Intimate partner violence and pregnancy: epidemiology and impact

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Intimate partner violence is a significant public health problem in our society, affecting women disproportionately. Intimate partner violence takes many forms, including physical violence, sexual violence, stalking, and psychological aggression. While the scope of intimate partner violence is not fully documented, nearly 40% of women in the United States are victims of sexual violence in their lifetimes and 20% are victims of physical intimate partner violence. Other forms of intimate partner violence are likely particularly underreported. Intimate partner violence has a substantial impact on a woman's physical and mental health. Physical disorders include the direct consequences of injuries sustained after physical violence, such as fractures, lacerations and head trauma, sexually transmitted infections and unintended pregnancies as a consequence of sexual violence, and various pain disorders. Mental health impacts include an increased risk of depression, anxiety, posttraumatic stress disorder, and suicide. These adverse health effects are amplified in pregnancy, with an increased risk of pregnancy outcomes such as preterm birth, low birthweight, and small for gestational age. In many US localities, suicide and homicide are leading causes of pregnancy-associated mortality. We herein review the issues noted previously in greater depth and introduce the basic principles of intimate partner violence prevention. We separately address current recommendations for intimate partner violence screening and the evidence surrounding effectiveness of intimate partner violence interventions.

Key words: intimate partner violence, physical violence, psychological aggression, reproductive coercion, sexual violence, stalking

It is an honor and a privilege to be asked by President Pinkerton to deliver the President's Invited Lecture to this august body. I would like to add my congratulations to those of others in relation to her distinguished service to the South Atlantic Association of Obstetricians and Gynecologists and the excellent meeting she and Dr Toledo have developed.

I chose to use this opportunity to focus on a brief update about the subject of intimate partner violence (IPV). It is focused for the practicing obstetricians and gynecologists in our unique role providing care to pregnant women and our role in the ambulatory setting as primary health care providers for women.

In 2010 I addressed the topic of IPV at length.[1] I specifically reviewed information about the prevalence, short- and long-term health consequences, financial consequences, and the lack of unanimity about screening. Furthermore, I examined training and testing expectations by 2 of our specialty organizations, barriers to screening and offered recommendations related to clinical care, education, and research.

But that was then and this is now. Fortunately, there have been important studies to address this topic in the interval. Our goal today is to provide a concise update on the state of the art and expand upon previously recommended guidelines for clinical care. We will focus on perinatal IPV. Herein we will update information about the definition, prevalence, consequences and attempts at prevention.

In the second part of this review, screening (including compliance with recommendations and barriers), promising interventions, and clinical recommendations will be addressed and offered.[2] At the conclusion of this review, it will be apparent that while IPV remains a devastating plague to our society, the case for screening has been strengthened and there are promising new interventions available.

IPV is a significant public health problem that continues to destroy lives daily and should be largely preventable. In this review we will focus on IPV in women, with a particular focus on pregnant women.

IPV is defined variously by different organizations and countries. Based on changes in the IPV field of knowledge, the definition of IPV was expanded in 2015. This was the result of a comprehensive process sponsored by the National Center for Injury Prevention and Control and Centers for Disease Control and Prevention (CDC). An important part of this process was to improve the quality of available IPV data, refining not only the definition but also data elements and data collection processes.

In 2015 Intimate partner violence surveillance, uniform definitions, and recommended data elements (version 2.0) was published.[3]

The definition(s) currently recommended by the CDC are as follows:

IPV is a preventable public health problem: the term describes physical

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violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner.

An intimate partner is a person with whom one has a close personal relationship that can be characterized by the following: emotional connectedness, regular contact, ongoing physical contact and/or sexual behavior, identity as a couple or familiarity, and knowledge about each other's lives.

There are 4 main types of IPV including the following:

- Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm.
- Sexual violence is divided into 5 categories. Any of these acts constitute sexual violence, whether attempted or completed. All of these acts occur without the victim's freely given consent, including cases in which the victim is unable to consent because of being too intoxicated (eg, incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.
  - Rape or penetration of victim. This includes completed or attempted, forced, or alcohol/drug-facilitated unwanted vaginal, oral, or anal insertion.
  - Victim was made to penetrate someone else. This includes completed or attempted, forced, or alcohol/drug-facilitated incidents when the victim was made to sexually penetrate a perpetrator or someone else without the victim's consent.
  - Nonphysically pressured unwanted penetration. This includes incidents in which the victim was pressured verbally or through intimidation or misuse of authority to consent or acquiesce to being penetrated.
  - Unwanted sexual contact. This includes intentional touching of the victim or making the victim touch the perpetrator, either directly or through the clothing, on the genitalia, anus, groin, breast, inner thigh, or buttocks without the victim's consent.
  - Noncontact unwanted sexual experiences. This includes unwanted sexual events that are not of a physical nature that occur without the victim's consent.
- Stalking is a pattern of repeated, unwanted, attention, and contact that causes fear or concern for one's own safety or the safety of someone else (eg, family member or friend).
- Psychological aggression is the use of verbal and nonverbal communication with the intent to harm another person mentally or emotionally and/or to exert control over another person.

We strongly encourage all clinicians and investigators to adhere to these consensus-derived definitions. Doing so and using the recommended collection processes and data elements will facilitate surveillance for IPV at local and national levels. Additionally, this allows for comparison of health-related events from different data sources and to monitor trends over time.

Prevalence

In the opinion of the authors, IPV has reached epidemic proportions in the United States and globally. Although it affects both women and men, women are affected much more frequently and severely. Based on the most recent data published from the United States in 2014, it is estimated that in 2011, 7000 women were raped and 25,000 women were victims of other forms of sexual violence each day.[4]

The National Intimate Partner and Sexual Violence Survey was conducted by national random-digit–dial telephone methodology, and nearly 13,000 interviews were completed of English- and Spanish-speaking individuals in 50 states and the District of Columbia. Nearly 1 in 5 women (19.3%) had been raped in their lifetime and 2 in 5 (43.9%) experienced other forms of sexual violence during their lifetimes. About 1 in 5 women (22.3%) have experienced severe physical violence, and stalking was experienced by 1 in 10 (9.2%). Of female rape victims, an estimated 78.2% were first raped before 25 years of age and 40.4% experienced rape before age 18 years[4] (Figure). [F1]

The Behavioral Risk Factor Surveillance System survey provides evidence that significant health disparities exist in the prevalence of IPV based on race/ethnicity, age, income, and educational attainment.[5] The data from global assessments are equally worrisome. Globally, 30% of women aged 15 years and older have experienced physical and/or sexual IPV over their lifetime. There is considerable regional variation with the lowest rates (~15% to 20%) in East Asia, Western Europe, and North America and the highest rate (65%) in central Sub-Saharan Africa.[6]

Reproductive coercion is a prominent aspect of IPV and includes behaviors aimed at controlling reproductive or sexual health such as refusal to use birth control, coerced pregnancy termination or continuation, sabotage of birth control efforts, etc. Obstetrician/gynecologists are in a unique position to detect the presence of reproductive coercion. If present, as many as 75% of patients report other forms of IPV.[7]

Estimates of the prevalence of IPV during pregnancy vary widely and are heavily influenced by sociodemographic characteristics. Data from a 2009-2010 survey in a 30-state area revealed that 3.2% of pregnant women reported that they had been pushed, hit, slapped, kicked, choked, or physically hurt in some other way during their most recent pregnancy. Nearly 7% of teen mothers reported IPV during pregnancy compared with fewer than 2% of mothers older than 30 years of age.

Rates of IPV during pregnancy for mothers with less than 12 years of education were 4.5% compared with 1% in those with more than 16 years of education. Overall, the highest prevalence of IPV during pregnancy was reported in non-Hispanic American Indian/Alaska Native and non-Hispanic black gravidas (6.5% and 5.8%, respectively), and the lowest prevalence was seen among non-Hispanic Asian gravidas (1.5%).[8] Bailey[9] reported even higher rates, noting physical and sexual violence to be present in 28% and 20%, respectively, of

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