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## Perinatal Intimate Partner Violence

**Christine K Hahn, Ph.D., Amanda K. Gilmore, Ph.D., Rosaura Orengo Aguayo, Ph.D., and Alyssa A. Rheingold, Ph.D.**

National Crime Victims Research & Treatment Center (NCVRTC), Department of Psychiatry & Behavioral Sciences, Medical University of South Carolina, 67 President St., 2nd Fl. S., MSC 861, Charleston SC 29425-8610

### Abstract

This article reviews the prevalence and outcomes of perinatal intimate partner violence (IPV). Reported rates of perinatal intimate partner violence range from 3.7% to 9%. Perinatal IPV is associated with a multitude of mental and obstetric health outcomes that impact the mother and child. Perinatal medical providers have an opportunity to detect victims of IPV and facilitate services for this population. Screening, safety planning, and referral procedures are essential for addressing this public health problem.

### Keywords

intimate partner violence; physical violence; sexual violence; perinatal; pregnancy

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Intimate partner violence (IPV) is a serious public health problem that involves physical violence, sexual violence, stalking, psychological aggression, or control of reproductive health perpetrated by a current or former intimate partner (see Box 1)<sup>1,2</sup>. An intimate partner is an individual with whom one has a close personal relationship; however, the characteristics of the relationship such the degree of contact or familiarity with one another can vary<sup>1</sup>. Based on results from the National Intimate Partner and Sexual Violence Survey 5.9% of women reported experiencing IPV in the past year<sup>2</sup>. Prevalence of lifetime exposure to specific forms of IPV is alarming, ranging from 8.6% for reproductive control to 47.1% for psychological aggression.

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CORRESPONDING AUTHOR: Christine K Hahn, Ph.D.; hahnc@musc.edu; 67 President St., 2nd Fl. S., MSC 861, Charleston SC 29425-8610.

Address for all authors: 67 President St., 2nd Fl. S., MSC 861, Charleston SC 29425-8610

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The highest rates of IPV are reported among women who are of reproductive age, with the greatest prevalence occurring among individuals 18 to 34 year's old<sup>1, 2</sup>. Therefore, it is essential to investigate IPV among perinatal women. The current review outlines the:

1. Definition and prevalence,
2. Maternal risk factors and obstetric health associations,
3. Neonatal outcomes,
4. Long-term impact on children, and
5. Screening and referral interventions for perinatal IPV.

## Perinatal IPV

Perinatal IPV refers to experiences of violence that occur 12 months prior to pregnancy, during pregnancy, and up to one year following a pregnancy<sup>3-4</sup>. Based on population studies, estimated rates of perinatal IPV in the form of physical violence range from 3.7% to 9%<sup>3-4</sup>. However, it is difficult to estimate the rates of perinatal IPV because these population-based studies have focused on physical violence, without adequately assessing for other forms of perinatal IPV such as sexual violence and psychological aggression. Further, frequencies of IPV are higher in clinic-based samples compared to epidemiological samples. Among 104 rural women attending prenatal care in the beginning of their third trimester, 20.2% experienced sexual IPV, 27.9% reported physical IPV, and 79.8% endorsed psychological aggression during their pregnancy<sup>5</sup>. Other clinic-based studies have reported rates of perinatal IPV up to 16.4% and 73% for physical and psychological IPV, respectively<sup>6-7</sup>. Perinatal providers are in a unique position to identify, evaluate, and facilitate services for women experiencing IPV.

## Maternal Risk Factors and Mental and Obstetrical Health Associations of Perinatal IPV

Risk factors for perinatal IPV include lower socioeconomic status, being unmarried, housing instability, younger age, Medicaid insurance, and fewer years of education<sup>4, 8</sup>. Rates of IPV tend to be slightly higher during the year prior to pregnancy than during pregnancy. For example, based on data from the Pregnancy Risk Assessment Monitoring System (PRAMS) 4.7% of women reported physical violence perpetrated by a partner in the year prior to pregnancy compared to 3.7% during pregnancy<sup>4</sup>. Exposure to IPV among perinatal women is associated with a host of pervasive and serious maternal mental and physical health consequences.

### Mental Health

Perinatal IPV is associated with symptoms of posttraumatic stress disorder, major depressive disorder, and problematic substance use, which typically extend to postpartum periods (see Box 2)<sup>6, 9</sup>. It is important to distinguish the nature of perinatal IPV from other forms of traumatic events. In population-based studies, women exposed to various forms of interpersonal violence (e.g., child abuse, sexual abuse, IPV) have high rates of PTSD,

depressive, and substance use symptoms<sup>10–11</sup>. These symptoms are typically higher among individuals exposed to interpersonal violence compared to individuals who have other experiences of traumatic events such as natural disasters, armed conflicts, or accidents<sup>11</sup>. High rates of symptoms may result from IPV because of contextual factors, such as the relationship with the perpetrator and nature of the abuse. For example, within IPV the perpetrator may be someone who the individual depends on for emotional, financial, or instrumental (e.g., household chores, childcare) support. In addition, IPV is invasive, and, more often than not, involves repeated victimizations. Women exposed to IPV often experience ongoing legitimate fear about the potential for future harm, which can exacerbate distress<sup>12</sup>. These contextual factors are especially relevant to risk for developing mental health symptoms.

Perinatal physical, sexual, and psychological IPV are associated with PTSD during and after pregnancy. For instances, 40% of low-income pregnant women who reported perinatal IPV met criteria for PTSD<sup>13</sup>. A majority of these low-income pregnant women reported that other life events were distressful; therefore many women with perinatal IPV may have exposure to several traumatic events, which is associated with worse mental health outcomes<sup>11</sup>. Perinatal physical and psychological IPV are also associated with increased depressive symptoms during pregnancy<sup>14</sup> and postpartum<sup>15</sup>. More specifically, among a large urban sample women who endorsed perinatal IPV were three times more likely to meet criteria for depressive disorders during pregnancy<sup>16</sup>. In addition, perinatal IPV was associated with increased risk of depression and PTSD symptoms among women who were up to 14-months post-delivery of their child<sup>17</sup>. Finally, compared to women who are not exposed to perinatal IPV, women with exposure reported higher levels of suicidal ideation during pregnancy<sup>18</sup> and subsequent to delivery<sup>19</sup>. During 2003 to 2007, 2.0 per 100,000 births resulted in maternal suicide and 54.3% of the people who committed suicide experienced IPV that was suspected to relate to the suicide<sup>20</sup>.

Nicotine, drug, and alcohol use is also a concern among women exposed to perinatal IPV<sup>21, 22</sup>. Although many women are able to successfully refrain from using substances while pregnant, the prolonged stress and fear associated with IPV can make abstaining difficult. The self-medication model proposes that substance use is reinforcing because it reduces distress, therefore over time it becomes a pattern of learned behavior to cope with distress<sup>23</sup>. In support of this theory, more severe IPV, PTSD, and depression symptoms predicted greater problems with substance use among community samples of women<sup>24</sup>. With regards to perinatal IPV and nicotine use, physical IPV the year before and/or during pregnancy was associated with a 2.6 times increased risk of smoking cigarettes during pregnancy compared to non-abused women<sup>25</sup>.

Substance use and mental health symptoms also frequently co-occur among women exposed to perinatal IPV. In a primarily Latina sample of pregnant women, those with perinatal IPV and depressive symptoms were more likely to report co-occurring substance use problems<sup>26</sup>. Further, among a sample of women attending prenatal visits, women with positive alcohol use screens were 2.26 more likely to report physical IPV within the past year, and women who had positive depression screens were 3.37 times more likely to report physical IPV in the past year<sup>27</sup>. Taken together, research supports that women who report perinatal IPV are

also at increased risk to use alcohol, nicotine, and drugs compared to women who do not report IPV.

In summary, lifetime exposure to IPV and perinatal IPV poses significant risk for women to experience PTSD, depression, suicidal ideation, and smoke during perinatal periods<sup>25, 26</sup>. Furthermore, IPV six to twelve months after deliver results in higher levels of distress and depression compared to women who are not exposed to postpartum violence<sup>28</sup>. Therefore, providers need to be aware that exposure to lifetime IPV may elevate risk for mental health distress among perinatal women. The impact of perinatal IPV moves beyond mental health consequences to a range of obstetric health outcomes.

### Obstetric Health

There is substantial evidence that perinatal IPV is linked to multiple obstetric complications. Exposure to IPV may impact women's physical health through direct impact of physical violence that results in maternal or utero-placental injury. However, another mechanism is related to the body's response to acute and chronic stress. The impact of exposure to acute and chronic stress can result in overactive and underactive responses in the hypothalamic-pituitary-adrenal (HPA) axis<sup>29</sup>. The HPA axis regulates hormone secretion through a negative feedback system, which involves interaction between the hypothalamus, pituitary and adrenal glands that communicate signals to reduce or increase the production of hormones, such as cortisol or cortisol releasing factor. Exposure to IPV can impact the negative feedback system, thereby affecting the secretion of hormones in a manner that can have negative implications for autoimmune and inflammatory responses.

The physiological impact related to frequent and ongoing threat associated with IPV may be especially relevant to obstetric health. Women who experienced perinatal IPV are more likely to have high blood pressure or edema, vaginal bleeding in the second or third trimester, severe nausea, vomiting or dehydration, kidney infection or UTI, premature rupture of membranes and premature birth<sup>4</sup>. Women with IPV are five times more likely to experience placental abruption, or separation of the placenta from the uterus, a complication associated with fetal growth restriction, preterm birth and intrauterine fetal demise<sup>8</sup>. Regarding timing of perinatal IPV, exposure to IPV before and during pregnancy have both been associated with negative health outcomes, however some risks may become greater for women who experience abuse 12 months prior to becoming pregnant, including vaginal bleeding, severe nausea, vomiting or dehydration, and kidney infections or UIT<sup>4</sup>.

Perinatal IPV is also associated with miscarriages, preterm birth, and diminished intrauterine growth<sup>4, 30, 31</sup>, with results from one study supporting that psychological IPV had a greater impact than physical IPV on low birth weight<sup>31</sup>. Further, women who experience perinatal IPV are also less likely to breastfeed and more likely to discontinue breastfeeding after 4 weeks of delivery<sup>32</sup>. The gravest risk is death of the fetus, baby, and mother. In a large national sample of women who had delivery-related discharges, women who reported perinatal IPV were four times more likely to have a stillbirth and three times more likely to have a delivery result in fetal death compared to non-abused peers<sup>33</sup>. Also, women exposed to IPV during pregnancy were three times more likely to be the victim of attempted or

completed homicide compared to those who did not endorse perinatal IPV<sup>34</sup>. Clearly, the potential health outcomes associated with perinatal IPV are extensive and severe.

Perinatal IPV is associated with increased health care costs, utilization of emergency room visits during pregnancy, and receipt of care in the intensive care unit (ICU) during pregnancy<sup>30</sup>. Unfortunately, women exposed to perinatal IPV are less likely to receive adequate prenatal care (i.e., receive care after the fourth month of pregnancy or attended fewer than 50% of expected prenatal health care appointments)<sup>35</sup>. Women exposed to IPV face several potential barriers to receiving medical treatment including ongoing abuse, interpersonal and financial control from their perpetrator, economic stressors, and emotional barriers such as shame<sup>36</sup>. It is essential to increase access to services among this population because IPV is often chronic and the negative consequences of perinatal IPV extend past the short-term impact on the baby to longer-term developmental issues.

### **Long-term Impacts of Perinatal IPV on Children**

Perinatal exposure to IPV has been shown to have long-term adverse consequences on children's mental, cognitive, and physical health. For instance, youth exposed to perinatal IPV are at an increased risk of developing subsequent internalizing and externalizing problems (e.g., depression, anxiety, posttraumatic stress, low self-esteem, anger and irritability, risky behaviors), and to struggle academically and socially<sup>37</sup>. Furthermore, health care utilization and costs for children with perinatal and postnatal exposure to IPV are higher and result in greater emergency department, primary care, and mental health visits<sup>38</sup>.

#### **Executive Functioning**

Pregnant women in abusive relationships are less likely to receive adequate prenatal care, have access to healthy foods, and are at increased risk of experiencing trauma-related stress, all of which has been linked to premature delivery, low-birth weight, abnormal brain development and impaired hypothalamic–pituitary–adrenal (HPA) axis functioning at birth and later in life<sup>39</sup>. As a result, perinatal exposure to IPV has been linked to long-term deficits in children's executive functioning (e.g., impulsivity, poor-decision making), cognitive functioning (e.g., lower IQ levels and academic achievement), and delays in reaching appropriate neurodevelopmental milestones<sup>40</sup>. Exposure to IPV in the home from birth to age 3 years has also been associated with an increased risk of developing attention-deficit/hyperactivity disorder<sup>41</sup>. Thus, perinatal IPV can have lasting effects on multiple aspects of a child's executive functioning.

#### **Attachment**

Perinatal exposure to IPV can also have an adverse effect on mother-child interactions, or attachment. Perinatal IPV has been associated with less positive attunement to the infant, negative cognitions about parenting ability and self-efficacy, and decreased maternal responsiveness<sup>42</sup>. In turn, these can increase the risk of hostile interactions between the caregiver and child, and neglectful parenting practices<sup>43</sup>. It is important to understand the risks of perinatal IPV on the caregiver-child relationship, because relationships marked by qualities such as unpredictability, difficulty trusting, and unresponsiveness have been

associated with increased risk of developing externalizing problems and risk-taking behaviors across the lifespan (e.g., substance use, antisocial behavior, truancy)<sup>44</sup>. Providing caregivers with histories of IPV resources related to parenting is essential to preventing difficulties in the caregiver-child relationship.

### **Exposure to Additional Adverse Events**

Most individuals experience more than one traumatic event across their lifetime, which is associated with more severe mental health symptoms<sup>11</sup>. Similarly, children exposed IPV in the home are also at an increased risk of experiencing a wide range of adverse events including: physical abuse, sexual abuse, community violence, and bullying<sup>45</sup>. They also have a two-fold increased risk of victimization or perpetration of IPV as adults. This demonstrates the cumulative impact that perinatal IPV may have on increasing risk for future exposure to adverse events across generations.

### **Summary of Impact**

Perinatal IPV is associated with adverse mental health and obstetrical health consequences for the mother, fetus, and child (see Table 1). Although more research is needed to elucidate risk for the mental and obstetric health outcomes among pregnant women according to timing and form of IPV, there is adequate support that violence experienced immediately prior, during, and/or after pregnancy, as well as lifetime IPV, results in grave health consequences. Screening for IPV during perinatal care is essential to addressing the safety needs and obstetric health risks among this population.

### **Perinatal IPV Screening**

The U.S. Preventive Services Task Force (USPTF) recommends IPV screening for women of childbearing age, insuring that such screening would have a moderate net public health benefit<sup>46</sup>. The Health Resources and Services Administration (HRSA) has developed guidelines into the Affordable Care Act (ACA) that require routine IPV screening and counseling as a preventive service for adolescent and adult women<sup>47</sup>. Additional organizations, including the American Medical Association (AMA), American Congress of Obstetrician Gynecologists (ACOG), and the American Nurses Association (ANA) have mandated screening for IPV across health care specialties. The Centers for Disease Control and Prevention outline a list of all available screening tools for assessing IPV within healthcare settings (for a review of selected screening tools see Table 2)<sup>48</sup>. There are several considerations to weigh when choosing a screening tool. Important considerations can include:

- Screening administration
- Type of IPV assessed
- Question types
- Cultural considerations

## Screening administration

Screening results can differ based on type of administration. Self-report measures can often increase the likelihood of disclosure and may remove potential administrator bias, which at times could sway patients to respond a particular way<sup>49</sup>. For example, if a provider has a full patient load that particular day the provider may unintentionally send subtle messages to the patient to not endorse IPV (no eye contact, reading through screening questions quickly, asking questions as a negative, etc.). Provider-administered measures are also available, and potential benefits of provider administered screening includes building rapport and natural progression to safety planning. Therefore, it is important for each clinic to decide which administration of screening is preferred. There are many provider-administered screening tools that include standardized questions for providers to ask either all patients (universal screening) or patients who are at risk for IPV (targeted screening). Administration of screening when the partner is with the patient can further complicate the likelihood that an individual will report IPV, therefore, whenever possible, these screeners should be completed with the patient alone. This can be difficult to manage if a packet of screeners is provided to patients in the waiting room, as oftentimes perpetrators accompany their partners in the waiting room. Therefore, the timing and type of administration should be carefully considered for this sensitive topic.

## Type of IPV assessed

When choosing a screening tool, it can be imperative to ensure that the types of IPV one is hoping to screen for is included in the measure. Not all measures of IPV include an assessment of physical, emotional, and sexual violence. Further, most screening questions do not assess for control of reproductive or sexual health. This may be important information to obtain post-delivery when discussing future birth control methods. Therefore, individual clinics may decide to add questions to existing screeners.

## Question types

When assessing potentially traumatic events, like IPV, the questions used concerning violence exposure can be an important consideration. Screening tools rely on a series of questions that ask if someone has ever experienced a particular type of violence. Behaviorally specific questions that inquire if someone has ever experience a particular experience (e.g., “Has your partner ever strangled you?”) can elicit more accurate responses than general questions (e.g., “Has your partner ever abused you?”). Behaviorally specific questions have been informed by decades of research and generally yield more accurate responses<sup>48, 49</sup>.

## Cultural considerations

There are a couple of cultural considerations when choosing IPV screening tools. First, in some cultures, there is a strong philosophy that IPV should be “kept in the family” and not discussed with those outside of the family. Therefore, it may be helpful to choose screeners that have been validated in ethnic minority populations. Second, many screening tools assume that the individual is in a heteronormative monogamous relationship. Therefore, it may be important to assess what type of relationship(s) the individual is a part of prior to

delivering the screening tool or to choose screening tools that do not assume the partner is male or that there is only one partner.

## Safety Planning During Pregnancy

If an individual receives a positive screen for IPV, safety planning can be an important next step. Depending on what the individual wants to do, safety planning may include safety within the relationship, safety while leaving the relationship, and safety after leaving the relationship. Below are some safety planning strategies that a provider can help the patient prepare for based on the patient's willingness to leave the relationship.

If the individual is not willing to leave the relationship, safety planning may focus on **how to stay safe within the relationship**, which can include:

- Identifying safe areas of the home
- Gathering important documents such as copies of birth certificates
- Making copies of important financial or ownership documents
- Providing assistance with contraceptive health and screening for sexual health issues
- Practicing how to escape if needed and have an escape bag packed
- Identifying individuals to call in an emergency including a local domestic violence shelter or national hotline with trained advocates such as the National Disaster Violence Hotline

If the individual is preparing to leave the relationship, safety planning may focus on **how to safely leave the relationship**, which can include:

- Contacting a local domestic violence shelter or national hotline
- Documenting any injuries (provider can do this during the visit and place pictures in the medical record)
- Identifying a safe place to stay

If the individual has recently left the relationship, safety planning may focus on **how to stay safe after leaving the relationship**, which can include:

- Filing for a restraining order or order of protection
- Changing the route to work and/or school
- Changing the locks
- Alerting neighbors, family, co-workers, or school personnel to call the police if they see the perpetrator

The aforementioned screening tools can be used to assist with identifying when safety planning is needed<sup>48</sup>. After a positive screen or endorsement of IPV, safety planning checklists can be completed with the patient and provider. The National Coalition Against Domestic Violence ([http://www.ncdsv.org/images/DV\\_Safety\\_Plan.pdf](http://www.ncdsv.org/images/DV_Safety_Plan.pdf)) provides a thorough



safety-planning checklist that includes several different strategies to assist in facilitating safety at various steps of responding to IPV.

## Referral to Treatment

Evidence suggests that individuals are more likely to utilize interventions suggested by their healthcare provider<sup>50</sup> compared to any other official personnel. Additionally, pregnancy and pre-conceptional periods are time when women are most amenable to take advantage of interventions and make significant life-style changes. Importantly, findings have demonstrated that, at 2-year follow-up, women provided with referrals directly from the healthcare provider reported less violence and assault risk, as well as decreased healthcare costs<sup>51</sup>.

Depending on institution or clinic resources, intervention approaches can range from provider brief intervention and referral to treatment to “systems level” approaches. A “systems level” approach to intervention has proved most successful for IPV care<sup>52</sup>. Such approaches are designed to transform the entire organization to focus on IPV detection and care. The intervention areas of these programs aim to:

1. Create a supportive environment,
2. Link victims to community organizations,
3. Systematic inquiry and referral integrated into the electronic health record, and
4. Provision of on-site IPV services.

However, not all clinics have the capability for on-site IPV services. Therefore, providers need to be well-informed regarding local resources including local victim advocacy non-profits, shelters, and national hotlines. Many local IPV organizations have information cards of local referrals that can be provided to patients. When offering referrals, providers should demonstrate patience and compassion as it may take IPV victims a number of visits before following up on recommendations. A “warm hand-off” where providers contact a local agency or national hotline on the phone with the patient in the office can streamline connecting IPV victims to referrals.

## Summary

IPV is a serious public health problem that involves various forms of physical and psychological aggression. Exposure to IPV has negative impacts on the body’s stress response and autoimmune functioning, which may in part explain the association between perinatal IPV and a range of obstetric consequences from increased vaginal bleeding to stillbirths. Although these health consequences typically come to the attention of providers, their relationship to IPV is much harder to detect. More research is needed to understand the mechanisms in which perinatal IPV leads to adverse obstetrical outcomes. Given the ongoing nature of IPV, and the mental health sequelae, perinatal care is a critical time period for providers to reach this population. Proper screening procedures, safety planning, and referrals are important methods to combat this public health problem.

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### Key Points

- Violence perpetrated by an intimate partner is estimated to occur in between 3.7% to 9% of perinatal women.
- There is a pervasive impact of perinatal IPV on several psychological and physical outcomes relevant to the mother and child. These include grave outcomes such as suicidal ideation, stillbirths, and maternal death.
- Screening for IPV during perinatal health care visits is essential to detect women who are at risk for the adverse obstetric health outcomes, facilitate safety planning, and initiate referral to mental health treatment.

**Box 1****Definitions and Lifetime Prevalence of Forms of IPV****Physical Violence (32.4%)**

- Behaviors with the potential for causing injury, harm, disability, or death
- Examples include slapping, pushing, choking, pulling hair, kicking, and use of restraint

**Sexual Violence (16.4%)**

- Unwanted sexual experiences that range from non-contact to completed rape
- Rape includes completed forced penetration, attempted forced penetration, and completed alcohol or drug facilitated penetration

**Stalking (27.4%)**

- Patterns of harassing or threatening tactics that cause fear or safety concerns

**Psychological Aggression (47.1%)**

- Expressive aggression and coercive control behaviors
- Examples include name-calling, insults, denying access to basic resources

**Control of reproductive or sexual health (8.6%)**

- Refusal to wear a condom or attempting to get a person pregnancy when they did not want to become pregnant

**Box 2****Common Mental Health Symptoms Among Women Exposed to IPV****Posttraumatic Stress Disorder Symptoms**

**Posttraumatic Stress Disorder Symptoms** develops after exposure to one or more traumatic events and is characterized by four clusters of symptoms:

- Re-experiencing or intrusive thoughts and memories about the traumatic event and intense reactions to cues that remind the individual of the event.
- Avoidance of external (e.g., people or places) and internal cues (e.g., feelings or thoughts)
- Changes in one's cognitions and mood including exaggerated self-blame, decreased interest in pleasurable activities and ability to experience positive emotions.
- Arousal and reactivity difficulties, such as increased irritability, exaggerated startle response, concentration difficulties, sleep problems, hypervigilance, and reckless behaviors.

**Major Depressive Disorder Symptoms**

**Major Depressive Disorder Symptoms** are marked by depressed mood and loss of interest or pleasure. Symptoms include:

- Changes in weight or appetite
- Sleep disturbance
- Suicidal ideation
- Fatigue
- Worthlessness
- Psychomotor agitation or retardation
- Difficulties concentrating

**Substance Use Disorder Symptoms**

**Substance Use Disorder Symptoms** can be in relation to various substances ranging from alcohol to nicotine. Symptoms include:

- Impaired control such as taking the substance longer than intended, cravings, and spending a significant amount of time attempting to get access to, use, or recover from the substance
- Impairment in social functioning or use of the substance in risky situations
- Tolerance or withdrawal from the substance

**Table 1**

Consequences that are associated with Perinatal IPV

<b>Impact on Mother's Mental Health</b>	<ul style="list-style-type: none"> <li>• Depression, PTSD, anxiety</li> <li>• Substance Use</li> <li>• Suicide</li> </ul>
<b>Impact on Mother's Obstetric Health</b>	<ul style="list-style-type: none"> <li>• High blood pressure or edema</li> <li>• Vaginal bleeding</li> <li>• Severe nausea</li> <li>• Vomiting or dehydration</li> <li>• Kidney infection or UTI</li> <li>• Premature rupture of membranes</li> <li>• Placental abruption</li> </ul>
<b>Impact on Mother and Fetus/Infant</b>	<ul style="list-style-type: none"> <li>• Miscarriage</li> <li>• Stillbirth</li> <li>• Fetal and mother death</li> <li>• Lower intrauterine growth and birth weight</li> </ul>
<b>Long-term Impact on Child</b>	<ul style="list-style-type: none"> <li>• Executive and cognitive functioning difficulties</li> <li>• Insecure and disorganized attachment</li> <li>• Exposure to additional traumatic events</li> </ul>

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**Table 2**

## Description of Selected Screening Tools

Tool	Advantages	Disadvantages
Abuse Assessment Screen (AAS)	<ul style="list-style-type: none"> <li>• 5 items assessing physical, sexual, and emotional abuse</li> <li>• Studied among pregnant women with good sensitivity (93%)</li> <li>• Spanish Version available</li> </ul>	<ul style="list-style-type: none"> <li>• Specificity is low (55%)</li> <li>• Clinician administered only</li> <li>• Does not include behaviorally specific description of sexual violence</li> </ul>
HITS	<ul style="list-style-type: none"> <li>• 4 items with acronym to assist administration</li> <li>• Clinician or self-administered</li> <li>• Studied in family practice settings with good sensitivity (86 to 96%) and specificity (91 to 99%)</li> <li>• Spanish version available</li> </ul>	<ul style="list-style-type: none"> <li>• Limited to assessing physical IPV and psychological IPV</li> </ul>
STaT (Slapped, Things, and Threaten)	<ul style="list-style-type: none"> <li>• 3 items assessing physical violence and threats</li> <li>• Studied in emergency department with good sensitivity (96%) and specificity (75%)</li> </ul>	<ul style="list-style-type: none"> <li>• Limited to physical violence</li> <li>• Clinician administered only</li> <li>• Available for purchase</li> </ul>
Ongoing Violence Assessment Tool	<ul style="list-style-type: none"> <li>• 4 items assessing physical, and emotional IPV</li> <li>• Studied in emergency department with good sensitivity (86 to 93%) and specificity (83 to 86%)</li> </ul>	<ul style="list-style-type: none"> <li>• Self-report only</li> <li>• Focuses only on present abuse rather than lifetime</li> </ul>