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Prenatal screening for intimate partner violence: A qualitative meta-synthesis

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ABSTRACT

Aim: The aim of this meta-synthesis was to glean an understanding of healthcare providers' experience with prenatal screening for intimate partner violence (IPV).
Background: Prenatal screening guidelines for IPV are in place; however, a gap exists between these recommendations and providers' practices.
Methods: Noblit and Hare's (1988) approach to synthesizing qualitative research studies was utilized. Eight research reports were identified and produced a sample of 142 experienced women's healthcare providers from the United States, New Zealand, and Sweden.
Results: The synthesis revealed five overarching themes: (1) therapeutic relationship, (2) understanding what she is not saying, (3) presence of partner, (4) variations of how and when to discuss, and (5) "lost in the maze" of disclosure. When analyzed as a whole, the five themes contribute to a lack of universal screening for IPV.
Conclusions: Given that IPV is a social problem with long-term negative sequela, providers are poised to identify women during the perinatal timeframe to ensure adequate referrals and services to stop the cycle of violence.

Pregnancy and the perinatal period are times of immense transformation for women that involve both physical and emotional changes. For some women, this time is one of great excitement and preparation, while for others, it can be fraught with worry, anxiety, and even fear for their lives and the life of their unborn child. This latter group of women often includes those who have a history of, or are currently experiencing, intimate partner violence (IPV). The Centers for Disease Control and Prevention (CDC) defines IPV as "physical violence, sexual violence, threats of physical or sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner" (Black et al., 2011, p. 37). In the United States, women experience IPV at an alarming rate. The CDC's ongoing national intimate partner and sexual violence survey reports that more than 1 in 3 women (35.6%) in the United States have experienced IPV in their lifetime (Black et al., 2011). Worldwide, the prevalence of IPV during pregnancy ranges from approximately 2% to 13.5% (Devries et al., 2010). The evidence on whether IPV increases or decreases during pregnancy is conflicting; however, unplanned pregnancy, which account for half of all pregnancies, is a risk factor for IPV (Goodwin, Gazmararian, Johnson, Gilbert, & Saltzman, 2000; Nelson, 2010). Unintended pregnancy increases a woman's risk of IPV by 2.5 times when compared to a planned pregnancy (Goodwin et al., 2000).

Maternal and fetal morbidity and mortality are serious adverse outcomes of IPV. Women experiencing IPV have an increased risk for poor pregnancy outcomes such as infection, anemia, placental abruption, preterm delivery, low birth weight, stillbirth, and are also more likely to use tobacco (Coker et al., 2012; El Kady, Gilbert, Xing, & Smith, 2005; Parker, McFarlane, & Soeken, 1994; Shah & Shah, 2010; World Health Organization (WHO), 2012).

Often, the 40-week pregnancy gestation is the only healthcare opportunity a woman has to be screened for IPV (WHO, 2011). Antenatal care provides women with regular follow-up appointments and the chance to form a therapeutic healthcare relationship with providers; therefore, this window of time lends itself to screening for IPV. Given the prevalence of women experiencing IPV, as well as the lifelong consequences of IPV, ACOG (2012) recommends screening at the first visit, once during each trimester, at the postpartum visit, and continually offering support and referral options to pregnant and postpartum women. The Institute of Medicine (IOM, 2011) also explicitly states that women should be universally screened for violence. However, the literature suggests that only 61% of women are actually being screened for domestic violence during pregnancy (Taylor et al., 2007). Despite clear guidelines, many women are not being screened in the antenatal setting.

1. Literature review

The literature has revealed barriers faced by women's healthcare providers that hinder screening for IPV. The time constraints of an office visit, limited knowledge on the topic of IPV, and feeling unprepared to deal with a disclosure have been found to be major barriers (Edin & Högberg, 2002; Finnbogadóttir & Dykes, 2012;

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Herzig, Danley, et al., 2006; Herzig, Huynh, et al., 2006; Hindin, 2006; Lauti & Miller, 2008, Stenson, Sidenvall, & Heimer, 2005; Taylor et al., 2007). Another important barrier to screening is that some women's healthcare providers themselves have experienced, or are currently experiencing IPV, making it difficult for them to discuss this issue. Research conducted among 236 midwives in Scotland regarding attitudes to domestic violence screening found that 19% disclosed that they themselves had suffered from IPV and this fact made screening women a difficult subject to approach (Barnett, 2005). Qualitative research has also validated that midwives report feelings consistent with secondary traumatic stress when learning about the violence their patient's are experiencing (Mollart, Newing, & Foureur, 2009). The fear of suffering from traumatic stress after hearing of their patients' experiences prevents providers from screening women for IPV.

Largely, a lack of training and knowledge on the topic of IPV are cited as reasons for providers that do not perform screening (Brykczynski, Crane, Medina, & Pedraza, 2011; Lazenbatt, Taylor, & Cree, 2009, Rönnberg & Hammarström, 2000). Providers state that they would benefit from training and resources regarding screening and referring women experiencing IPV (Edin & Högberg, 2002; Finnbogadóttir & Dykes, 2012; Herzig, Danley, et al., 2006; Herzig, Huynh, et al., 2006; Hindin, 2006; Lauti & Miller, 2008, Stenson et al., 2005; Taylor et al., 2007). For example, after a training program designed to increase awareness of IPV, midwives shared that they not only had a better understanding of domestic violence, but also felt they were more likely to recognize and to help women (Protheroe, Green, & Spiby, 2004, p. 94). Additionally, after an intervention study implementing routine screening for domestic abuse, midwives were asked to share their experiences. Midwives recognized the importance of routine screening, and stated time constraints, staff shortages, and personal experience with domestic violence as difficulties encountered (Mezey, Bacchus, Haworth, & Bewley, 2003).

Barriers to screening exist; however, it is essential to highlight that the qualitative literature reveals that women are not averse to being screened for IPV (Stenson, Saarinen, Heimer, & Sidenvall, 2001; Taylor, Bradbury-Jones, Kroll, & Duncan, 2013). When women were questioned regarding violence during antenatal care, 80% found the questioning to be acceptable (Stenson et al., 2001). There was no difference in acceptability among women who were experiencing violence and those who were not (Stenson et al., 2001). Furthermore, pregnant women found it acceptable to be screened for IPV when it was conducted in "a safe, confidential environment with a trained health professional who is empathetic and non-judgmental" (Bacchus, Mezey, & Bewley, 2002, p. 9). Women favor being asked more than once and stated that when they see a provider is hurried, they are less likely to disclose (Bacchus et al., 2002).

Women experiencing IPV do however face barriers to disclosing their situation. The taboo nature of discussing IPV, lack of awareness that IPV is wrong, fear of the perpetrator and of losing their children, as well as a desire to protect the perpetrator have all been identified by women as barriers to disclosure and to seeking help (Bradbury-Jones, Duncan, Kroll, Moy, & Taylor, 2011; Petersen, Moracco, Goldstein, & Clark, 2004; Rönnberg & Hammarström, 2000). Also, some women experiencing IPV may keep up a façade, making them more challenging to identify (Edin, Dahlgren, Lalos, & Högberg, 2010).

For women's healthcare providers, a juxtaposition exists between the belief that screening for IPV is important and the logistics of implementing such screening. The qualitative and quantitative state of the science on this issue reveals that there are barriers to screening faced by women's healthcare providers. The aim of this meta-synthesis is to examine women's healthcare providers' experiences of screening for IPV in order to further uncover potential barriers to screening and/or practices that facilitate screening. By synthesizing the experiences of women's healthcare providers, this meta-synthesis can inform healthcare practices for IPV screening in the prenatal setting.

2. Method

2.1. Procedure

An exhaustive search of the literature took place by both the author and a research librarian, whose area of specialty is nursing research, using CINAHL, PubMed, Scopus, and ProQuest. This literature review included articles from 2000 to 2013 publications. The following keywords, battered woman(en) OR intimate partner violence OR domestic violence AND midwife* OR midwiv* OR obstetrician OR gynecologist AND qualitative OR meta-synthesis OR mixed studies were used to search for research articles. All abstracts of articles retrieved in the search were read, and when the abstract did not provide enough detail, the entire article was read. Several articles were found regarding women's experiences of being screened for IPV and also of healthcare providers experiences of performing the screening for IPV in settings other than prenatal care. These articles were excluded because the researcher wanted to focus exclusively on women's healthcare providers, given the uniqueness of prenatal care. During this process, the reference lists of the eight scholarly articles meeting the inclusion criteria were also searched for potential research studies that also met inclusion criteria.

For this meta-synthesis, only women's healthcare providers were included given that the purpose was to better understand women's healthcare providers' experiences screening women for IPV. Any healthcare provider (midwife, certified nurse midwife, ob/gyn, nurse practitioner, physician's assistant, or registered nurse) caring for women in the prenatal setting was included. Further inclusion criteria were that the study (a) examined women's healthcare providers' experience of prenatal screening for IPV, (b) had a qualitative or a mixed methods research design, (c) reported research findings, (d) was published in or after 2000, and (e) was written in English. A decision to focus exclusively on pregnant females experiencing IPV from male partners was made given the different dynamics associated with IPV in gay and lesbian relationships. Additionally, studies looking at screening for IPV outside of the context of prenatal care were excluded given the specialized nature of prenatal care.

2.2. Sample

The resultant sample for this meta-synthesis is comprised of seven qualitative studies and one mixed methods study on women's healthcare providers' experiences with prenatal screening for IPV published between 2002 and 2012. All eight studies were published in peer-reviewed journals, specifically, five in midwifery journals, two in maternal/women's health journals, and one in an education and counseling journal. Demographic information was extracted from the research articles, finding that the eight research reports in this meta-synthesis produced a sample of 142 experienced women's healthcare providers from the United States, New Zealand, and Sweden who ranged in age from 26 to 74 years. The breakdown of providers from this sample is 78 obstetrician/gynecologists, 47 midwives (providing prenatal care in Sweden and New Zealand), 13 certified nurse midwives (providing prenatal care in the United States), 3 nurse practitioners, and 1 registered nurse. The women's healthcare providers had a range of time in practice from 6 months to 39 years.

Various qualitative research designs were utilized in the studies included, with focus group methodology ($n = 6$) as the most frequently used design. Tables 1 and 2 contain further details on the descriptive and methodological characteristics of the sample. Finally, with the inclusion of one mixed methods study, it should be noted that only the qualitative findings were synthesized for the purpose of this meta-synthesis. Also, method slurring which is stating the use of a