Acknowledging a persistent truth: domestic violence in pregnancy

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Summary

Violence against women has a devastating effect on women's sexual and reproductive health, and also affects the health of their children. Such behaviour is rooted in gender inequality, which is sadly persistent, arguably throughout all societies. This phenomenon is a serious health and development concern, in addition to a violation of a woman's human rights. Violence can begin or escalate in pregnancy and has significant consequences for the woman, fetus and child. Questioning pregnant women about the presence of violence and offering referral to a secondary agency can help to break the pattern of abuse.

Introduction

Violence against women has a devastating effect on women's sexual and reproductive health, and also affects the health of their children. Such behaviour is rooted in gender inequality, which is sadly persistent, arguably throughout all societies. This phenomenon is a serious health and development concern, in addition to a violation of a woman's human rights.[1]

'Domestic violence' where the assailant is, or has been, a sexual partner of the victim accounts for 25% of violent crime in the UK. In 2004, the estimated cost to the criminal justice system and NHS was £3.1 billion.[2] The term 'domestic violence' is being replaced in the literature by the expression 'intimate partner violence' (IPV) which does not imply the respectability that 'domestic' might evoke. However, IPV excludes other sources of violence in the home, for example from older children, parents, siblings and acquaintances, all of which can occur in pregnancy.

Pregnant women retain a privileged public position in society, but the frequent violence some are subjected to within their homes suggests discordance in their status in public and private spheres. Officially, we are deeply offended at the image of a pregnant woman being choked or kicked in the abdomen, but this instinctive distaste produces a strong taboo, and it is perhaps this which prevents us from rigorously screening and offering intervention to this vulnerable group.

Prevalence

Throughout the world, many studies have been performed to assess the prevalence of domestic violence in pregnancy. The reported rates of abuse vary significantly, from 5.4–27.7%.[3–8] This reflects both a genuine diversity in the occurrence of violence and in definitions of abuse used by researchers. In addition, the variation demonstrates that domestic violence is *not* inevitable but can perhaps become 'normalized' in certain social circumstances. The reported prevalence is also affected by women's willingness to divulge abuse.

- 12.9% of 481 women at antenatal booking assessment in Ireland gave a history of experiencing intimate partner abuse[3]
- In India, 18% of 2199 women experienced domestic violence during their last pregnancy[4]
- 27.7% of 612 Ugandan pregnant women screened in their second trimester reported domestic violence during that pregnancy[5]

- 17% of 475 pregnant women surveyed in the north of England reported a history of physical, emotional or sexual abuse[6]
- 5.4% of 279 pregnant women surveyed in Japan reported domestic violence[7]
- 9.7% of 217 women surveyed in Turkey reported being beaten by their partner in their last pregnancy.[8]

Studies that ask about violence more than once during detailed in-person interviews or ask later in pregnancy (during the third trimester) report higher prevalence rates, suggesting that disclosure rates may depend on trust in the questioner, and that pregnancy may lead to new or increased violence.[9]

The WHO recently published its findings from a large multi-national study of women and abuse.[10] The prevalence of physical violence in pregnancy was reported by women at between 1–28% in 15 different countries. Between a quarter and a half of these women experienced direct trauma to the abdomen during pregnancy. Over 90% of the assailants were the biological father of the unborn child.

Risk factors for being an abuser

A number of factors are associated with bringing violence into an intimate relationship. Perhaps the strongest predictive feature is being a heterosexual male; 81% of UK cases comprise a man assaulting a woman.[11] A history of alcohol problems,[12,13] violence in the abuser's family of origin, emotional insecurity, and features of antisocial and borderline personality disorders all put an individual at risk of becoming abusive.[14] In addition, youthfulness, low educational attainment and low socioeconomic status are positively correlated with committing domestic violence. However, domestic violence remains common in *all* demographic groups, so the practice of 'profiling' abusers perhaps simply reiterates pre-conceived ideas and perpetuates the taboo.

A focus group of young men aged 13–20 undergoing treatment for assaulting their partners described the presence of peer-supported norms of male multiple partnering and adversarial sexual beliefs. These values appear to perpetuate increased male sexual risk-taking, a lack of accountability for sexual risk, the rationalization of rape and negative responses to pregnancy.[15] Therefore there are also wider, less tangible predisposing factors which contrive to make abusive behaviour not only acceptable but even desirable.

Risk factors for being a victim of domestic violence

Physical abuse has been associated with younger women in short-term relationships who have drug and alcohol dependency problems and who also experience psychological and sexual abuse.[16] In a large, multi-national household survey of 3,995 women, significant risk factors for domestic violence were found to be past witnessing of their father beating their mother, poor mental health and poor family work status.[12] However, there is no 'typical' victim and it is unhelpful, and even stigmatizing, to focus our attention as clinicians on any single group. Conversely, it is also important not to assume that any individual is especially 'low risk.'

Consequences to the pregnant woman

Violence may start or escalate during pregnancy. Out of pregnancy, the most common physical injuries experienced are to the head and neck (40%), followed by musculoskeletal injuries (28%).[16] Pregnancy may alter the pattern of assault, with pregnant women more likely to be struck on the abdomen or have multiple sites of injury.[17] 34% of abused pregnant women also reported being choked.[18]

Pregnant women who experience domestic violence have been found to have a 37% higher risk of obstetric complications that warrant antenatal admission, for example hypertension, premature rupture of membranes and anaemia.[5] A large study in North America (n=118,579) found women reporting domestic violence prior to or during pregnancy were at higher risk of hypertension, oedema, vaginal bleeding, vomiting and dehydration, urinary tract infections and pre-term delivery.[19] A review of evidence of an association between domestic violence and pregnancy outcome found that abused pregnant mothers present more often with renal tract infections, gain less weight during pregnancy and are more likely to undergo operative delivery than non-abused mothers.[20] 23% of UK maternal deaths in 2003–2005 had features of domestic abuse; most had reported this abuse to a healthcare professional either during or prior to the pregnancy.[21]

It is unclear if the mechanisms causing these complications are direct or indirect; for example, is it abdominal trauma which results in ruptured membranes and increased fear and stress which cause hypertension, or is it that abused women do

not attend for antenatal care so their anaemia and pre-eclampsia, for example, go untreated? Interestingly, it has been argued that the reproductive health disadvantage of experiencing domestic violence is apparent in all socioeconomic groups; not only the most disadvantaged.[22]

Women who have experienced partner violence also have significantly more gynaecology consultations and complain of lower abdominal pain, dysmenorrhoea, dyspareunia, smear abnormalities, cancer worries and bowel symptoms more commonly than women not subjected to domestic violence.[23]

It is not simply the physical consequences of abuse which are relevant to medical care. Women who experience any level of physical violence or sexual coercion by their partners, either before or during pregnancy, have, perhaps unsurprisingly, higher levels of depressive symptoms compared to women who have not been abused.[24]

A small survey of abused women in America found that 34% reported that their abusive partners had limited their ability to decide whether or not to have children.[25] Women stated that they felt pressured or forced to conceive or have abortions; some also underwent sterilization in response to the abuse. Some women reported inconsistent behaviour in their partners, such as not allowing the use of contraception and then later demanding a termination. The emphasis is clearly on *controlling* the woman's reproductive choices as opposed to attaining a specific end.

Consequences to the fetus and child

Features of fetal morbidity, such as low birth weight,[5] preterm delivery and small size for gestational age, occur more frequently among abused than non-abused pregnant women. Proposed mechanisms include recurrent abruptions secondary to trauma or psychological stress in the mother resulting in increased fetal cortisol. Domestic violence is also responsible for increased fetal deaths in affected pregnancies (about 16.0 per 1000).[20] There are case reports of abruption resulting in fetal death after blunt trauma to the abdomen secondary to domestic violence,[26,27] and also of soft tissue injury to the fetus.

Births among women who have experienced domestic violence during their pregnancy had relative risks for perinatal and neonatal mortality 2.6 and 2.4 times higher than women who had not been beaten, after controlling for sociodemographic and maternal health behaviour risk factors.[4]

The effects on the child of domestic violence in pregnancy do not cease after birth. Women who report domestic violence occurring either during pregnancy or in the year prior to pregnancy are significantly less likely to breastfeed their babies. Similarly, women reporting recent violence who did initiate breastfeeding are more likely to cease breastfeeding by four weeks postpartum.[28] In Western culture breasts are sexualized so that their role in infant feeding has become obscured. Some women lack confidence or are discouraged, and indeed forbidden, from nursing their children.

Children who live in households where their mother is beaten have also been found to exhibit significantly more behavioural problems than children of the same age and sex who have non-abused mothers.[29] In one study, child protection services were concomitantly involved in half of the women known to be living in abusive relationships.[16]

Identifying domestic violence

The WHO recommends that the health sector

(1) Responds to violence against women
(2) Ensures that women are not stigmatized or blamed if they divulge abuse
(3) Gives appropriate medical attention
(4) Guarantees security and confidentiality.

Reproductive healthcare providers should be able to recognize and respond to violence and a structure should exist to refer patients on for appropriate support and follow-up.

Over half of abused women immediately postpartum describe their relationships as 'not abusive', even though they all reported experiencing behaviours defined as abuse on standardized screening instruments.[30] This highlights the necessity to ask specific questions about physical behaviour, as women may normalize physical violence and therefore not disclose its occurrence under general definitions of abuse. Examples of questions to ask women include, 'Has anyone at home ever made you feel frightened?' or 'Is there anyone at home who puts you down?'. Disclosure of abuse by pregnant women can also vary depending on whether the woman is assessed directly by a trained interviewer, completes a written questionnaire or is asked repeatedly during the course of the pregnancy.[18] In addition, fear of being reported to child protection services can inhibit women from disclosing that they are being beaten.[18] All women should have access to information on sources of help, for example from posters or in

hand-held notes. When a woman declines to answer questions relating to domestic violence or when the health professional remains suspicious of the presence of abuse, then referral information should still be offered. The woman may feel it is too dangerous to divulge this information or may not yet trust the clinician, and information given 'for a friend' can be helpful.

Universal screening to identify domestic violence in pregnancy is not standard practice, and indeed remains controversial as it does not fit the 'screening test, diagnostic test, treatment' medical model. Routine questioning may be a better concept. Asking about domestic violence at the antenatal booking appointment was found to be almost universally acceptable and worthwhile to pregnant women (99%, n=481).[3] When surveyed, however, only 39% of American obstetricians routinely screened their antenatal patients for domestic violence[31] and only 11% of primary care doctors routinely asked antenatal patients about abuse.[32] The doctor's perception of the prevalence of domestic violence and his or her sense of responsibility for addressing this were the only variables associated with screening. It is hoped that through education more clinicians will become aware of this issue and consequently more cases will be identified.

Interventions

There have been many studies performed evaluating the efficacy of different interventional approaches. A review of evidence for interventions which improve perinatal outcomes, however, concluded that there was limited evidence of effective and promising interventions for pregnant women experiencing domestic violence and that few studies were well-designed or powered to detect effectiveness.[33]

Behavioural

Behavioural interventions which can be used within existing obstetric care delivery systems, such as assessing a woman's readiness for change and her emotional responses to the violence, have been described.[34] A randomized, two-arm clinical trial comparing the effects of a nurse case management protocol with a single wallet-sized referral card[35] found that after two years, both groups reported significantly fewer assaults, threats of abuse and danger risks for homicide. In addition, both groups adopted significantly more safety behaviours. That disclosure of abuse is associated with the same positive outcomes as case management intervention suggests that a simple assessment to identify abusive behaviour, coupled with the offer of a referral to a secondary agency, may effectively interrupt and prevent recurrences of domestic violence. This theory is supported by emerging evidence from the MOZAIC project in London, where routine screening of pregnant women was coupled with referral to an advocacy service. At the 6-month follow-up there was a reduction in violence, controlling behaviour, injuries, anxiety and depression, and improvement in self-esteem and sources of support. However, some potential for harm to the participants was also reported from breaches in confidentiality and stereotyping of women.[36] A randomized controlled trial of 110 women in China[37] found that structured empowerment training for abused pregnant women resulted in less reported psychological (but not sexual) abuse, less minor (but not severe) physical violence and significantly lower postnatal depression scores. However, they reported more bodily pain.

Obstetric

Obstetric interventions include an assessment of risk of physical harm to a pregnant woman and her fetus from domestic violence.[34] If it is not safe for a woman to return home, an emergency admission can be made as a 'place of safety'. It is thought that through discussing the effects of abuse and validating their efforts to change, we can assist pregnant women to protect themselves. The responsibility to end the abusive behaviour lies with the perpetrator, not the victim. Counselling women about the obstetric consequences of domestic violence must be performed sensitively to avoid implying that she is somehow guilty of – or responsible for – these risks. Abusive partners are very good at blaming women for 'provoking' them into the kickings and beatings that lead to prematurity and stillbirth, and clinicians have to reiterate that *no-one deserves that*.

Documentation of injuries is important and should only be completed in confidential, hospital-held medical records and not in hand-held antenatal records which patients take home. Photos of injuries and direct quotes from the woman can be helpful and used retrospectively in any subsequent civil or criminal cases.

Perpetrators

There are also interventions to attempt behavioural change in the perpetrator. Counselling for

domestic violence perpetrators, when combined with arrest, can reduce violent behaviour. However, high reoccurrence rates are found, with 25% of offenders engaging in physical aggression within 1–2 years.[14]

It has been argued that when health care workers identify a case of possible domestic violence they should not focus solely on encouraging the victim to notify the police.[38] Many women are reluctant to involve the criminal justice system because they fear reprisals. If a woman does not have adequate community support to allow her to protect herself, then arrest and prosecution of her assailant may result in more severe violence on their release.[39] Thus it is important for advocacy and health services to have good liaison with local agencies, including housing, police, social services and solicitors, as each woman's journey to safety may require different tailored interventions.

Conclusion

Domestic violence in pregnancy is a common, chronic, complex social problem which is present in all cultures and will not be halted in a single consultation. Many studies have assessed the prevalence, consequences and possible interventions to reduce domestic violence in pregnancy. Unfortunately, most are not adequately powered to draw firm conclusions on which to base specific practice changes. However, the continuing issue of violence against pregnant women should not need to be highlighted to clinicians involved in their care.

Health professionals who are surprised at the prevalence of abuse may need to question why they are not obtaining similar disclosures. Are they directly questioning the women under their care? Are they performing their consultations in an appropriate setting and creating an atmosphere of confidence and trust? If clinicians acknowledge the presence of abuse and ask all pregnant women, they may allow women to make disclosures and find help from other agencies. Clearly, ensuring the safety of the woman is paramount (probably best judged by herself), but it is also important to have adequate multi-agency responses to violence, good working relationships with the police and information-sharing protocols to protect those women at highest risk of murder.

Further work now needs to be concentrated on establishing which interventions consistently reduce the incidence of violence in pregnancy and negate the harmful consequences of this abuse to both women and children.

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