Health Impact of Abuse on Pregnancy and Pre-Natal Care

Intimate partner violence, sexual coercion, and reproductive coercion often overlap in the lives of survivors of abuse, resulting in:

- Both avoidance of health care and increased health care utilization rates
- Unintended pregnancy
- Abortion
- Sexually transmitted infections, including HIV

For women, being in an abusive relationship increases the likelihood of:

- Multiple sex partners
- Inconsistent or nonuse of condoms
- Unprotected anal sex
- Having a partner with known HIV risk factors
- Exchanging sex for money, drugs, or shelter

Reproductive Coercion

- Birth Control Sabotage
  - Hiding, withholding, or destroying contraceptives
  - Not allowing a partner to obtain or use contraceptives
  - Threatening harm if survivor uses contraceptives
  - Breaking a condom on purpose, surreptitiously poking holes in condoms
  - Not withdrawing when that was the agreed upon method of pregnancy prevention
  - Pulling out vaginal rings
  - Cutting out a partner’s birth control implant (Nexplanon, etc.)
- Pregnancy Pressure
  - “I’ll leave if you don’t get pregnant.”
  - “I’ll have a baby with someone else if you don’t become pregnant.”
  - “I’ll hurt you if you don’t agree to become pregnant.”
- Pregnancy Coercion
  - Forcing a partner to carry to term against that partner’s wishes through threats or acts of abuse
- Abortion Coercion
  - Forcing a partner to terminate a pregnancy when the partner does not wish to
  - Injuring a partner in a way that leads to miscarriage

* These tactics can apply to any relationship where one partner is able to get pregnant. For example, an individual in a same sex relationship may insist that her partners be artificially inseminated to bear a child, using physical or emotional threats to force the issue.

Adolescent girls in physically abusive relationships were 3.5 times more likely to become pregnant than non-abused girls. (Roberts, et al, 2005)

Women and teens seeking abortions are nearly 3 times more likely to have been victimized by an intimate partner in the past year compared to women who are continuing their pregnancies. (Bourassa & Berube, 2007)
Health Impact of Abuse During Pregnancy

- Delayed prenatal care
- Smoking, alcohol or other drug use to cope
- Poor nutrition
- Disordered eating
- Anxiety
- Hypertension
- Headaches, migraines
- Depression
- Suicidal thoughts
- Multiple pregnancies in rapid succession

Possible impact on fetus
- Miscarriage, stillbirth
- Hemorrhaging, including placental separation
- Pre-term labor

Evidence indicates that an integrated approach that informs patients about the risk of contracting STIs/HIV in unhealthy relationships, teaches condom negotiation skills within the context of safety concerns, and offers less detectable, survivor-controlled protective strategies can lead to improved reproductive health outcomes and enhanced quality of care.

Harm Reduction Strategies
- Universal Education – Don’t Ask, Tell! – regarding healthy relationships
- Birth control that your partner doesn’t have to know about (IUC, Implanon)
- Emergency contraception
- Safety planning regarding partner notification related to STI/HIV
- Supported referral to violence prevention agencies

Universal Messages for Patients about Healthy Relationships:

“One of the things that I talk to all my patients about is how you deserve to be treated by the people you go out with. You have the right to:
- Be treated with kindness
- Be with your friends when you want to be
- Wear what you want to wear
- Feel safe and have your boundaries be respected
- Go only as far as you want to go with touching, kissing, or doing anything sexual
- Speak up about any controlling behavior including textual harassment such as receiving

Utilized with permission from the NWH Domestic Violence/Sexual Assault Program
Indicators of Abuse and/or Neglect of an Older Adult

On the Part of the Caregiver

- The person being cared for is not given the opportunity to speak for themselves without the presence of the caregiver.
- The caregiver has an attitude of indifference or anger toward the person they are caring for.
- Family members of the caregiver blame the person being cared for (frequently related to incontinence).
- The caregiver exhibits aggressive behavior, including threats, insults or harassment toward the person being cared for.
- The caregiver has problems with drugs or alcohol.
- The caregiver exhibits inappropriate displays of affection towards the person being cared for.
- The caregiver isolates family members from the person being cared for.
- The caregiver is unwilling to work with other care providers on a care plan for the person being cared for.

When Observing the Older Adult/Elder

- Sudden changes in the emotional or psychological state of the person
- Being emotionally upset or agitated
- Being extremely withdrawn and non communicative or non responsive
- Unusual behavior usually attributed to dementia e.g., sucking, biting, rocking
- Isolation (e.g., person may be locked in a room or confined space with only basic necessities)
- No social contact or stimulation
- Lack of basic care or assistance with ADLs
- Not providing proper food or fluids
- Failure to provide proper health care/Medical neglect
- Stench of urine or feces/ Being left to sit in urine/feces
- Indications of malnutrition or over-feeding
- Administration of inappropriate drugs/ Absence of necessary medication
- Not dressing someone (e.g., from the waist down because they are incontinent)
- Not dressing someone appropriately (e.g., wearing thin clothes in cold weather)
- Absence of mobility aids so the person’s movements are restricted
- Improper fitting or damaged dentures
- Nonfunctioning hearing aids, including lack of batteries
- Unexplained vaginal or anal bleeding
- Torn or bloody underwear
- Bruised breasts
- Venereal diseases or vaginal infections
- Multiple bruising, not consistent with a fall
- Black eyes, slap marks, kick marks, grasp marks, finger tip
- Bruising, other bruises
- Burns, such as cigarette burns, dunking burns (hands/feet being immersed in hot water)
- Fractures not consistent with falls
- Abandonment

Please be mindful The elderly often present with comorbid diagnoses and may underreport symptoms, or the symptoms may be masked by other diagnoses.” (Ladson, 2007; see also Goldstein, 1996) These statements are notable in light of recent studies of older veterans that indicate a link between PTSD and dementia. (Qureshi, 2010; Yaffee, 2010) Although the mechanism linking the two is unclear, what is clear in the research is that each, independently, is a risk factor for (re)victimization. (Qureshi, 2010; Yaffee, 2010; Lachs, 2004) It is also worth noting here the ways in which dementia can mimic signs of complex PTSD. Withdrawal, agitation, memory loss, difficulty with problem solving, disorientation in time or space, verbal aggression, difficulty sleeping, and clingy or childlike behavior may all be signs of both dementia and trauma in older adults.

Adapted in part from National Clearinghouse on Abuse in Later Life by Erin C. Miller
Psychology and Behaviors of People Who Abuse Intimate Partners

Characteristics of People Who Use Abusive Behaviors\(^1\)
- Controlling
- Entitled
- Selfish & Self-Centered
- Sense of Superiority
- Manipulative
- Externalize Responsibility
- Denial, Minimization, Victim-Blaming

Abusive Partners as Parents
People Who Abuse Their Partners Are More Likely to Be…
- Rigid, authoritarian parents\(^{ii}\)
- Underinvolved and neglectful \(^{iii}\)
- Manipulative, using children to control or abuse the partner\(^{iv}\)
- Such parenting styles have significant health, cognitive, behavioral, academic, emotional, and health impacts for children\(^v\)

The Role of Healthcare Staff
- If anyone ever states that they are in danger, or that they are being abused, \textit{BELIEVE} them
- Provide a warm referral – violence and abuse specialists (internal & external) have specialized training to discern who is the abuser and who is the survivor
- Also consider:
  - Social work staff\(^{vi}\)
  - External agencies where appropriate – Department of Children and Families, Elder Protective Services, Disabled Persons Protection Commission, etc.
- If someone states that a partner has been abusive, NEVER confront the partner. That could be dangerous for the patient, and for the health care staff
- If someone states that they have committed abusive actions, gently explore the possibility of an abuser education program with them. Staff should be encouraged to take a public health approach to people expressing concerns or feedback about their behaviors towards their partners or competent adult family members.
- Recognize that the following are \textit{NOT} appropriate in cases of partner abuse, and in most instances will make the situation \textit{worse}:
  - Couples counseling
  - Anger management
  - Mental health treatment (including, if not esp, individual therapy) absent abuser education
  - Substance abuse treatment absent abuser education

\(^{i}\) Bancroft, Silverman, Ritchie, 2012. Plus personal communication with David Adams, co-founder and co-Executive Director, Emerge
\(^{iii}\) Lapiere, 2010
\(^{iv}\) Lapiere, 2010; Mbilinyi, et al, 2007
Post-Separation Power and Control

Abuse Doesn’t End with Separation

- *In fact, it often becomes more severe*
- People who use abusive behaviors will work to continue the abuse even, if not especially, post-separation
- People who use abusive behaviors to gain power & control will often simply shift tactics when their control is challenged
- Separating safely is a process, not an event

The Prevalence of Post-Separation Abuse

- Seventy-six percent of separated women reported suffering post-separation abuse
- Of these women:
  - 76% were subjected to continued verbal and emotional abuse
  - 41% were subjected to serious threats towards themselves or their children
  - 23% were subjected to physical violence
  - 6% were subjected to sexual violence
  - 36% stated that this violence was ongoing

Post-Separation Tactics of Continuing Control

- Withholding of financial support
- Disregarding children
- Disrupting survivor’s relationships with her children
- Undermining survivor’s ability to parent
- Discrediting survivor as a parent
- Endangering children
- Harassment and intimidation
- Stalking
- Assault of children and/or survivor

Risk of Assault & Lethality Increases Upon Separation

- Separated women are 3x-9x more likely to be victimized than divorced women
- Separated women are 25x more likely to be hurt than married women.
- “Fatality review teams and inquests around the world point to the dramatically increased risk when women and children attempt” to leave and abusive partner/parent.
- Almost half of males on death row for DV homicide killed in retaliation for a partner leaving them.
Be Alert for the Following\textsuperscript{vi}:

- Increasing frequency of physical violence
- Increasing severity of physical violence
- Gun(s) in the home
- Forced sex
- Abusive person’s use of illegal drugs
- Abusive person’s threats to kill
- Survivor believes abusive person is capable of killing them
- Stalking

Your Role as a Healthcare Provider

- To start by believing
- To document neutrally and objectively
- To understand that “safety” may mean many things
- To support the survivor’s goals (Not to impose your own or the hospital’s)
- To assist with the very first steps of common sense safety planning around the survivor’s major concern(s).
- To refer to DV specialists for continued safety planning, advocacy and support
- To practice diligent self-care

\textsuperscript{i} Humphreys & Thiara, 2002
\textsuperscript{iii} Bachman & Saltzman, 1991
\textsuperscript{iv} Jaffe, 2003; see also Miami-Dade County DV Fatality Review Team, 2000; Canadian Center for Justice Statistics, 2000; Johnson & Bunge, 2001; Stark, 2007
\textsuperscript{v} Rapaport, 1994
\textsuperscript{vi} Danger Assessment by Jacquelyn Campbell, RN, PhD, dangerassessment.com see also Campbell, et al, 2009 and subsequent related articles
Brief Guidance: Assessing, Intervening and Documenting Abuse

**Universal education should precede screening.**

Do not begin assessing unless you have a protocol in place for how you plan to respond AND a relationship with your local domestic violence program/organization.

Assessing

- Relationship-build
- Always discuss the limits of confidentiality before you start asking questions
- Ask in private
  - Build privacy into routine, so sudden excuse does not have to be invented
- Normalize
  - Recognize that verbal, emotional abuse is the least of it, and the easiest for the patient to acknowledge
- Never use family/friends to interpret
- Be specific and direct – patients are unlikely to disclose except as the result of specific and direct questions
  - Asking direct and specific questions facilitates appropriate medical care
- Never touch a patient without their explicit permission
- Be mindful of body language, tone of voice, nuance of word choice, proximity to patient (non-verbal cues)
  - Ask repeatedly in different formats - in person, in writing, via computer
- Expect patients to deny, minimize (that is ok and to be anticipated)
- Expect patients to blame themselves, their partner’s use of alcohol, stress, etc.
- Honor people’s choice not to disclose
  - Let them know that you are a safe person if they ever are afraid of a partner (or anyone else)
- Routine Questions –
  - “Because violence in so common in people’s lives, I now ask everyone I see about abuse in their lives . . .
- If Abuse is Suspected -
  - “Sometimes, when I see an injury like yours, it is the result of someone hitting their partner/family member. Did that happen to you?”
- Some Possible Assessment Questions
  - Have you ever felt afraid of your partner, or an ex-partner?
  - Does your partner ever belittle you, put you down, intentionally make you feel badly about yourself?
  - Does your partner ever try to control you, tell you where you can go or with whom you can spend time?
  - Does your partner ever physically hurt you or threaten to hurt you? (Your children? Your pets? Your elders)
  - Has your partner or anyone else ever coerced you into having sex when you didn’t want to?
  - In hospital-based settings we are also increasingly asking questions about “choking” in response to anything that sounds like a disclosure. Please be sure you have a strangulation protocol/plan before you start assessing for strangulation experiences.
DOs of Intervention

- Believe
- Be calm
- Validate & normalize the patient’s feelings
- Mirror the patient’s language
- Reflect what the patient is disclosing in order to: 1) clarify the problem, and 2) confirm that you are fully engaged
- Use open ended questions
- Explore situation systematically, thoroughly
- Assume the person has resources and skills
- Assume that the person is in touch with reality
  - “Paranoia” is a necessary survival skill for survivors of domestic and sexual violence
- Assume that everything the patient is telling you is true
- Function on the premise that the patient is the expert in her/his own situation

DON’Ts of Intervention

- Don’t assume
- Don’t finish the patient’s sentences
- Don’t interrupt
- Don’t solve the problem for the client
- Don’t be judgmental
- Don’t tell the patient that everything will be ok

Brief Guidance for Documentation

- Please avoid all of the following:
  - Patient “alleges” assault
  - Patient “denies” abuse
  - Patient “refuses” to talk to police or shelter patient, “declines” assistance
  - Patient is “non-compliant”
  - Patient is “resistant”
- Instead of patient “alleges,” try . . .
  - Patient states, patient disclosed, patient revealed
- Instead of patient “denies” abuse, patient is “resistant”, patient “refuses,” try . . .
  - Provided information regarding dynamics of abuse
  - Collaboratively crafted safety plan
  - Offered services of domestic violence/sexual assault advocate
  - Provided information and referrals to area resources
- Please do not document details of safety plan
- Please do not document name of DV organization/advocate to which you referred the patient.
Documentation Considerations for Domestic Abuse in Pedi/OB Electronic Health Records

Documenting domestic abuse in a pediatric medical record is complex and involves consideration of many factors. The following guidance is meant to help you reflect on the different aspects of documentation, it is not intended as rules you have to abide by. As always, the NWH DV/SA program is available for consultation on documentation questions. Ultimately, though, it is your clinical judgment that will be your best guide.

Questions to consider when documenting domestic abuse in a pediatric (or OB) chart:

- Who has access to the medical record?
- What information do other providers need to know?
- What are the survivor’s safety concerns?
- What type(s) of abuse is being disclosed?
- Are there child protection concerns? (if yes, you do need to document the abuse and make sure to consult with social work and/or the SCAN team regarding filing and documentation concerns)
- What are the survivor’s plans for the relationship?
- What are the child’s medical issues?
- Can the survivor’s own providers document the information, if documentation is necessary but not safe to put in the pediatric chart?
- What does the survivor want?
- What are the potential benefits to documenting the domestic abuse? (custody, immigration, criminal-legal)

At times, it’s okay to:

- Use vague terms if necessary, “turbulent dynamics in the relationship,” “tension in the relationship”
- Not document that you referred to “NWH DV/SA” or “REACH” specifically. You can write “referred to domestic abuse program” without being specific as to which program, and whether or not it was internal or external.

You should make sure to document the work you have done. “Discussed safety options” for example.