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Intimate Partner Violence and Community Service Needs Among Pregnant and Postpartum Latina Women

David P. Eisenman, MD, MSHS
David Geffen School of Medicine at UCLA

Erin Richardson, PhD
UCLA School of Public Health

Lekeisha A. Sumner, PhD
Sawssan R. Ahmed, PhD
Honghu Liu, PhD
Jeannette Valentine, PhD
Michael Rodríguez, MD, MPH
David Geffen School of Medicine at UCLA

Health care providers are advised to refer abused women to needed community services. However, little is known about abused women's perceived need for services, particularly among Latina women. We examined the relationship between intimate partner violence (IPV) and perceived needs for legal, social, and job services among a prospective cohort of 210 pregnant Latinas. IPV was associated with needing social and legal services at most time points. Women with recent IPV experiences reported greater service needs than women with more remote IPV experiences, who in turn reported greater need than women without IPV experiences. We conclude that IPV may be associated with ongoing perceived needs for social and legal services among Latina perinatal patients.

Keywords: intimate partner violence; Hispanic health; community services; pregnancy

As health care organizations debate screening for intimate partner violence (IPV) in clinical settings, research continues on how clinicians can assist survivors of IPV and on which health service responses and referrals are most appropriate for these patients (American Academy of Family Physicians Commission on Special Issues and Clinical Interests, 1994; American College of Obstetricians and Gynecologists, 1994, 1995; Nelson, Nygren, McInerney, & Klein, 2004; Nicolaidis, 2004; Ramsay, Richardson, Carter, Davidson, & Feder, 2002; Wathen & MacMillan, 2003). Pregnancy and the perinatal period may be high-risk times for partner violence generally (Martin, Mackie, Kupper, Buescher, & Moracco, 2001), and among Latinas specifically, estimates of the prevalence

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of IPV during the pre- and perinatal period range from 5% to 29% (Castro, Peek-Asa, Garcia, Ruiz, & Kraus, 2003; Gazmararian et al., 1996; Mattson & Rodriguez, 1999; Yost, Bloom, McIntire, & Leveno, 2005). Therefore, screening for IPV as part of comprehensive prenatal care may be particularly important (American College of Obstetricians and Gynecologists, 2006) for low-income Latinas who have the lowest rates of access to health care (Weinbaum et al., 2001) and for whom a health care visit provides a "window of opportunity."

Aside from its acute and chronic health consequences, IPV is associated with poverty, unemployment, housing instability, and homelessness (Bair-Merritt, Blackstone, & Feudtner, 2006; Boy & Salihu, 2004; Pavao, Alvarez, Baumrind, Induni, & Kimerling, 2007; Riger & Staggs, 2004; Shinn et al., 1998; Staggs & Riger, 2005; Wood, Valdez, Hayashi, & Shen, 1990). These social and legal problems may be brought on by impaired health and may further aggravate poor health, for instance, by reducing access to health insurance and health care services. Therefore, providing for the health and safety of abused perinatal women may require services delivered by multiple community service providers. Aside from recommending referrals to specialty health (e.g., mental health, substance abuse) and violence prevention services (e.g., shelters), it is commonly recommended that providers refer abused women to community resources, including legal, social, and job services (Raphael, 2002). These programs seek to improve the well-being of women and their children by supporting and enhancing their ability to function independently of the abusive partner. Studies consistently report that abused women consider individualized community referrals as one of the most valuable services that health care providers can offer when addressing intimate partner violence (Caralis & Musialowski, 1997; Hamberger, Ambuel, Marbella, & Donze, 1998; Petersen, Moracco, Goldstein, & Clark, 2003; Rodriguez, Quiroga, & Bauer, 1996). Specialized IPV programs located in health care settings provide referrals to these community services as a key component of their services (Fisher & Shelton, 2006; Hadley, Short, Lezin, & Zook, 1995).

A comprehensive systems model for delivering coordinated care that links adult primary care to community services has been developed (McCaw, Berman, Syme, & Hunkeler, 2001). However, specialty programs and comprehensive models may not be feasible in most health care settings, including those that provide care to low-income Latina populations. Health care systems interested in expanding services to this IPV population will find a limited evidence base for urging clinics without specialized IPV programs to develop links to community social and legal services. If these health care settings are going to develop referral resources for Latina victims of IPV, it becomes important to understand the needs of this vulnerable population. Latina victims of IPV, especially immigrant Latina victims, are particularly important to understand since studies report that they have disproportionate rates of unmet health needs (Lipsky & Caetano, 2007; Lipsky, Caetano, Field, & Larkin, 2006; West, Kantor, & Jasinski, 1998). Still, no research directly addresses Latinas' perceived needs for community services, and there are no such studies focusing on perinatal Latinas.

There may be a number of barriers uniquely experienced by Latina IPV victims that limit their ability to access services. Research suggests that sociocultural factors may affect the services desired by women victimized by intimate partner violence (Klevens, 2007; Rodriguez, Bauer, Flores-Ortiz, & Szkupinski-Quiroga, 1998; West et al., 1998). Language barriers, low income, and unemployment, all commonly experienced by Latino victims of IPV, may hinder awareness of and access to community services (Klevens, 2007;

West et al., 1998). These obstacles may be most relevant to recently immigrated Latina victims of IPV who may fear that they will be deported if they contact a social services or domestic violence agency in an effort to live safely or independently from their partners. In addition, the social isolation that some immigrants experience can limit their awareness of services. Once born, their children's welfare may be the main factor influencing Latinas' decisions to seek assistance and whether to leave their abusing partner. The fear of losing custody or impoverishment may make them hesitant to access services (Klevens, 2007). However, while it is intuitively logical that their need for services would be significant during this time, little is known about either their particular service referral needs or factors associated with their service needs during this critical period in the health of the woman and her child.

This study examines the perceived need for community services among Latinas with a history of IPV during and after their pregnancies. The specific research questions addressed are (a) how is IPV related to perceived need for particular community services, and (b) does the relationship between IPV exposure and perceived need for community services persist over time and controlling for sociodemographic and health factors?

METHODS

Study Design

Data for the present study were drawn from the baseline and first two follow-up waves of the Proyecto CUNA, a prospective, longitudinal cohort study following 210 pregnant Latina women, 92 of whom had a lifetime history of IPV exposure and 118 whom had no lifetime IPV exposure. Participants completed face-to-face interviews during pregnancy and at 3, 7, and 13 months after the births of their baby (postpartum). Outcomes of interest to this analysis were obtained at pregnancy and at 3 and 7 months postpartum but not at 13 months postpartum.

Subject Recruitment

From January 2003 to January 2004, women were recruited from the obstetric/gynecologic clinics at two private nonprofit health care organizations (one private medical center and one health maintenance organization) where more than 80% of the population was Latina. Women were eligible for inclusion if they were aged 18 years or older, self-identified as Latinas, spoke English or Spanish, were at least 12 weeks pregnant (i.e., second or third trimester), received care at one of the sites, intended to live in Los Angeles County for 12 months after the birth of their child, and planned to raise their child during their first year of life. Baseline (prenatal) interviews took place between April 2003 and March 2004. The 3-month postpartum interviews were conducted from September 2003 to July 2004. The 7-month postpartum interviews were conducted from December 2003 to January 2005. Each respondent was interviewed in person using a structured questionnaire by a bilingual Latina researcher. Participants were compensated $20 for their time. The UCLA institutional review board (IRB) and local IRBs reviewed and approved the study.

Full details of the study recruitment procedures are published elsewhere (M. Rodriguez et al., 2008). Briefly, the recruitment goal was to have roughly equal representation of pregnant women who reported exposure to IPV (IPV+) and women who reported no exposure to IPV (IPV–). All women attending the clinics were approached by research staff and

informed about the study while they waited to be seen for appointments (n = 1,728). Of the 1,728 potentially eligible women who were originally approached for the study, 140 refused screening, while 44 women were either approached twice or were lost before they could be approached, leaving 1,544 who were actually screened. If a respondent expressed interest in the study and met the inclusion criteria, she was screened before or after her obstetric visit in a private area by the interviewer to determine study eligibility. Of these 1,544 women, 682 screened eligible, while 862 screened ineligible. Of these 682 eligible women, nine IPV+ women and 46 IPV– women refused enrollment, while 417 IPV– women were turned away because of the quota of IPV– women being filled. This left 118 IPV– and 92 IPV+ women (total n = 210) who were enrolled in the study.

Measures

IPV status was ascertained using the four-question Abuse Assessment Screen (AAS), which addresses experiences of being made to feel fearful or insecure or being physically or sexually abused by a partner (McFarlane, Parker, & Soeken, 1995). The AAS assesses for abuse within the past 12 months and was developed for both pregnant and nonpregnant women. This measure was adapted to additionally assess lifetime experiences of abuse. Criterion-related validity for the AAS was established by comparing responses to individual items on the AAS with scores from other violence scales that have demonstrated reliability and validity and have been used in family violence research. A significant positive relationship ($p < .01$) was found between the AAS and the other instruments, while reliability was established at 97.5% using a test–retest method (Soeken, McFarlane, Parker, & Lominack, 1998). Exposure to IPV was assessed at all three interviews.

Perceived need for services was determined by an affirmative response to one of three items. Perceived legal services need was determined by the item, "In the past 12 months, have you needed legal services to help you with problems of child custody, immigration, family violence, or other legal problems?" Perceived social services need was determined by the item, "In the past 12 months, have you needed any social services such as housing services, child care and other child services, support groups, or alcohol/drug treatment?" Perceived job services need was determined by the item, "In the past 12 months, have you needed services for job preparation such as language or computer skills or a GED program?" At the second and third follow-up assessments, the items were appropriately modified and repeated (e.g., "Since our last interview in [month and year inserted], have you needed any . . . ?"). Other items included age, total family income in the previous year, employment status, martial status, nativity (foreign/U.S. born), interview language, and self-reported general health status. Self-reported general health status was assessed with the single item from the SF-36, which states, "In general, would you say you health is . . ." Responses are scored on a five-category Likert scale as excellent, very good, good, fair, and poor (Ware & Sherbourne, 1992). This item predicts health outcomes and services utilization in diverse populations (DeSalvo, Fan, McDonell, & Fihn, 2005).

ANALYSES

To examine the proportion of participants with perceived need for services at each wave, we assigned them to one of three IPV exposure groups at each wave: participants

reporting IPV in the past 12 months (recent IPV), participants reporting IPV more than 12 months ago (ever IPV), and participants who reported never experiencing IPV (IPV–). Repeated measures modeling with generalized estimating equations (GEE) was used to test for differences in the need for services as a function of IPV status over time, controlling for demographic differences and associations of interest. GEE models enable analyses to model dichotomous outcome variables with correlated longitudinal data and clustered data. To overcome the problem of small cell sizes resulting from the three-level IPV variable, we derived a dichotomous indicator of IPV status coded "1" for participants reporting IPV at any time (ever plus recent) and "0" for participants who were IPV–. First, analyses examined univariate descriptive statistics of the outcomes and all covariates. A correlation matrix revealed no evidence of multicollinearity among covariates. Second, analyses assessed the bivariate relationships between our dependent variables (legal, social, job) with IPV status and the other covariates of interest (age, income, employment, marital status, nativity, interview language, health status). Marginal repeated measures GEE models with chi-square testing were used to assess the strength of associations between outcome measures and each of the covariates. Third, all covariates that were significantly related with outcome measures were placed into multivariate repeated measures models accounting for legal and social service needs. A p value $\leq .05$ was considered significant in our analysis, and only the variables IPV status, income, and marital status reached significance to be included. Additionally, nativity and health status were added to the models because of their importance to our research aims. Multivariate modeling of job service need was not performed since IPV status was not associated with job service need.

RESULTS

The sample ranged in age from 18 to 42 years old. They were predominantly foreign born (76.2%) and unemployed (55.6%) and earned less than $20,000 in the past year (60.6%) (Table 1). Among the IPV+ women, 80.4% reported that their partners or ex-partners had threatened them or made them feel afraid or unsafe, and 71.7% reported that they had been physically harmed by their partners or ex-partners. A smaller percentage (19.6%) of IPV+ participants reported being forced to partake in undesired sexual activity. IPV+ women were significantly older, nonmarried, and U.S born and earned lower incomes compared to IPV– women.

At all three time points recent IPV+ women and ever IPV+ women reported significantly greater need for legal services than IPV– women. At the prenatal interview, 27.2% of recent IPV+ women reported needing legal services compared to 27.1% of ever IPV+ women and 10.2% of IPV– women ($p = .006$). At 3 months postpartum, 19.3% of recent IPV+ women reported needing legal services compared to 13.4% of ever IPV+ and 4.6% of IPV– women ($p = .03$). Finally, at 7 months postpartum, 29.0% of recent IPV+ women reported needing legal services compared to 12.1% of ever IPV+ and 7.6% of IPV– women ($p = 0.006$) (Table 2). At both prenatal and 3 months postpartum, recent and ever IPV+ reported greater need for social services than IPV– women, though it was statistically significant only at the $p < .05$ level at 3 months postpartum when 46.2% of recent IPV+ women reported needing social services compared to 25.4% of ever IPV+ women and 11.0% of IPV– women ($p < 0.001$). The differences in need for job services at the prenatal and 3 month postpartum assessments were not statistically significant.

TABLE 1. Baseline Characteristics of Study Participants by IPV Status (n = 210)

Characteristic	IPV+ (n = 92)	IPV– (n = 118)	p Value
Age, years (mean [*SD*])	29.4 (0.62)	26.5 (0.49)	<0.001
Income			
≤$20,000	52.3%	67.0%	0.04
>$20,000	47.7%	33.0%	
Employment status			
Full/part-time work	53.3%	37.4%	0.02
Not working	46.7%	62.6%	
Partner status			
Married	81.5%	93.2%	0.01
Single/divorced/separated	18.5%	6.8%	
Birthplace			
United States	30.4%	18.6%	0.05
Non–United States	69.6%	81.4%	
Language of interview			
English	46.7%	33.9%	0.06
Spanish	53.3%	66.1%	
Health status			
Excellent/very good/good	76.1%	78.0%	0.75
Fair/poor	23.9%	22.0%	

Note. SD = standard deviation.

Overall, 43.8% of recent IPV+ women and 40.0% of ever IPV+ women reported needing legal services at any time during the study period compared to 14.2% of IPV– women (p < .001). Similarly, 46.9% of recent IPV+ women and 46.7% of ever IPV+ women reported needing social services at any time during the study period compared to 29.3% of IPV– women (p = .04).

The greater need for legal and social services among IPV+ women persisted after controlling for marital status, birthplace, income, and health status in our generalized estimation equations. IPV+ women had a greater odds of reporting a need for legal services (adjusted odds ratio [OR] 2.30, 95% confidence interval [CI] 1.15, 4.62) and social services (adjusted OR 2.18, 95% CI 1.21, 3.95) than IPV– women (Table 3). Marriage and good health status were both associated with reduced need for legal services (adjusted OR 0.36, 95% CI 0.14, 0.90; adjusted OR 0.44, 95% CI 0.25, 0.78, respectively). An income greater than $20,000 was associated with a reduced need for social services (adjusted OR 0.47, 95% CI 0.24, 0.94). There was no difference in service needs between Latina women who were born in the United States compared to those born outside the United States.

TABLE 2. Proportion With Each Service Need by IPV Status in the Prenatal and Postpartum Periods and Overall

	Prenatal, % (*n*) *N* = 210			3 Months Postpartum, % (*n*) *N* = 203			7 Month Postpartum, % (*n*) *N* = 194			Overall, % (*n*)		
IPV Status	IPV Recent	IPV Ever	IPV–	IPV Recent	IPV Ever	IPV–	IPV Recent	IPV Ever	IPV–	IPV Recent	IPV Ever	IPV–
Service												
Legal	27.2 (6)	27.1 (19)	10.2 (12)	19.3 (5)	13.4 (9)	4.6 (5)	29.0 (9)	12.1 (7)	7.6 (8)	43.8 (14)	40.0 (23)	14.2 (15)
		$p = .006$			$p = .03$			$p = .006$			$p < .001$	
Social	27.2 (6)	15.7 (11)	10.2 (12)	46.2 (12)	25.4 (17)	11.0 (12)	13.3 (4)	19.0 (11)	16.2 (17)	46.9 (15)	46.7 (28)	29.3 (31)
		$p = .09$			$p < .001$			$p = .79$			$p = .04$	
Job	18.2 (4)	18.6 (13)	13.6 (16)	15.4 (4)	9.0 (6)	6.4 (7)	6.9 (4)	6.9 (4)	7.6 (8)	29.0 (9)	28.8 (17)	21.2 (22)
		$p = .62$			$p = .33$			$p = .35$			$p = .46$	

TABLE 3. Adjusted Odds Ratios for Legal and Social Services From Prenatal Period Through 7 Months Postpartum

	Legal Services			Social Services		
Variable	Adjusted OR	95% CI	*p* Value	Adjusted OR	95% CI	*p* Value
IPV exposure	2.30	(1.15, 4.62)	0.02	2.18	(1.21, 3.95)	0.01
Married	0.36	(0.14, 0.90)	0.03	0.75	(0.34, 1.66)	0.48
U.S. born	1.49	(0.67, 3.32)	0.33	1.32	(0.67, 2.63)	0.42
Good or better health	0.44	(0.25, 0.78)	<0.01	0.60	(0.34, 1.05)	0.07
Income >$20,000	0.57	(0.26, 1.25)	0.16	0.47	(0.24, 0.94)	0.03

Note. Reference groups: no IPV exposure, not married (single/divorced/separated), non–U.S. born, fair/poor health, income <$20,000. Adjusted OR = adjusted odds ratios; 95% CI = 95% confidence intervals.

DISCUSSION

This study of the relationship between IPV and the ongoing need for services among Latinas in perinatal care supports the utility of maintaining links between such clinics and community services for the social and legal needs of battered women. IPV was associated with needing social and legal services at most time points. Women with recent IPV experiences reported greater service needs than women with more remote IPV experiences, who in turn reported greater need than women without IPV experiences. The multivariate models reveal IPV continues to be associated with these perceived needs after controlling for poverty, marital status, birthplace, and health status.

Several theories explain how IPV might influence women's needs for social and legal services. Feminist theory posits that male violence against women serves to support male societal dominance, such as by restricting women's obtaining legal immigration status or living apart from her husband (Gelles, 1993). There is some evidence that battered women can be prevented from using needed services by male partners who may use physical or emotional methods to control their partners' behavior (Logan, Evans, Stevenson, & Jordan, 2005; Sleutel, 1998). Although our study does not identify the role of the male partner in women's service needs, our results are to some extent consistent with these theoretical formulations since the association between IPV and women's perceived needs for services was not explained by individual characteristics of the abused women, though variables that may have been important, such as immigration status, were not collected. Similarly, trauma theories posit that traumatic stressors such as IPV are associated with impaired access to beneficial resources (Herman, 1992). One pathway conceives that trauma is associated with poorer physical and mental health, which itself may lead to impaired ability to obtain beneficial resources, such as job, social, or legal services. In our study IPV was associated with increased need for social and legal services, even controlling for health status. This implies that the relationship between abuse and the need for greater services was independent of one's health status. Nevertheless, participants who reported better health status were less likely to report a need for legal services, thereby providing limited support for theories that link better health to better access to resources.

Although this is the first longitudinal analysis of the social and legal services needs of women attending primary care, this study has limitations. First, self-reported measures of service need may be influenced by recall and social desirability biases. Second, IPV+ women reported greater need for these community resources, but the interview did not characterize or quantify which specific needs they had. For instance, legal problems may have ranged from obtaining a restraining order to filing for divorce to immigration-related concerns. Third, the study did not assess access to and use of these services. Fourth, given the sample size, this study had to limit the number of covariates, so omitted variable bias with the concomitant possibility that something other than IPV explains the results needs to be considered. Similarly, variables that were not collected may be important, such as women's immigration status (e.g., documented vs. nondocumented) and acculturation. Finally, only pregnant Latinas attending perinatal care were included in the study, limiting our ability to generalize to other women in primary care clinics. Since all these women had newborn children in the home, future research might inquire about the effect of Latina mothers' specific unmet needs (e.g., housing stability, protection from partner) on caregiving and the health of their children.

While researchers await these studies, health care systems and providers must continue to address intimate partner violence in their Latina patients. Health care providers have critical access to battered women during the times of their pregnancy and in the postpartum period. While abusive partners may restrict a woman's access to social services organizations, they usually allow women to seek medical care for their children (Raphael, 2000). Yet physicians working with new mothers fail to identify battering despite evidence that most physicians and patients, including Latina women, favor inquiries about abuse (Martin et al., 2001; Ramsay et al., 2002; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Our study results underscore the need for routine inquiry about domestic violence among Latina women. However, aside from routine inquiry about domestic violence, health care providers dealing with at-risk pregnant women and their young children should have mechanisms in place for effectively linking battered women to relevant community services. Studies document that identifying abused women in health care settings leads to increased referrals to community resources, such as social services (Ramsay et al., 2002; Wathen & MacMillan, 2003). Our results indicate that protocols are particularly needed for effectively linking battered Latina women to relevant social and legal services.

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Correspondence regarding this article should be directed to David P. Eisenman, MD, MSHS, Division of General Internal Medicine and Health Services Research, Department of Medicine, David Geffen School of Medicine at UCLA, Los Angeles, CA 90024. E-mail: DEisenman@mednet.ucla.edu