Perspectives on Pediatric & Adolescent Gynecology from the Allied Health Care Professional

Intimate Partner Violence and Adolescent Mothers

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Introduction

A 20-year-old mother, ‘Tasha’ walked into our clinic with her 4-year-old daughter and 6-month-old son. The children looked healthy and well cared for; Tasha appeared more tired than usual and kept her head down. She had a head scarf over her hair, pulled over one half of her forehead.

I have known Tasha for 4 years, so after initial greetings, I asked her how she was doing. Finally, she looked up, and I caught a glimpse of some bruising and swelling near the edge of her headscarf, at the side of her eyebrow.

“What happened to your eye?” Tasha reported that the father of her younger child, whom she has known for about 18 months, hit her in the eye during an argument. She said that she called the police, and he then moved out of their apartment and she had filed a restraining order against him. After some discussion, Tasha disclosed that her partner had hit her twice before their child was born, but she never discussed it with her midwife or with me, her primary care NP, because she was embarrassed and thought she could handle it on her own. She said that she realized she had to do something to stop him after their last altercation because she did not want her children to grow up seeing the violence, and she knew it was not healthy for her daughter.

Intimate partner violence (IPV) is defined as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. 1 IPV is unfortunately very common in my practice. My practice is an urban teen-tot program that provides medical care and intensive social services to teens and their children. Sometimes, the young mothers I work with will disclose violence soon after it starts; however, more often, the women will disclose the violence after it has been going on for a long period of time—months or years. At almost every office visit, my colleagues and I ask our families about violence and controlling behaviors between them and their partners and/or their relatives; nevertheless, it is still difficult for many to disclose the abuse they are experiencing. Embarrassment, shame, or feeling that they somehow deserve the abuse are among the many reasons why people do not discuss their abuse or seek help to stop it.

Many of my patients have told me that they finally sought help and left the abuser out of fear for their children’s safety.

Adolescent parents are more likely to have a history of intimate partner violence than older parents and they have a higher risk of experiencing intimate partner violence in the future. In addition, there is a very strong link between intimate partner violence and current and future depressive symptoms. A retrospective study by Lindhorst and Oxford 2 found that adolescent exposure to IPV directly correlated to higher levels of depression later on in life. Depressive symptoms were especially high in adult women who reported both adolescent IPV and adult IPV, and lowest among adult women who had no exposure to IPV. 2 Efforts to prevent intimate partner violence and to intervene early should be an integral part of all adolescent medical care. Even though many people experiencing intimate partner violence are reluctant to discuss it with their providers, care providers should ask their patients if they are experiencing IPV. Although some patients may not be ready to discuss their situation the first, second, or even third time that they are asked, consistent screening lets the patient know the provider is concerned and that help is available. According to Lindhorst and Oxford, 2 “Battered women want to be asked by their care providers about their IPV exposure, as long as this exploration is done in a way sensitive to the woman’s need for confidentiality and safety.” This means that patients should be asked about intimate partner violence or family violence in private, without any friends or family members present. It may not be possible to have the patient seen alone at every visit, but providers should make sure they have a moment alone with the patient at most visits so that there is time to ask about violence in a calm, protected environment. Ideally, it should be made a matter of clinic policy that patients be seen without their partner for at least a portion of their visit.

McCloskey et al 3 found that among women in abusive relationships, talking with a healthcare provider about the abuse increased a woman’s likelihood of receiving services and exiting the relationship, which in turn, led to better physical health as compared with women in abusive relationships who did not discuss the abuse with their

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3 Efforts...should be asked by their care providers about their IPV exposure, as long as this exploration is done in a way...confidentiality and safety.”

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This study interviewed women who had described IPV during the preceding year, and asked about physical and mental health in the month preceding the interview. While improved physical health was reported, there was no general finding of improved mental health in the short term.

Screening pregnant or parenting adolescents once a year is probably not frequently enough because pregnancy and the postpartum period are times with higher rates of abuse. In our practice we ask at least every 6 months, but more frequently during pregnancy and in the first few months after delivery. Our team has found that screening is most effective when many members of the team are involved with screening—the nurse, NP, MD, and social workers. Some patients may be reluctant to mention the abuse to a primary care provider but will bring it up with the social worker or nurse, or vice versa.

The American College of Obstetricians & Gynecologists (ACOG) recommends that all pregnant and non-pregnant women should be screened at routine ob-gyn and family planning visits. Specifically, ACOG suggests screening at the first prenatal care visit, at least once per trimester and at the postpartum check-up. In addition, whenever a patient comes in with 'suspicious' injuries such as a black eye, other facial bruising, neck bruising, or unusual genital pain, then more specific questions should be asked about possible IPV.

The ACOG website at www.ACOG.org offers a 3-question Domestic Violence Screening Tool that providers can use. In my practice, I often ask, “Do you feel safe at home? How are things with your partner or family, any hitting, punching, pushing or name calling?” I find these questions are a brief yet informative way to screen for IPV.

What should we do when a patient has disclosed IPV? In some practices, a social worker is available to talk with patients or families and guide them through the process to get her to a safe living situation and out of immediate danger. The initial goal is to help the patient develop a safety plan that provides for their immediate needs, usually a safe place for them and their children to stay, and assistance with mobilizing her social network. In some cases, police or child protective services may need to be called in. Providers should make a point of offering use of a private phone in the clinic or office because some women may not have anywhere else to make a private phone call. Having a cell phone does not mean a patient has freedom and confidentiality in her calls—frequently an abusive partner is also very controlling and may monitor cell phone, e-mail, and computer use.

If providers are not sure about what resources are available to them in their communities, then they can contact the 24-hour resource line run by the National Domestic Violence Hotline at 800-799-SAFE or www.ndvh.org for assistance. Other helpful websites for providers and patients related to IPV are: www.loveisrespect.org and www.futureswithoutviolence.org.

References