

Recognising domestic violence in pregnancy

Joanna Cook¹ & Susan Bewley²

¹ Clinical Research Fellow, Imperial College London

² Professor of Complex Obstetrics, King's College London

Recognise the risks of violence at various stages of pregnancy

Domestic violence (DV) is common and is reported by up to 31% of women in the UK;¹ worryingly the abuse often commences or escalates in pregnancy and the post-natal period.² DV is a pattern of psychological, physical or sexual assaults, which increases a pregnant woman's risk of multiple and diverse adverse outcomes. A pregnant woman experiencing DV is more likely to request termination and repeated terminations, seek to end a previously wanted pregnancy or spontaneously miscarry.³ If the pregnancy continues, she is more likely to experience antepartum haemorrhage, chorioamnionitis and preterm labour.² Her baby is more likely to be of lower birth weight or to be stillborn.⁴ Women experiencing violence are also at greater risk of pelvic pain, sexually transmitted and urinary tract infections.⁵ The sequelae of a violent relationship can, of course, extend in to other, non-clinical aspects of a pregnant woman's life: She can be at greater risk of abusing drugs and alcohol,⁶ smoking,⁷ chronic stress and there may be sibling-child protection concerns. As such, healthcare professionals may feel impotent or overwhelmed. They may avoid encouraging the disclosure of abuse, even when they have cause to be suspicious. However, it is important to emphasise that the role of the doctor or midwife is not to 'cure' all the complex consequences of abuse, but to cultivate a trusting and confidential relationship so that women can disclose DV and be directed to other specialist agencies which can then provide individualised support and assistance. The healthcare setting can be a safe location for disclosing DV and supporting intervention; almost all women interact with healthcare, there are strong cultures of confidentiality and staff are usually kind and trustworthy.

Strategies for routine enquiry

A clinician who embeds DV screening into most consultations is more likely to appear confident, comfortable and able to help. It is important to make yourself aware of local referral pathways and specialist services such as your safeguarding midwife or consultant; in addition, the Freephone 24 Hour National Domestic Violence Helpline, run in partnership between Women's Aid and Refuge, is a useful resource (Figure 1).

Many women are accompanied to antenatal appointments by their partners, friends or family members, but it is important to briefly see each woman alone. Normalising any request to see women alone can be explained as part of routine practise. It may not be safe to directly question all women about DV, especially if you are unable to see a woman by herself. If you are worried, remember to pass on your concerns to other staff that will see her in future. Ensure that you are in a private space, with soundproof walls, not just curtains. Never use family translators when you are questioning a woman about abuse; her safety and confidentiality may both be compromised.

Initial 'open questions' such as 'how are things at home?' or 'are things OK at home with your partner and family?' can be used to allow a woman to describe her circumstances. More direct questions can follow, such as 'does anyone try to control or humiliate you?', 'are you afraid of anyone at home?', or 'has someone hurt you at home?'⁸ You may want to further justify your questions: 'Over one in four women experiences violence or undermining at home at some stage – so it's important that I ask everyone if they feel safe.'

Sometimes pregnant women will present with minor, often recurring symptoms, which cannot easily be medically explained. Whilst these complaints may be part of the physiological changes of pregnancy (abdominal discomfort, vaginal discharge, frequency) they may also be a presentation of past or current abuse. You may want to acknowledge the potential connection: ‘Some women with these symptoms may be at risk of suffering abuse from a partner or other adult. Is that happening to you?’ Other behaviours, like persistent smoking in pregnancy, booking late, missing appointments or self-discharging from hospital should raise your suspicions.⁹ Similarly, injuries to the face, neck, breasts, abdomen and inner thighs are less likely to be accidental¹⁰ and should prompt private questioning.

A woman will not discuss abuse until she has assessed your potential reaction and she should never feel under pressure to disclose. Enquiring about abuse can be valuable, even if the response is negative. Such questions convey that you feel DV is an important healthcare issue, that you are prepared to listen and know where to obtain further support. You may want to offer referral information anyway - ‘here is a number you can call if you or a friend ever have any concerns.’ Even if the woman is not experiencing abuse, she may discuss the topic with friends who are, thereby indirectly assisting them in seeking help for themselves.

Some women subjected to DV will still not reveal it when asked. This can be because she falsely perceives the abuse to be insignificant or her fault. She may feel shame and be concerned that her confidentiality will not be maintained. She may fear for her own safety if she discloses, or that Social Services will become involved and take her child(ren)

from her. These barriers are complex, but you can initiate systemic changes to help overcome them. Promoting a culture of confidentiality in your workplace and publicising this commitment to your patients in posters, leaflets and your professional websites can be helpful. Be critical of your consultation style and ask colleagues to sit-in on your clinics and provide feedback on your listening skills and how you may come across to more vulnerable women. It is also important to maintain good links with community midwives and health visitors who may have more insight in to the social situations of your patients.

Responses to reduce risk

If a pregnant woman discloses DV to you there are several simple strategies you can employ to reduce the risk of further harm.

As a person in a position of authority, it is important that you acknowledge that psychological, physical or sexual abuse is unacceptable and a crime. Showing great respect and concern for pregnant women in abusive relationships is a simple intervention that can increase self-esteem and validate their disclosure. Repeatedly reiterate that it is not her fault and that no one deserves to be treated this way. Statements such as ‘everybody deserves to feel safe at home’ and ‘abuse is common in all kinds of relationships and it tends to continue’ can support women to pursue positive change.

Women should be informed about local specialist services and given the local or national domestic violence helpline numbers. Be careful not to insist she takes written advice away, as this may further compromise her safety if seen by family members. Warn her that the severity of abuse often worsens in pregnancy or in

the post-natal period. Those experiencing abuse are experts in their own care and will have insights into their own safety that you will not possess. You should involve the woman in any response to external agencies (DV advocates, the Police and Social Services). Make her aware of your commitment to confidentiality and its limits. Ask how you (or other agencies) can safely contact her again without arousing the perpetrator's suspicion.

Never make any written reference to DV in 'handheld' maternity notes as this may reveal a woman's disclosure to family members and put her at greater risk of escalating abuse. Involve the woman in your record keeping and make an objective, contemporaneous account of the abuse in the woman's confidential medical records. Explain that this may be accessed, with her permission, in any future legal proceedings. Some women will not want to involve the police and the reasons for this should be explored. Possibly she feels the DV is not significant – which may be a coping strategy, or alternatively involving the police may further compromise her safety and so be detrimental at that specific point in time.

The safety of the unborn child and any other children in the household should be briefly explored. Try to emphasise to women that social services' central role is to support parents to protect their children, not to separate families.

Finally, aim to always practise within your expertise – address the medical consequences of abuse and explain that DV is a risk factor for poor health. But do not be tempted to give personal, immigration, housing, legal or social care advice. You may unintentionally mislead your patient and undermine her trust in your relationship. A local safeguarding specialist or DV advocate is far better placed to explain the options and assistance available.



Figure 1: Poster advertising the freephone 24 Hour National Domestic Violence helpline, run in partnership between Women's Aid and Refuge. This service is staffed 24 hours/day and can assist women in accessing local services and sources of support. Women's Aid also run training programmes specifically for nurses, midwives or health visitors.

Further reading

Bewley, S & Welch, J (eds) 2014, *ABC of domestic and sexual violence*, London, Wiley Blackwell

Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively
<http://www.nice.org.uk/guidance/ph50>

References

1. Flatley J. Focus on: Violent Crime and Sexual Offences, 2011/12. Home Office Statistical Bulletin 2013. p. 65.
2. Silverman JG, Decker MR, Reed E, Raj A. Intimate partner violence victimization prior to and during pregnancy among women residing in 26 U.S. states: associations with maternal and neonatal health. *American journal of obstetrics and gynecology*. 2006 Jul;195(1):140-8. PubMed PMID: 16813751.
3. Hall M, Chappell LC, Parnell BL, Seed PT, Bewley S. Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis. *PLoS medicine*. 2014 Jan;11(1):e1001581. PubMed PMID: 24409101. Pubmed Central PMCID: 3883805.
4. Jasinski JL. Pregnancy and domestic violence: a review of the literature. *Trauma, violence & abuse*. 2004 Jan;5(1):47-64. PubMed PMID: 15006296.
5. Audi CAF, Segall-Correa AM, Santiago SM, Perez-Escamilla R. Adverse health events associated with domestic violence during pregnancy among Brazilian women. *Midwifery*. 2012 Aug;28(4):416-21. PubMed PMID: WOS:000306662700008. English.
6. Martin SL, Beaumont JL, Kupper LL. Substance use before and during pregnancy: links to intimate partner violence. *The American journal of drug and alcohol abuse*. 2003 Aug;29(3):599-617. PubMed PMID: 14510043.
7. Cheng D, Salimi S, Terplan M, Chisolm MS. Intimate partner violence and maternal cigarette smoking before and during pregnancy. *Obstetrics and gynecology*. 2015 Feb;125(2):356-62. PubMed PMID: 25568990.
8. Sohal A, Johnson M. Identifying domestic violence and abuse. In: Bewley S, Welch J, editors. *ABC Domestic and Sexual Violence* London: John Wiley & Sons; 2014. p. 30-6.
9. Dalton M. Women's, Reproductive and Sexual Health Services. In: Bewley S, Welch J, editors. *ABC of Domestic and Sexual Violence*. London: John Wiley and Sons; 2014. p. 69-71.
10. Grisso JA, Schwarz DF, Hirschinger N, Sammel M, Brensinger C, Santanna J, et al. Violent injuries among women in an urban area. *New Engl J Med*. 1999 Dec 16;341(25):1899-905. PubMed PMID: WOS:000084210200006. English.