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INTIMATE PARTNER VIOLENCE AND THE PERINATAL PERIOD: PRACTICAL INTERVENTIONS AND IMPLICATIONS

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INTIMATE PARTNER VIOLENCE DURING THE PERINATAL PERIOD[1]

The perinatal period is sometimes one in which women are quite vulnerable to intimate partner violence (IPV). Pregnancy, in particular the first pregnancy, is an important time of transition that can generate substantial upheaval in the lives of individuals, couples, and families (Meleis, 2010; Mercer, 2004; Poissant, Chan, & Lévesque, 2011). The results of the 2009 General Social Survey (GSS) revealed that 11% of women who were IPV victims were pregnant at the time of the violence (Statistics Canada, 2013). Well-adapted and effective interventions carried out with women who were victims of perinatal intimate partner violence (pIPV) are necessary, given that pIPV has considerable negative repercussions for their well-being and their physical, mental, sexual, and reproductive health (Public Health Agency of Canada, 2016).

The literature shows that screening is effective in increasing the identification rate for women who are IPV victims (Flores, Lampron, & Maurice, 2010; Garcia-Moreno et al., 2015; O'Doherty et al., 2015). That being said, one of the major barriers for implementing IPV screening is the lack of consensus concerning the best practices for detection and intervention (Feder et al., 2009; Sprague et al., 2012). It is still unclear how screening can be conducted to identify cases of IPV. When should screening be done? During the first visit? In all the visits? Once trust has been established? What screening tools should be used and how should they be applied? What are the most effective tools? These questions also apply to the more specific field of pIPV. There is a debate as to whether routine screening for IPV during pregnancy is effective, which in turn leads to a reluctance to introduce it into the health services (Eustace, Baird, Saito, & Creedy, 2016; Spangaro et al., 2016).

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(Statistics Canada, 2013)

1 For more information about pIPV, see the fact sheet *Intimate Partner Violence and the Perinatal Period: A Brief Review of Current Knowledge.*

INTERVENTIONS: SCREENING FOR pIPV[2]

Perinatal Period: Window of Opportunity

Identifying women who are victims of pIPV is the first step to take to ensure their safety and well-being (Spangaro et al., 2016). That being said, the perinatal period represents a window of opportunity in which to screen for women who are IPV victims (Deshpande & Lewis-O'Connor, 2013). During pregnancy, screening for pIPV is facilitated by the frequent contacts between women and health and social service professionals (Deshpande & Lewis-O'Connor, 2013; O'Reilly, Beale, & Gillies, 2010; Taylor et al., 2007). These numerous meetings make it easier to establish a trusting relationship and to spot pIPV (Paterno & Draughon, 2016; Taylor et al., 2007). Research suggests that pregnant women are capable of revealing sensitive, personal information about pIPV when the relationship with the health professionals and practitioners is judged to be safe, reassuring, and professional (Baird, Salmon, & White, 2013). Consequently, the research supports the idea of establishing a therapeutic relationship with women before carrying out pIPV screening (Eustace et al., 2016; LoGiudice, 2015). What is more, studies show that using screening tools during pregnancy and conducting multiple screens, that is one per trimester during pregnancy and postpartum tests, significantly increases the probability of identifying women who are IPV victims (Deshpande & Lewis-O'Connor, 2013; McMahon & Armstrong, 2012; O'Doherty et al., 2015; O'Reilly et al., 2010; Paterno & Draughon, 2016). Continuous healthcare all throughout the perinatal period given by the same health-care professionals increases the probability of successful screening over time, facilitates the contact with services, and reinforces the women's social support network (Eustace et al., 2016). In short, screening allows medical, social, and legal services to propose adapted interventions (Garcia-Moreno et al., 2015; O'Doherty et al., 2015).

Screening methods and tools for pIPV

Various methods and measurement tools have been developed, assessed, and identified that can be used to screen for pIPV (Deshpande & Lewis-O'Connor, 2013). Face-to-face screening would seem to be an effective method, in that the relational aspect and the fact of questioning a woman directly play an important role in the successful screening of pIPV victims (Spangaro et al., 2016). The effectiveness of screening tools that have been specifically adapted for the pregnancy period is also recognized, as it makes it possible to ask questions about various forms of pIPV – be they physical, psychological, or sexual – that come to the fore during this precise period (McMahon & Armstrong, 2012). For example, the Abuse Assessment Screen, which is probably the IPV screening tool that is most often used with pregnant women, comprises five open-ended questions on the

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2 In the present fact sheet, screening is seen as an intervention where all women are questioned about present and past pIPV , regardless of the reason for their medical visit (Flores et al., 2010; O'Doherty et al., 2015).

occurrence, nature, and consequences of IPV before, during, and after pregnancy (Deshpande & Lewis-O'Connor, 2013). The use of this tool would seem to improve the pIPV detection rate among women during pregnancy as compared to a regular medical interview without a standardized instrument (Deshpande & Lewis-O'Connor, 2013). A well-structured screen helps professionals to detect pIPV and intervene more quickly (Deshpande & Lewis-O'Connor, 2013). As the presence of the partner acts as a barrier to victims disclosing their pIPV problems, it is recommended to first invite the woman to come and take her vital signs alone and carry out the screening at this time, and then invite her partner for the rest of the prenatal visit (LoGiudice, 2015). Likewise, the frequent concomitance between IPV, mental health problems, and alcohol and drug consumption points to the importance of using a more global, multifactorial approach in the interventions (Kiely, El-Mohandes, El-Khorazaty, & Gantz, 2010; Mejdoubi et al., 2013). It is likewise recommended that screening tools be adapted to ethnocultural contexts (O'Reilly et al., 2010).

THE CHALLENGES AND ISSUES INVOLVED IN pIPV INTERVENTION

Numerous obstacles, be they personal, professional, or organizational, hinder the support provided by health and social service practitioners and professionals to women in a pIPV context (Taylor et al., 2007). Even though pIPV screening is considered to be important, worthy of interest, and an integral part of prenatal care, a majority of practitioners only carry the screening out one time, that is during the first meeting (Taylor et al., 2007). Studies reveal that time constraints, insufficient understanding of pIPV, lack of preparation and support, the presence of the partner, poor knowledge of clearly defined tools, protocols, training, and resources available for female victims, and worries about their own safety all represent obstacles to conducting pIPV screening for practitioners and professionals (Eustace et al., 2016; LoGiudice, 2015; Taylor et al., 2007). Furthermore, screening frequency and methods vary according to the health professionals' attitudes, feelings of effectiveness, preferences, and professional and personal experience regarding IPV (Eustace et al., 2016; LoGiudice, 2015; Taylor et al., 2007). The impression of not being prepared leads health professionals and practitioners to feelings of fear and anxiety and diminishes their faith in their ability to question women and manage the disclosure of pIPV (Eustace et al., 2016; LoGiudice, 2015). Moreover, the diversified nature of the women's situations and the complexity of the parents' needs are issues that affect the quality of the interventions (Lessard & Alvarez-Lizotte, 2015; Spangaro et al., 2016). Likewise, interventions must be culturally appropriate if they are to be well-adapted (O'Reilly et al., 2010).

It is possible that victims do not recognize the intimate partner violence, that they are not aware that they are victim, that they are not ready to make changes or accept help (Van Parys, Verhamme, Temmerman, & Verstraelen,

2014). In this sense, some interventions (e.g., develop a safety plan, seek help) can take place too early in the process or not be adapted to the specific needs of the victims, and thus turn out to be ineffective (Van Parys et al., 2014). It is important to consider the personal pace of the pIPV victims in the intervention process (Van Parys et al., 2014). In a pIPV context, the victims' feelings of fear, shame, self-blame, guilt, and concern of losing their financial security can keep them from revealing their situation (Spangaro et al., 2016). Likewise, the fear of institutional authorities regarding the children's protection can keep mothers from disclosing pIPV (Spangaro et al., 2016).

In the Province of Québec, the challenges and issues that health professionals and practitioners encounter in IPV screening are little or not at all known, particularly as regards the perinatal period (Bernier, Bérubé, Hautecoeur, & Pagé, 2005). The few studies that have examined this topic have revealed that the participants' lack of knowledge and ability concerning IPV, the discomfort that professionals can feel, the powerlessness felt in conducting interventions, and the practitioners' personal attitudes are all obstacles to identifying IPV victims (Bernier et al., 2005). Moreover, it is possible that recent changes in the health services (e.g., merging of institutions, redefinition of rules and mandates) and of the community networks (e.g., continuous underfunding) could affect the ability of professionals, practitioners, and organizations to respond to pIPV.

IMPLEMENTATION OF pIPV SCREENING

To improve the screening of pIPV victims in health-care organizations and to increase the case identification rate, different strategies have been found to be effective (Baird et al., 2013; Eustace etal., 2016; O'Reilly et al., 2010; Paterno & Draughon, 2016; Spangaro et al., 2016; Taylor et al., 2007; World Health Organization, 2013):

- Creation of reassuring, multidisciplinary, clinical environments;
- Establishment of appropriate administrative outlooks that are favourable to pIPV screening: mechanisms that can monitor screening activities and react to the practitioners' needs;
- Development of the professionals' and practitioners' knowledge and skills concerning pIPV;
- Access to resources and tools for pIPV screening;
- Regular use of the same tools;
- Provision of training to support professionals and practitioners, to help them feel more confident, and to provide them with the means to conduct routine screening;
- Establishment of intervention protocols, standards, and procedures (e.g., written policies, standardized tools, and intervention reinforcement procedures);
- Access to services that provide support for women who are IPV victims.

The effectiveness of home visits

It has also been shown that well-structured, standardized home visits carried out by qualified practitioners can help to reduce victimization and the perpetrating of IPV during pregnancy (Mejdoubi et al., 2013; Van Parys et al., 2014), and this up to two years after the birth of the child (Mejdoubi et al., 2013). These visits encourage proactive, pIPV related interventions that give practitioners access to the family environment, facilitate the detection of pIPV and related risk factors, and make room for adapted interventions which have a positive effect on the women and decrease the presence of pIPV in the couple (Mejdoubi et al., 2013). Accordingly, access to the family environment allows practitioners to act earlier in the process when pIPV risk factors are observed (Mejdoubi et al., 2013). In addition, interventions and home visits give practitioners an opportunity to enter into contact and connect with women who are infrequent users of health services and centres (Mejdoubi et al., 2013). Indeed, a major advantage of home visits is that they allow practitioners to meet with young, pregnant, high-risk women during times of vulnerability and over prolonged periods, women who are notoriously difficult to reach through regular services (Mejdoubi et al., 2013).

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IMPLICATIONS FOR PRACTICE

The advantages of systematic screening are numerous: it leads to a significant increase in the identification of pIPV cases, and some studies have pointed out that, overall, screening decreases the negative consequences on pregnancy (LoGiudice, 2015). Through repeated meetings with professionals from the health and social services network and practitioners from community networks (e.g., pregnancy monitoring, babysitting services, breast-feeding clinics), the perinatal period represents a window of opportunity to act on IPV and to identify and implement targeted interventions (Deshpande & Lewis-O'Connor, 2013). Conditions leading to a higher identification rate of pIPV victims have been documented. Nonetheless, there are certain challenges and issues that obstruct the implementation of pIPV screening in different health networks. As such, a better understanding of the practitioners' and professionals' needs is required if they are to make more effective, better adapted interventions and be more aware of the different issues that arise in the various vulnerable situations in women's perinatal periods.

Fathers' experiences are examined less often in pIPV studies (Bourassa, Labarre, Turcotte, Lessard, & Letourneau, 2014; Haland, Lundgren, Liden, & Eri, 2016). This has resulted in a lack of knowledge about both their experiences and the use of adapted interventions that encourage them to take responsibility and help them to change during this period

(Peled & Perel, 2007). Just as for mothers who are pIPV victims, it is important that we better understand the needs of fathers who are pIPV perpetrators so that we may develop interventions related to their situations that will also promote the safety and well-being of women and children.

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