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Leann Stadtlander
leann.stadtlander@waldenu.edu

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Pregnancy and Intimate Partner Violence

by Lee Stadlander, PhD

Abstract: Millions of pregnant women are abused each year around the world. Interpersonal violence (IPV) affects physical and mental health, both short and long term. It is associated with alcohol and drug abuse, eating and sleep disorders, physical inactivity, poor self-esteem, posttraumatic stress disorder, self-harm, unsafe sexual practices, suicide, and homicide. IPV has also been associated with adverse pregnancy outcomes such as preterm birth, low birthweight, and being small for gestational age. This article provides background information on pregnancy and IPV, as well as screening questions that may be used to support clients, and offers resources for childbirth professionals.

Keywords: intimate partner violence, domestic violence

Pregnancy and Intimate Partner Violence

Intimate partner violence (IPV) is defined as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another” (National Coalition Against Domestic Violence, 2015, para.1). It includes physical violence, sexual violence, threats, and emotional/ psychological abuse. It is an international issue, for example, 50-60% of women in Ethiopia experience IPV in their lifetimes (Berhane, 2004); in India 34% of women have experienced physical abuse (Begum, Donta, Nair, & Prakasam, 2015), in the United States more than 10 million people are abused victims annually (Black et

al., 2011). The severity of violence may sometimes escalate during pregnancy or the postpartum period (Brownbridge et al., 2011; Cheng & Horon, 2010).

Pregnancy and IPV

The prevalence of IPV during pregnancy varies greatly internationally. A World Health Organization 19-country-study (Devries et al., 2010) showed that the prevalence of IPV during pregnancy was 3.8%-13.5% in Africa, 2.0%-5.0% in the United States, 1.8%-6.6% in Europe and 2.0% in Australia. IPV has been associated with poor pregnancy weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight (Brown, 2009, Committee on Health Care for Underserved Women, 2017).

United States data from a 2009-2010 survey (U.S. Dept. of Health, 2013) indicated that 3.2% of women reported that they had been pushed, hit, slapped, kicked, choked, or physically hurt in some other way during their most recent pregnancy. Nearly 7% of teen mothers reported IPV during pregnancy compared with fewer than 2% of mothers older than 30 years of age. Rates of IPV during pregnancy for mothers with less than 12 years of education were 4.5% compared with 1% in those with more than 16 years of education. Overall, the highest prevalence of IPV during pregnancy was reported in non-Hispanic American Indian/ Alaska Native and non-Hispanic black women (6.5% and 5.8%, respectively), and the lowest prevalence was seen among non-Hispanic Asian women (1.5%).

The Effects of IPV

IPV affects both physical and mental health, these effects can be direct (such as those sustained from injury and physical violence) or those that occur indirectly (e.g., chronic health problems resulting from prolonged stress; Chisholm, Bullock, & Ferguson, 2017). The adverse effects may persist for years, even if IPV stops (Alejo, 2014). Functional disorders (conditions for which there is no identifiable medical cause and are difficult to diagnose) are common in survivors, these include such disorders as irritable bowel

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syndrome and other gastrointestinal symptoms, fibromyalgia, various chronic pain syndromes, and overall poor health. Mental health disorders include high levels of depression and thoughts of suicide and attempted suicide. IPV is also associated with alcohol and drug abuse, eating and sleep disorders, physical inactivity, poor self-esteem, posttraumatic stress disorder (PTSD), self-harm, and unsafe sexual practices (Chisholm et al., 2017).

In a study using the Edinburgh Postnatal Depression Scales, nearly 50% of pregnant women subjected to IPV exceeded the cutoff score for depression (Alhusen, Ray, Sharps, & Bullock, 2015). Violent maternal deaths are also associated with IPV. The National Death Reporting System shows that the reported rates for pregnancy-associated suicide and homicide were 2.0 and 2.9 deaths per 100,000 live births, respectively, with differences observed in incidence by maternal age and race/ethnicity. A total of 54.3% of pregnancy associated suicides involved intimate partner conflict that appeared to contribute to the suicide (Palladino, Singh, Campbell, Flynn, & Gold, 2011). Homicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner (El Kady, Gilbert, Xing, & Smith, 2005).

IPV has also been associated with adverse pregnancy outcomes such as preterm birth, low birthweight, and being small for gestational age. These newborns are also at an increased risk of developmental and behavioral issues (Chisholm et al., 2017).

Recognizing IPV as a Childbirth Professional

Childbirth professionals are in a unique position to assist clients, as these professionals tend to be trusted and can see women privately. However, for childbirth professionals to become effective in helping clients in IPV relationships, they must accept two premises (Taft & Hooker, 2017). The first premise is that IPV is a serious public health issue, rather than a private one, and falls within the purview of the health professional. The second premise is that no one, under any circumstances, deserves to be physically, sexually, or emotionally abused. Professionals must maintain empathy and support for women, refrain from judgment, and remember that escaping from IPV is a process not a discrete event (Taft & Hooker, 2017). Professionals should never insist that women leave an abuser but support them in the process. When the woman judges she has sufficient resources, is safe and confident to leave, she will do so. Statements by a health professional to the IPV survivor that she is a worthwhile person and

does not deserve to be hurt, can be extremely empowering to a woman in a vulnerable position (Bloom et al., 2011).

The American College of Obstetricians and Gynecologists (Committee on Healthcare for Underserved Women, 2012) recommends screening for IPV at the first prenatal visit, at least once per trimester, and at the postpartum checkup. Studies have shown that patient self-administered, or computerized screenings are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening (Ahmad et al., 2009; Chen et al., 2007). Screening for IPV should be done privately. Health care providers should avoid questions that use stigmatizing terms such as “abuse,” “rape,” “battered,” or “violence” (see sample questions below) and use culturally relevant language instead. They should use a strategy that does not convey judgment and one with which they are comfortable. Written protocols will facilitate the routine assessment process. Even if abuse is not acknowledged, simply discussing IPV in a caring manner and having educational materials readily accessible may be of tremendous help. Providing all clients with educational materials is a useful strategy that normalizes the conversation, making it acceptable for them to take the information without disclosure. Other suggestions from the American College of Obstetricians and Gynecologists (Committee on Healthcare for Underserved Women, 2012) include:

- Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.
- Use professional language interpreters and not someone associated with the client.
- At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform clients of the confidentiality of the discussion and exactly what state/country law mandates that a health care provider must disclose.
- Incorporate screening for IPV into the routine medical history by integrating questions into intake forms so that all clients are screened regardless of whether abuse is suspected.
- Establish and maintain relationships with community resources for women affected by IPV.
- Keep printed take-home resource materials such as safety procedures, hotline numbers, and referral information in privately accessible areas such as restrooms and examination rooms. Posters and other educational materials displayed in the office also can be helpful.
- Ensure that staff receives training about IPV and that training is regularly offered.

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Example Intimate Partner Violence Screening Questions

Framing Statement:

"We've recently started talking to our clients about some issues related to safe and healthy relationships because it can have a large impact on your health."

Confidentiality:

"Before we get started, I want you to know that everything we discuss today is confidential, meaning that I won't talk to anyone else about what is said unless you tell me that... (insert the laws in your state/ country about what is necessary to disclose)."

Sample Questions

"Has your current partner ever threatened you or made you feel afraid?" (Some alternatives: threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages)

"Has your partner ever hit, choked, or physically hurt you?" ("Hurt" includes being hit, slapped, kicked, bitten, pushed, or shoved.)

For women of reproductive age:

"Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms?" Alternative: "Does your partner support your decision about when or if you want to become pregnant?"

"Has your partner ever tampered with your birth control or tried to get you pregnant when you didn't want to be?"

For women with disabilities: "Has your partner ever prevented you from using a wheelchair, cane, respirator, or other assistive device?"

"Has your partner ever refused to help you with an important personal need such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, or getting food or drink or threatened not to help you with these personal needs?"

Contingency Planning

A protocol with all the information needed to perform an IPV assessment and resources should be kept available for personnel. If a woman indicates she is in a violent relationship, the childbirth professional should acknowledge the trauma and assess the immediate safety of the woman and her children while assisting her in the development of a safety plan. Risk factors for intimate partner homicide include having experienced

Intimate Partner Violence Resources

Hotlines

- National Domestic Violence Hotline 1-800-799-SAFE (7233) <http://www.thehotline.org/>
- Rape Abuse & Incest National Network (RAINN) Hotline 1-800-656-HOPE (4673) Web Sites

Websites

- Futures Without Violence (previously known as Family Violence Prevention Fund) for survivors and offers free technical assistance specifically for health care providers and settings www.futureswithoutviolence.org
- National Coalition Against Domestic Violence www.ncadv.org
- National Network to End Domestic Violence www.nnedv.org
- National Resource Center on Domestic Violence www.nrcdv.org
- Office on Violence Against Women (U.S. Department of Justice) www.usdoj.gov/ovw

Free Posters/Photos for IPV Awareness

- <https://www.pinterest.com/pin/561261172283367831/?lp=true>
- <https://www.shutterstock.com/search/stop+domestic+violence>

previous acts of violence, estrangement from partner, threats to life, threats with a weapon, previous nonfatal strangulation, and partner access to a gun (Campbell, Glass, Sharps, Laughon, & Bloom, 2007). Clients should be offered information that includes community resources (mental health services, crisis hotlines, rape relief centers, shelters, legal aid, and police contact information) and appropriate referrals. Professionals should not try to force clients to accept assistance or secretly place information in her purse or carrying case because the perpetrator may find the material and increase aggression.

Assistance in responding to IPV is often best found through a local domestic violence agency or shelter. When abuse is identified, it is often very useful to offer a private phone for the client to use to call a domestic violence agency. Controlling partners often monitor cell phone call logs and Internet usage. Offering a private phone to call a shelter or hotline is a simple but important part of supporting a victim of violence. For example, the National Domestic Violence hotline is a multilingual resource that can connect a client to local domestic violence programs, help with safety planning, and provide support.

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Lee Stadlander is a researcher, professor, and coordinator of the Academic Psychology Doctoral Program at Walden University. As a clinical health psychologist, she brings together pregnancy and psychological issues.

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