Aggression and Violent Behavior 34 (2017) 128–138

Contents lists available at ScienceDirect

Aggression and Violent Behavior

The unique needs of pregnant, violence-exposed women: A systematic review of current interventions and directions for translational research

Kathryn H. Howell [a,*], Laura E. Miller-Graff [b], Amanda J. Hasselle [c], Kathryn E. Scrafford [d]

[a] Department of Psychology, University of Memphis, 356 Psychology Building, Memphis, TN 38152-3230, United States
[b] Psychology and Peace Studies, University of Notre Dame, 107 Haggar Hall, Notre Dame, IN 46556, United States
[c] Department of Psychology, University of Memphis, 202 Psychology Building, Memphis, TN 38152-3230, United States
[d] Department of Psychology, University of Notre Dame, 107 Haggar Hall, Notre Dame, IN 46556, United States

ARTICLE INFO

Article history:
Received 21 June 2016
Received in revised form 28 January 2017
Accepted 30 January 2017
Available online 2 February 2017

Keywords:
Domestic violence
Perinatal
Treatment
Mental health

ABSTRACT

Intimate partner violence (IPV) is, unfortunately, a common lifetime experience for women, with heightened risk of exposure during pregnancy. IPV exposure in pregnancy is associated with serious physical and mental health problems in the perinatal period, as well as detrimental effects on the health and well-being of the developing infant. The objectives of the current review are to: (1) present representative literature on the effects of IPV in pregnancy, (2) conduct a systematic review of existing interventions for IPV-exposed pregnant women and (3) provide recommendations for future translational research in this area. The review indicated that despite the broad range of negative effects associated with IPV exposure during pregnancy, interventions are scarce and largely limited to crisis intervention approaches. Available interventions seeking to address broader or intergenerational effects of violence are limited in scope, and effectiveness data are preliminary in nature. As such, there is a great need for theory-based interventions that address women's complex needs, including specific developmental necessities of both the pregnant woman and her child (e.g., breastfeeding, early parenting, infant care). Incorporating these elements within a strengths-based paradigm may also decrease stigma related to IPV and facilitate empowerment and self-efficacy for this at-risk group.

Contents

* Corresponding author.
E-mail addresses: k.howell@memphis.edu (K.H. Howell), lmiller8@nd.edu (L.E. Miller-Graff), hasselle@memphis.edu (A.J. Hasselle), kathryn.e.scrafford.8@nd.edu (K.E. Scrafford).

http://dx.doi.org/10.1016/j.avb.2017.01.021
1359-1789/

1. Introduction

Intimate partner violence (IPV), which involves emotional, physical, and/or sexual abuse committed by a romantic partner, affects millions of women in the United States each year (Black, 2011). It is estimated that approximately 23.6% of American women experience IPV during their lifetime (Black, 2011; Coker et al., 2002; Rivara et al., 2007; Sarkar, 2008; Silverman, Decker, Reed, & Raj, 2006). Women may experience IPV at any time, but multiple studies indicate that the risk for exposure rises during pregnancy (Campbell & Lewandowski, 1997; Shah & Shah, 2010; Silverman et al., 2006). Given that violence during pregnancy affects not only a woman's well-being, but also the well-being of her unborn child, it is especially crucial to examine the effects of, and to develop effective interventions for, IPV during pregnancy. Pregnancy may present a window of opportunity during which women are highly motivated to make changes in their lives—a compelling argument for targeting intervention efforts to this population (Campbell & Lewandowski, 1997). The objectives of the current review are to: (1) present representative literature on the effects of IPV in pregnancy, (2) conduct a systematic review of existing interventions for IPV-exposed pregnant women and (3) provide recommendations for future translational research in this area.

1.1. Physical health consequences for women exposed to IPV

As the frequency and severity of IPV intensifies, women's risk for detrimental physical health outcomes rises (Black, 2011). Clearly, IPV puts women at risk for experiencing injuries, ranging in severity from cuts and bruises to broken bones to life-threatening wounds (Black, 2011; Bonomi et al., 2009; Campbell & Lewandowski, 1997). Beyond direct injuries, physical health consequences of IPV include somatic symptoms, gastrointestinal problems, neurologic problems, compromised cardiovascular health, immune/endocrine system dysfunction, and poor sexual or reproductive health (Black, 2011; Bonomi et al., 2009; Campbell & Lewandowski, 1997; Coker, Smith, Bethea, King, & McKeown, 2000; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Rivara et al., 2007; Silverman et al., 2006). While IPV poses serious health risks to all women, pregnant women may be at risk for additional adverse health-related outcomes. IPV-exposed pregnant women are at increased risk for high blood pressure, edema, vaginal bleeding, severe nausea, vomiting and dehydration, and increased hospital visits during pregnancy (Campbell & Lewandowski, 1997; Silverman et al., 2006). Silverman et al. (2006) found that pregnant women who endorsed IPV during the past year reported more adverse health outcomes throughout their pregnancy than women who had not experienced IPV. Factors specific to pregnant women that may exacerbate physical health consequences include inadequate prenatal care, unintended pregnancy, and suboptimal weight gain during pregnancy (Campbell & Lewandowski, 1997; Shah & Shah, 2010).

1.2. Mental health consequences for women exposed to IPV

Exposure to IPV not only confers risk for poor physical health outcomes, but also negatively influences women's psychological functioning (Bogat, Levendosky, Theran, Von Eye, & Davidson, 2003; Campbell & Lewandowski, 1997; Goldstein & Martin, 2004).Women endorsing IPV exposure are at increased risk for depressive symptoms and diagnosis (Black, 2011; Bonomi et al., 2009; Pico-Alfonso et al., 2006; Rivara et al., 2007; Silverman et al., 2006), heightened anxiety (Afifi et al., 2008; Black, 2011; Bogat et al., 2003; Pico-Alfonso et al., 2006; Rivara et al., 2007), and posttraumatic stress symptoms (Black, 2011; Bogat et al., 2003; Campbell & Lewandowski, 1997; Pico-Alfonso et al., 2006). Similarly, IPV-exposed pregnant women report poorer mental health (Tiwari et al., 2008) and lower life satisfaction than do pregnant women with no IPV history (Varma, Chandra, Thomas, & Carey, 2007). Specifically, pregnant women with IPV histories are more likely to be hospitalized due to substance abuse or mental health-related diagnoses than those with no IPV history (Lipsky, Holt, Easterling, & Critchlow, 2004). Hospitalizations aside, alcohol and illicit drug abuse are more prevalent among pregnant women experiencing IPV than those with no IPV exposure (Campbell & Lewandowski, 1997). Additionally, among pregnant women endorsing proximal or distal IPV exposure, researchers have noted increased risk for elevated depressive symptoms, both during pregnancy and postpartum (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Garabedian et al., 2011; Ogbonnaya, Macy, Kupper, Martin, & Bledsoe-Mansori, 2013; Ross & Dennis, 2009; Tiwari et al., 2008; Varma et al., 2007). Furthermore, Jackson et al. (2015) found that IPV history predicted more severe postpartum depressive symptoms, beyond the influence of prenatal depression. In addition to associations with depression, IPV-exposed pregnant women are at increased risk for self-harming thoughts (Tiwari et al., 2008), suicidal ideation (Alhusen, Frohman, & Purcell, 2015), higher stress levels (Jackson et al., 2015), PTSD symptoms (Rodriguez et al., 2008; Varma et al., 2007), somatic complaints (Varma et al., 2007), and alterations in self-perception (Rose et al., 2010).

1.3. Consequences of IPV exposure on fetal and infant development

IPV exposure during pregnancy is unique in that it may influence the course of a child's development, even before birth. For example, victimized pregnant women are less likely to receive adequate prenatal care and are more likely to engage in behaviors that could compromise fetal health, including smoking, substance use, and unhealthy diet (Black, 2011; Campbell & Lewandowski, 1997; Shah & Shah, 2010). In addition to these risk factors, IPV-related stress and trauma have been linked to physical health issues during pregnancy, such as suboptimal maternal weight gain, pre-term delivery, premature labor, ruptured membranes and organs, fetomaternal hemorrhaging, placental abruption, gynecological problems, and preeclampsia, all of which may contribute to adverse fetal outcomes (Black, 2011; Campbell & Lewandowski, 1997; Dutton et al., 2006; Lipsky, Holt, Easterling, & Critchlow, 2003; Shah & Shah, 2010; Silverman et al., 2006). Lastly, maternal depression, which is more prevalent among victimized pregnant women, can compromise healthy fetal development, resulting in an increased risk for elevated prenatal activity, delayed prenatal growth, prematurity, low birth weight, and compromised physical health indices among newborns (Field, Diego, & Hernandez-Reif, 2006; Marcus, 2008; Silverman et al., 2006). Prenatal maternal stress may influence newborn health via maternal HPA axis activity, which has been associated with abnormal fetal brain development and impaired HPA function in infants (Marcus, 2008). These findings suggest multiple pathways through which maternal health following IPV exposure may negatively impact fetal development.

Consistent with findings that IPV exposure is associated with a number of risk factors for adverse pregnancy outcomes, IPV proximal to or during pregnancy confers a higher risk of fetal/infant mortality as a result of miscarriage, spontaneous abortion, perinatal death, and neonatal death (Black, 2011; Campbell & Lewandowski, 1997; Coker, Sanderson, & Dong, 2004; Lipsky et al., 2003; Shah & Shah, 2010; Silverman et al., 2006). Additionally, children of IPV-exposed mothers are more likely to have lower gestational weight gain and be classified as low birth weight (LBW) or very low birth weight (VLBW) infants (Campbell & Lewandowski, 1997; Coker et al., 2004; Dutton et al., 2006; Lipsky et al., 2003; Shah & Shah, 2010; Silverman et al., 2006). LBW may be a result of physical consequences of IPV, such as abdominal trauma, infections, and chronic illnesses. It is also possible that the stress of IPV confers risk for LBW among infants of victimized mothers or that the suboptimal health behaviors observed among women with IPV increase risk for LBW (Campbell & Lewandowski, 1997).This association represents a serious concern, as LBW/VLBW/preterm infants are at increased risk for demonstrating deficits in cognition, executive function, academic performance, intelligence, motor skills, neurosensory functioning,