3rd INTERNATIONAL CONGRESS OF CLINICAL AND HEALTH PSYCHOLOGY ON CHILDREN AND ADOLESCENTS

16/18 NOVEMBER 2017 | SEVILLE SPAIN

PREVALENCE OF OBSTETRIC VIOLENCE IN SPAIN

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BACKGROUND

- **In 2014, the WHO warned about the seriousness of disrespect and mistreatment during childbirth, becoming a public health problem, and how it compromises mothers' and babies' biopsychosocial wellbeing**
- There are already some preliminary data on how bad practices or mistreatment during childbirth can affect maternal mental health (Allen, 1998; Elmir et al., 2010; Maggioni et al., 2006) and interfere with early bonding, attachment and subsequent babies' development (Beck, 2006; Beck y Watson, 2008, Gregory et al., 2013).
- However, research on the field is still limited and more information on the actual frequency of this kind of practices is needed

Aim → To retrospectively describe Obstetric Violence incidence from the perception of the users

METHOD

Cross-sectional study. An **online questionnaire** was created. Any woman who had delivered a baby in Spain after 2008 (the year a Public Strategy for Normal Childbirth was published by the Spanish Health Ministry) was allowed to answer it

It was opened from November 2015 to September 2016 and it included questions on **professionals' behaviours during childbirth towards women, information and consent prior to any medical procedure, and labour, childbirth and postnatal received attention**

RESULTS

N= 1921 women, with an average age of **31,6 years**
92% were **Spanish**, 79,6% had a **college degree** and 95,4% **delivered in a hospital**

1. Attitudes and messages of health's professionals	
They did not request authorization to treat users	70.3%
They did not request permission to treat users	66%
Unprofessional and incorrect language used	40%
Someone said they were doing it wrong	33.8%
They criticized the expressions of pain, cries or moans	32.5%
They questioned the ability to breastfeed	35.1%
Women who opted for artificial breastfeeding were judged by them	25%

2. Informed consent	
The intervention has been offered (induction, Kristeller, episiotomy, etc.) but women were not informed	50.7%
It was not indicated why a particular maneuver was advised in the case	60.8%
The different options of action (including the expectant attitude) were not presented	76.6%
The possible consequences were not explained	80.4%
Side effects of the intervention were not explained	84.6%
Action was taken without the informed consent of women	51.1%

3. Birth Plan	
Derogatory treatment due to Birth Plan's presentation	25.3%
The birth plan was not respected	65.8%
Not allowed to eat or drink	55.7%
Wandering around	53.4%
Use of personal material (such as music or clothing)	58.2%
Or support material	51%
They were not allowed to choose the posture in the expulsion	74.7%
They could not decide on the fate of their placenta	79.2%

4. Neonatal admission	
Mothers were not explained nor asked for consent for each performance on their babies	66.7%
They could not be with their babies	42.7%
They were forced to leave when procedures or tests were performed on their babies	42.6%
Mothers were criticized because their babies cried	20.1%
They were urged to go home and leave their babies unaccompanied	27.6%
They could not be accompanied by the person or persons of their choice during admission	21%

5. Neonatal death	
The mothers did not receive clear information on autopsy and burial	75%
The mothers did not have the freedom and time to decide on the bodies of their babies	65.2%
The mothers were not accompanied or helped to see, touch or hug their babies	58.5%
The mothers could not be with them	35.7%
Pejorative language was used to refer to their dead children	24.5%

35.9% of the women answered that they had needed or still need psychological help to overcome the memories or consequences of their deliveries

CONCLUSIONS

- In line with previous studies (Terán et al, 2013; Valdés-Santiago et al, 2013), these data constitutes empirical evidence on the **high prevalence of traumatic deliveries in Spain**.
- The **psychological impact** on mothers (post-traumatic syndrome, depression, etc.) and babies (difficulties in mother-baby bonding and its influence on their development) have important consequences (Ayers, 2004; Beck, 2004; Olde, van der Hart, Kleber y van Son, 2006).
- As pointed out by Sadler et al. (2016), this kind of violence **should be visible and penalised**, being urgent to obtain more objective data on that subject.
- In order **to prevent** obstetric violence, **psychological support interventions must be directed to health personnel** (Olza, 2014; Pintado-Cicarela et al, 2015).

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A SYSTEMATIC REVIEW OF OBSTETRIC VIOLENCE

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OBSERVATORIO DE LA VIOLENCIA OBSTÉTRICA

BACKGROUND

- Obstetric violence (OV) is defined as the **appropriation of the body and reproductive processes of women by health personnel, which is expressed by dehumanized and hierarchical treatment and an abuse of medication, converting these natural processes into pathological ones. This originates loss of autonomy and of the capability for women to decide freely about their bodies and sexuality, which negatively impacts on their quality of life and their babies**
- Some laws established in Latin America related on this issue (Venezuela, 2007; México, 2007-2014; Argentina, 2009) have helped to its visibility, although the term has started to be considered only recently in Spain

  "*The judicature, the public prosecutor's office and the legal operators in general* ***tend to exclude to pregnant women, consciously or unconsciously, of the laws that protect human rights in the applications of the medicine. The implicit argument –and false– is that submitting pregnant women to medical authorities, their babies are being protected***" (Fernández-Guillén, 2015)
- Some of the practices reported under the heading of OV are the denial of information about procedures used during childbirth care, derogatory humiliations and attitudes, excessive rates of C-section deliveries, and standardized medical practices without a proven improvement to the welfare of women (enemas, episiotomies, sedatives, obligatory supine position or Kristeller manoeuvre)

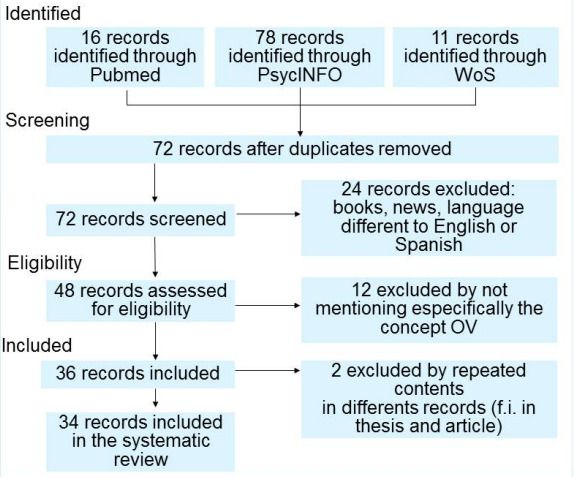
Aim → To systematically review the worldwide available evidence on OV until August 2017

METHOD

The electronic databases PUBMED, PSYCINFO and WEB OF SCIENCE were examined by the words "violencia obstétrica" or "obstetric violence".

Only the articles in English or Spanish were considered. Data from reports, thesis or still-non-published articles were included when they were considered relevant and were accessible (See Figure 1)

Figure 1. Flow of information through the different phases of the systematic review according to Moher et al (2009).



RESULTS

Table 1. Description of the included studies (N= 34).*

Nº and Author/s	Year	Type of document
1. Camacaro	2009	Qualitative Study (Sociology)
2. Villegas	2009	Theoretical Study (Medicine, Law)
3. D'Gregorio	2010	Editorial (Obstetrics and Gynaecology)
4. Faneite et al	2012	Descriptive Study (Obstetrics and Gynaecology)
5. Valdés-Santiago et al	2013	Descriptive Study (Obstetrics and Gynaecology)
6. Salgado et al	2013	Qualitative Study (Obstetrics and Gynaecology)
7. Teran et al	2013	Descriptive Study (Obstetrics and Gynaecology)
8. Castro & Erviti	2014	Theoretical Study (Multidisciplinary)
9. Bohren et al	2014	Review (Public and Reproductive Health)
10. Arguedas	2014	Theoretical Study (Philosophy and Bio-Ethic)
11. Olza	2014	Theoretical Study (Psychiatry)
12. Froes et al	2014	Qualitative Study (Obstetrics and Gynaecology)
13. Melo et al	2014	Randomised Controlled Trial (Obstetrics and Gynaecology)
14. Frías	2014	Descriptive Study (Sociology)
15. Dixon	2014	Qualitative Study (Anthropology)
16. Martínez	2015	Qualitative Study (Nursing)
17. Fernández-Guillén	2015	Theoretical Study (Law)
18. Bellón	2015	Theoretical Study (Philosophy and Bio-politic)
19. García	2015	Descriptive Study (Sociology)
20. Calafell	2015	Theoretical Study (Sociology)
21. Pintado-Cicarela et al	2015	Quantitative Study (Psychology)
22. Bohren et al	2015	Review (Public and Reproductive Health)
23. Smith	2015	Qualitative Study (Anthropology)
24. Vacaflor	2016	Theoretical Article (Law)
25. Diaz-Tello	2016	Theoretical Article (Law)
26. Sadler et al	2016	Theoretical Article (Several approaches)
27. Junqueira et al	2017	Quantitative Study (Health Sciences)
28. Pope	2017	Theoretical Article (Law)
29. Fritz et al	2017	Randomised Controlled Trial (Health Sciences)
30. McGarry et al	2017	Review (Nursing and Midwifery)
31. Lokugamage & Pathberiya	2017	Review (Law)
32. Leinweber et al	2017	Quantitative Study (Midwifery)
33. Leinweber et al	2017	Quantitative Study (Midwifery)
34. Chadwick	2017	Editorial (Anthropology)

*The studies are listed chronologically, by year of publication.

34 studies published on OV around the world:

- 20 in Latin America (Mexico, Venezuela, Brazil, Argentina, Costa Rica)
- 4 in Spain
- 2 in USA
- 2 in UK
- 2 in Australia
- 1 in South Africa
- 3 in collaboration of different countries

CONCLUSIONS

- **They are reflected significant rates of OV practices**
  - The 29% of women have perceived some kind of abuse in their childbirths from part of professionals that attended to them. Excessive rates of medical interventions
  - 67% reported not to having received previous information or consent to medical interventions, 49% was object of a dehumanising treat from professionals
  - Most of the women that delivered by C-sections were frustrated because of the medical routines (not allowed to be accompanied, separation mother-baby, etc.)
- **OV is associated with patriarchal system, relations based on power, violence against women, and is related to the violation of fundamental human rights**
  - The OV emerges as a structural mechanism of control of the woman by the obstetric power
  - Each country should legally regulate those practices according to their specific conditions
  - Term OV is known growingly, although the constitutive acts of OV are not clear, nor the mechanisms to complaint or help to victims
  - The main obstacle is the usual conceptualization of OV from the medical context as a problem basically of "quality of the attention"
  - The OV is a barrier detected for care seeking
- **OV is estimated to show a great impact on the physical and psychological wellbeing of mother and baby, as well as on psychological wellbeing of professionals that provide care to them**
  - Between 1% and 6% of women will develop complete PTSD following childbirth and 35% of women present some degree of PTSD symptoms postpartum
  - Women are often traumatized as a result of the actions or inactions of midwives, nurses and doctors
  - Strong positive association between the several indicators of OV and postpartum depression
  - Posttraumatic stress contributes to attrition in midwifery. Intention to leave the profession, a peritraumatic reaction of horror , peritraumatic feelings of guilt, and a personal traumatic birth experience were strongly associated with probable PTSD (17% of midwifes met criteria for that)
- **It is highlighted the importance of give visibility to the problem and the requirement of attention by society and professionals to contribute to the study of the cases and emphasize their prevention, being the development of psychological research and psychotherapeutic interventions urgent**
  - Professionals may exert OV because of lack of technical skills to deal with emotional and sexual aspects of childbirth, unsolved trauma and or professional burnout
  - A simulation, team-training program and discussions regarding routine care has an impact on adopting evidence-based practices, contributing to an increased quality of care

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