Domestic violence and pregnancy

Loraine Bacchus
MA

Susan Bewley
FRCOG

Gillian Mezey
FRCPsych

Domestic violence is increasingly recognised as an important public health issue, resulting in significant physical, psychological and social impairment. Health professionals frequently and often unknowingly come into contact with abused women. Timely identification and referral of women to the appropriate community services can interrupt the cycle of violence, prevent further injury and initiate the help-seeking process. This review examines the prevalence of violence during pregnancy and related health effects. Risk markers associated with violence are presented along with suggestions for identifying and dealing with disclosures of violence.

DEFINITION

A widely accepted definition of domestic violence is the physical, sexual or emotional abuse of an adult woman by a man with whom she has or has had an intimate relationship, regardless of whether the couple are living together.[1] Although domestic violence can be perpetrated by other family members or occur within same-sex relationships, it is argued that male partners particularly use violence in order to maintain dominance and control over female partners.[2] Women who experience domestic violence are more likely than men to experience serious injury and live in fear of their violent partners.[3] Definitions of domestic violence vary according to the frequency, severity and nature of the violence, as well as the context in which it occurs and the relationship between the victim and the perpetrator.[4]

EPIDEMIOLOGY

Epidemiological studies of domestic violence in the UK have found the lifetime prevalence of domestic violence to be 1 in 3–4 women[5–7] and annual prevalence rates of 1 in 9–10 women.[6,8,9] Differences in estimates are largely due to the use of non-standard definitions and methodological designs.

THE EXTENT OF DOMESTIC VIOLENCE IN PREGNANCY

Although an understanding of domestic violence is necessary in gynaecology, it is particularly important in obstetric care. Studies suggest that pregnancy often triggers domestic violence or exacerbates a pre-existing problem, although it can also be associated with a reduction in violence.[10–13] Moreover, the pattern of violence may change, with assaults directed to the abdomen, breasts and genitals.[12]

Reported rates of physical, sexual or emotional violence by a partner during pregnancy range from 0.9%[14] to 20.2%.[15] The research predominantly comes from the USA and Scandinavia and the studies are summarised in *Table 1*. There has been no published British study on the extent and effects of domestic violence in pregnancy, although there are preliminary reports of rates of 1.8–5.8%.[16] Higher rates are elicited in response to direct questioning by trained health professionals[17] and repeated questioning.[18] Women appear to be at greater risk of violence during the postpartum period[18] and one study has found higher rates of domestic violence among pregnant teenagers.[19]

Table 1. Domestic violence in pregnancy and postpartum: epidemiological studies

First author (year)	Sample size (*n*)	Perpetrator(s)	Data collection method	Period of observation	Prevalence (%) and type of violence
Amaro (1990)[41]	1243	'Was the assailant known to you?'	2 interviews: 1 during first prenatal visit and 1 immediately postpartum	Entire pregnancy	7%, physical, sexual
Berenson (1992)[42]	342	Not specified	1 interview during first prenatal visit	Up to first visit	6.7%, physical
Campbell (1992)[10]	488	'The man you are with' and 'anyone else'	1 interview 2–5 days postpartum	Entire pregnancy	7.2%, physical[a]
Gielen (1994)[18]	275	'Someone close to you'	4 interviews: 3 during pregnancy and 1 at 6 months postpartum	Entire pregnancy and 6 months postpartum	10%, physical prenatally;[b] 19%, physical postpartum[b]
Helton (1987)[43]	290	'Male partner'	1 interview at any point in pregnancy	Varied	8%, physical
Hillard (1985)[12]	742	'Anyone at home'	1 interview during first prenatal visit	Up to first visit	3.9%, physical
O'Campo (1994)[15]	358	'Someone else close to you'	1 interview during third trimester	Up to third trimester	20.2%, physical
Parker (1994)[44]	1203	'Husband, ex-husband, boyfriend, stranger, other'	3 interviews during first prenatal visit and during second and third trimesters	Up to third trimester	16%, physical
Sampselle (1992)[14]	934	Not collected	Self-administered questionnaire at any point during pregnancy	Up to first visit	0.9%, physical, emotional, sexual
Stewart (1993)[13]	548	Not specified	Self-administered questionnaire during pregnancy	Up to first visit	6.6%, physical
Taggart (1995)[45]	502	'Partner or someone important to you'	Self-administered questionnaire during pregnancy	Varied	20%, physical

[a]Refers only to violence by the 'the man you are with'; [b]Refers only to violence by a 'partner'

THE IMPACT OF DOMESTIC VIOLENCE

Violence against women is increasingly recognised as an important public health issue that has serious consequences for their physical and mental health. Domestic violence has been associated with psychiatric illness, including depression, anxiety, post-traumatic stress disorder and suicide.[20] In addition, many women experience physical injury or continuing physical health problems as a result of a violent attack or sexual assault.[21] Apart from the personal costs of domestic violence, there are economic costs to society, related to the use of resources such as medical treatment, housing, legal assistance and counselling.[8] Children are often involved as a result of witnessing or experiencing violence between their parents; up to 36% of children of violent relationships witness their mothers being assaulted.[22]

THE IMPACT OF DOMESTIC VIOLENCE ON OBSTETRIC OUTCOME

Domestic violence has an adverse effect on the health of the pregnant mother and her child both before and after birth. Domestic violence during pregnancy has been associated with placental abruption, chorioamnionitis, stillbirth, miscarriage, low-birth-weight infants and premature labour.[23–25] Abdominal trauma during pregnancy may lead to fetal fractures and rupture of the mother's uterus, liver or spleen[26] and in extreme cases the violence may result in maternal or fetal death.[27]

Studies have found an association between maternal health risk behaviours and domestic violence during pregnancy. Associated increased smoking, alcohol and illicit drug use are all potentially injurious to the mother and developing fetus.[28,29] Women may use these substances in an attempt to cope with the trauma and stress of living in an abusive relationship.

The nature and extent of the association between domestic violence and poor obstetric outcome is unclear. Some studies have not been able to establish violence as an antecedent factor for some outcome variables and more prospective work is needed.

Women who experience domestic violence in pregnancy appear to be less able to make proper use of antenatal care,

leading to late booking and non-attendance.[30] Also, they are more likely to describe their pregnancy as unplanned and elect to have an abortion.[12,31,32] Higher rates of domestic violence have been associated with increased parity, being divorced or separated[12] and being better educated than the partner.[18] Protective factors include being older and having a confidante or social support.[18] The presence of abuse should be considered when women present with any of the following indications:

- late booking
- poor obstetric history
- vaginal bleeding
- genitourinary infections
- injuries to the face, head, neck, chest, or abdomen
- unresolved admissions
- repeat presentation with depression, anxiety, self-harming and psychosomatic symptoms
- substance misuse, excessive alcohol use.

INTERVENTIONS IN HEALTH CARE SETTINGS

Protocols and good practice guidelines for dealing with domestic violence have been developed by the Royal College of Midwives[33] and the Royal College of Obstetricians and Gynaecologists.[34] A recent Department of Health report has advocated training and education for all health professionals and the use of routine screening to identify cases of domestic violence.[35]

General practitioners are often consulted by women needing help for injuries or symptoms resulting from domestic violence. However, women frequently report these contacts to be unhelpful. General practitioners tend not to enquire directly about the cause of any injuries and over-prescribe antidepressants and tranquillisers.[36] In the USA, similar findings have been reported in emergency rooms, with up to a third of female trauma patients identified as suffering from domestic violence.[37]

The failure of health professionals to identify domestic violence and offer appropriate intervention has been attributed to a number of factors, including:

- lack of knowledge and adequate training
- lack of time
- fear of offending the woman
- fear of opening-up issues that could get out of control
- a belief that domestic violence is not the province of health professionals
- feeling powerless to 'fix' the situation.[38]

Furthermore, in the absence of direct questioning, women do not volunteer information about experiences of domestic violence due to embarrassment and shame.[37]

INTERVENTIONS IN OBSTETRIC SETTINGS

All pregnant women have contact with health service professionals, which provides an opportunity to identify and help women experiencing domestic violence. Studies in obstetric settings have shown that the use of repeat screening and a structured screening questionnaire significantly increases the rate of detection of domestic violence.[39]

Midwives are ideally placed to identify and intervene in cases of domestic violence: they spend considerable amounts of time with women; they visit women in the home; they have an opportunity to conduct physical examinations; and they have the opportunity for confidential time alone with women. Obstetricians should also be alert to domestic violence being the hidden cause of many presenting symptoms.

Simple measures include giving all pregnant women information about local supportive services, such as the Women's Aid Federation and Refuge, and asking simple sympathetic direct questions such as 'Do you and your partner fight?', 'Does it get physical?' or 'Have you been hit or hurt?'. Women who disclose violence require a sympathetic and non-judgemental hearing. Their safety should be assessed (death is more likely if violence is accompanied by threats to kill, use of weapons or sexual abuse) and hospital admission can act as a safety valve. The following comments illustrate women's experiences of routine enquiry for domestic violence in a South London maternity service:[40]

> It helped that she didn't behave like 'he's done that to you!' That would have made me feel bad. She didn't make it seem like she was shocked. She was very understanding and she didn't ask me questions like 'why did you let him do this'. She didn't judge me. She just listened and was saying 'okay, you're doing fine, just remember that you're strong now, you've gotten through this'. She was praising me for having the strength to pull through this and that's what made it easier for me to give her more information about what happened.
>
> It would be easier to speak to the same midwife because every time you see someone different you're re-living everything again and again. They've got to find out everything from the beginning. You think you can't do it and it's the sort of thing that puts you off.
>
> When someone asks me the question [about domestic violence] it means they're interested in what I have to say, which makes me want to say something. If I just said something about it myself, I don't know if that person wants to listen to me or not. That's why it's hard to bring it up yourself.

Documentation should be meticulous and confidential (i.e. not in the handheld notes) and an offer made to inform the police (domestic violence is a crime). Follow-up support by the same health professional to whom the woman discloses abuse is essential during both pregnancy and the postnatal period. Women are best placed to assess their own safety, but it is worth discussing an 'exit plan' if the violence worsens. As yet, there is little in the way of proven or

effective interventions with perpetrators to stop violent behaviour. Health professionals should avoid being judgemental about a woman's decision to stay with a partner and avoid being taken in by seemingly caring partners who dominate or never leave the woman alone.

AUTHOR DETAILS

Loraine J Bacchus MA, *Research Psychologist,* Department of Forensic Psychiatry, St George's Hospital Medical School, London, UK

Susan Bewley FRCOG, *Clinical Director,* Women's Health Services Directorate, Guy's and St Thomas' Hospitals Trust, 9th Floor New Guy's House, Guy's Hospital, London SE1 9RT, UK (corresponding author)

Gillian Mezey FRCPsych, *Consultant and Senior Lecturer in Forensic Psychiatry,* Department of Psychiatry, St George's Hospital, London, UK

References

1 McKay A, MacGregor L. *Hit or Miss.* Dundee: Tayside Regional Council; 1994
2 Harwin N. Understanding women's experience of abuse. In: Bewley S, Friend J, Mezey G, editors. *Violence Against Women.* London: RCOG Press; 1997. p. 59–75
3 Mirlees-Black C. *Domestic Violence: Findings from a New British Crime Survey Self-completion Questionnaire.* London: HMSO; 1999. Home Office Research Study 191
4 Lloyd S. Defining violence against women. In: Bewley S, Friend J, Mezey G, editors. *Violence Against Women.* London: RCOG Press; 1997. p. 3–12
5 Dominy N, Radford L. *Domestic Violence in Surrey: Developing an Effective Inter-agency Response.* London: Surrey County Council and Roehampton Institute; 1996
6 Mooney J. *The Hidden Figure: Domestic Violence in North London.* London: Islington Council; 1993
7 Williams M, McKiernan J. *Bringing It Out in the Open. Domestic Violence in Northern Ireland.* Belfast: HMSO; 1993
8 Stanko EA, Crisp D, Hale C, Lucraft H. *Counting the Costs: Estimating the Impact of Domestic Violence in the London Borough of Hackney.* Wiltshire: Crime Concern; 1998
9 McGibbon A, Cooper L, Kelley L. *What Support?* London: Hammersmith and Fulham Council, Community Safety Committee; 1989
10 Campbell JC, Poland ML, Waller JB, Ager J. Correlates of battering during pregnancy. *Res Nurs Health* 1992;**15**:219–26
11 Gelles RJ. Violence and pregnancy: a note on the extent of the problem and needed services. *Family Coordinator* 1975;**24**:81–6
12 Hillard PJ. Physical abuse in pregnancy. *Obstet Gynecol* 1985;**66**:185–90
13 Stewart DE, Cecutti A. Physical abuse in pregnancy. *Can Med Assoc J* 1993;**149**:1257–63
14 Sampselle CM, Peterson BA, Murtland TL, Oakley DJ. Prevalence of abuse among pregnant women choosing certified nurse-midwife or physician providers. *J Nurse Midwifery* 1992;**37**:269–73
15 O'Campo P, Gielen AC, Faden RR, Kass N. Verbal abuse and physical violence among a cohort of low-income pregnant women. *Women's Health Issues* 1994;**4**:29–37
16 Bacchus L, Mezey G, Bewley S, Haworth A. Domestic violence in pregnancy: does use of a screening instrument increase detection? *Unpublished results*
17 Gazmararian JA, Lazorick A, Spitz AM, Ballard TJ, Saltzman L, Marks JS. Prevalence of violence against pregnant women. *JAMA* 1996;**275**:1915–20
18 Gielen A, O'Campo PJ, Faden RR, Kass NE, Xue X. Interpersonal conflict and physical violence during the childbearing year. *Soc Sci Med* 1994;**39**:781–7
19 Parker B, McFarlane J, Soeken K, Torres S, Campbell D. Physical and emotional abuse in pregnancy: a comparison of adult and teenage women. *Nurs Res* 1993;**42**:173–8
20 British Medical Association. *Domestic Violence: A Health Care Issue?* London; 1998
21 Campbell JC. Mental and physical health effects of intimate partner violence on women and children. *Psychiatr Clin North Am* 1997;**20**:353–73
22 National Children's Home: Action for Children. *The Hidden Victims: Children and Domestic Violence.* Highbury; 1996
23 Berenson AB, Wiemann CM, Wilkinson GS, Jones WA, Anderson GD. Perinatal morbidity associated with violence experienced by pregnant women. *Am J Obstet Gynecol* 1994;**170**:1760–9
24 Schei B, Samuelson SO, Bakketeig LS. Does spousal abuse affect outcome of pregnancy? *Scand J Soc Med* 1991;**19**:26–31
25 Webster J, Chandler J, Battistutta D. Pregnancy outcomes and health care use: effects of abuse. *Am J Obstet Gynecol* 1996;**174**:760–7
26 Newberger EH, Barkan SE, Lieberman WS, McCormick MC, Yllo K, Gary LT, *et al.* Abuse of pregnant women and adverse birth outcome. Current knowledge and implications for practice. *JAMA* 1992;**267**:2370–2
27 NHS Executive. *Confidential Enquiries into Maternal Deaths 1994–1996.* Wetherby; 1998 Nov 16. HSC 1998/211
28 Bhatt RV. Domestic violence and substance abuse. *Int J Gynaecol Obstet* 1998;**63** Suppl 1: 25–31
29 McFarlane J, Parker B, Soeken K. Physical abuse, smoking and substance use during pregnancy: prevalence, interrelationships and effects on birth weight. *J Obstet Gynecol Neonatal Nurs* 1996;**25**:313–20
30 Taggart L, Mattson S. Delay in prenatal care as a result of battering in pregnancy: cross-cultural implications. *Health Care for Women International* 1996;**17**:25–34
31 Gazmararian JA, Adams MM, Saltzman LE, Johnson CH, Bruce FC, Marks JS, et al. The relationship between pregnancy intendedness and physical violence in mothers of newborns. *Obstet Gynecol* 1995;**85**:1031–8
32 Glander SS, Moore ML, Michielutte R, Parsons LH. The prevalence of domestic violence among women seeking abortion. *Obstet Gynecol* 1998;**91**:1002–6
33 Royal College of Midwives. *Domestic Abuse in Pregnancy: A Position Paper.* London; 1997
34 Bewley S, Friend J, Mezey G, editors. *Violence Against Women.* London: RCOG Press; 1997
35 Henwood M. *Domestic Violence: A Resource Manual for Health Care Professionals.* London: Department of Health; 2000
36 Richardson J, Feder G. Domestic violence: a hidden problem for general practice. *Br J Gen Pract* 1996;**46**:239–42
37 McLeer SV, Anwar R. A study of battered women presenting in an emergency department. *Am J Public Health* 1989;**79**:65–6
38 Brown JB, Lent B, Sas G. Identifying and treating wife abuse. *J Fam Pract* 1993;**36**:185–91
39 Norton LB, Peipert JF, Zierler S, Lima B, Hume L. Battering in pregnancy: an assessment of two screening methods. *Obstet Gynecol* 1995;**85**:321–5
40 Bacchus L, Mezey G, Bewley S. Women's perceptions and experiences of routine enquiry for domestic violence in a maternity setting. *Unpublished results*
41 Amaro H, Fried LE, Cabral H, Zuckerman B. Violence during pregnancy and substance use. *Am J Public Health* 1990;**80**:575–9
42 Berenson AB, Miguel VVS, Wilkinson GS. Prevalence of physical and sexual assault in pregnant adolescents. *J Adolesc Health* 1992;**13**:466–9
43 Helton A, McFarlane J, Anderson ET. Battered and pregnant: a prevalence study. *Am J Public Health* 1987;**77**:1337–9
44 Parker B, McFarlane J, Soeken K. Abuse during pregnancy: effects on maternal complications and birth weight in adult and teenage women. *Obstet Gynecol* 1994;**84**:323–8
45 Taggart L, Mattson S. Delay in prenatal care as a result of battering in pregnancy: cross-cultural implications. *Health Care for Women International* 1995;**17**:25–34