Domestic Violence and Maternal and Child Health

Domestic Violence and Maternal and Child Health

New Patterns of Trauma, Treatment, and Criminal Justice Responses

Stephen J. Morewitz
Stephen J. Morewitz, Ph.D. & Associates

Kluwer Academic / Plenum Publishers
New York Boston Dordrecht London Moscow

Library of Congress Cataloging-in-Publication Data

Morewitz, Stephen John, 1954–
Domestic violence and maternal child health / Stephen J. Morewitz.
p. cm.
Includes bibliographical references and index.
ISBN 978-1-4757-0978-0 ISBN 978-0-306-48530-5 (eBook)
DOI 10.1007/978-0-306-48530-5
1. Family violence–United States. 2. Maternal and infant welfare–United States.
I. Title.

HV6626.2.M67 2004
362.82'92–dc22 2004042123

ISBN 978-1-4757-0978-0

Softcover reprint of the hardcover 1st edition 2004

233 Spring Street, New York, New York 10013

http://www.kluweronline.com

10 9 8 7 6 5 4 3 2 1

A C.I.P. record for this book is available from the Library of Congress.

Preface

DOMESTIC VIOLENCE AND MATERNAL CHILD HEALTH is one of the first books to evaluate the impact of intimate partner abuse on maternal and child health. New abuse patterns against pregnant women and their unborn babies and children are described based on quantitative and qualitative findings from the Stalking and Violence Project (SVP), case studies from a clinical psychologist's private practice, and a review of the literature. (See **Appendix A-Research Methods** and **Appendix B-Study Results, Tables 1-9**).

Intimate partner abuse is prevalent and can endanger the lives of pregnant women, their fetuses and their children. The long-term societal impacts of violence are significant for the cycle of violence can be transmitted one from generation to the next. Despite the research studies that have been conducted in this area, little is known about the risk factors for partner abuse and the impact of that abuse on maternal child health and adult health. More research needs to be done about how nurses, physicians, social workers, and therapists can better diagnose and treat partner violence during and after pregnancy. Effective interventions by the police, courts, and legislators also need further investigation.

One of the central assumptions in this book is that partner abuse is a patterned set of behaviors developed by the batterer to exert power over women in intimate and non-intimate relationships. Abusive individuals use violence to develop and maintain relationships and retaliate against their partners. In this way, partner abuse

becomes a dysfunctional aspect of maintaining and ending relationships.

Violence against pregnant women should be understood in the context of the complex dynamics of pregnancy and the postpartum period. Pregnancy can be a time of great joy as the expectant mother and her family prepare for their new baby and prepare to adopt new family roles. Despite the joys of pregnancy, it can be a period of significant psychological distress and financial hardship for many expectant mothers.

There are many questions still to be addressed in this field. One of the central questions is to what degree do stressors during and after pregnancy trigger or exacerbate partner abuse? Pregnancy can place a heavy financial burden on families who already on the margins of poverty. To what extent do the added financial pressures of a pregnancy lead to violence against the pregnant woman? Does a reduction of intimacy due to pregnancy facilitate partner violence? Is abuse more likely to occur when a pregnancy is unwanted? What effects do the reorganization of family, social, and occupational roles, due to the pregnancy have either on the commission of or the escalation of partner abuse?

Developmental issues, such as risk-taking behaviors and sexual assertiveness during adolescence, may influence the incidence and severity of violence against pregnant adolescents. Other factors may trigger the onset of violence during pregnancy and the postpartum period. For example, to what extent do partner jealousy and the use of alcohol and drugs by both the victims and their abusive partners facilitate violence?

Throughout this analysis, the focus is on the conditions that increase pregnant women's vulnerability to abuse, the factors that reduce the impact of partner violence, and how professionals and the criminal justice and social services systems can effectively respond to violence.

Chapter 1 presents theories about the possible causes and risk factors for partner violence during and after pregnancy. Case studies from the SVP illustrate some of the causative factors underlying partner abuse during and after pregnancy.

In Chapter 2, the prevalence of different forms of violence during and after pregnancy is examined. Some examples of physical, sexual, and emotional abuse are described by SVP cases.

Chapter 3 delineates the relationship between partner violence and child abuse in the family. The risk factors of partner abuse among mothers with young children and the effects of partner violence on child development are presented.

In Chapter 4, the prevalence, risk factors, and consequences of child and newborn kidnapping by parents are explored. SVP cases illustrate some of the risk factors for parental child abductions, such as the possible association between partner abuse and parental child abductions.

In Chapter 5, Clinical Psychologist Mark Goldstein analyzes the psychological and social effects of partner abuse during pregnancy. Depression, anxiety, and social isolation are some of the problems described in this chapter. Case studies from Dr. Goldstein's clinical practice illustrate the severe trauma of partner abuse during pregnancy.

The possible effects of partner violence on women's intentions to become pregnant, their use of contraceptives, and their decisions on whether or not to terminate a pregnancy are evaluated in Chapter 6. The impact of partner abuse on causing a pregnancy and the quality of partner interactions are examined.

The impact of physical, sexual, and psychological violence on maternal, fetal, and neonatal outcomes are described in Chapter 7. The risks of low birth weight, premature labor, and other maternal complications are discussed. The effects of partner abuse on sexually transmitted diseases, human immune virus (HIV), and substance abuse are also investigated.

The responses of police and courts to partner abuse and the legal responsibilities of health care providers are analyzed in Chapter 8. Conditions that lead abused pregnant women to obtain restraining orders and factors that affect police and court intervention are described. Findings from the SVP show some of the conditions under which abused pregnant women seeking restraining orders.

The use of medical, counseling, and shelter services by pregnant and non-pregnant victims of violence are presented in Chapter 9. Obstacles to the use of medical and counseling services are discussed as well as ways to enhance access and use of these services.

Chapter 10 offers strategies to improve clinicians' screening and documentation of intimate partner abuse. Use of different screening instruments and the role of health professional training in improving

diagnosis and treatment of abused pregnant women are presented. The effectiveness of training programs in helping trainees and practitioners better to diagnose and treat violence is assessed.

The clinical treatment of abused pregnant women is described in Chapter 11. The application of a change model is emphasized to help clinicians better understand the needs of abused pregnant adolescents and adults.

The task of identifying and treating offenders is the topic of Chapter 12. Different treatment approaches and data on their effectiveness are presented.

In the Conclusion, the major findings of this book are summarized and the implications of this analysis are presented.

Acknowledgments

I would like to thank Mrs. Myra Kalkin Morewitz and Dr. Harry A. Morewitz for their advice and support. I also want to thank Bill Tucker, Senior Public Health Editor at Kluwer Academic/Plenum Publishers, who has been supportive as well as thorough and thoughtful.

Contents

1

Partner Violence: Causes and Risk Factors

In abusive relationships, the periods before, during, and after pregnancy can be associated with increased partner violence. Partner abuse frequently involves physical, sexual, and psychological forms of violence (Tolman, 1989). Psychological abuse consists of explicit and implicit threats of harm, extreme controlling behaviors, pathological jealousy, denigration, and isolating behaviors (Ellsberg, Pena, and, Herrera, et al., 2000; Bradley, Smith, and Long, 2002; Sonkin, Martin, and Walker, 1985).

Despite the recognition of the fact that violence occurs during pregnancy, little is known about the causes and risk factors of partner abuse around the time of pregnancy. This chapter explores the theories of partner violence and risk factors associated with partner violence before, during, and after pregnancy. Knowledge about these theoretical perspectives and risk factors has been used both to assess victims and to develop treatment programs for victims and offenders (See **Chapter 10-Screening Victims for Violence**, **Chapter 11-Treating Victims of Abuse**, and **Chapter 12-Identifying and Treating Offenders**).

The Feminist Model

The feminist model suggests that men's use of violence against pregnant women exemplifies the patriarchal nature of social institutions (Healey and Smith, 1998). In this patriarchal social system, men hold positions of power and prestige, while women are devalued and hold subordinate positions. Men use physical, sexual, and psychological abuse against women when they feel that their dominance is being challenged. Moreover, men's physical strength help them dominate women through the use of violence. Reports show that some males in different age groups believe it is acceptable for them to batter their female partners (Glover, Bannerman, and Pence, et al., 2003; Simon, Anderson, and Thompson, 2001). Attitudinal acceptance of men hitting their female partners reflects societal acceptance of battering by men as a way to dominate women in intimate relationships.

Family System or Couple System Model

Another theoretical approach, the family system or couple system model, suggests that violence during pregnancy results from a dysfunctional family or couple (Healey and Smith, 1998). According to this view, violence against pregnant women emerges from dysfunctional interactions among the family members or intimate partners instead of being caused solely by one family member. Family system theorists believe that most violence is psychological, but as it increases in severity, either partner may resort to physical violence. Moreover, according to the family system viewpoint, any of a variety of interactions can trigger abusive behaviors. For example, a family member's failure to maintain a culturally acceptable role can lead to violence in an attempt to force that individual into reassuming the more subservient role.

Additional evidence of the family system model of violence comes from studies documenting domestic violence across generations. Castro, Peek-Asa, and Ruiz (2003) evaluated the role of intergenerational violence as a risk factor for abuse before and during pregnancy using a sample of 914 pregnant women in Mexico. The researchers showed that parental violence observed by women in

childhood and a history of abuse in the abusive partner's childhood were some of the strongest indicators of violence.

Intergenerational violence also has been found among women attending general practice settings. Based on a large-scale study of women in 20 general practices in Australia, Hegarty and Bush (2002) noted that having a history of child abuse or observing domestic abuse between their parents were associated with partner abuse during adulthood.

Psychological Approaches

Psychological theories of domestic violence propose that partner violence during pregnancy results from personality disorders or childhood traumas that predispose certain persons to violence (Healey and Smith, 1998). Some psychological theorists focus on early negative childhood experiences, such as child abuse, parental rejection and failure to meet the emotional needs of a child, as precursors to later abuse against pregnant partners.

Psychodynamic approaches emphasize the deep-rooted, unconscious motives underlying partner violence during pregnancy. For example, individuals commit violence against their partners in reaction to feelings of possessiveness, jealousy, or revenge (Meloy, Cowett, and Parker, et al., 1997). Abusers react to these feelings with rage, a reaction that is acceptable in many cultures, especially for males. An abusive partner's rage may lead to stalking incidents and denigration of their partner. Moreover, the violent partner's feelings of possessiveness, jealousy, or revenge may conceal more subtle emotions such as envy. Envy can cause a violent person to consider his partner as a worthless individual who possesses nothing of value (Klein, 1975; Meloy, Cowett, and Parker, et al., 1997).

Psychoanalytic theories also suggest that pathological narcissistic traits foster the use of violence against intimate partners. These traits are prevalent in criminal populations, especially among intimate partner batterers and obsessional followers (Meloy, Cowett, and Parker, et al., 1997; Meloy, 1988; Meloy, 1989; Meloy, 1992; Dutton, 1995). Individuals who are pathologically narcissistic are especially predisposed to feelings of shame and are more likely to

consider others, particularly their partners as objects to be controlled and manipulated rather than as individuals deserving of empathy and respect (Meloy, Cowett, and Parker, et al., 1997). Pathologically narcissistic persons, therefore, are likely to use violence as a defense against feelings of shame as well as to further their control and manipulation of their partners. Advocates of the psychoanalytic perspective also note that persons who continue to be affected by early childhood disappointments and anger with their parents are likely to batter their partners (Meloy, Cowett, and Parker, et al., 1997).

Cognitive-Behavior Theory

In contrast, cognitive-behavior theorists focus on the belief that abusers know exactly what they are doing when they abuse their pregnant partners (Healey and Smith, 1998), for the abusers' behaviors have been learned as a consequence of positive and negative reinforcements. The abusers have learned to engage in particular behaviors, such as violence, as a reaction to specific circumstances. Moreover, abusers' behaviors are affected by how they mentally construct and interpret their social environment and the ways that they think about themselves and others.

Community Poverty and Partner Violence

Besides focusing on individual theories of partner abuse, researchers have proposed that community-wide characteristics such as poverty significantly influence the risk of partner violence. One possible theory is that community poverty may aggravate the frustration and low-self-esteem of intimate partners, increasing their likelihood of employing violence to deal with their frustration and low self-esteem.

Based on a sample of 16 states participating in the Pregnancy Risk Assessment Monitoring System, Saltzman, Johnson, and Gilbert (2003) showed that there was a higher prevalence of abuse before and during pregnancy for women who had less a high school education and were receiving Medicaid benefits.

Using a representative sample of ethnically diverse married and cohabiting couples derived from the 1995 National Alcohol Survey, Cunradi, Caetano, and Clark, et al. (2000) evaluated the extent to which neighborhood poverty predicted intimate partner abuse. The researchers reported that couples living in very low socioeconomic status neighborhoods were at increased risk of both male-to-female and female-to-male partner violence. African-American couples who lived in impoverished neighborhoods had an increased probability of experiencing male-to-female partner abuse. Both White and African-American couples living in very low socioeconomic status neighborhoods were at increased risk for female-to-male partner violence.

Couples living in urban areas, especially inner-city, low-socioeconomic status areas, may be especially at risk for partner, family and neighborhood violence. Based on a case-control investigation of 405 adolescent girls and women who had been intentionally injured, Grisso, Schwarz, and Hirschinger, et al. (1999) noted that 53% of the violence-related injuries suffered by women had been committed by non-partners. Among women, various neighborhood factors, including low median income, a high rate of residential mobility, and low educational levels were independently related to the risk of violent injuries. In addition, women's use of illegal drugs and alcohol predicted violence by both their partners and non-partners.

Another investigation found a large percentage of partner violence in high-crime areas. Based on a survey of 160 mothers living in high-risk crime neighborhoods, Linares, Groves, and Greenberg, et al. (1999) discovered that 40% of the mothers had filed a restraining order against a current boyfriend or husband, 39% ex-husband or boyfriend, 8% someone known to the mother, and 9% other individuals. The researchers noted that the percentage of mothers filing restraining orders in these high-risk crime neighborhoods is substantial given the fact the women in the sample did not come from a shelter or referral.

Researchers have also examined how poverty increases the risk of violence against pregnant women in developing countries. Nasir and Hyder (2003), in their review of the literature, found that low income among pregnant women and low educational attainment among both partners were risks factors for domestic violence against pregnant women.

In a study of 600 pregnant women in India, Purwar, Jeyaseelan, and Varhadpande, et al. (1999) showed that abused pregnant women were more likely to be living in a slum, come from an extended family and have a husband with low educational attainment. A study of domestic violence in Mexico by Castro, Peek-Asa, and Ruiz (2003) found that low socioeconomic status was one of the strongest predictors of domestic violence, including partner violence during and before pregnancy. In Turkey, Sahin and Sahin (2003) evaluated the incidence of domestic violence against pregnant women and discovered that abused pregnant women had lower levels of education and income and had more children than non-abused pregnant women.

The results of the Stalking and Violence Project (SVP) also support the community poverty perspective since a majority of the domestic violence victims and offenders lived in very low socioeconomic status areas (See **Appendix A-Research Methods** and **Appendix B-Study Results, Tables 1–4**).

Theorists who emphasize community-wide factors associated with partner violence stress the need for community-level interventions to reduce the negative effects of poverty, substance abuse, and the disorganization caused by high residential mobility on partner violence (Grisso, Schwarz, and Hirschinger, et al., 1999).

Ethnic and Racial Perspective

Various theorists have examined race, ethnicity, and cultural factors as predictors of intimate partner violence (Nannini, Weiss, and Goldstein, et al., 2002; Kantor, Jasinski, and Aldarondo, 1994; Meloy, Cowett, and Parker, et al., 1997). This social approach proposes that certain ethnic and cultural norms, values, and beliefs influence the incidence of partner violence (Meloy, Cowett, and Parker, et al., 1997). For example, Hispanic beliefs about machismo and marianismo may foster beliefs about the subservience of women in the family.

Differences in partner violence among Whites and African-Americans have been examined. In a 16-state study of physical abuse around the time of pregnancy, Saltzman, Johnson, and Gilbert, et al.

(2003) showed that women who were young and not White had increased exposure to physical abuse.

Cunradi, Caetano, and Schafer (2002) studied possible ethnic and racial differences in alcohol-associated problems, e.g., drinking dependence syndrome and adverse drinking consequences, and intimate partner abuse based on a multi-ethnic sample of 1,615 married and cohabiting couples from the 1995 National Study of Couples. The researchers reported that among African-American couples, male and female alcohol problems were predictive of intimate partner abuse. In contrast, male alcohol-related problems were not predictive of male-to-female partner violence among White or Hispanic couples. Among White couples, female alcohol problems were predictors of female-to-male partner abuse, but not male-to-female partner violence.

Ethnic and cultural differences also may influence the coping strategies of victims of intimate partner abuse. For example, the cultural script of marianismo, with its emphasis on submissiveness, self-sacrifice, and stoicism, may inhibit Hispanic women from confronting their abusive partners or leaving a violent relationship (Fernandez-Esquer and McCloskey, 1999; Triandis, 1983). In addition, ethnic and racial factors have been studied regarding the use of the police, courts, health care, and other services by the victims of partner abuse.

However, research is this area has been mixed. Based on an investigation of 1,970 families, Kantor, Jasinski, and Aldarondo (1994) studied the rate of spouse abuse in three Hispanic-American groups and in one Anglo-American group. The researchers discovered that the rate of partner abuse did not differ among the different groups when other other factors, such as attitudes toward violence, age, and economic stressors, are taken into account.

Pregnancy Issues and Partner Violence

In addition to theoretical approaches to partner violence, researchers have explored the risk factors associated with partner abuse during pregnancy. Campbell, et al. (1993) suggest that partner violence can center around the following five issues during pregnancy (Campbell, et al., 1993; Datner and Ferroggiaro, 1999).

1. Individuals may commit violence against their pregnant partners because they are jealous of the fetus. In these instances, the partners resent the attention given to the fetus. Threats of violence can be directed specifically towards the pregnant woman's fetus. For example, in SVP Case 9513, the abusive partner threatened to harm his pregnant partner in such a way that she would lose her unborn baby. In this case, Ms. C had been in a dating or engagement relationship with Mr. D, a 34-year-old man. Mr. D had come to her place of employment several times and warned her that he would "jump" her when she left her home and that she would lose her unborn baby as a result. Mr. D's sister also made threatening phone calls to Ms. C.

Men can be resentful of the pregnancy, feeling that it has intruded on their relationship with their partners (Sammons, 1981). In fact, during the pregnancy, the woman may be less likely to consider and care for her partner's needs, whether they be emotional, physical, or sexual. Pregnancy can alter the frequency and quality of sexual intimacy between partners, thus leading to arguments and decreased satisfaction with the relationship.

2. Pregnancy-specific violence may be triggered by the increased financial stress associated with a pregnancy. The period of pregnancy necessitates new financial expenditures that may put added pressure on the partner to provide additional sources of income for the family. Unemployment and low wages can be stress factors for partners who must support a growing family.

3. If the pregnancy is unwanted, partners may exhibit anger toward the fetus. Blunt trauma to the abdomen and other forms of partner violence may reflect that anger in the partner's attempt to harm or kill the fetus (Sammons, 1981). In this context, the abusive partner seeks to eliminate the burden of being responsible for a baby or association with their partner (Hendrix, 1978). Violent men also may seek to kill the fetus in order to prevent the birth of another individual with their "bad genes" (Walker, 1979).

4. Violence can occur during pregnancy as a continuation of the partner abuse that took place before the pregnancy (See **Chapter 2-Prevalence of Abuse**). In these instances, the same factors that precipitated partner abuse before pregnancy will continue to foster

partner abuse during pregnancy, for the abusive partner's need to control his partner and his increasing family will not disappear.

Helton, et al. (1987) found that 87.5% of women battered during pregnancy had reported previous partner violence. These findings support the cognitive-behavior model since abusive partners are continuing to receive positive reinforcement for their violent behavior (Healey and Smith, 1998).

Partner violence may take place because the abusive partner is jealous and believes that his partner is cheating on him. Ellsberg, Pena, and Herrera, et al. (2000) noted that extreme jealousy and control were recurring features of abusive relationships. Bradley, Smith and Long, et al. (2002) also found evidence of controlling behavior by partners. In their survey of 1,871 women in 22 general practice settings, the researchers showed that 69% of the women reported controlling behavior by their partners.

The results from the SVP revealed that 24% of the pregnant women as compared to 9% of non-pregnant women in the sample, reported that their abusive partner was jealous (Chi-Square = 5.18, df = 1, $P < .02$, See **Appendix B-Study Results, Table 6**). For example, in SVP Case A1, Ms. N, who was five-months pregnant, reported that her husband. Mr. O, came home from work during his lunch hour and gave her a black eye by slapping her across the face. He accused her of having another man in the house, because he thought he had heard a man's voice in the background while he was on the phone with his wife earlier in the day. To make amends for his brutal treatment, Mr. O bought his wife some eye makeup to cover her bruising.

5. Another theory of partner abuse during pregnancy centers deals with the grieving process (Sammons, 1981; Lieberknecht, 1978; Weingourt, 1979). This theory proposes that pregnant women who have been abused have lost their self-respect, their trust in their partners, and suffered a demeaning loss in their family roles whether or not they have left their abusive partners (Sammons, 1981). The result of this grieving process may be that the battered victim will displace her anger with her abusive partner and herself and focus that anger on the people who are trying to help her. This displacement could be demonstrated by the use of passive-aggressive behaviors such as missing medical appointments and refusing to follow professional advice.

Pregnancy and Partner Relationships

Other researchers have examined how changes in partner relationships, arguments, partner attitudes toward the pregnancy, adolescent developmental issues, and other conditions increase the risk of violence during pregnancy. Walker (1979) observed that partner violence tends to occur in a three-phase cycle. During the first phase, there is a gradual build-up of tension in the relationship. The second phase consist of the acute battering event. This abusive incident is then followed by the third phase, which Walker calls "the Honeymoon Period". This is the time when the partner asks for forgiveness and demonstrates love and for the battered partner. Pregnancy, because of its unique demands, facilitates the "tension-building" phase and helps to trigger the acute battering incidents. Roy (1977), in a survey of 150 cases, discovered that pregnancy was one of 9 factors that precipitated violence.

Women who have stressful experiences during pregnancy, especially if they are in a fight or have increased arguing with their partner, are at increased risk of being physically abused during pregnancy. Saltzman, Johnson, and Gilbert, et al. (2003) showed that these factors increased the likelihood of physical abuse during pregnancy.

Pregnant women who terminated their relationships with their partners tend to face increased physical and sexual violence and threats, including kidnapping, stalking, and even murder by their estranged partners. The SVP results showed that 24% of both the pregnant and the non-pregnant women indicated that their relationships with their abusive partners had ended or were in the process of ending (See **Appendix B-Study Results, Table 6**). Five percent of the pregnant and 3% of the non-pregnant women indicated that filing for their divorces and its aftermath contributed to partner abuse (See **Appendix B-Study Results, Table 6**).

One of the major causes of abuse during pregnancy is when an estranged partner uses physical, sexual, and/or psychological violence to retaliate against the pregnant woman. Pregnant women, whose estranged partners are also the fathers of their children, are especially at risk of violence. For example, in SVP Case 391C, Ms. K, who was 3-months pregnant was beaten in the head and face and had her right index finger bitten by Mr. J., the father of her children.