Professional Guidance on Intimate Partner Violence and...

PREGNANCY

PREVALENCE

The majority of research has found that between **3% and 9% of women experience abuse during pregnancy** (Martin, Mackie, Kupper, Buescher, & Moracco, 2001 and Saltzman, Johnson, Gilbert, & Goodwin, 2003). That is about the same percentage of women who are diagnosed with Gestational Diabetes. There are well-established risk factors that are associated with higher rates of abuse, including young age, single relationship status, minority race/ethnicity, and poverty (Tjaden and Thoennes, 2000, and Vest, Catlin, Chen, & Brownson, 2002). Women whose partners did not want the pregnancy reported high levels of physical abuse (14%) during pregnancy (Chu, Goodwin, & D'Angelo, 2010).

EFFECTS

In addition to the acute injuries and non-acute presentations commonly seen in women experiencing abuse, pregnant women are more likely to have **poor weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery and low birth weight**. They are more likely to begin prenatal care later and miss more appointments than women not experiencing abuse (ACOG, 2012).

Pregnancy may act as a trigger for accusations of infidelity among some partners. Men who doubt their paternity may be more likely to endanger the fetus by directing physical aggression to their partners' abdomen (Graham-Kevan and Archer, 2011). A systematic review of 225 articles addressing trauma in pregnancy found that intimate partner violence (IPV) was second only to motor vehicle accidents as the most common cause of traumatic injury during pregnancy. Pregnant women experiencing IPV are more than 2.5 times more likely to deliver preterm and more than 5 times more likely to deliver a baby weighing less than 5 ½ pounds (Mendez-Figueroa, Dahlke, Vrees, and Rouse, 2013).

In Maryland, between 1993 and 2008, **homicide was the leading cause of death of women during pregnancy and the first postpartum year**. Of the solved cases, most homicides (63%) were committed by a current or former intimate partner and most occurred during the first three months of pregnancy (Cheng & Horon, 2010).

INTERVENTIONS

Screening for IPV is recommended by the American College of Obstetricians and Gynecologists (ACOG), the Association of Women's Health, Obstetric and Neonatal Nurses, the American College of Nurse-Midwives, and the American Academy of Pediatrics as well as other major professional medical associations.

Screening for IPV during obstetric care should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup (ACOG, 2012). When IPV is disclosed, health care providers should offer a supportive response, assess for immediate danger for the patient (and any children), and help the patient to begin safety planning. A protocol with all necessary information should be available to all staff who interact with patients. ACOG published a Committee Opinion in 2012 to support screening and referrals during pregnancy (see Resources section).

Outpatient OB offices and inpatient Maternity units can benefit from the expertise of staff in a hospital-based advocacy program or partnering with a local domestic violence agency. Advocates can provide training on how to screen, assess for danger and refer to appropriate resources that may be available within the program or in the community.

Physicians and nurses must be mindful that some routine assessments and exams during pregnancy and labor may be threatening to a woman who has been abused. The routine procedure of vaginal exams may trigger negative experiences, causing anxiety and fear. Explaining and talking through the assessment or exam allows a woman to be a part of her care and shows sensitivity towards her past experiences.

Breastfeeding also may bring up uncomfortable feelings of past or current abuse. However, assumptions should not be made about a woman's desire or ability to breastfeed, based on her experiences with abuse. Research has shown that breastfeeding initiation and duration rates are similar for abused and non-abused women (Bullock, Libbus and Sable, 2001). If a woman is not able to put her baby to breast, but still wants to breastfeed, offer the option of pumping. Have a certified lactation consultant work with her to develop a pumping schedule that will support an adequate milk supply. Being able to provide breast milk can be empowering and may boost her confidence in her ability to care for the baby.

PREGNANCY

REFERENCES

Brown, H.L. (2009). Trauma in Pregnancy. *Obstetrics & Gynecology, 114*, 147-160.

Bullock, L.F., Libbus, M.K., & Sable, M.R. (2001). Battering and breastfeeding in a WIC population, *Canadian Journal of Nursing Research*, *32*(4), 43-56.

Cheng, D., Horon, I. (2010). Intimate partner homicide among pregnant and postpartum women. *Obstetrics and Gynecology, 115*(6), 1181-1186.

Chu, S.Y., Goodwin, M.M., D'Angelo, D.V. (2010). Physical violence against U.S. women around the time of pregnancy, 2004-2007. *American Journal of Preventive Medicine*, *38*(3), 317-322.

Intimate Partner Violence. (2012) Committee Opinion No. 518. American College of Obstetricians and Gynecologists. *Obstetrics and Gynecology*, 119: 412-417.

Graham-Kevan, N., Archer, J. (2011). Violence during pregnancy: Investigating infanticidal motives. *Journal of Family Violence*, *26*, 453-458.

Martin, S.L., Mackie, L., Kupper, L.L., Buescher, P.A., Moracco, K.E. (2001). Physical abuse of women before, during, and after pregnancy. *Journal of the American Medical Association*, *285*, 1581–1584.

Mendez-Figueroa, H., Dahlke, J.D., Vrees, R.A., Rouse, D.J. (2013). Trauma in pregnancy: An updated Systematic Review. *American Journal of Obstetrics and Gynecology*, *209*(1), 1-10.

Saltzman, L.E., Johnson, C.H., Gilbert, B.C., Goodwin, M.M. (2003) Physical abuse around the time of pregnancy: An examination of prevalence and risk factors in 16 states. *Maternal Child Health Journal, 7*, 31–43.

Tjaden, P., Thoennes, N. (2000). Full report of the prevalence, incidence, and consequences of violence against women: findings from the National Violence Against Women Survey. Research Report. Washington, DC: National Institute of Justice and the Centers for Disease Control and Prevention.

Vest, J.R., Catlin, T.K., Chen, J.J., Brownson, R.C. (2002). Multistate analysis of factors associated with intimate partner violence. *American Journal of Preventive Medicine*, *22*, 156–164.

RESOURCES

ACOG screening tool:

http://www.acog.org/About%20ACOG/ACOG%20Departments/Violence%20Against%20Women/Screening%20Tools%20%20Domestic%20Violence.aspx

Screening and counseling toolkit from Futures without Violence

http://www.healthcaresaboutipv.org/introduction/

ACOG Committee Opinion

https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co518.pdf?dmc=1&ts=20170109T1459005651