization:

   ☐ Social Services ☐ Health Services ☐ Professional ☐ Non-governmental Organization
   ☐ Federal Government ☐ Provincial Government ☐ Municipal Government ☐ Parliament
   ☐ Media ☐ Criminal Justice ☐ Universities – Colleges ☐ Schools
   ☐ Student ☐ Library ☐ Corporate ☐ Religious/Spiritual Organization
   ☐ Public ☐ Aboriginal ☐ Other:_____

3. Did you find the content of this resource:

   Accurate? ☐ Yes ☐ No ☐ No opinion *Up-to-date?* ☐ Yes ☐ No ☐ No opinion
   Comprehensive? ☐ Yes ☐ No ☐ No opinion *Relevant to your needs?* ☐ Yes ☐ No ☐ No opinion
   Balanced in its portrayal of the issues? ☐ Yes ☐ No ☐ No opinion

4. How would you rate this resource (1 = very poor, 5 = very good) in terms of its:

   Style and "voice" 1 2 3 4 5 *Use of understandable vocabulary and concepts* 1 2 3 4 5
   Overall attractiveness 1 2 3 4 5 *Organization (Is it easy to find information?)* 1 2 3 4 5

5. How would you rate the overall usefulness of this resource? (1 = very poor, 5 = very good) 1 2 3 4 5

6. How do you plan to use this resource? (Check as many as required.)

   ☐ Education ☐ Public Awareness ☐ Treatment ☐ Training ☐ Research ☐ Personal
   ☐ Reference ☐ Prevention ☐ Policy/Program Development ☐ Other:_____
   ☐ Don't plan to use this resource

7. Did this resource influence your thinking and/or practice? ☐ Yes ☐ No
   Please explain:

8. Will you recommend this resource to others? ☐ Yes ☐ No

9. Will you use information in this handbook: (Check as many as required.)

- ☐ Raise awareness of the issues among health or social service providers?
- ☐ Train others about the issues?
- ☐ Develop/modify policies or programs/intervention strategies?
- ☐ Develop/modify other resources/materials tools?
- ☐ Make changes in your practice/organization?
- ☐ Other: _____
- ☐ Will not use this resource.

10. How useful did you find the following features? (1 = not useful, 5 = very useful)

Sample screening questions	1 2 3 4 5	Use of boxed "messages"	1 2 3 4 5
Other sample tools	1 2 3 4 5	Selected bibliography	1 2 3 4 5

Which features did you find most useful? _____

Which features did you find least useful? _____

11. How useful did you find the following sections? (1 = not useful, 5 = very useful)

Foreword	1 2 3 4 5	*Preparing to Respond*	1 2 3 4 5
Principles Underlying This Handbook	1 2 3 4 5	*Identification and Screening*	1 2 3 4 5
Overview	1 2 3 4 5	*Assessment*	1 2 3 4 5
Understanding the Dynamics of Abuse	1 2 3 4 5	*Intervention*	1 2 3 4 5
Understanding the Impacts of Abuse	1 2 3 4 5	*Reporting and Confidentiality*	1 2 3 4 5
Points of Intervention	1 2 3 4 5	*Documenting Abuse*	1 2 3 4 5
Overview of the Process	1 2 3 4 5	*Overcoming Barriers & Finding Solutions*	1 2 3 4 5
Potential Signs of Abuse	1 2 3 4 5	*Prevention Strategies*	1 2 3 4 5

12. Does this document raise other issues or identify knowledge gaps that you think should be addressed?

☐ Yes ☐ No

Please explain:

13. Please use the space below to add any other comments or attach a separate sheet.

Thank you for taking the time to complete and return this feedback form.
National Clearinghouse on Family Violence