

INTIMATE PARTNER VIOLENCE AND THE PERINATAL PERIOD: A BRIEF REVIEW OF CURRENT KNOWLEDGE

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Data from the World Health Organization (2013) shows that intimate partner violence (IPV) is a social and public health problem that is both serious and ongoing. This problem primarily affects women, given that they are the victims in 80% of IPV cases (World Health Organization, 2014). Moreover, according to worldwide estimations by the WHO, 35% of women, slightly more than one out of three, indicate having suffered physical, psychological, or sexual violence at the hands of their intimate partner during their life (World Health Organization, 2013).

IPV DURING THE PERINATAL PERIOD

The perinatal period starts with the beginning of pregnancy and ends 2 years after the child's birth. This is a period of greater vulnerability, particularly to IPV. Indeed, the data on perinatal intimate partner violence (pIPV) demonstrates the need to examine pIPV, given that pregnancy, especially the first pregnancy, is an important transition moment that can cause individual, couple, and family upheaval (Meleis, 2010; Mercer, 2004; Poissant, Chan, & Lévesque, 2011).

Prevalence and forms of pIPV

In a Canadian study carried out in 2006, 10.9% of the respondents reported having been victims of pIPV, the rate for the Province of Québec being 10.4% (Public Health Agency of Canada, 2009). Furthermore, the population data for the 2009 General Social Survey (GSS) revealed that some 63,300 women indicated having been victimized by their partner while they were pregnant in the five years preceding the study, which represents 11% of the women who were IPV victims (Statistics Canada, 2013). The majority of women who report physical violence during pregnancy are also victims of verbal and psychological violence (Taillieu & Brownridge, 2010). More precisely, the prevalence of emotional and verbal violence during pregnancy ranges from 1.5% to 36%, that of physical abuse from 3% to 13.8%, and that of sexual violence from 1% to 8% (James, Brody, & Hamilton, 2013; Taillieu & Brownridge, 2010). Just as with IPV, the prevalence rates obtained for pIPV are influenced by the retained definitions, the tools used to measure this violence, and the chosen sampling strategies.

Different trajectories for pIPV

There is a lack of consensus in the scientific literature regarding whether or not the perinatal period is a risk factor, that is to say, whether IPV decreases, increases, or remains stable during this period (Bailey, 2010). For some women, IPV was present before pregnancy, whereas for others, pregnancy marked the beginning of the violence, the intensification of the severity, or the reoccurrence of IPV (Casanueva & Martin, 2007; Statistique Canada, 2013; Taillieu & Brownridge, 2010). The most important factor in predicting IPV during pregnancy would be the violence victims were subjected to before pregnancy (James et al., 2013; Taillieu & Brownridge, 2010). Between 60% to 96% of women who were victims of IPV during pregnancy reported having also been subjected to IPV before the pregnancy (Taillieu & Brownridge, 2010). In certain cases however, pregnancy also triggered the violence, whereas in other cases, it helped to decrease or stop the violence (Daoud et al., 2012; Taillieu & Brownridge, 2010). For some women however, the pregnancy brought on an increase in psychological violence at same time as the physical violence decreased (Martin et al., 2004).

pIPV in a separation context

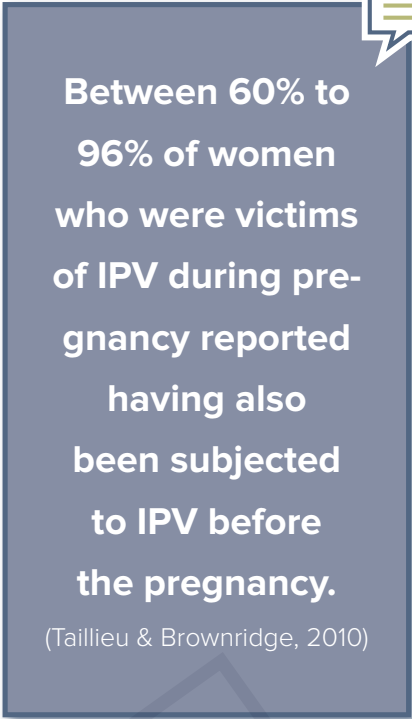
pIPV often continues after separation, especially when it was present before the pregnancy occurred (Kelly & Johnson, 2008). While sometimes seen by mothers as a way of protecting themselves and their foetus against IPV, separation can also contribute to the continuation of IPV by provoking strong reactions (e.g., anger, stress, sadness, jealousy) in the partner and fuelling an increase in violence and control (Decker, Martin, & Moracco, 2004; Saltzman, Johnson, Gilbert, & Goodwin, 2003).

pIPV in racialized minority women

Women from all cultures, social classes, and ethnicities are at risk of being subjected to pIPV. That being said, women from racialized minorities are 2 to 3 times more likely to be subjected to violence during pregnancy (Cha & Masho, 2014; Daoud et al., 2012; James et al., 2013; McMahon et al., 2011; Taillieu & Brownridge, 2010). In Canada moreover, it is indigenous women that report the highest frequency of IPV during pregnancy (Daoud et al., 2012).

RISK FACTORS

The ecological model shows that the risk factors for being a victim or perpetrator of PPV are present at different levels, namely: individual, relational/familial, community, and social. They can likewise combine to explain the increased likelihood of being in an IPV context during the perinatal period (Public Health Agency of Canada, 2016; World Health Organization, 2010).



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(Taillieu & Brownridge, 2010)

Risk factors associated with pIPV

Individual level		
Being the perpetrator of pIPV ¹	Being the victim of pIPV	
A lesser ability to make the transition into parenthood (e.g., high stress level and insecurity, feeling of failure and incompetency, lack of information about parenting and baby care, etc.)	IPV before pregnancy	
Attitudes conducive to violence	Young age	Single
Alcohol and drug use	Belonging to a minority group	
Behavioural problems and antisocial behaviour	Financially dependent on their partner	
Lack of social support		
Low level of education		
Separation during pregnancy		
Unplanned or unwanted pregnancy		
Precarious socio-economic status		
Relational and familial level		
Problems in the couple's relationship (e.g., pregnancy-related tension and conflicts)		
Tolerance for violence in one's family and friends		
Adherence to gender standards held by family and friends		
Community and social level		
Power dynamics and inequality between men and women		
Cultural and religious belief systems (e.g., social representations of the mother and motherhood)		
Socio-economic characteristics of the community: poverty and hardships		
Traditional gender roles and standards		
Social standards favouring a tolerance for violence		

¹ Currently available data on the risk factors associated with pIPV focus on the victimization of women and the perpetration of men. (Bailey, 2010; Daoud et al., 2012; Decker, Martin, & Moracco, 2004; Haland, Lundgren, Eri, & Lide'n, 2014; James et al., 2013; Kelly & Johnson, 2008; Perel & Peled, 2008; Saltzman, Johnson, Gilbert, & Goodwin, 2003; Taillieu & Brownridge, 2010)

CONSEQUENCES OF IPV

On the health and well-being of women

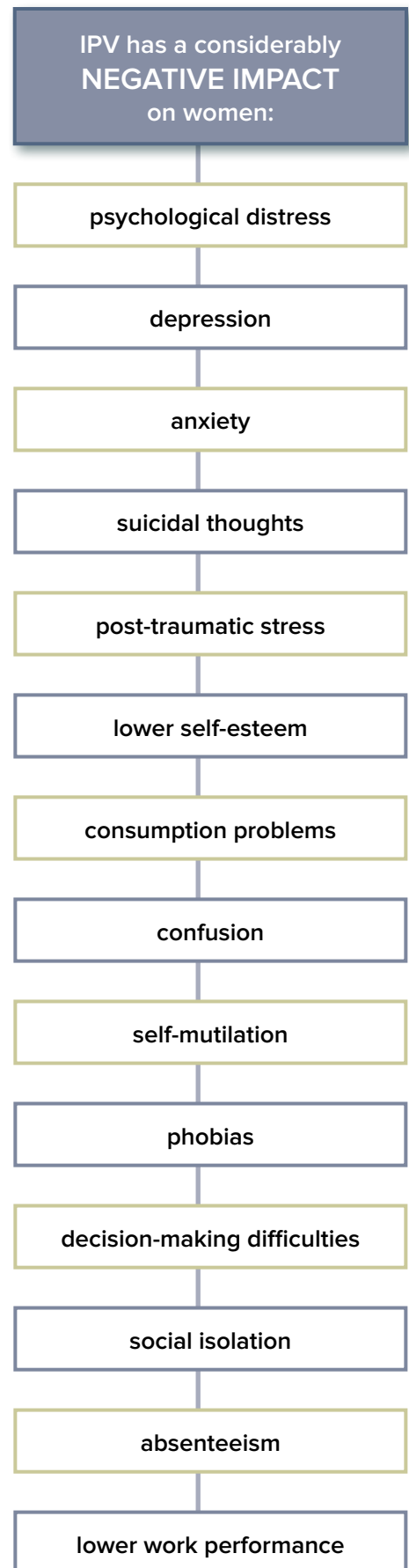
IPV has a considerably negative impact on women's physical, mental, sexual, and reproductive health as well as on their well-being (Public Health Agency of Canada, 2016). This includes psychological distress, depression, anxiety, suicidal thoughts, post-traumatic stress, lower self-esteem, consumption problems, confusion, self-mutilation, phobias, decision-making difficulties, social isolation, absenteeism, and lower work performance (Buchanan, Power, & Verity, 2014; Kelly & Johnson, 2008; McMahon, Huang, Boxer, & Postmus, 2011; Statistique Canada, 2013; World Health Organization, 2013). Hypervigilance as well as nightmares, flashbacks, and avoidance of things that recall past events can remain well after periods where IPV occurred (Kelly & Johnson, 2008). IPV can also be the source of gynecological problems such as pelvic pain, urinary infections, and sexually transmitted diseases, and can negatively affect women's ability to use and negotiate contraception (Agrawal, Ickovics, Lewis, Magriples, & Kershaw, 2014; Sylvie Lévesque, 2010; Morland, Leskin, Block, Campbell, & Friedman, 2008; Taillieu & Brownridge, 2010; World Health Organization, 2014). IPV can likewise be associated with unplanned and unwanted pregnancies (Miller et al., 2014; Moore, Frohwirth, & Miller, 2010).

On the Development of the Foetus and Infant

Babies born to mothers who are victims of IPV during pregnancy have a lower weight at birth, obtain lower scores on the Apgar test, and are more likely to be hospitalized in an intensive care unit (Silverman, Decker, Reed, & Raj, 2006; Wiemann, Agurcia, Berenson, Volk, & Rickert, 2000). During pregnancy, IPV can hinder a baby's development and increase, in proportion to its frequency, the probability of stillbirth, miscarriage, premature birth, and low birth weight (Hill, Pallitto, McCleary-Sills, & Garcia-Moreno, 2016; Morland et al., 2008; Shah & Shah, 2010; Taillieu & Brownridge, 2010; World Health Organization, 2014). Abdominal trauma resulting from physical violence and sexually transmitted diseases ensuing from sexual violence and forced sexual intercourse can all damage the placenta and prematurely rupture the membranes (Hill et al., 2016; Morland et al., 2008).

On the development of children

Early childhood is a crucial period in the development of children. As such, IPV is recognized in the Youth Protection Act as a form of psychological maltreatment that can affect children's development (Gouvernement du Québec, 2012). Exposure to IPV can affect different areas of development in babies and young children and, in numerous ways, lead to short, medium, and long term consequences such as high levels of



distress, sleep problems, night terrors, separation anxiety, behavioural problems, social and educational problems, serious internalizing and externalizing disorders, post traumatic stress disorder, aggressiveness, anxiety, and low self-esteem (Buchanan et al., 2014; Kelly & Johnson, 2008; Lawrence, Orengo-Aguayo, Langer, & Brock, 2012; McMahon et al., 2011). Exposure to IPV also leads to a greater risk of the children reproducing the aggressor and victim roles that they were exposed to (Ehrensaft & Cohen, 2011; Ehrensaft et al., 2003; Smith et al., 2000; Valdez, Lim, & Lilly, 2012).

On parenting skills

IPV influences the use of one's parenting skills (Lapierre & Damant, 2012; Sylvie Lévesque, 2015). Research indicates that the presence of IPV hinders the creation of a solid affective relationship between the mother and child (Buchanan et al., 2014) and increases the risk of the child being maltreated (Grasso et al., 2016; Holmes, 2013). In certain cases nonetheless, the mothers are able to reduce the effects of IPV on their children. Many women set up strategies to protect themselves and their children from IPV and try in all sorts of ways to prevent the children from being injured (Buchanan et al., 2014; S. Lévesque & Chamberland, 2016). As regards fathers who are IPV perpetrators, some of them recognize the harmful nature of some of their parenting practices (Bourassa, Turcotte, Lessard, & Labarre, 2013) and are concerned about the repercussions of their violence on their children (Rothman, Mandel, & Silverman, 2007). As such, work conducted with fathers who are IPV perpetrators has noted their desire to help their children develop a feeling of security and to become good fathers, despite the violence they have subjected their partners to (Haland et al., 2014; Rothman et al., 2007). Conversely, the results of other studies show that even though fathers are often aware of the effects of IPV on their children, they see their violent behaviour as a paternal right (Veteläinen, Grönholm, & Holma, 2013).

CONCLUSION

The data supports the need to examine the problem of pIPV and to avoid treating it as homogeneous in nature. As shown, different individual, relational, and structural factors influence the probability of experiencing pIPV. These factors must be taken into consideration if we are to adopt a holistic view of the subject and to encourage beneficial interventions for both the victims and perpetrators of pIPV. At present however, there are some gaps in the literature, with little recent epidemiological data drawn from either the mothers' or fathers' viewpoint or the victims' or perpetrators'. As such, it would be necessary to know more about the different trajectories so as to better understand the problem and, ultimately, implement effective, well-adapted interventions.

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