

Abuse during Pregnancy: Progress, Policy, and Potential

The publication of the Ballard et al.¹ article on measurement issues related to violence during pregnancy in the *Journal* signals the arrival of a second generation of research related to this important topic. Tremendous progress has been made in establishing that abuse during pregnancy indeed occurs more often than other routinely screened complications of pregnancy (e.g., gestational diabetes, preeclampsia), with resulting health consequences that are often severe.^{2,3} The body of knowledge on abuse during pregnancy is particularly broad because of its contributions from a variety of disciplines, its origins in clinical and/or advocacy concerns, and its inclusion of qualitative as well as quantitative research. Despite progress made in the first decade of research, initiatives in public health policy, program, and research are sorely needed. Both a review of past achievements and an outline for future directions are provided here.

In an important review of the first generation of research on abuse during pregnancy, Gazmararian and colleagues² estimated that prevalence rates range from 0.9% to 20% but found rates in most studies to be in the range of 3.9% to 8.3%. The wide variation in reported prevalence may relate in part to the issues addressed in the Ballard et al. article.¹ In addition, the clinical screens used in most of the studies reporting the highest prevalence rates have been purposively different from most measures of severity and frequency of violence that assume abuse. Those longer instruments tend to be exhaustive lists of all of the various ways in which a partner might assault, psychologically abuse, and/or control a person. They may be problematic for women who do not think of their situation as abusive and may result in women underreporting their abuse, especially if they are in a period of hope that the relationship can be improved. A short clinical screen may actually be more useful in determining prevalence, although it is less useful in determining severity and frequency for more complex research questions.

Variations in prevalence estimates may also depend on several factors that are both clinically relevant and methodologically important: when women are asked (if early in pregnancy, later abuse may be missed; if at delivery, women may be under enormous stress and even more invested in the relationship); how many times women are assessed (once or more than once during pregnancy); who asks them (professional category,

racial/ethnic group, gender); whether they are assessed in a face-to-face interview, a telephone survey, or a self-administered questionnaire; their perception of the degree of anonymity and/or confidentiality of responses; and their trust in the inquirer. Many of these issues have been discussed as methodological influences,^{1,2} but it is important for clinicians and researchers to remember that battered women decide to whom and when to disclose their abuse. As researchers, we may think in terms of false negatives and false positives, misclassification, underreporting, and denial. A battered woman thinks in terms of safety (How will her abuser retaliate if he finds out she has told someone? Will her children be jeopardized?), possible sources of help, future unintended consequences (such as losing health insurance), whether or not research is useful to her ethnic group, and shame.

Abuse during pregnancy is uniquely distressing to most of us, including the battered women themselves. The bewilderment, disbelief, embarrassment, and agony in the voices of battered women when they are interviewed about why they thought their husbands or boyfriends beat them during pregnancy—when, in most cases, the men had said they wanted the baby—are personally shocking and unforgettable.⁴ Abuse during pregnancy invokes interest and concern in persons ordinarily disposed to think of domestic violence as a purely feminist concern—an issue that harms families and divides the sexes—or as culturally imperialistic if given too much emphasis. The pregnancy perspective on domestic violence can translate the issue into a maternal-child health concern rather than—or, more properly, in addition to—a human rights issue. It enlists the power and resources of the health care system to assist the advocacy and criminal justice systems in addressing and preventing this type of violence.

At times, the concern specifically about pregnancy relegates the women who are being hit, demeaned, and violated to the status of baby carriers. The emphasis of much of the research on infant health outcomes to the detriment of inquiry into the effects on maternal health seems to be a result of this perspective. At the same time, those of us in the field appreciate our allies from the maternal and child health community who are engaged in clinical care, advocacy, research, and policy formation. Whether our major concern is the mother or the unborn child, all

of us realize that their health and well-being are inextricably intertwined and that both need full attention. Although the research has not yet sorted out exactly which mothers and infants are at risk, to what degree they are at risk and for which particular deleterious health outcome, both mothers and unborn children clearly are in jeopardy in a variety of ways from this form of violence. All clinical endeavors that target the health of mothers and infants need to address domestic violence in general and abuse during pregnancy in particular.

One of the most hopeful aspects of all of the policy and research endeavors directed to the problem is that the perinatal period provides the critical “window of opportunity” when we in the health care system see the same women repeatedly.⁵ Routine screening for abuse of all pregnant women at least once each trimester is warranted by the prevalence of such abuse (which is greater than the prevalence of toxemia, for which we take all pregnant women’s blood pressure at each prenatal visit). The 4-question Abuse Assessment Screen has good validity support and has been adapted in a variety of ways to fit specific clinical settings.^{6,7}

There are many specific fields of inquiry that could well include abuse during pregnancy systematically in their research, clinical, and policy initiatives. These fields include the following:

- **Population control:** A few studies have established the linkage of abuse and unintended pregnancy.^{8,9} It has been shown that abuse can be assessed in planned parenthood settings,¹⁰ but full-scale policy or clinical initiatives are missing.

- **International women’s health:** The World Health Organization has begun to address the issue of domestic violence. Not enough is being done, however, to support research, education, and clinical attention in developing countries as part of all maternal and child health initiatives.^{11,12}

- **Postpartum assessment and intervention:** At least 2 studies have revealed a greater prevalence of abuse during the postpartum period than during pregnancy.^{9,13} Routine assessment for abuse needs to be part of every postpartum home, clinic, and nurse-midwife and/or obstetrician visit.

Editor’s Note. See related article by Ballard et al. (p. 274) in this issue.

- Postpartum depression: In spite of well-documented links of intimate partner violence with depression and posttraumatic stress disorder,^{14,15} domestic violence is not included in most postpartum depression research or treatment recommendations.

- HIV/AIDS and other sexually transmitted diseases: Although a few studies have established linkages^{16,17} and some prevention programs have begun to include domestic violence considerations, again, not enough is being done. Abuse and sexually transmitted diseases may often be linked through forced sex in intimate partner relationships, a neglected area in research and one necessitating particularly sensitive clinical inquiry and intervention.^{18,19}

- Breast-feeding: Although the evidence here mostly involves anecdotal and clinical reports, the knowledge base about batterers and their sense of ownership of their partners' bodies suggests that domestic violence is an important factor in determining initiation and cessation of breast-feeding. This issue needs investigation and inclusion in programmatic initiatives to increase breast-feeding.

- Child abuse: The well-substantiated overlap of child abuse and wife abuse²⁰ has resulted in several innovative state (e.g., Michigan, Iowa) and local programs for cross training professionals engaged with child abuse and with domestic violence. For example, assessment of and interventions for domestic violence are included in child abuse prevention and healthy child programs such as Healthy Start in Maryland. However, more resources are needed both for full-scale evaluations of these initiatives in terms of efficacy and effectiveness and for replications that are culturally and locally appropriate.

- In addition, given the link between domestic violence and child abuse, abuse during pregnancy might be used for identification of families at risk for child abuse. The presence of stepchildren increases the risk for both child and adult female homicides.^{21,22} Statements of battered women taken from qualitative studies suggest that a potential cause of abuse during pregnancy is a man's suspicion, regardless of the truth, that he is not the baby's father.^{4,8} Male questioning of paternity may thus be an important risk factor for severe and potentially lethal violence that could be used to identify women in need of particularly assertive and comprehensive interventions. It also warrants additional research.

- Adolescent pregnancy: Recent studies have suggested a prevalence of abuse during adolescent pregnancy even greater than that for adult women.^{23,24} Programs dealing with adolescent pregnancy need to

address abuse during pregnancy in terms of prevention, early identification, and intervention before, during, and after pregnancy.

- Substance abuse: A substantial body of knowledge supports a connection between abuse during pregnancy and maternal substance abuse (including smoking).²⁵⁻²⁸ This connection warrants more systematic inclusion of domestic violence assessment and intervention in substance abuse treatment programs. Intimate partner violence needs to be considered in substance abuse prevention initiatives. The interaction between such violence and substance abuse are complex, involving both perpetrator and victim. How young women might be initiated into substance abuse²⁷ through controlling intimate-partner relationships needs further study. So, too, do the long-term effects of conditions such as posttraumatic stress disorder with substance abuse during pregnancy as a possible coping mechanism.

- Cultural influences: There has been a start toward careful delineation of abuse during pregnancy in different ethnic groups and toward setting this abuse within cultural contexts,²⁹ but this is an area needing much more attention in the next generation of research. Investigations into abuse and ethnicity need to include the full range of ethnic groups and need to consider such issues as cultural norms, acculturation, education, neighborhood structures,³⁰ and economic resources actually under the control of women.

A recent evaluation supporting the efficacy of a brief intervention for intimate partner abuse is an exciting advance that will, it is hoped, be followed by further tests of interventions.^{31,32} Another development is the Centers for Disease Control and Prevention (CDC) support for research on abuse during pregnancy. Leading investigators were brought together by CDC to synthesize research knowledge (e.g., Gazmararian et al.²) and generate new ideas. Among these investigators were Ballard and colleagues,¹ who proposed that questions about abuse during pregnancy be systematically included in the ongoing databases. Similar efforts could be mounted by the World Health Organization.

Yet, the support for research on violence against women is, in general, still inadequate, and the lack of support by the National Institutes of Health in particular is problematic.³³ The leadership of such organizations as the American Association of Women's Health, Obstetric and Neonatal Nurses, the American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists, and the Nursing Network on Violence Against Women International has helped make routine abuse assessment a reality in

many prenatal and nurse-midwifery clinics. These organizations have also ensured attention to the issue in both nursing and medicine continuing education. In spite of the progress, however, screening for abuse is not routine in private obstetric and gynecological medical offices, and content on abuse is not often included in medical school or advanced-practice nursing curricula.³⁴

We have made a great deal of progress in a little more than 10 years. Yet, even with every advance and accomplishment in research, clinical assessment and intervention, and policy initiatives, there is more to be done. The new initiatives in public health and policy need to be tested systematically in sound and informed research that does not forget its clinical and advocacy base, keeps safety as the primary concern, and includes the voices, cultures, and concerns of the women themselves. □

Jacquelyn C. Campbell
The Johns Hopkins University
School of Nursing
Baltimore, Md

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Editor's Note: A Final Tribute to Reviewers

Each February, the Journal publishes a list of reviewers who, over the past year, have generously given of their time and talents to review manuscripts. On a previous occasion, we expressed our special appreciation for this ever more difficult assignment, given the growing demands on reviewers' time.¹ The task has since become even more vital to sustaining the integrity of the Journal, because reviews are increasingly difficult to obtain from a research and academic community under always-heavier pressure.

Insightful reviews inform and guide authors, editors, and readers alike. Although

reviewers can expect few rewards, during the tenure of this editor it has been our practice to invite reviewers who have illuminated important issues in a paper to write an accompanying front piece. Page constraints reduce these to a small and select number, however. For the most part, peer reviewing remains an unsung service performed by conscientious and generous public health professionals.

In this editor's final communication to reviewers for the Journal, we want to express our appreciation for the meticulous attention and constructive thought that so many review-

ers have given the papers we have sent them. It has been gratifying to work together with you to further the cause of public health. □

Mervyn Susser, Editor
Mary E. Northridge, Deputy Editor

Reference

1. Susser M, Northridge ME. Editor's Note: Reviewing for the journal. *Am J Public Health.* 1996;86:161.

Editor's Note. See "A Thank You to Reviewers" (p. 314) in this issue.