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‘Living with intimate partner violence’ A literature review of pregnant women’s experiences

Pregnancy brings joy to most women’s lives. However, some women do not enjoy their pregnancy, due to physical and/or emotional health problems, or social circumstances such as being in a relationship characterised by intimate partner violence (IPV). The aim of this review is to explore women’s experiences of pregnancy and being in a relationship with IPV. The electronic databases PubMed, CINAHL, PsycINFO and Web of Science were searched in June 2015 for related qualitative studies. Twelve studies, including 157 participants, were identified and included in this review. Four themes emerged from the data: 1) Feeling trapped/fear around disclosure and uncertainty, 2) Adapting and changing, 3) Protecting the unborn and 4) Hope and faith. In order to provide support to these women, midwives need to know how to identify women living with IPV, and how to help them through information and formal social support networks.

INTRODUCTION

The World Health Organization (WHO) (2014) defines intimate partner violence (IPV) as a ‘behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours’. Worldwide, one in three women have been either beaten, forced into sex or otherwise abused at some point (Heise et al 1999), but statistics related to IPV during pregnancy are more difficult to come across. A multi-country study on violence against women found a prevalence of physical IPV during pregnancy ranging between 1-28 per cent (WHO 2005). These figures perhaps underestimate the prevalence, since they do not include psychological, sexual or financial abuse, all of which can occur with or without physical abuse.

Intimate partner violence during pregnancy is particularly worrying as it is associated with fatal and non-fatal adverse outcomes for both women and their babies, stemming from direct trauma to

the abdomen and also the physiological effects of stress (WHO 2011).

Pregnancy has been described as an event that is associated with increased violence by abusive partners as the baby is perceived as a direct threat to the partner, and they attempt to re-establish their control over the woman (Bacchus et al 2006). Stockl and Gardner (2013) also described how pregnancy was viewed as a time where feelings of control, power and dominance became stronger in abusive partners. The threat is that partners become violent with the progress of pregnancy (Finnbogadottir et al 2014). Therefore, this review was conducted with the aim of looking at women’s experiences of pregnancy and being in a relationship with IPV.

METHODOLOGY

The electronic databases PubMed, CINAHL, PsycINFO and Web of Science were searched for qualitative studies published in English, related to women’s experiences of IPV during pregnancy, yielding 1,319 results. In total, 12 articles involving 157 participants were found to be relevant and were included for the final review.

RESULTS

Synthesis of included studies resulted in the emergence of four themes related to pregnant

It is associated with fatal and non-fatal adverse outcomes for both women and their babies

Table 1 Studies contributing to each theme

		Feeling trapped/fear around disclosure and uncertainty	Adapting and changing,with pregnancy as a turning point	Protecting the unborn	Hope and faith
1	Bacchus et al (2003)	x	x		
2	Bacchus et al (2006)	x	x		
3	Chang et al (2005)	x			
4	Edin et al (2010)	x	x	x	x
5	Engnes et al (2012a)	x		x	
6	Engnes et al (2012b)	x	x	x	x
7	Finnbogadottir et al (2014)	x	x	x	x
8	Lutz (2005)	x	x	x	x
9	McCosker et al (2004)	x	x	x	
10	Salazaar et al (2012)		x		
11	Stockl and Gardner (2013)		x		

women's experiences of IPV: 1) Feeling trapped/fear around disclosure and uncertainty; 2) Adapting and changing; 3) Protecting the unborn; and 4) Hope and faith. Table 1 shows the papers that provided data for each of these themes, crosses in the table indicating reference to the following quotations:

FEELING TRAPPED/FEAR AROUND DISCLOSURE AND UNCERTAINTY

Feeling trapped by the fear of having to cope with their new baby alone was felt by many women.

"It is more difficult [to leave] when you're pregnant because you feel stuck"

(Bacchus et al 2006: 599)

"...a commitment that you can't pull out of. The baby needs a father and a mother"

(Bacchus et al 2006)

Although women recognised that pregnancy was a time to end the relationship for the sake of the baby, there was still fear around disclosing their situation due to the stigma attached to it. There were uncertainties about disclosing the IPV to the midwife and fear of being deemed as incompetent mothers and losing their children.

"It is a very shameful situation...and when you burst the bubble, there must be someone available to follow you up"

(Engnes et al 2012a: 646)

ADAPTING AND CHANGING, WITH PREGNANCY AS A TURNING POINT

Women experiencing IPV during pregnancy felt they had adapted their behaviour in an attempt to reduce the violent outbursts from their partners. The years of abuse, humiliation and criticism had changed them. While avoiding confrontation and protecting the baby, these women had lost who they were.

"shrinking, resigning themselves and becoming paralysed, eventually leading to exhaustion"

(Engnes et al 2012b: 5)

Pregnancy was a time where partners also turned to sexual violence as a form of control and power over the woman. One woman stated:

"He became more aggressive and violent when I became pregnant"

(Bacchus et al 2006: 593)

Women experiencing IPV during pregnancy felt they had adapted their behaviour in an attempt to reduce the violent outbursts from their partners

PROTECTING THE UNBORN

The main concern for the majority of women was the wellbeing and protection of their babies. For some, >>>>

pregnancy was their only motivation for living.

"the child was the only thing that kept me going...at that time I was close to giving up"

(Engnes et al 2012a: 645)

HOPE AND FAITH

Many women expressed a hope that, through enduring the violence and staying with their partner, better times would follow. They felt that the arrival of the baby would cause a change in the attitude of the partner. As one woman said:

"...love would mend the relationship"

(Lutz 2005: 812)

Women believed that, despite the violence, they looked forward to the possibility of family happiness (Finnbogadottir et al 2014: 5).

Women need health professionals who can address the issue directly but with sensitivity

DISCUSSION

Across the globe, IPV is unfortunately common, with one in three women experiencing some form of IPV at some point in their life, with greater prevalence among the pregnant population (Heise et al 1999). Intimate partner violence affects both the physical and psychological health of a pregnant woman, which can ultimately affect her unborn baby (WHO 2011). Due to the nature of violent relationships, women often become isolated from their support networks. Pregnancy is a unique time in which these isolated women come into contact with the maternity services, and it gives midwives a chance to provide information relating to their situation, and also aid them in leaving the relationship. This highlights the need for midwives to educate themselves on this aspect, in order to feel confident in providing help and support to women experiencing IPV in pregnancy.

IMPLICATIONS FOR MIDWIFERY PRACTICE

Maternity care provides a unique window for identifying women who are experiencing IPV, as it may be the only point of contact for women in a health care setting (WHO 2011). From analysing studies focused on the woman's own experience of IPV in pregnancy, the following recommendations can be suggested to practising midwives in order to support these women.

EMPOWERMENT:

It is important for midwives to empower the woman

to control the situation herself (Engnes et al 2012a). Restoring the woman's autonomy is the key to helping a woman overcome the cycle of abuse. One of the most frequently tested interventions, called 'empowerment counselling', aims to: give women information about the different types of abuse; discusses the cycle of violence; carries out an assessment to identify risks; and develops a safety plan in collaboration with the woman (WHO 2011). This could be incorporated into the midwifery care of the abused woman with further referral to a professional in the area, such as a medical social worker, who can provide appropriate support (Finnbogadottir et al 2014).

IDENTIFICATION WITH HISTORY TAKING:

Chang et al (2005) identified the need to enquire routinely about IPV as part of the booking history, of all women, not just women who are believed to be 'at risk'. (McCosker et al 2004) have recommended that midwives ask questions of women with reference to physical abuse, along with other forms of abuse, such as financial or emotional abuse.

Women often go through two processes of leaving an abusive relationship: the emotional leaving and the actual physical act of leaving. Asking specific questions can help women to begin the emotional process of leaving and opens the door for disclosure at a later time (Edin et al 2010).

SAFE ENVIRONMENT AND MAINTAINING CONFIDENTIALITY

Facilitating a safe environment with confidentiality during booking visits can make it easier for the woman to disclose IPV, if it exists (Chang et al 2005). Creating a trusting relationship with the woman is the key, with a holistic approach to looking at all aspects of the woman's health and wellbeing. Being respectful and non-judgemental of women's decisions are some of the approaches that help them disclose IPV, allowing them to reflect on their relationship.

EDUCATION

Education on the topic of IPV for health care professionals is essential in ensuring women get the right help. Women need health professionals who can address the issue directly but with sensitivity (Bacchus et al 2003). Midwives need to know what support networks are available for women experiencing IPV and thus, can act as coordinators and refer women as and when appropriate (Engnes et al 2012a). Availability of information in the form of posters or leaflets may help women disclose about IPV to the health care provider (Chang et al 2005).

CREATING SOCIAL SUPPORT

Sometimes a midwife may be the only social support because of the isolation associated with IPV (Finnbogadottir et al 2014). Edin et al (2010) described how vital it is for these women to be encouraged to create formal support networks with health professionals or social workers, and build up their own social networks with family and friends, which are often diminished due to the nature of IPV relationships. Building informal support networks has been found by women to be one of the most effective ways to end IPV (Salazaar et al 2012).

IMPLICATIONS FOR RESEARCH

More qualitative research is recommended to examine how women experiencing IPV perceive the maternity services, and to focus on what the maternity services can do for them. Also, quantitative research is recommended, since there is insufficient evidence to recommend any interventions, and thus there is a need for more high quality randomised controlled trials to assess which interventions would influence maternal and neonatal mortality and morbidity (Jahanfar et al 2014).

CONCLUSION

Pregnancy is a turning point for violent relationships, and with the right support from midwives and professionals, women experiencing IPV can turn their lives around for the better, for both themselves and their baby. Midwives have a responsibility to identify and support these women in getting the right help, at an appropriate time, to change their situation. [tpm](#)

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