Intimate partner violence and pregnancy: How midwives can listen to silenced women

Abstract

Intimate partner violence (IPV) during pregnancy is a challenging professional issue for midwives, and is associated with serious health consequences for the woman and her baby including significant long-term physical, psychological and social ramifications. One in four women will experience IPV in their lifetime and midwives have an important role in the screening, care and management of pregnant women who may be experiencing IPV. Antenatal screening for IPV is recommended for all women, regardless of presence of risk factors or indicators of abuse.

Keywords: Intimate, Partner, Violence, Pregnancy, Midwifery Care

Gemma Grier
Registered Nurse/
Midwifery Student
Edith Cowan University

Sadie Geraghty
Lecturer
Edith Cowan University

Domestic violence towards pregnant women is both a serious public health and human rights concern. Intimate partner violence (IPV) has been defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners (Williams et al, 2013). IPV describes the incidence of abuse from a current or previous spouse; and includes both heterosexual and same sex couples (Centres for Disease Control and Prevention, 2014). IPV can present in varying forms of abuse including physical, psychological, emotional, sexual, economic and social. During pregnancy, IPV is of particular concern, because it can result in physical, psychological and gynaecological health conditions; and is associated with causing serious complications during pregnancy and adverse outcomes for the baby. There is increasing evidence to suggest that women are at increased vulnerability of IPV during pregnancy and 1 year post-birth (Van Parys et al, 2014). Therefore, midwives have an important role in the screening, detection and the management of women experiencing IPV during pregnancy.

Background of intimate partner violence

IPV has existed in society for hundreds of years, yet over the last few decades, it has been viewed as a serious public health issue. It was once perceived as socially acceptable for a man to beat his wife, providing that the weapon used was no greater than the width of his thumb (Williams et al, 2013). Disconcertingly, there are still countries where IPV towards women is still considered an acceptable social and cultural norm. However, in many developed countries in today's society, not only is IPV socially unacceptable, it is considered criminal behaviour.

Although it is widely accepted that males are predominately the perpetrators of IPV, it should be acknowledged that females may also abuse their partners, accounting for approximately 8% of reported IPV incidents (Hester, 2012). The incidence of female perpetration of IPV is rising and is grossly under detected (Carlyle et al, 2014). There is evidence that supports that some incidences of female perpetration are acts of self-defence related to alcohol abuse and victimisation; however, this is not always the case (Hellmuth et al, 2013).

It is estimated that one in four women will experience IPV sometime in their lifetime, and 30% of incidences of IPV will occur for the first time during pregnancy (Menezes Cooper, 2013). The worldwide prevalence of IPV during pregnancy is thought to range from 1–30% (Garcia-Moreno and Watts, 2011). The prevalence of IPV can only be estimated and it is widely believed that many incidences go unnoticed due to under-reporting. These statistics demonstrate the concerning prevalence of IPV during pregnancy; thus indicating the need for effective antenatal screening during pregnancy.

Risk factors for intimate partner violence

IPV can affect anyone regardless of factors such as culture, gender, religion, sexual preferences, age or socioeconomic status. However, research has identified correlations between certain risk factors and victims of IPV. Risk factors include previous history of abuse as a child or adult, separation from partner, aged 18–24 years, lack of social support, unemployment, low socioeconomic status,

disability, ethnicity and rural/remote isolation (Keeling, 2012). It is important to acknowledge that women with disabilities and mental health issues may be at increased vulnerability for IPV (Keeling, 2012). Further risk factors associated with IPV include women who are multiparous, smoke during pregnancy and those whom are unmarried or not in a de-facto relationship; as well as unwanted or unplanned pregnancies (Garcia-Moreno and Watts, 2011).

There is evidence to support that women from certain ethnic or cultural backgrounds may be at increased risk of IPV. About 44% of women from Pakistan report regular physical IPV from their spouses; with 27% of women from Muslim counties countries experiencing high prevalence of economical, emotional and physical IPV from their spouses and in-laws (Cooper, 2013). This is of relevance to midwives working in areas where there are a high proportion of refugees, migrants and immigrants; with refugees and migrants at greater risk of IPV due to complex cultural and social issues.

There is much debate on whether pregnancy itself is an associated risk factor for IPV. Pregnancy is often associated with onset or escalation of domestic abuse of women. It has been stated that women are more vulnerable to IPV during pregnancy and up to 1 year after birth (Van Parys et al, 2014). According to findings of a multi-country study by Garcia-Moreno and Watt (2011), the majority of women who reported IPV during pregnancy had reported previous abuse prior to pregnancy; however, 50% of women from three countries identified that the abuse first commenced during pregnancy. For some women, pregnancy provides protection and allows a reprieve from current domestic violence by their partner.

Women in the postnatal period may be more susceptible to IPV due to increased stress, adjustment to new parenting challenges and changes to physical and intimate relationships. There has been a correlation found between pregnancy and IPV which is believed to be result of the partners' feelings of jealousy towards the baby, and a perceived threat to the dynamics of the existing relationship (Williams et al, 2013).

Indicators of intimate partner violence

It can be challenging for midwives to recognise signs of IPV, especially when the abuse is not physical in nature and the indicators are less obvious. Some common signs and symptoms of IPV include unexplained bruising, low maternal weight-gain, reduced self-esteem, marked anxiety and depression, expression of lack of safety and fear of upsetting their partner (Menezes Cooper, 2013). Further indicators of IPV, specific to physical abuse, include any injury that is targeted towards a women's abdomen, breasts, genitalia or buttocks.

Another indicator associated with IPV in pregnancy is late, or inconsistent, attendance of antenatal care; this is thought to be due to fear of detection of abuse, or coercive behaviour of the perpetrator. Other possible indicators of IPV during pregnancy are unwanted pregnancies and requests for terminations. Women presenting for a termination are six times more likely to be experiencing IPV compared to pregnant women attending antenatal clinics (Wokoma et al, 2014).

Adverse outcomes of intimate partner violence for mother and baby

IPV during pregnancy affects both the health and wellbeing of the woman and her baby. It may result in various physical health conditions for the mother including cuts, bruises, fractures, ruptured ear drums, acute and chronic pain issues, gastrointestinal conditions, sexually transmitted diseases, sexual dysfunction, vaginal bleeding and infection of the reproductive and urinary tracts. Moreover, IPV can have fatal consequences for the mother and baby, including miscarriage, maternal death from injury and suicide (Fiolet et al, 2013).

Some of the psychological adverse outcomes involve fear, anxiety, depression disorders, post-traumatic stress disorders, poor self-esteem, eating disorders, and drug and alcohol abuse (Fiolet et al, 2013). Many pregnant women who experience IPV develop body dysmorphia, which is further associated with lower breastfeeding rates (Keeling, 2012). There is also a correlation between IPV during pregnancy and increased risky behaviours such as smoking, drug and alcohol use, poor antenatal health care and poor nutrition (Jahanfar et al, 2013). Substance and alcohol abuse is commonly associated with victims of IPV, as it is believed to be a coping strategy for many women. It can also have detrimental economic and social costs; and there is a strong correlation between homelessness and domestic abuse (Mitchell, 2011).

IPV during pregnancy is further associated with serious complications for the pregnancy and the baby. Some of the maternal pregnancy complications comprise miscarriage, premature rupture of membranes, placental abruption, placental praevia, premature labour and delivery, and postpartum haemorrhage (Meuleners et al, 2011). Adverse outcomes for the unborn baby attributed to maternal IPV include fetal distress, low birth-weight and fetal

death. IPV can also damage the mother–infant bond leading to behavioural and developmental problems in the child. Children who witness or experience IPV are at increased risk of committing or receiving abuse in later life; and are more susceptible to many long-term psychological, developmental and physical issues (Williams et al, 2013).

Responding to a disclosure/non-disclosure of intimate partner violence

Disclosure

A midwife may suspect domestic violence in a woman's life, but cannot act on this unless the woman has disclosed the violence. The woman will only disclose this information if she feels she can trust the midwife. Furthermore, if a woman does disclose domestic violence, she will need to give her consent to the midwife for assisting the woman to change her social situation. Some women do not know that they have a right to live without violence (Williams et al, 2013) and that violence against another person is a criminal act.

Disclosure of any form of domestic violence can be challenging for midwives to hear; however, it is imperative that midwives respond appropriately to disclosures and ensure that they are correctly documented, and proper referral processes are in place. Women should also be provided with information on available resources. In the event of disclosure, the midwife should actively listen and validate the woman's experience through reassurance that the violence is not the woman's fault, she has a right to feel safe, and that help is available.

In responding to disclosure of IPV, the midwife has the responsibility of further assessing the safety of the woman, any children or other family members, social situation and any significant risks, such as access to weapons, the nature of abuse, isolation; as well as making appropriate referrals to social workers and her direct supervisors. The midwife must also ensure medical treatment is provided, where necessary, for women with IPV-related injuries. Resources such as local police, legal support services, child protection services and emergency accommodation; as well as local domestic violence agencies and helplines can be provided by midwives. Midwives should encourage women to consult the police if IPV is disclosed or suspected. In addition, the midwife can provide information on the perpetration of abuse and the serious adverse health outcomes associated with IPV during pregnancy. Education may be effective in empowering the woman and enabling her to break the cycle of abuse.

Non-disclosure

It is important to acknowledge that women who experience IPV during pregnancy may be fearful and reluctant in disclosing their abuse to midwives. Therefore, if IPV during pregnancy is suspected it is imperative that the midwife establish a trusting rapport and ensure a professional and sensitive approach in inquiry. In the case of non-disclosure, where the midwife suspects IPV, it is recommended that the midwife provide education and information on available services as well as consideration of assisting the woman with preparation of a safety plan. It is important that midwives follow relevant policies, referral processes and legislation regarding domestic violence while being aware of ethical considerations such as confidentiality and consent. It is widely accepted that early intervention is best practice in the care of women who are confirmed or suspected to be victims of IPV; midwives should be aware of appropriate interventions to enhance the safeguarding of women (Jahanfar et al, 2013).

Interventions for midwives to prevent or reduce intimate partner violence

Interventions that may be effective in preventing or reducing IPV are those associated with the empowerment of women. Active listening and an empathetic approach are arguably the most effective midwifery interventions in empowering women and reducing IPV (Kulkarni et al, 2012). The goal of empowerment is to improve outcomes for victims by enhancing their self-efficacy, knowledge and problem solving skills; thus enabling them to regain power from the perpetrator and break the cycle of abuse (Cattaneo and Goodman, 2015). Interventions based on empowerment such as education and personal skill development, are associated with positive long-term outcomes for women who suffer intimate partner violence; especially improved psychological health (Smith and Segal, 2014).

Other interventions associated with improving outcomes for women suffering IPV were identified in a recent Cochrane review that found psychological therapy sessions aimed at improving the relationship with the partner and enhancing social support networks may be effective in reducing psychological and physical IPV (Jahanfar et al, 2013). Further interventions to reduce IPV were highlighted, including home visitation programmes and cognitive behavioural therapy which demonstrated effective results in reducing physical, sexual and psychological forms of IPV. It should be acknowledged that due to time and resource constraints midwives may have

to refer women to accessible support services for further support including domestic violence helplines and websites.

Interventions for women suffering from intimate partner violence

There are several self-help interventions and strategies that midwives can provide to women who suffer IPV to enhance their safety. Some suggestions include an awareness of the perpetrators triggers and red flags, awareness of safe areas/exits, enhancing the victim's support network, knowledge of emergency contacts and knowledge of domestic violence services (Pritchard et al, 2014). Some women disclose domestic violence, but choose not to leave their partners. In these cases, referral services for men, which provide anonymous free counselling for perpetrators of IPV; as well as any perpetrator support programmes in the local area could help to reduce the incidence of IPV. Midwives may also assist women in the event that they choose to leave an abusive relationship by suggesting the woman prepare a bag containing clothes and toiletries, passport, birth/marriage certificates and bank account details, unlisted mobile number, medications, prescriptions, credit cards and emergency cash. Women should also be informed about available legal interventions such as restraining and protection orders. Furthermore, it is important that midwives follow relevant policies and legislation regarding IPV and the referral process; while having awareness of ethical considerations such as confidentiality and consent. It is recommended that midwives do not practice outside their scope of practice and follow unit policies and procedures when referring women and if in doubt, contact their supervisor of midwives.

Recommendations

To ensure effective screening, care and management of women suffering IPV, midwives need access to relevant training and education. It is also recommended that midwives familiarise themselves with local support services and agencies and the referral processes. Midwives need to be able to acknowledge the potential emotional and psychological affect associated with caring for women suffering IPV. It is also important that midwives recognise the potential impact of personal experiences with domestic abuse in caring for victims of IPV. There is evidence to support that for some midwives, their personal experience with IPV may present a barrier in providing effective care; whereas other midwives have reported that personal experience has enhanced their empathy and quality of care to other victims (Beynon et al, 2012). Midwives should be aware of available support strategies such as debriefing with peers as well as community and workplace counselling services (Beynon et al, 2012).

Key points

- Intimate partner violence (IPV) during pregnancy is a challenging professional issue for midwives
- IPV has serious health consequences for the woman and her baby including significant physical, psychological and gynaecological health conditions
- Midwives have an important role in the screening, detection and management of women experiencing IPV during pregnancy
- It is approximated that one in four women will experience IPV sometime in their lifetime, and 30% of incidences of IPV will occur for the first time during pregnancy
- Antenatal screening for IPV is recommended for all women, regardless of presence of risk factors or indicators of abuse

Conclusion

IPV during pregnancy is a challenging professional issue for midwives, and is associated with serious health consequences for the woman and baby, including significant long-term physical, psychological and social ramifications. The consequences of IPV can have a significant adverse impact on a woman's morbidity and can ultimately result in mortality. There is evidence to suggest that pregnancy is associated with the onset or escalation of IPV, which is not only a human rights concern but is illegal. One in four women will experience IPV in their lifetime and midwives have an important role in the screening, care and management of pregnant women who may be experiencing IPV. Midwives have a duty of care to ensure the wellbeing and safety of a woman and her unborn child; and must consider relevant legislation, policies and procedures. Antenatal screening for IPV is recommended for all women, regardless of presence of risk factors or indicators of abuse. The midwifery care of a women suffering IPV involves establishing a trusting rapport, ensuring safety of the woman, ensuring confidentiality, direct questioning, active listening, providing reassurance and providing information on support and available resources. Midwives should ensure a multifactorial approach in the care and management of a women experiencing domestic abuse during pregnancy; and employ interventions that empower the woman, as empowerment is associated with positively enhancing long term outcomes for women experiencing IPV. Practising midwives should ensure ongoing professional development that enables effective screening, care

and management of women experiencing IPV; thus striving to reduce the prevalence of domestic abuse during pregnancy. BJM

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