

RELATIONSHIP STRATEGIES AND INTERDISCIPLINARY COLLABORATION

Improving Maternity Care With Survivors of Childhood Sexual Abuse

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ABSTRACT

Women's health care providers are being challenged to screen for and respond to the effects of abuse and violence in their clinical practices. Many feel poorly equipped to do so. Addressing the impact of a history of childhood sexual abuse on the survivor client's experience of pregnancy, birth, breastfeeding, and postpartum adjustment is a particularly challenging task. Professionals from several disciplines experienced in working with trauma survivors responded to a case study. Valuable points common to all six case respondents focused on strategies to use to improve communication and relationships with survivor clients. These health care providers also advocate interdisciplinary collaboration. © 1998 by the American College of Nurse-Midwives.

ADDRESSING THE LONG-TERM EFFECTS OF VIOLENCE AGAINST GIRLS AND WOMEN

As supported by U.S. and international research in epidemiology, sociology, and psychology, approximately one in three girls experiences unwanted sexual contact before the age of 18 years (1–3); in addition, the long-term effects of childhood sexual abuse can be severe and can affect psychological and physical health, including childbirth (1,4–8). Increasing amounts of research and clinical experience indicate that survivors want to be asked how the abuse is affecting them (5,9,10). Yet, for the majority of health care providers, stumbling blocks to routine screening remain; these include lack of training, feeling overwhelmed, frustration that the provider cannot really help, and poor fit of violence-related problems with the clinical medical model (11,12). These barriers persist despite the abundance of information about abuse and recommendations for assisting victims of domestic violence, including childhood

sexual abuse, being disseminated by the American College of Obstetricians and Gynecologists (13) and by the American Medical Association (14).

Some women with a history of child sexual abuse trauma will have sought care from mental health care providers for trauma-related problems such as depression, substance use, an eating disorder, repeated victimization, suicidal behavior, dissociative disorder, anxiety, or post-traumatic stress disorder (PTSD) (5). Some may currently be in therapy or using medication for symptom relief. Others may not have experienced major morbidity or may be unaware of any link between current life problems and prior abuse because of trauma-induced amnesia (15,16). For any of these women, pregnancy may trigger reactions that can bring the abuse issues or related psychological, somatic, or interpersonal symptoms to the forefront.

A trigger can be any emotion, sensation, or experience resembling an aspect associated with abuse (6). This trigger then kindles a post-traumatic stress response that can spiral through three clusters of symptoms (17): 1) intrusive reliving (such as flashbacks or body memories) can activate 2) autonomic arousal (causing fight or flight symptoms), which, in turn, may lead to 3) numbing or avoidance efforts (such as dissociation or substance use or phobic reactions). Since pregnancy is a physical, emotional, spiritual, and social experience based in sexuality and gender role, it is not surprising that many internal and external stimuli trigger at this time. Indeed, the entire childbearing year may be emotionally challenging and evocative of abuse experiences for the survivor (18–22).

ALLYING WITH THE CLIENT IN HER HEALING

The purpose of the alliance for care in pregnancy is safe and satisfying care of the mother and infant. However, the woman's abuse history is a contextual factor that can

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have a powerful potentially damaging impact on both the process and the outcome. The client's history and its meaning need to be factored into the plan of care. Because abuse trauma can cause interpersonal as well as physiologic and psychological problems over the long term, it is particularly important to attend very deliberately to the interpersonal aspects of practice when providing maternity care to abuse survivors.

BORROWING PSYCHOTHERAPY PRACTICE SKILLS AND CONCEPTS

Collaborating with mental health professionals and borrowing some of their perspectives and strategies for working with clients can be very beneficial when caring for pregnant survivors. Some of the interpersonal practice strategies of psychotherapists can help health care providers facilitate the survivor's efforts at healing and avoid retraumatization (23).

It is one thing to know that therapists working with survivors see their task as facilitating the client's recovery. It is something else altogether to know how they do it. Therapists come from the disciplines of psychology, social work, psychiatry, and mental health nursing. They vary widely in their choice of theoretical orientations. Many hold to traditional perspectives and practices, while others have adopted feminist approaches to therapy (24,25). Despite this diversity among therapists, most of the clinicians and researchers working with women sexual abuse survivors (and writing about it) place the empowerment and safety of the client in the caregiving situation at the top of their list of objectives (5,18,24). They enact these values primarily through relationship processes that can readily be adopted by other practitioners.

A COLLABORATIVE CASE STUDY

To illustrate relationship strategies and interdisciplinary collaboration, a nurse-midwife, clinical psychologist, childbirth educator, consultant obstetrician, labor and delivery nurse, and postpartum abuse survivor, all of whom have professional experience working with abuse survivors during childbearing, provided input into a hypothetical case study (See Appendix). Although their recommendations for this specific client's care plan were

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valuable, this article focuses on those points in their responses that illustrate three concepts that can be generalized to care of any survivor. These three processes help create an empowering and safe client-provider relationship and will be referred to as: 1) egalitarian work, 2) exploring meaning, and 3) framing and boundaries.

THE CASE: M'S 20-WEEK VISIT

M, is a 27-year-old married woman, an attorney, who, when asked at her initial prenatal visit, disclosed that she was an incest survivor. She stated then that she had "dealt with all that" in therapy a few years ago and doubted that past abuse would have an impact on her experience of this desired pregnancy. She is a client of a nurse-midwifery service in a university medical center's managed care organization.

The client's medical history includes asthma in childhood and bulimia that caused her to enter therapy and which she states is now resolved.

Her sexual and reproductive histories include no prior pregnancies, condom use for contraception, and no routine gynecologic care prior to beginning prenatal visits. Her husband has been her only sexual contact in adulthood. M did not disclose any of the circumstances of the sexual abuse except to call it "incest."

History of this pregnancy includes entry to care at 6 weeks gestation, constant nausea from the date of the missed period and persisting to this visit at 20 weeks with occasional vomiting. She is of normal weight and has gained only 4 lbs. in the pregnancy. M calls the midwives frequently, often in the late evening, with concerns about normal physical changes and discomforts of pregnancy. She has declined the use of Doppler ultrasound to listen to fetal heart tones. Last week, she felt fetal movement for the first time, and, that same evening, she went to urgent care for an asthma attack that subsided with inhaler therapy.

M had rescheduled this prenatal visit twice. She started the encounter by expressing anger at the midwife who was running 20 minutes behind schedule. She appears tense and states that she is not sleeping well at all. Upon questioning, M states that she is having some nightmares and startles awake several times a night, often feeling a wave of nausea upon awakening. She states that she needs to discuss plans for labor and birth at this visit, insisting that having this information will make her feel better. She stands up abruptly to leave when the midwife suggests that they schedule a separate visit to allow more time to talk about her concerns about labor and birth.

SUMMARY OF CASE CONCERNS

For the most part, the case respondents' concerns relating to the client's physical care center around risks

that increase if asthma, vomiting, poor weight gain, and risk for intrauterine growth restriction are not addressed. While each of these problems might typically be managed with a standard medical approach, the case respondents also recognized that these phenomena could be reconceptualized as manifestations of long-term sequelae of abuse, such as PTSD, exacerbated by the triggering crisis of pregnancy. These clinicians also focused on emotional concerns (eg, increased anxiety and fear) and interpersonal issues (eg, lack of trust, power imbalance, struggles with dependence, communication obstacles, and nonadherence to plans of care) that are likely to surface, given what is known about childhood sexual abuse.

CONCEPTS FROM INTERPERSONAL PRACTICE

Egalitarian Work

Jean Baker Miller, MD, author of the book, *Toward a New Psychology of Women* (26), describes an ideal of an egalitarian helping relationship in which the goal is to make the inequality “temporary” by working to bring the less powerful one up to a greater level of parity (in terms of increasing her knowledge and ability to act autonomously). Unequal power is inherent in a maternity caregiving relationship because of the greater knowledge of the helper and the heightened dependency related to the client’s pregnancy and need for care. The normative hierarchical traditions in the provider-patient relationship may intensify a client’s sense of vulnerability and need to be considered as we approach clinical work with survivors.

Laura Brown, PhD, the psychotherapist respondent to this case and author of *Subversive Dialogues: Theory in Feminist Therapy* (27), writes at length about the relationship in feminist psychotherapy in ways that are valuable to other caregiving disciplines. She points out that even when providers do not feel very powerful in the context of the system in which they work, relative to the client, they are powerful. She warns “[that] power ignored becomes power out of control” (p 106). Brown suggests that it is possible to move toward a more egalitarian working relationship when caregivers have awareness of their sources of power (eg, clinical knowledge and skills, nurturance, presence) and acknowledge that the client brings a willingness to collaborate (or not), knowledge of her own life, and a particular expertise in relation to her abuse history, its effects on her experience of childbearing, and what she needs in order to do as well as she can. It is empowering to “locat[e] knowledge and reason equally in the client and in the [caregiver]” (p 117). Brown acknowledges that each working relationship is likely to begin in a more hierarchical mode but can move toward more egalitarian ways of working.

In the case responses, there are several points that illustrate an empowering, egalitarian approach to the caregiver-client relationship. The primary care provider, Karen Holz, CNM, labels the points of her plan *interactions* rather than using the more expected word *interventions*, implying that both players are involved in a potentially equal way and emphasizing that building trust and communicating needs and concerns form a main category of work with this client. Holz also talks about “staying open to her [the client’s] goals and needs, rather than imposing [one’s own] beliefs . . . ,” and acknowledges that “the order, timing, and advisability of these interactions would vary depending on the needs, ability, and willingness to participate in the process expressed by the client,” a point that clearly acknowledges that the client has power to influence the plan of care.

In her case response, Laura Brown suggests a way of reframing the client’s experiences so that she knows “that such distress is *not* a sign of psychopathology, but is, rather, evidence of her attempts to cope . . . which places her responses into an active coping context.” This conceptualization underscores that the struggling client is contributing work to keep her balance. Brown also suggests that, “it will be essential to give M as much power and control as possible over both the process and content of what happens during her pregnancy care.”

As a childbirth counselor and educator and as an advocate for appropriate childbearing care for incest survivors, Penny Simkin, PT, proposes individual birth planning for these clients. She explains,

The sexually abused client is especially vulnerable during pregnancy and birth because many issues come up that are similar to the abuse issues, [including]: the loss of control over her body that comes with normal pregnancy changes and fetal movement; nakedness, exposure of her genitals; insertion of fingers or instruments into her vagina; lack of trust in her caregiver, related to the helplessness, pain, lack of control and knowledge that come with birth, and being a “patient” who must depend on and trust authority figures . . . ; and vaginal pain with expulsion.

She goes on to explain that by preparing for childbirth with an educator/counselor member of the team who will address the birth and abuse issues in tandem, the survivor increases her knowledge and power and is better able to work with her provider to “minimize the negative repercussions” from the abuse. Simkin suggests that having a labor doula who understands the client’s needs will increase her base of support.

In his role as the nurse-midwife’s consultant obstetrician, Timothy R.B. Johnson, MD, FACOG, discusses ways in which the provider and client need to come to agreements about care plans and openly exchange lists of expectations that each has of the other. Since childhood sexual abuse can have long-term impacts on

interpersonal aspects of the survivor's life, such as difficulty trusting, problems expressing or containing anger, or problems setting boundaries on others' behaviors, clear understandings and commitments between caregivers and survivor clients can help prevent conflict or betrayal. The work of drafting these plans can be more or less egalitarian. Some clients might find it difficult to disagree with the more powerful provider who, in turn, could easily impose "the usual routine" as the plan of care. The task of developing an individual plan and expectations in a mutual way can be a forum for bringing out the client's contribution and for offering the client a powerful "corrective" experience in terms of her expectations of herself and of providers.

Elizabeth Macnee, RN, the birthing unit nurse, acknowledges the power within the institution to set policies and routines. She encourages the client to do the work of informing herself in advance so that she is prepared to cope or prepared to "relate what things she liked and didn't like" and "think of modifications." She encourages the client to bring with her whatever she will need to feel comfortable during labor, such as her own clothes, as a way of showing that she is taking some control. Macnee also indicates awareness that M is going to present greater than usual challenges in building alliances when she is in the throes of labor, because of her problems with trust. M's feelings about the need to work with health care personnel, such as the labor room nurse, whom she cannot likely get to know in advance, can be discussed ahead of time.

The survivor respondent, who recently gave birth and who has worked on the staff of a labor and delivery unit, commented that she has often seen providers and staff demean, objectify, and overpower traumatized clients who are struggling in labor. She suggests that providers who form a more egalitarian working relationship with their clients benefit because they are less judgmental, understand the women better, and feel the strength of an alliance. They feel less isolated in their efforts to advocate for their clients. She notes that some "backlash" toward potentially demanding or uncooperative clients is inevitable in the provider-dominated, habit-driven hospital culture. However, when the care providers speak of these women with the respect due to an ally and collaborator, it becomes less likely that others will objectify and belittle clients who present these challenges.

Exploring Meaning

In Michel Foucault's famous study of the growth of clinical knowledge, *The Birth of the Clinic: An Archeology of Medical Perception* (28), he traces the shift from the 18th century physician's question, "What is the matter with you?" to the modern doctor's query, "Where does it hurt?" (p xviii). In the first question there is an

assumption that the patient has some knowing about the problem and that the healer can use this understanding to good purpose. Implied in the second question is an acceptance that the professional healer can (in theory and myth, anyway) be expected to go from symptom to diagnosis to treatment using taxonomies of differential diagnosis with no explanatory input from the patient. But incest and its sequelae have been absent from the taxonomy of the health care professions—even from those of the mental health professions until recent history (5,29). This is a clinical instance where the client's understanding of "what is the matter?" is central to her ability to link symptom, meaning, and response.

Within the psychotherapy disciplines, it is a central project of the therapy and healing for the survivor client to do the work of understanding and explaining how her distress, her symptoms, and her history fit together. Exploring meaning is an implicitly understood strategy for accomplishing this work. It is so ingrained in the expectations of therapists that popular caricatures poke fun at the stereotyped question, "Tell me more about that."

In the health care disciplines, the central project of the work is to care for or cure the patient. Appointment times are very short. Providers are supposed to be experts with great stores of knowledge to apply to each "case." Rapid assessment and accurate assumptions based on textbook cases are valued in lieu of deep knowledge about individual clients. This way of working, if applied to M, would lead to "therapeutic" actions that are responses to the "symptoms" as they fit into the usual medical model. Nausea may be understood to be simply "part of being pregnant" instead of a possible communication that this (formerly?) bulimia woman may be purging or wishing to. Without an understanding of post-traumatic stress responses and their impacts, one could respond to the asthma attack as a flare-up secondary to the respiratory changes of pregnancy instead of as a symptom of anxiety or panic. Without exploring meanings of problems with the client, a provider may just impose meanings from the usual maternity care context. As Kaschak put it (30), "A slice of experience can be viewed as if it were experience itself" (p 25). M could be given an inhaler and antiemetics; but, these would not treat PTSD or anxiety or bulimia. Understanding the context of the abuse history and the client's understanding of the nausea and asthma attack symptoms will lead to effective responses. Brown (27) discusses diagnosis in depth, considering the ways in which meaning is co-created between caregiver and client, the ways in which setting affects that process, and the ways in which symptoms both express (for the client) and provoke (in the caregiver) meanings.

Exploring meaning is a relationship task that goes beyond the need to understand symptoms. Macnee

implies this when she points out that M may benefit from an early epidural. Many survivors might see the procedure as invasive and might fear greatly the relative paralysis of their legs. Some women see epidural anesthesia as undesirably medicalizing birth. However, M might see the use of this medical technology as tremendously empowering if she has control over its use and if it represents a safeguard against overwhelming or triggering pain. One would only know her view if she were asked.

Certain behaviors, such as the phone calling, also may have meanings to provider and client that are open to interpretation. Holz posits several possible understandings.

This behavior may be due to the high anxiety related to the physical sensations of pregnancy; extreme fear that her body is being “taken over, possessed, owned, controlled” by another (the baby) as it was during the abuse; a “testing” to see if the CNMs are trustworthy and will be there when she needs them; a search for unconditional positive regard and validation that she lacked in a dysfunctional, incestuous family, etc.

Brown states,

Her frequent phone calls in the evening suggest that when she is home from work, and can no longer engage her usual coping strategy of distraction through work, M is feeling frightened. While she feels uncomfortable asking directly for emotional support, her midwives will be more effective if they offer that as well as (but not instead of) the information that is the official reason for her call.

The survivor respondent suggests that M may be confused by the friendly personal style that is typical of midwives and may be confused about the limits of a caregiving relationship that is not clearly authoritarian. Any of these hypotheses may be correct or incorrect. It makes sense to explore with the client what needs and expectations she is expressing in this pattern of calls.

Her lack of prior gynecologic care is another behavior worth exploring. Holz wonders if “lack of gynecological care for several years says M may not always be able to take good care of herself yet, at least as it relates to medical care.” Brown suggests that

. . . her pregnancy, with its heightened focus on her bodily sensations and requirements for necessary but invasive gynecological care that she has avoided completely in the past, is restimulating feelings and recollections of the incest that she thought she had successfully banished from her consciousness. It seems quite probable that she is having a recurrence of painful intrusive recollections in the form of the nightmares which are awakening her nightly.

Johnson considers that

Many “survivor” patients are very fearful of any type of physical contact, particularly the type occurring during

prenatal care. Patients can dissociate during an early pelvic examination and can be very fearful of subsequent pelvic examinations, anesthesia during labor and delivery, vaginal delivery, forceps, or the invasion of their body by cesarean section. They can be concerned about the probes used with ultrasound and fetal assessment . . .

The co-authors know of survivors who have been abused or traumatized by both female and male physicians during gynecologic exams. Any one, or indeed more than one, of these meanings of this avoidance behavior may be behind M’s lack of prior care. Again one will not know how to support her around this issue unless she is asked about it.

All of the respondents discuss the importance of teaching the survivor about how an abuse history can have an impact on her experience of pregnancy. Brown explains,

M and other women with a child sexual abuse history need to hear normalizing information from their care providers about what is happening to them emotionally. This means communicating to her that even women who have “dealt with” an experience of incest are likely to have some recurrence of distress at the time of pregnancy because of what pregnancy entails—genital invasion, attention to her body, physical changes. Offering such normalizing information may help M feel more comfortable disclosing her feelings, and perhaps more likely to consider accepting a referral to psychotherapy as a sort of “emotional booster shot” at this highly stressful time in life.

This is important groundwork because it gives the survivor a sign that, even if she does not seek a therapist’s support, it is safe to bring incest-related meanings into her conversations with health care providers about issues, plans, conflicts, and symptoms. Some clinicians can talk comfortably about the impacts of abuse on childbearing from accumulated clinical or personal experience. Research findings would certainly be helpful to others who have less clinical experience working openly with survivors or who have not heard stories from survivors about how incest affected their childbearing year. Meanwhile, providers can continue to operate in a “praxis” mode where they act on their best theoretical understanding, collaborating with the client and other experts. Lawrence Shulman, a professor of social work practice describes this learning process realistically: “We will make many mistakes along the way . . . saying things we will regret and having to apologize to clients, learning from these mistakes, correcting them, and then making more sophisticated mistakes” (31, p 27).

Framing and Boundaries

The “frame” for psychotherapy is the set of “rules” or “norms” that set the parameters about how the work will

be done. A familiar stereotype has therapist and client meeting once a week in a quiet, private, room with two chairs talking confidentially during a 50-minute "session" for the client's benefit. However, it is also known that, depending on the problems the client is coping with, this frame may expand to include more frequent sessions, phone contact with the therapist for emergencies, medications to help with symptoms, or even hospitalization to manage a crisis.

The "frame" for maternity care is equally familiar. In the case of M, whose nurse-midwives are on staff at a university medical center, the frame will be typical of hospital-based maternity care. It will include prenatal visits in a clinic setting at certain expected intervals for a certain length of time. Confidentiality is an ideal, although its maintenance is often problematic. Prenatal care would normally involve the usual players: midwives, nurses, medical assistants, back-up obstetricians, possibly other physicians, and community childbirth educators. It would include assumptions about the goals and limits of the interactions, including the assumption that M is an appropriate client for midwifery care. Care would usually only involve services that will be reimbursed by third-party payers. For most clients, this frame is adequate and can remain implicit and unquestioned.

When working with incest survivors, it is useful to keep the elements of the "usual" frame in mind and consider if modifications would be useful. This is the usual approach whenever a client develops a recognized complication. For example, if a woman developed pregnancy-induced hypertension, the frame would need to change with regard to the amount of contact between the client and provider and the amount of payment available for fetal surveillance and laboratory testing in order to meet the outcome goals of safety for mother and fetus. Members of the maternity care team and payers alike accept this expanded frame of care because there is research to support its worth. If ongoing risk assessment of a survivor client indicates that she is having problems, one may need to reconsider the structure of care for her in light of potential risk for complications that could affect outcomes. M may well need an expanded frame that allows for more frequent visits or additional services (such as offers of supportive psychotherapy, psychiatric evaluation for medication for relief of anxiety or compulsion to purge, or a doula's support in labor). The provider may need to put "psychological stress" or "risk for intrauterine growth restriction secondary to history of bulimia" or "post-traumatic symptoms" or "anxiety" on her problem list and care plan in order to justify these expenses to managed care payers. Research findings and case documentation are needed to build an argument for the clinical value and cost-effectiveness of such interventions in maternity care. Secondary prevention is unquestionably preferable to the hypothesized further

morbidity of preterm contractions, dysfunctional labor, postpartum mood disorders, unsuccessful breastfeeding, and impaired parenting (1,7,12,32-35).

While the "frame" can be seen as the set of constraints that surround the client and provider, "boundaries" can be seen as the set of limits that they find between them. Typically, boundaries are constructed to protect the well-being of one or the other member of the relationship. In many caregiving relationships, the boundaries are not problematic, especially where there is a strong basis for trust. But for a survivor whose physical and emotional integrity was violated repeatedly, boundary issues and the trustworthiness of the caregivers can be very important. Violations of boundaries can stir up anger and create awkwardness in the relationship. For example, three evening calls in a week from one woman with no obvious emergent problem could begin to seem like a violation of the midwives' boundaries related to time, privacy, and rest. Similarly, if the midwife did a vaginal exam in labor without asking permission and with no urgent need to do so, that would be a violation of the woman's boundaries about body integrity and control. The caregiver needs to pay particular attention to boundary issues and debrief problems when they arise.

Important boundaries usually exist around safety issues. In the case study, Johnson anticipates this type of boundary when he stated, "How she will accept obstetric back-up services and whether . . . by a male or female obstetrician-gynecologist . . . needs to be discussed." Since a majority of women sexually abused in childhood report having been abused by males (96% in Russell's large study) (2), survivors may choose midwifery care because they want female providers (36). If M would indeed refuse care from a male provider, this is a boundary issue that needs to be discussed. Perhaps a female obstetrician would always be available for back-up. Or, perhaps M would accept care from a male if the midwife were present as a support (and chaperone). Neglecting to discuss the issue leaves open the very real possibility that M would feel betrayed if a male physician's help were needed and there was no time to "negotiate" about it.

Safety issues exist for the provider as well. Most providers have clinical boundaries to which they strictly adhere. As an example, Holz discussed her "bottom line" about using only a fetoscope in prenatal care, but relying on a Doppler or monitor for auscultation in labor. She is very willing to explain to a client why she needs this option for herself: It is easier given the noise and movement in labor, the benefits of effective auscultation in labor outweigh any known or theoretical risk of ultrasound, and it is consistent with community standards where she practices. Holz says that clients usually respect and accept this limit when they hear the reasons for it. But she acknowledges that,

Allowing ourselves to be manipulated into practicing in ways we do not feel safe benefits no one. . . . Clients need to be told of these limitations and how they affect care early in the relationship and with complete honesty. Rarely, issues will arise between a client and caregiver that cannot be resolved to the satisfaction of both.

The concept of “boundaries” may be useful to conceptualize a few other issues very briefly. First, the fetus may be the most significant “boundary violator” for an incest survivor. Holz tells us that M may be experiencing “extreme fear that her body is being ‘taken over, possessed, owned, controlled’ by another (the baby) as it was during the abuse.” Brown made a similar point in her case response that “her [the client’s] pregnancy, with its heightened focus on her bodily sensations . . . is restimulating feelings and recollections of the incest.” This conceptualization of emotional conflict occurs also in the psychoanalytic case literature (22). Birth itself may feel like a violation of the integrity of the vagina, or abdomen in the case of cesarean delivery. As Simkin pointed out, we may need to “explore the difference between birth and rape,” because these may be associated at some level in the survivor’s awareness.

Second, many nurses and midwives rely on touch as a means of nonverbal communication used to soothe and support the client in labor when words may be inadequate or counterproductive. This may still constitute a boundary violation to some clients. As such, it would not be therapeutic at all and would likely be stress inducing. This can be especially true for women whose abuse involved being stroked or fondled. The provider needs to ask the woman explicitly if she finds touch to be helpful or not.

Third, it is worthwhile to acknowledge here that there is often no way to provide maternity care without having to cross a client’s body boundaries at some point. Some survivor clients do not have any particular stress with intrusive procedures. Others will truly consent to examination, for example, but they may experience the exam as traumatic nevertheless. The provider may not be aware of any adverse reaction (10). Or, the client’s stress may be evident as she struggles to cooperate. If she used the psychological protective mechanism of dissociation to cope with traumatic abuse in childhood, she may dissociate during times of current distress, such as during an exam or in labor. Recognizing and deciding how to respond to dissociation can be difficult. This is often an area of discomfort because it is generally not addressed in training providers to administer routine health care (although nurses and physicians may have learned about it in the context of their psychiatric rotations). The nurse-midwife author found consulting with a therapist who treats survivors to be a very useful help for developing strategies and judgment for assisting a client who is dissociating.

The concept of dissociation goes to one final “boundary” issue. Maternity care practitioners can borrow concepts from interpersonal practice theory to apply to their work, but they cannot expect to become immediately expert at using them. Sometimes, the nature of the relationship or aspects of the client’s presentation (such as dissociation, depression, or substance abuse) will challenge the provider’s ability. It is tempting to argue that dealing with some of these difficulties (dissociation, for example) is beyond the average practitioner’s scope of practice; to be sure, it transcends most comfort zones. Certainly, the appropriate use of psychological referral and consultation resources is essential; in addition, obstetric co-management or even transfer for a client who becomes high risk for trauma-related reasons may become necessary. However, it is critical to acknowledge that, sooner or later, a traumatized client will show up in such distress that intervention must take place then and there. Thus, practitioners will need to work to expand their abilities and push the boundaries of their competence and the traditional borders of their disciplines in order to meet the emotional and interpersonal, as well as physical, needs of victims of violence within their health care practice.

FINAL THOUGHTS

Women’s advocates are calling for a more multidisciplinary approach to health care that can take into account the context of a woman’s life, including past and current abuse. It has been said that the impact of violence on health is made invisible by its ubiquity. Women’s health care providers are beginning to perceive that violence in the lives of girls and women is a common reality. It is time to consider systematically that perhaps some of the problems clients face in childbearing may not be only pregnancy-related—they also may be trauma-related. Research is needed on the impacts of childhood sexual abuse on childbearing, including physiologic studies of PTSD in women and its potential alterations to pregnancy processes, while feedback and evaluation of attempted interventions must follow. Meanwhile, practitioners can benefit from collaborative relationships with clients, maternity care coworkers, and colleagues from the psychological disciplines in order to gain increased knowledge from hands-on clinical experience. Laura Brown provides the final word:

A feminist perspective, which draws our attention to the lives of girls and women, to the secret, private, hidden experiences of everyday pain, reminds us that traumatic events do lie within the range of normal human experience. . . . When we begin to acknowledge that reality, we make our professions revolutionary; we challenge the status quo, and participate in the process of social change (37, p 132).

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(Appendix follows on page 295)

APPENDIX

Case Respondents

Karen Holz, CNM, practices in Fairfax and Alexandria, Virginia. She has long been interested in care of survivors. She wrote "A practical approach to clients who are survivors of childhood sexual abuse" in the *Journal of Nurse-Midwifery* (1994) and is a co-author of the home study program on domestic violence (1996).

Laura Brown, PhD, is a clinical psychologist in private practice in Seattle, Washington. She is a prolific writer on trauma and numerous aspects of feminist therapy. The Association of Women in Psychology of the American Psychological Association honored her with its 1997 award for distinguished contributions to the profession. Her 1994 book, *Subversive Dialogues: Theory in Feminist Therapy*, contains many ideas that can be applied to feminist practice in the health care disciplines.

Penny Simkin, PT, is a childbirth educator and counselor affiliated with the Seattle School of Midwifery and

on the editorial board of *Birth*. She publishes and speaks around the world about numerous aspects of childbirth, labor support and doula care, and care of incest survivors in birth.

Timothy R.B. Johnson, MD, FACOG, chairs the Department of Obstetrics and Gynecology at the University of Michigan and teaches in the Program in Women's Studies. He is a consultant for the University of Michigan Nurse-Midwifery Service and a trustee of the ACNM Foundation.

Elizabeth Macnee, RN, is a staff education coordinator and a birthing unit nurse at the University of Michigan Women's Hospital.

The survivor respondent once worked as a nursing assistant on a labor and delivery unit. She recently gave birth to her fourth child. She is a mental health professional and agreed to respond to this case study by contributing thoughts from a client's perspective but asked not to be identified.