Trauma-Informed Birth Support for Survivors of Abuse

Presented by Pamela S.F. Glenn
for the National Resource Center on Domestic Violence

NRCDV

Goals

- To provide information for both victim advocates working in shelter settings and birth doulas regarding the identification and impact of IPV & abuse in pregnant women
  - Pregnant women living in shelters
  - Pregnant women not in a shelter experiencing abuse in their homes/relationships
- To provide a beginning discussion and framework for partnership between these two groups

Why these two communities?

Both doulas and DV victim advocates care deeply about women and issues that impact their health and well-being

Both groups seek to improve health outcomes for women

Both serve in an empowerment-based, advocate role and as a companion to women during times of need

Both support providers engage women on a time-limited basis, although the impact of their service to and relationships with women may last a lifetime

Domestic Violence & Abuse Services

Each state has a coalition that addresses domestic violence intervention, prevention and public policy to enhance safety for victims in their state.

Each county within that state has a local domestic violence shelter and other non-shelter services to assist victims in their community.

These efforts are supported by national organizations that provide technical assistance, training, resources and federal policy advocacy.

Domestic Violence & Abuse Victim Advocate

What services are provided in shelter?

Most women connect with the shelter by calling the **National Domestic Violence Hotline (1-800-799-7233/SAFE)**, their local domestic violence program, if known, or through law enforcement as they respond to 911 dispatch calls.

After completing a short intake to assess their situation and being accepted into shelter, survivors can expect to receive:

- safe shelter in a communal living environment,
- meals and other sundries,
- clothing and access to a laundry room,
- supportive counseling and
- case management services to assist with meeting long-term needs for housing, legal assistance, childcare, and job placement, among other needs.

What do shelter advocates do?

Shelter advocates have a broad range of responsibilities:

- responding to crisis line calls, conducting initial screening, intake and orientation of new families,
- assisting families with transportation to/from the confidential shelter location,
- maintaining a positive, welcoming atmosphere and environment with the shelter,
- assisting with childcare and other children's programming,
- overseeing the "run of the house" including food shopping, meal preparation, cleaning and maintenance,
- planning family-oriented activities for residents and
- managing disputes between residents, among many other duties that come with being a part of the shelter community.

DOULA: CHILDBIRTH COMPANION

What is a doula?

- From an ancient Greek word meaning *woman who serves* or *servant woman*, pronounced doo-lah.
- Many historic images of women giving birth depict a laboring woman, often squatting, with two women supporting her (one a midwife and the other a doula).
- In modern terms, a doula is a compassionate, experienced and professional woman who guides a mother through pregnancy, labor, delivery and postpartum recovery.
- Most doulas receive training from a certifying organization that includes intensive research, coursework, and attendance at several births while in training.

Most doulas provide:

- Free initial consultation/interview
- In-person prenatal visits and birth planning
- On-call services prior to the birth, continuous labor support through delivery and immediately after
- Postpartum follow-up visits
- Help and support with breastfeeding
- Referrals to other community resources

Any expectant woman may want and benefit from the assistance of a doula, whether her birth is natural, includes the use of medication for pain relief, or other forms of medical intervention.

How do doulas help?

Most women hire a doula during their 2nd trimester and begin intensely working together in the 3rd trimester.

Doulas support pregnant women through:

- Comprehensive birth planning and education
- Emotional support and calming presence
- Assisting with comfort measures for pain relief
- Suggesting position changes to ease labor
- Birth coaching and advocacy

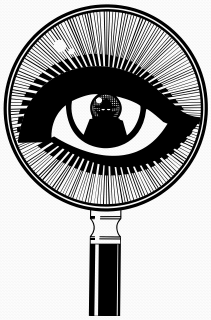
NOTE: Doulas are not medical professionals and cannot help women deliver babies. Midwives and physicians perform that function.

Doula support has been proven to make a difference

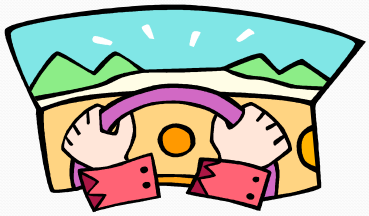
The best results occurred when women had continuous labor support from a doula—someone who was NOT a staff member at the hospital and who was NOT part of the woman's social network:

- 12% increase in the likelihood of a spontaneous vaginal birth
- 9% decrease in the use of any medications for pain relief
- 31% decrease in the use of Pitocin (to speed contractions)
- 28% decrease in the risk of C-section
- 34% decrease in the risk of being dissatisfied with the birth experience

Source: Dekker, R. The Evidence for Doulas: Evidence Based Birth, 2013.



SET REALISTIC DEFINITION OF SUCCESS



LISTEN & OBSERVE

VALIDATE

Just like victim advocates, doulas are not expected to intervene

REFER

Warm referrals to local domestic violence & abuse victim service providers

Abuse Stereotypes, Myths & Images

Who gets abused? Who abuses?

- All ages, including elderly
- All cultures & religious backgrounds
- All socioeconomic levels
- All types of relationships: single, dating, married, living together, lesbian/gay
- People with disabilities
- Rural, suburban, metropolitan
- Work environments
- *MALES AND FEMALES*

Abuse: Definition

The **INTENTIONAL** use
of abusive tactics
in order to obtain and maintain
POWER AND CONROL
over an intimate partner

University of Michigan

The Abuser

Abusers act not because they are *out of control,* they act out of the need *to control.*

Murray, 2000; psfg

Anger management is NOT an accurate term in these situations because it assumes that violence comes from anger; rather, violence comes from a need for power and control.

Dale Trimble, Men's Therapist

Abuse Types

Physical
- 95% is male against female

Emotional

Sexual

Other:
- Spiritual
- Financial/Economic

Each type of abuse is often co-occurring with another, meaning that abusers frequently use multiple tactics of abuse to manipulate, confuse, coerce and control survivors.

Scope: Women & Men

Emotional Abuse

Nearly half of all women and men in the U.S. have experienced psychological aggression by an intimate partner in their lifetime (48.4% and 48.8% respectively)

Physical Abuse

Women and men experienced many types of physical violence ranging from being slapped to having a knife or gun used against them.

Women had a significantly higher lifetime prevalence of severe physical violence by an intimate partner:

- 24.3% for women
- 13.8% for men

National Intimate Partner and Sexual Violence Survey, 2010 Summary Report, CDC, Division of Violence Prevention.

Scope: Women

It is estimated that 20% to 30% of women in the U.S. have been physically and/or sexually abused by an intimate partner in their adulthood

1 out of every 3 women experiences at least one physical assault by a partner during adulthood

1 in 4 women reported lifetime coerced sex and of these women, more than 1/3 were 15 years old or younger at the time of their 1st coerced sexual experience

1) NCG, 2002 2) NCADV, 2003 (Am Psych Asso, 1996) 3) Stockman, Campbell, Celentano, 2010

Scope: Sexual Violence

- Nearly 1 in 10 women in the U.S. (9.4%) has been raped by an intimate partner in her lifetime, including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration.
- An estimated 16.9% of women have experienced sexual violence other than rape (being made to penetrate an intimate partner, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences) by an intimate partner in their lifetime.

Source: *National Intimate Partner and Sexual Violence Survey*, 2010 Summary Report, CDC, Division of Violence Prevention.

Scope During Pregnancy

- Domestic violence often begins or increases during pregnancy
- Physical violence was found to occur during 7-20% of pregnancies
- Women with unintended pregnancies are at greater risk (3x greater in one study) of IPV than those with planned pregnancies (Over ½ pregnancies in US are unintended)
- Abused pregnant women are 3 x more likely to be victims of attempted/completed homicide Weil, Fletcher, Sokol, *UpToDate, 2013*
- Homicide perpetrated by a current/former partner is a leading cause of maternal mortality
  El Kady, Dina, et al 2005

Scope: Femicide

- 94% of female murder victims are killed by a man they knew. *National Intimate Partner and Sexual Violence Survey*, 2010 Summary Report, CDC, Division of Violence Prevention
- Approximately 70% of murdered women are killed by a husband, boyfriend, or estranged partner/ex-boyfriend
- About 2/3 of these women had been physically abused by their partner or ex
- Separated & divorced women are most at risk, especially the 1st 3 months after leaving…"BUT there remains a greater risk for women who stay"
  Campbell, 1995; Campbell, 4/10/03

Dynamics of Abuse

Isolation:

The abuser uses a variety of tactics to isolate their partner from family, friends, and outside activities

The abuser monopolizes all of their partner's time

Murray, 2000

Dynamics of Abuse

Saying “I love you” too soon

The relationship progresses very quickly

Murray, 2000

Dynamics of Abuse

Controlling a Partner’s Identity

The abuser defines their partner and tries to control their identity

Dynamics of Abuse

Degrading

The abuser degrades their partner by calling them names, such as “bitch” or “whore,” or by using degrading remarks

The abuser may humiliate their partner in public OR just the opposite—in private when no one else is around

Murray, 2000

Dynamics of Abuse

Possessiveness

The abuser interrogates their partner who must be accountable for every moment they are not together

The abuser frequently checks up on their partner using pagers, phones, cell phones

Murray, 2000

Dynamics of Abuse

Jealousy with NO BASIS for it

The abuser frequently becomes jealous when there is *no basis* for it

Dynamics of Abuse

Fear and Intimidation

The abuser may use an intimidating look, behavior, or tone of voice to get what they want

The abuser may threaten, break treasured items, become physically violent, and/or display a weapon

Murray, 2000

Dynamics of Abuse

Sexual Coercion

The abuser forces, pressures, manipulates or threatens their partner to do something sexually they do not want to do

The abuser may use alcohol or drugs to make their partner more vulnerable to unwanted sexual activity

The abuser may use calculated actions that lead to pregnancy

BIRTH CONTROL SABATOGE

Active interference with a partner's contraception

- Hiding, withholding or destroying a partner's birth control pills
- Breaking or poking holes in a condom on purpose or removing it during sex in an explicit attempt to promote pregnancy
- Pulling out vaginal rings
- Tearing off contraceptive patches

Chamberlain & Levenson, 2013 Futures Without Violence

- Example: IUC removal during sex

Dynamics of Abuse

Crazymaking

The abuser denies, minimizes, or may blame the partner for an abusive incident

The abuser accuses the partner of behaviors they have not even considered

The abuser keeps changing "the rules"

The abuser accuses their partner of being the crazy one causing all their problems

Dynamics of Abuse

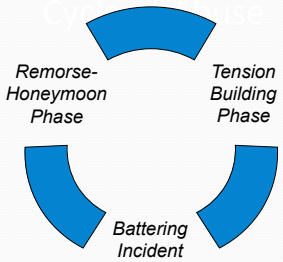
Manipulation/Desperation

The abuser places their partner in the "rescuer" role

The abuser threatens suicide if the partner leaves them

Murray, 2000

Cycle of Abuse



Source: ACNM, 1995 (C. King)

Why do people stay in abusive situations?

Stages of Leaving

- Precontemplation: The patient is not concerned about the situation
- Contemplation: The patient has considered change but not ready to take action
- Determination: The patient has decided to make changes in their situation
- Action: The patient is actively seeking help and taking steps to address the IPV

Weil, Fletcher, Lin, *UpToDate, 2013*

Question:
What about those who choose to stay with their abuser?

Physical Health Effects Include:

Arthritis
Chronic pain, including neck & back pain
Migraine and other headache types
STD's including HIV/AIDS
Chronic pelvic pain & gynecological problems
Peptic ulcers
Chronic irritable bowel syndrome
Frequent indigestion, diarrhea, constipation
Chronic disease
Brain injuries

NCG, 2002; Valera, 2003; Campbell, 2002 & NIH 2013

Mental Health Effects Include:

Clinical depression & dissociation
Anxiety, Chronic Stress, PTSD
Sleep and eating disturbances
Constant fear and fatigue
Intense startle reactions
Substance abuse: smoking, alcohol, prescription and non-prescription drugs
Risk behaviors: unsafe sex, lack of contraception

Health Partners, 1995; Campbell, 2002 & NIH 2013; Sutherland, 2002; Lemon, 2002

Pregnancy Complications Include:

- Low weight gain
- Anemia & Infections
- 1st & 2nd trimester bleeding/hemorrhage
- Spontaneous AB "miscarriage"
- Placental separation (abruption)
- Fetal fractures; fetal death
- Preterm labor & LBW
- Rupture of uterus, liver, spleen
- Depression & suicide attempts
- Substance abuse
- Teens at higher risk of abuse during pregnancy

NCD, 2002; Health Partners, 1995; FVPF, 2002; ACOG Committee Opinion #518, 2/12

Abuse Inquiries and Warm Referrals

BIRTH PLANNING

PREGNANCY, BIRTH, & POSTPARTUM PLANNING

Planning begins with the first visit and evolves throughout the pregnancy

The Effects of Sexual Abuse on Pregnancy & Birth

Abuse issues are sometimes triggered unexpectedly during pregnancy, labor, and birth, in the form of conscious memories or flashbacks to the abuse, or unconscious body memories (tension, anger, sick feelings, or other discomfort) when a woman is reminded of abuse in some way.

Our Bodies Ourselves, 2008

Common triggers include:

- Growing uterus
- Fetal movement
- Vaginal exams
- Invasive procedures
- Pain/Discomfort

During pregnancy, birth & postpartum

Vagina, abdomen, back, breasts, perineum

Prenatal Care Provider

Our interactions with our care providers—authority figures who may expect compliance and trust—may remind us of our perpetrator or perpetrators, with whom we have felt helpless, unequal, submissive, or overpowered.

Our Bodies Ourselves 2008

It is vital to include the prenatal care provider in the plan development as well as birth staff to enhance safety for all

Giving Birth: History of Abuse

For women that have previously experienced abuse, labor and delivery may trigger (or bring up) deep memories associated with the trauma through experiences, feelings, smells, objects, people or places at the birth:

- Feeling out of control of one's body, choices or privacy
- Feelings of being violated during internal vaginal exams, while the baby is in the birth canal/vagina, or by giving birth
- Feeling tied down/restrained by medicinal lines (such as blood pressure cuffs, IVs, fetal monitors, catheters, epidurals, etc.)
- Having adverse reactions to the presence of medical authorities, including loss of modesty and dignity in their presence
- Feeling exposed or vulnerable while in various positions for labor (such as when squatting, pulling her legs back in a winged position for delivery, being on her hands and knees)

How can doulas help?

Provide trauma-informed care throughout pregnancy, labor, birth & postpartum:

- Take time to develop trust & rapport: Non-judgment, compassionate, safe environment; Gentle, noncritical tone of voice; Understand impact of shame
- Explore the woman's past experiences with health care
- Identify what plans have already been put into place
- Empower the pregnant woman to be the decision maker during this process
- Take care not to overwhelm
- Coach on ways to ask for clarity and express herself with medical professionals
- Treat her with dignity and respect; prompt others to do the same
- Work to make sure her wishes are honored (assuming no contraindications)
- During labor, watch for cues that Mom may be experiencing triggers. If flashbacks and disassociations occur, acknowledge her concerns, practice grounding techniques, reassure her that she is safe, use positive affirmations for empowerment

BIRTH PLAN: Antepartum

- Identify Midwife or MD options
  - Open communication re: Birth plan
  - Disclosure re: hx of abuse & potential effects
- Offer birth settings which meet patient's needs
  - Location/privacy
- Offer continuous doula labor support
  - Define the doula role for this patient
  - Doula to accompany her to prenatal visit?
- Arrange birth classes
  - Who does pt want to accompany her?
- Pregnancy complication arrangements

BIRTH PLAN: Intrapartum

- Transportation when labor starts
  - When to go to the hospital/birth place?
- Who will be present for support during L&D?
  - **Are there concerns about who may be at the birth?**
  - **Are there protection from abuse/restraining orders in place?**
    - **If so, how will this be handled?**
- Comfort measures and pain relief options
  - Non-pharmaceutical: walking, shower/tub, massage
    - **Is the Mom comfortable with touch?**
  - Pharmaceutical: medication, epidural, etc.
- Positioning during labor and pushing stages
- Preference for Electronic Fetal Monitoring
  - Intermittent vs. continuous
- Discussion regarding medical interventions
  - IV, induction, episiotomy, C/S, etc.

BIRTH PLAN: Postpartum

- Breast vs. bottle feeding
  - Consider lactation consultant
- Immediate newborn care
- Location
- Recovery & rest time
- Support
  - Consider Public Health Nurse visits
- Birth control
  - Hidden methods: DMPA & IUC
- Observe for postpartum depression
- Bonding/Touch

Women Living with Abuse

RED FLAGS for Doulas

The pregnant woman

- Frequently reschedules, misses or cancels appointments at the last minute
- Has not received prenatal care or waits very late in the pregnancy to do so
- Exhibits *EXTREME* worry about her baby's health
- Tells you about abnormal bleeding, inadequate nutrition
- Discloses a history of repeated abortions, STIs, abuse or trauma, including depression, anxiety, PTSD, suicide attempts, drug/alcohol use
- Has untreated injuries (bite marks, burns, head injuries, bruises, scars) which are inconsistent with her story, in various stages of healing, usually proximal rather than distal (often hidden). She often minimizes being hurt
- Has multiple, vague somatic complaints
- Talks about being socially isolated

The partner

- May "hover," but never fully participates in visits
- Exhibits over Concern
- Answers questions for patient

Basics of Initial Inquiry

- In private
  - Non-judgment, compassionate safe environment
  - How questions are asked is critical:
    - Gentle, noncritical tone of voice
  - Understand impact of shame
- Normalize the inquiry
- Initially avoid the word abuse
- Focus on cues, including potential emotional abuse
- Define types of emotional abuse; Name the behavior
- Link impact of IPV & abuse to health
- State observations respectfully
- Inform regarding risks (safety plan) & resources

YOUR RESPONSE: *Keep the door open*

Patient denies abuse despite evidence

Be respectful

Provide resources

Avoid blaming/shaming

Follow-up in future

YOUR RESPONSE:
Keep the door open

Patient discloses abuse
- Empowerment statement
- Validation
- "Survivor"
- Be authentic
- Inform re: Risks
- Safety Plan
- Avoid recreating dynamics of power & control
- Warm referral to shelter advocate

Are you safe at this time?

Respect the patient's self-assessment
+
BALANCE
WITH
INFORMING PATIENT
ABOUT DANGER AND RISK

"Are you safe at home"
*DOES **NOT** WORK WELL*
J Campbell, NIH 12/9/13

Partner with DV Victim Advocates

- Know who the providers are in your community
  - Visit http://vawnet.org/links/state-coalitions.php for a listing of state coalitions; contact the provider in your county
- Be prepared to make warm referrals, if needed
  - Connect with the shelter director/manager, understand the services they provide to pregnant survivors
- Consider offering volunteer services to pregnant women in emergency/safe shelter
- Conduct cross-training with advocates interested in learning more about childbirth

Harm Reduction Approach

Harm Reduction "provides a client-centered approach to working with people 'where they are' rather than 'where they should be.' "

Strategies for REDUCING the physical, emotional, and social harms associated with risk-taking behavior

Goal is to help people stay safer in an unsafe environment (that they are not yet willing or able to leave)

Patt Denning, *Practicing Harm Reduction Psychotherapy, 2000.*

Harm Reduction Approach

Provides tips to help patients stay safer

"Here are some ideas on how you can stay safer…."

- Support system: neighbor, 911
- Physically protecting oneself: fetal position if getting beat up, cover your head
- Safety plan of escape→Consult

"No matter what, I'm here for you."

Gayle Thomas, Certified Harm Reduction Trainer, 2/24/03