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Assessment for Intimate Partner Violence in the Perinatal Period:

When, Where, and What Next?

Dr. Patricia Janssen and Dr. Sarah Desmarais

Series editor: Linda Sheldon, SFU;
Krishna Pendakur, SFU and Daniel Hiebert, UBC, Co-directors

Metropolis British Columbia

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 For more information, contact the Co-directors of the Centre, Krishna Pendakur, Department of Economics, SFU (pendakur@sfu.ca) and Daniel Hiebert, Department of Geography, UBC (daniel.hiebert@ubc.ca).

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Assessment for Intimate Partner Violence in the Perinatal Period: When, Where, and What Next?

Dr. Patricia Janssen

University of British Columbia School of Population & Public Health

and

Dr. Sarah Desmarais

University of British Columbia School of Population & Public Health

Abstract

Violence perpetrated by an intimate partner is becoming increasingly recognized as an important determinant of health among women. Couples new to Canada may have few support networks and may be facing unemployment or underemployment. This, in combination with being isolated by language and culture, creates vulnerability and isolation, which in turn increase the risk for intimate partner violence. Pregnancy offers a unique opportunity to screen for intimate partner violence because it brings healthy women into contact with health care providers. Three hundred twenty-one women responded to a question on an antenatal assessment form about violence and 5.9 percent responded affirmatively. Among 330 women screened during their hospitalization for giving birth, 3.0 percent disclosed that they were afraid of their partner, but none disclosed physical violence. No women disclosed violence during their postpartum home visit, including the women who did disclose prenatally or in the hospital. Women appear to be more comfortable disclosing violence on paper forms compared to when speaking with a nurse.

Introduction

The United Nations Declaration on the Elimination of Violence defines intimate partner violence as any act of violence that results in or is likely to result in physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UNGA 1993).

Violence perpetrated against women is associated with a multitude of physical (injuries, infection, chronic pain) and mental (depression, substance abuse, posttraumatic stress syndrome) health problems. Women experiencing violence during pregnancy have a threefold increase in risk for antepartum hemorrhage, preterm delivery, and intrauterine growth restriction and an eightfold increase in perinatal death. Studies have shown that 50–60 percent of men who batter their wives also batter their children. A study of immigrant and refugee women in Canada showed that among those experiencing violence, only 12 percent disclosed to a physician (CCSD 2004). This low rate of disclosure may result from both the unwillingness of care providers to ask women about violence and women's reluctance to disclose as they are not aware of available resources to support their choices. Pregnancy imparts both a unique opportunity and unique challenges with respect to assessment for violence exposure because women present for care accompanied by their partners. It therefore becomes important to measure which time and which approach is most conducive to women's ability to disclose and ask for help.

Background

In 2008, Vancouver Coastal Health Authority approved a policy calling for routine assessment for domestic violence for all adult patients, clients, and residents (VCHA 2008). This policy was instituted to improve health care professionals' ability to address domestic violence in the community and to provide resource and referral information for both the survivor and perpetrator of domestic violence, appropriate to the patient/client situation and safety needs.

The movement towards routine, universal assessment for violence exposure during the childbearing cycle has been fuelled by emerging literature regarding the consequences to the mother, fetus, and newborn. In 2003 Janssen et al. published a prospective study of forty-seven hundred women presenting for birth in two Vancouver hospitals. Women exposed to violence experienced a threefold increased risk for antepartum hemorrhage and intrauterine growth restriction and a sevenfold increase in risk for perinatal death. The Janssen study was followed by a Seattle-based study that reported a threefold increase in low birthweight and extreme prematurity, and an eightfold increase in neonatal death among infants of women exposed to violence (Lipsky et al. 2003). A large California population-based study in 2005 confirmed these findings (Kady et al. 2005). Furthermore, the rate of maternal death was 1 percent higher than that seen for any other maternal complication of pregnancy. This latter study concluded that if we are to decrease maternal and perinatal mortality throughout the childbearing years, we must direct resources to violence prevention.

In addition to the direct sequelae of violence, exposure in pregnancy and postpartum has been shown to be associated with both the initiation of alcohol

and drug use and an inability to reduce intake (Perham-Hester and Gessner 1997). In addition to substance use (Abbott et al. 1995), female victims of violence suffer from high rates of posttraumatic stress disorder (PTSD) and depression (Campbell, Sullivan, and Davidson II 1995); Gleason 1993; Kemp, Rawlings, and Green 1991), including postpartum depression (PHAC 2009). After pregnancy, during the postpartum period, the incidence of partner-perpetrated violence is known to increase in both frequency and severity (Stewart and Cecutte 1993).

There is evidence that interventions following screening for domestic violence improve women's safety. Two intervention trials of safety planning for women abused during pregnancy reported reductions in danger scores on standardized risk assessment tools as well as actual assaults up to eighteen months post intervention (McFarlane, Soeken, and Wiist 2000; Parker et al. 1999). A recently published randomized controlled trial of an integrated cognitive behavioural intervention delivered by telephone during pregnancy and postpartum demonstrated a reduction in recurrent episodes of intimate partner violence, odds ratio, 0.48, 95 percent, confidence intervals 0.29-0.80, even after controlling for alcohol use and depression. Reduction of physical violence and improvement of quality of life has been demonstrated for up to two years following a stay in a women's shelter accompanied by advocacy services (Sullivan and Bybee 1999). Among women referred to case managers to address issues of violence after a visit to an emergency room, 50 percent remained violence-free after six weeks (Krasnoff and Moscati 2002). There is currently no evidence that assessment for intimate partner violence is associated with harm to women (FVP 2004). Furthermore, studies have shown that women are receptive to questions about abuse (Stenson et al. 1999; Webster, Stratigos, and Grimes 2001; Baccus, Mezey, and Bewley 2002; Rodriguez et

al. 2001; Friedman et al. 1992) and that routine questioning helps to identify women who are victims of violent behavior (Covington et al. 1997). Studies involving identification of female victims of violence have demonstrated that more than 80 percent of women identified through routine questioning are willing to receive information and referrals (Krasnoff and Moscati 2002).

Professional practice organizations and regulatory bodies, including the Canadian Nurses Association (CNA 1992), Health Canada (Health Canada 1999), the Association of Women's Health, Obstetric and Neonatal Nurses (Campbell and Furniss 2002), and in BC, the British Columbia Reproductive Care Program (BCRCP 2003, Obstetrical Guideline 13) have published guidelines advocating routine assessment for domestic violence in pregnancy and postpartum women. In 2005 the Society of Obstetricians and Gynecologists of Canada (SOGC) (Cherniak et al.) and the Registered Nurses Association of Ontario (RNAO) published detailed reports recommending that all women be routinely assessed for exposure to intimate partner violence. The RNAO Guideline acknowledges the multiplicity of benefits associated with assessment, including the opportunity for women to discuss violence, to link health consequences to abuse, to avoid stigmatization, to reduce isolation, to assist children of abused women, and to inform women about choices in advocacy and services (RNAO 2005). Guideline panel members concluded that routine, universal inquiry, in accordance with comprehensive staff education and ongoing agency and managerial support, constitutes best practice at this time.

In spite of virtually universal recommendations to incorporate screening for domestic violence into maternity care, the majority of physician providers do not include violence screening as part of their routine assessments. Large population-based surveys have repeatedly shown that less than 30 percent of obstetricians (Horan et al. 1998; Durant et al. 2000) and less than 10 percent

of family practice physicians ask about violence (Sugg et al. 1999; Lapidus et al. 2002). Barriers to screening that have been identified for nursing and physician caregivers have included lack of knowledge or time, inability to establish privacy, and lack of support for practitioners to acquire skills in this domain (Waalen et al. 2000; Janssen, Landolt, and Grunfelt 2003).

The most current and relevant source of information on the prevalence of violence exposure during pregnancy and postpartum comes from the Canadian Maternity Experiences Survey, a nationwide survey conducted by Statistics Canada in 2006 (PHAC 2009). This representative telephone survey of 6421 women living with their babies at approximately six months postpartum was conducted in sixteen languages. It reported that approximately 5.7 percent of women experienced violence from an intimate partner during the prior two years (Beydoun et al. 2010). Among women abused prior to pregnancy, only 20 percent continued to be abused during pregnancy (O'Campo et al. 2010b, 89). As previous interactive patterns between women and their partners resume following the postpartum period, however, the prevalence of violence exposure would be expected to increase. Indeed, a two-year clinic-based longitudinal study of seventy-six battered women in North Carolina, US demonstrated a sharp decrease in physical violence from four episodes per month pre-pregnancy to one episode per month during pregnancy, followed by a rebound to pre-pregnancy levels at one month post delivery (Macy et al. 2007). Psychological violence peaked at eighteen episodes per month at one month postpartum, much higher than pre-pregnancy levels of six. Sexual violence also escalated to three episodes per month at one month postpartum compared to pre-pregnancy levels of one per month. This is the only longitudinal study to date that has measured changes in acts of violence pre-, during and post-pregnancy.

In addition to the potential for women to be injured or killed, the impact of witnessing intimate partner violence on young children is just beginning to be appreciated. A small study of thirty-eight women in the UK reported impaired bonding to both the fetus and the newborn as well as elevated levels of post-partum depression among women experiencing either physical or psychological abuse (Zeitlin, Dhanjal, and Colmsee 1999). Reviews of the co-occurrence of child abuse in homes where there is domestic violence report a range of prevalence of child maltreatment from 50–75 percent in selected populations such as shelters (Osofsky 2003) to 7 percent in population-based samples (Fantuzzo et al. 1997). A systematic review of forty-seven studies addressing sequelae to school-age child witnesses from the Canadian nursing literature reported significant increases in both externalizing (aggressive, destructive, and antisocial) and internalizing (anxious, sad, worried, fearful and withdrawn) behavior (Onyskiw 2003). Rates of abnormal behavior, including clinical depression, were as high as 50–70 percent among children evaluated in these studies. This same author used data from the Canadian National Longitudinal Survey of Children and Youth to report that 8.6 percent of Canadian children witness violence in their families and that these children have lower health status and more conditions or health problems that limited their participation in normal age-related activities (Onyskiw 2002). These children were more likely to require specialty pediatric care and to use prescription medications. A small study of fifty-six children whose mothers had been in shelters in Australia reported a prevalence of 20 percent for the diagnosis of post-traumatic stress disorder (Mertin and Moir 2002). Encouragingly, findings from a randomized controlled trial of treatment for abused mothers that measured children's behaviours before and one year after their mothers' treatment program demonstrated that treatment of mothers before the child was age five could reverse

abnormal internalizing and externalizing behaviour scores (McFarlane, Groff, and Watson 2005). Children aged six and older, although improved, did not achieve normal behavioural scores.

At present in British Columbia, family practitioners and obstetricians do not routinely screen for violence exposure (Janssen, Dascal-Weichhendler, and McGregor 2006), and women do not routinely have contact with public health nurses after the first week postpartum. In 2006–07, three pregnant or newly mothering women in the Lower Mainland of BC were murdered by their husbands, and a fourth was shot and critically injured (Janssen, Henderson, and Mackay 2009). Postpartum assessment will not prevent deaths and abuse during the current pregnancy and should not substitute for assessment of women deemed to be at risk by nurses or physicians. However, many women are reluctant or unable to disclose violence during pregnancy. A representative surveillance program during pregnancy of a general obstetrical population in Belgium reported that only 19.2 percent of women experiencing physical abuse and 6.6 percent of those experiencing sexual abuse disclosed to a general practitioner or obstetrician during pregnancy (Rolens et al. 2007). Given the low disclosure rate reported in the literature and in our work, universal postpartum assessment may be the best approach to preventing adverse maternal, fetal, and newborn outcomes in subsequent pregnancies. This, in turn, may provide an opportunity to prevent sequelae of violence including physical injury, postpartum depression, abnormal bonding, and—potentially—neglect and injury for children.

Methods

Setting and Participants

Richmond Health Services serves a geographically distinct area separated from Vancouver by the Fraser River. The population of this largely retail and farming area consists of persons of European descent (45 percent), Chinese descent (50 percent), and other immigrant communities (5 percent). Approximately fifteen hundred women give birth at Richmond hospital each year.

Exposure Ascertainment

Women who register to give birth at the hospital are asked to complete a questionnaire which asks, among other questions, whether they are experiencing physical or sexual violence from their partner or a family member. For our study, delivery suite nurses also asked women about their history of violence exposure using questions drawn from the Abuse Assessment Screen, a brief, validated tool which has used extensively during pregnancy (McFarlane et al. 1992). They assessed women in private and used only staff as interpreters, not family members. In preparation for this study, in the fall of 2008 we trained the Richmond community health nurses to ask about violence during the postpartum home visit which all women are offered after giving birth.

Outcomes

Rates of disclosure were measured during the antepartum, intrapartum, and postpartum periods. Our research assistant, who is a public health nurse, reviewed responses on the antepartum pamphlets, assessment forms that

were placed in-hospital charts, and postpartum community health records. We planned to determine among women who disclosed in any one stage whether or not that woman disclosed in any other stage. To protect women's confidentiality, the research assistant provided summary data to the researchers without any individual identifiers attached.

Results

Prenatal Assessment

From the assessment form *Helping You in Your Pregnancy*, distributed to all women registered to give birth at Richmond Hospital and attending prenatal care at the Noakes clinic, the following questions were asked:

> *Growing up, were you ever hurt, injured, or abused by a parent or other person?*
>
> *Have you ever been abused physically or neglected? Emotionally? Sexually?*

During our study period, from June 2009 to January 2010, 321 women responded to the question and 5.9 percent responded affirmatively. Among 330 women screened during their hospitalization for giving birth, 3.0 percent disclosed that they were afraid of their partner but none disclosed physical current violence exposure. No women disclosed violence during their postpartum home visit, even those who did disclose prenatally or in hospital.

Intrapartum Assessment

During their hospitalization for giving birth, women at Richmond Hospital were told:

As health care providers, we know that violence in relationships affects women's health. Because of the widespread problem of violence against women, we ask everyone these questions.

- *Do you feel unsafe in your current relationship?*
- *Since you've been pregnant, has your partner tried to hurt you in any way, for example being hit, slapped, kicked, choked or other physical harm?*
- *In the year prior to your pregnancy, has your partner hurt you?*

Among the 369 women screened, 268 had negative responses and 9 had a positive response (3.2 percent). For a further 92 women, forms were left blank as nurses were not able to find an opportunity to assess women in private.

Postpartum Assessment

During home visits, public health nurses routinely ask women about violence exposure as part of a clinical pathway. During our study period, none of the women at home disclosed violence, including those who disclosed violence in the antepartum or postpartum period.

Recommendation

We learned that assessment during the hospital intrapartum stay is not often feasible because women are most often admitted in active labour and usually accompanied by their intimate partner. Even during the postpartum stay, there is seldom an opportunity for privacy and women are both exhausted and pre-occupied with attending to their new baby. During the first forty-eight hours after discharge, public nurses are directed through clinical pathways to ask women about violence exposure during home visits. We learned that during this early postpartum period, women are almost always accompanied by their partner or another family member, thus making assessment inap-

propriate. As well, the majority of women who have experienced domestic violence prior to pregnancy are no longer exposed during pregnancy; consequently, the response to a question during the initial postpartum period about current exposure to violence would be negative among women who would in reality be at risk for exposure in subsequent weeks or months (O'Campo et al. 2010). Because of these factors, we recommend a telephone call at two months postpartum by public health nurses to assess exposure to domestic violence. Currently, public health nursing practice recommends telephone follow-up or home visits for families deemed to be at high risk for any number of problems. Our recommended protocol would ensure that all women would have a two-month postpartum phone call.

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Appendix I

Vancouver Coastal Health Authority

North Shore/Coast Garibaldi, Vancouver & Richmond

Intimate Partner Violence

Intrapartum Assessment Form

For patient's nurse to complete prior to discharge. ***Please ask to spend a few minutes alone with your patient.*** *If you need a translator, please do not use a family member.*

Suggested script: (Can use your own words)

As health care providers we know that violence in relationships affects women's health. Because of the widespread problem of violence against women, we ask everyone these questions.

Do you feel safe in your current relationship? Yes _____ No _____

Since you've been pregnant, has your partner tried to hurt you in any way, for example being hit, slapped, kicked, choked or other physical harm?

Yes _____ No _____

In the year prior to your pregnancy, has your partner hurt you?

Yes _____ No _____

****

1. Provide safety planning if any answer is "yes".
2. Offer referral to a social worker
3. Offer a community resource card.
4. Document above interventions (1- 3) in progress notes.