Understanding the effect of domestic violence on pregnancy, labour, and delivery

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Over the last 15 years, the substantial effect of violence and abuse from past or current intimate relationships on the mental health and physical well-being of women and children has been well recognized by medical organizations[1-4] and practising physicians.[5,6] But the specific implications for pregnancy, labour, and delivery are not as well understood.

Regular encounters with pregnant women provide family physicians, obstetricians, and midwives with opportunities to screen for abuse, recognize its physical and emotional manifestations, consider its consequences for labour and delivery, and offer abused women assistance and referrals as appropriate.

Incidence of abuse

Estimates of the prevalence of abuse vary depending on the population studied and the methods used. In a 1993 Statistics Canada survey[7] of 12 300 adult women, 29% of the women who had ever been married or involved in a common-law relationship reported that they had been assaulted by their partners; 51% reported at least one incident of physical or sexual violence since the age of 16. Younger women (18 to 24 years), women whose household income was less than $15 000, and women whose marriages (or common-law partnerships) had lasted less than 2 years reported higher rates of abuse; neither educational level nor geography was associated with a variation in the rate of abuse. When asked about the occurrence of violence in relation to their pregnancies, 21% of women abused by a partner reported being assaulted during pregnancy.

The incidence of physical abuse in pregnancy has been examined in two Canadian studies of pregnant women. When women receiving prenatal care from family physicians and obstetricians working in either private, community-based, or university teaching clinics in Toronto, Ont, were asked about their experience of physical abuse in pregnancy, 6.6% reported physical abuse *during* the current pregnancy, and 11% reported being abused *before* their current pregnancy.[8] Similarly, a recent study[9] of pregnant women attending a publicly funded, community-based health program in Saskatoon, Sask, found that 5.7% reported physical abuse during the pregnancy and when interviewed in the third trimester, 8.5% reported abuse in the previous year. The risk of abuse for this group of women was increased if they were aboriginal, if their partners had a problem with alcohol, and if they had high levels of perceived stress in the preceding year.

Although a systematic review of the literature[10] found no consistent relationship between violence during pregnancy and adverse pregnancy outcomes, some of the studies reviewed did find a difference between abused and nonabused women in mean birth weight and incidence of low birth weight.[11,12] Both direct and indirect causes could explain such adverse pregnancy outcomes.[9,13]

Nonetheless, abuse during pregnancy has been associated with delayed entry into prenatal care; increased behavioural risks, such as using tobacco, alcohol, and illicit drugs; and poor maternal nutrition, all of which have been associated with an increased risk of low birth weight and preterm delivery.[14-16]

Labour and delivery can be particularly difficult for women with histories of sexual abuse, and physicians unaware of the abuse might have difficulty understanding their patients' seemingly unusual behaviour. As labour progresses, the increasing pain, the subsequent sense of loss of control, and the repeated pelvic and genital examinations by various caregivers might result in unexpectedly extreme responses by labouring women: from too quiet and passive to screaming, crying, or uncontrollable terror. Other women might respond by becoming overly controlling or demanding. Still others might dissociate during labour or delivery. Moreover, some accoucheurs have speculated that a history of abuse might also play a role in inadequate fetal descent and prolonged second stage labour, based on their interactions with abused women during labour.[14]

Studies have also shown an association between abuse during pregnancy and subsequent child abuse.[17]

Keeping alert for signs of abuse

Because family physicians deal with both mental and physical health problems within the family and social context of patients' lives, they should consider the possibility that all their female patients of childbearing age could have a history of violence and abuse and ask about this during regular checkups and prenatal visits. Asking the first two questions of the WAST (Woman Abuse Screening Tool) is an effective way for family physicians to identify abuse in adult patients who go for prenatal care, for a periodic health examination, or for assessment of a particular health problem.[18] The WAST has been incorporated into the Antenatal Psychosocial Health Assessment (ALPHA) form, an evidence-based screening tool that can be used as a checklist for psychosocial enquiry[19] and will soon be incorporated into the Ontario Antenatal Record. In addition, how a woman reacts during a physical examination might alert us to the possibility of abuse (eg, vaginismus or excessive modesty).

Discussing these issues with our patients in a nonjudgmental, nonthreatening way can facilitate disclosure. When abuse is disclosed, the importance of the woman's having a safety plan should be stressed. Many community agencies provide written materials to help women develop safety plans.

Family physicians typically provide medical care to members of pregnant women's families as well and might find themselves caring for the partners or other family members who perpetrated the violence. In such situations, physicians must ensure that the needs of the abused woman and the perpetrator are addressed independently, "such that their rights to autonomy, confidentiality, honesty and quality of care are maintained."[20] Couple or marital therapy is contraindicated unless the woman's safety can be ensured and unless the man has taken responsibility for his abusive behaviour.

When current abuse is disclosed, it is necessary to determine whether the home environment is safe for the newborn and whether the woman and her partner are physically and emotionally able to care for a newborn appropriately. If there are other children in the family, we should enquire about whether they have ever been abused or if there is any risk of abuse. Any concerns about the safety of the children must be reported to the appropriate child protection agency. On the other hand, physicians are not obliged to report past or current episodes of woman abuse. In addition, some provincial licensing authorities have mandated that physicians have a duty to warn third parties if they become aware of a serious risk of violence.[21]

Further research is required to help define the many unresolved issues around how domestic violence affects pregnancy, labour, and delivery. For example, we need to consider regional, social, cultural, or sex differences in clinical care. In addition, practitioners would be helped by more research into the clinical clues that violence is an issue in their patients' lives, including important risk factors.

Little is known about how our clinical care affects patients; for example, does screening for violence help or hinder? We need to look at how extensively and how sensitively we screen. Are nonabused women intimidated or put off by our style of questioning? Do some screening efforts harm abused women and, if so, which ones?

Another strongly held belief is that the duration of the doctor-patient relationship affects disclosure or subsequent management of the problem. If a long-term relationship facilitates disclosure or helps a patient in any way, how can new caregivers "shortcut" the development of a trusting or helpful relationship? Can other professionals or agencies use our previously established relationship to enhance their work with our patients? Or does a long-term relationship actually hinder screening, identification, and disclosure? Are practitioners and agencies new to patients better able to help with violence issues?

More research is needed on the effect of pregnancy outcomes, including the particular physiologic mechanisms through which violence could affect pregnancy outcomes. Further work is also needed on care of patients with multiple problems, eg, patients with a history of violence who also abuse alcohol, tobacco, or other drugs. Are we giving such women the comprehensive care they need? Can one practitioner respond to all the needs of such complex patients, and how do we share this type of care with colleagues whose expertise complements our own?

Finally more work needs to be done to determine whether certain interventions are best suited to specific patient populations (adolescents, refugees, immigrants), and whether certain practitioners are better suited to specific roles (family physicians, delivery room nurses, other health care providers, or community workers).

Collaboration is key

Collaborative research and education projects among family physicians, obstetricians, midwives, and community workers involved with abused women will help us all to better understand one another's roles in helping these women. For example, courses, such as Advanced Life Support in Obstetrics (ALSO) and Advances in Labour and Risk Management (ALARM) provide a perfect opportunity for multidisciplinary discussion about the serious effect of violence on pregnancy, labour, and delivery. Because we often have long-term relationships with families, family physicians can provide exemplary clinical care to these women before, during, and after their pregnancies, and help prevent adverse health consequences for their children.

We refer those clinicians and researchers with particular interests in these issues to our more detailed summary and analysis of the existing literature on the College of Family Physicians of Canada's website: http://www.cfpc.ca/maternity.htm.

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