# An exploration of Australian midwives' knowledge of intimate partner violence against women during pregnancy


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**Title page**

# An exploration of Australian midwives' knowledge of intimate partner violence against women during pregnancy

**Running head: Partner violence knowledge**

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**Abstract**

*Background:*

Intimate partner violence is now recognised as a global public health issue. Living with intimate partner violence results in a poorer health status with reduced quality of life and higher utilisation of health services. Increased awareness, education and training and an understanding of multi-agency working are vital for shaping attitudes and providing skills which will support health practitioners to respond to women who are subjected to partner violence and abuse. Midwives are well placed to identify, provide immediate support and refer women onto appropriate support agencies but may lack appropriate education, training or support.

*Aim:* To investigate midwives' knowledge of intimate partner violence against women during pregnancy.

*Methods:* An online survey link was distributed through the Australian College of Midwives. The survey included personal and professional details, and 25 questions that tested knowledge about intimate partner violence.

*Findings:* 152 midwives completed the online questionnaire. Knowledge scores ranged from 27 to 48 (out of a possible 50), with the mean total score of 42.8 (SD = 3.3). Although 60 percent of participants scored 48 or more, two thirds did not know about the risks and signs of intimate partner violence. One third of midwives did not know about age risks associated with intimate partner violence. Around 25 percent incorrectly believed that perpetrators are violent because of alcohol or drug use. Nearly ninety percent (88%) of participants had some education or training about intimate partner violence. Those with some training achieved higher knowledge scores than those with no formal training (Mann Whitney U =1,272, p = .003).

*Conclusion:* This sample of midwives generally reported a high level of knowledge about intimate partner violence. Specific training and education about intimate partner violence was beneficial in

improving knowledge. Misconceptions about risks and characteristics of perpetrators of violence need to be addressed in future training and education on intimate partner violence.

**Keywords:** Australia, intimate partner violence, knowledge, midwives, pregnancy

**An exploration of midwives' knowledge of intimate partner violence against women during pregnancy**

## Introduction

Intimate partner violence (IPV) is a global health issue[1]. Pregnant women who have experienced partner physical or sexual violence, or both are significantly more likely to report having had at least one induced abortion than women who have never experienced partner violence[1]. Between one quarter and one half of all women physically abused during pregnancy were kicked or punched in the abdomen, with between 8% and 34% reporting that the violence got worse during the pregnancy. However, between 13-50% of pregnant women are abused for the first time during pregnancy.[1] In Australia, 34 per cent of women experience at least one form of violence from a partner.[2] Experiencing IPV during pregnancy is of special concern as the violence not only poses a threat to the woman but also to her fetus. The consequences of IPV during pregnancy include a higher incidence of neonatal death, premature labour, low birth weight infants and miscarriage.[3,4] Governments and professional bodies have published policy statements promoting the implementation of routine antenatal enquiry during pregnancy, however, the overall response from many health sectors has been poor.[5]

Women experiencing IPV often seek help from a wide range of health care professionals.[6] The central role of midwives in the provision of antenatal care provides opportunities for them to routinely enquire about IPV.[7] However, there is a reluctance by midwives to ask women about partner violence due to perceptions about the private delicacy of the subject and routine presence of a partner at every visit.[8,9] Other barriers to routine inquiry include time constraints, oversight due to preconceived ideas about victims of abuse, language difficulties, and lack of knowledge and training.[8,10-12] Despite midwives' hesitancy in asking women about violence in their relationship, women themselves find the questioning acceptable in maternity settings.[9,13,14] Such inquiry needs to be made in a sensitive manner by a well trained professional in a safe, confidential environment.[9,15] Knowledge about IPV needs to underpin midwives' enquiries.

Clinicians frequently underestimate the prevalence of IPV and have misconceptions about victim characteristics, risk factors, signs and symptoms of violence and co-morbidity patterns relating to violence.[9,15-17] This lack of knowledge is one of the major factors contributing to the failure of health professionals to screen, detect, or acknowledge violence among women.[10] One survey with 96 nurses working in postpartum units in three Canadian urban hospitals found that 37.6% of nurses reported a lack of knowledge as the most important barrier to screening, followed by systemic factors (29%) such as lack of hospital protocols and screening tools.[12] Lack of knowledge was also was significantly related to the frequency of screening for different forms of violence (physical, sexual and emotional).[12]

In the United Kingdom, Jackson & Fraser[18] reported that 56% of midwives did not feel adequately prepared to deal with disclosure of sexual abuse, with a further 29% being 'unsure'. In this study community midwives rated themselves as more able to deal with disclosures of sexual abuse compared with hospital-based midwives. Similarly, in a survey of nearly 200 Swedish primary health care nurses, 86% considered themselves to be insufficiently prepared to manage women exposed to IPV.[19]

Due to the nature of the midwife's role and the intimacy of the relationship that can develop with a woman, midwives may be the first person to whom a woman may feel confident to disclose about violence within her relationship. However, this can only occur if the midwife feels knowledgeable and confident about asking women about IPV, yet comparatively few studies have focussed specifically on knowledge about IPV. This paper presents findings of a descriptive cohort study which aimed to explore midwives' knowledge relating to intimate partner violence against women during pregnancy.

**Participants and Methods**

A convenience sample of midwives was recruited through the Australian College of Midwives (ACM). Inclusion criteria were midwives engaged in antenatal maternity service provision. Members of ACM include midwifery clinicians, academics, researchers and policy makers. It is therefore difficult to determine the proportion of members engaged in direct antenatal care provision. Current membership of the ACM during the survey period was around 4000.

The online survey link was distributed through an electronic bulletin of the Australian College of Midwives. The bulletin contained a direct link to the on line survey. The survey was open from September to December 2013. The link also contained an information sheet about the study.

**2.1 Measures**

The online survey included questions about personal details, educational qualifications, years of experience, training about IPV, and knowledge about partner violence. The Knowledge Scale of the PREMIS (Physician Readiness to Manage IPV Scale)[20] was reviewed for use with midwives in Australia. The original scale included 6 multiple choice items, an item requiring matched responses about stage of change to five different behaviours, and 11 questions requiring a true/false/don't know response. A critical review of the scale and consultation with an expert panel indicated the need for several changes in order to reduce duplication of item topics (such as alcohol abuse, and characteristics of victims and perpetrators); removal of items about 'stage of change' as not all respondents would be familiar with this approach; removal of items about practice rather than knowledge; and adoption of one form of response option.

Twenty-five questions on knowledge about IPV, with responses on a scale of "true", "false" and "unsure" were used. Correct answers attracted a score of 2, unsure responses received a score of 1, and 0 for incorrect responses. Examples of questions were "a family history of abuse increases a woman's risk of IPV" and "a woman experiencing violence may not be able to leave a relationship because of the needs of her children". Three items (6, 7, 8) were reversed scored. The online survey was piloted with 8 clinical midwives for face validity. Following feedback from the midwives the survey was modified accordingly enhancing its lucidity.

**Data Analysis**

Survey responses were converted from excel into a SPSS database Version 20. Data were analysed using descriptive statistics. Shapiro-Wilk test for normality was performed and was significant (<0.001), therefore non-parametric tests such as spearman rho, Mann-Whitney U-test, and Kruskal Wallis test were used.

**Ethics**

Ethical approval was obtained from Griffith University Human Research Ethics Committee.

**2.3. Findings**

One hundred and fifty-two surveys were received and could be analysed. The majority of participants (98%) were females. Participants' ages ranged from 23 to 69 years with a mean age of 46.3 years. In regards to highest qualification 40.8% (n = 62) held a certificate or diploma, a third had a degree (n = 53, 34.9%) and the remainder held a masters or doctoral degree (n = 33, 21.7%). The mean number of years as a qualified midwife was 17.6 years. The majority of participants (80.9%) practised in a public hospital. Almost half (48.6%) worked part-time, and others worked fulltime (45.3%). Participant characteristics are outlined in Table 1.

In regards to educational preparation about IPV, one third of participants (33.6%) indicated no IPV education during their pre-registration midwifery program while half (51%) stated they received a "minimal amount" of IPV education. However, a greater proportion of respondents had received some form of workplace training about IPV (n = 125, 82.2%). Attending a lecture or talk (61.6%) was the most common type of training, followed by reading the hospital policy (44%), and attending a skill-based workshop (39.2%).

**Midwives' knowledge of intimate partner violence**

Knowledge of IPV scores ranged from 27 to 48, with the mean total score of 42.8 (SD = 3.3), as shown in Table 2. Over sixty percent of participants answered 24 out of 25 knowledge questions correctly. Misconceptions were evident with the majority of participants (88.6%) being unsure or not knowing that chronic unexplained pain is a warning sign that a woman may have been abused. A quarter of participants (25.6%) believed that perpetrators are violent because they drink or use drugs. Around 60% of midwives (60.9%) did not know or were unsure if younger women were at increased risk of IPV. A third of respondents (33.1%) did not know or were unsure that women are at greater

risk of injury when they leave a violent relationship. Table 2 outlines participants' responses to the knowledge questionnaire.

**Associated factors**

Factors associated with midwives' knowledge of IPV were also investigated. There was no significant relationship between knowledge and number of years as a qualified midwife and employment status. However, a significant relationship was found between knowledge and training on IPV ($p<0.05$). Midwives who reported some training had a higher knowledge score compared to those who reported no training (Mann Whitney U =1,272, p = .003).

Knowledge scores influenced practice with almost half (46.3%) of participants reporting that they asked women about partner violence "a great deal" of the time ($p = 0.035$). Regarding the disclosure of partner violence, 41.4% of participants indicated 1 in 5 of their clients had disclosed experiences of old or new abuse in the last six months. However, there was no significant relationship between knowledge score and midwives' reported rate of disclosure by women.

**Discussion**

Internationally the provision of IPV training and education for midwives and other health care professionals continues to inconsistent and sporadic.[5] The current study found that these Australian midwives who completed the online survey had a good level of knowledge related to IPV against women with a mean total score of 42.8 out of 50. These results, however, need to be considered in light of limitations associated with the study such as sampling bias, validity of the measure used, and potential response bias. Although we were unable to accurately determine a response rate, it is clear that the number of participants was low from the potential pool of midwives who are currently providing antenatal care. It could be that the topic was not of interest; the notion of "testing" knowledge was a barrier, or that distributing the survey at the end of the year was not an optimal time. It could be that midwives with an interest in IPV completed the survey and these midwives differ in their commitment to education or their clinical practices from those who declined.

Steps were taken to adapt the recognised PREMIS tool for midwives working in the Australian context. The use of a true/false response option does allow for a less intensive/threatening experience for respondents. The dichotomous response approach also allows for a total score to be calculated and some items were negatively worded to minimise response bias and encourage a more thoughtful process by respondents. However, the true/false format can result in higher overall scores due to the probability of a correct guess. We attempted to overcome this by providing an "unsure" option. Yet despite the high overall score, some midwives held misconceptions or were "unsure" about issues related to IPV.

**Common misconceptions about IPV**

Common misconceptions about IPV related to characteristics of women and their partners, and signs and symptoms. A third of respondents believed that perpetrators are violent because they drink or use drugs. Whilst there is an acknowledgement that alcohol and drug use can be a significant factor and increase the risk of violence in a relationship where IPV is already occurring,[21] it is not considered a common reason for the violence occurring but more likely to be a consequence.[22] Not every man who drinks alcohol or takes drugs will be abusive towards their partner.

Around sixty percent of midwives did not know or were unsure that younger women are at increased risk of IPV. Data clearly shows that younger women are at a greater risk of experiencing violence than older women. Australian statistics suggest young women are at higher risk of experiencing violence that older women, with 13% of the women aged 18 to 24 years experiencing violence in the last 12 months whereas 8.1% of women aged 25 to 34 years had experienced violence in that period.[2] The World Health Organisation[23] reported that younger women especially those aged 15 to 19 years are particularly at risk for physical and sexual violence, suggesting this pattern may well reflect that younger men tend to more violent than older men and violence may start early in a relationship.

Another misunderstanding related to the risk of violence that women face when they leave the relationship. Research indicates that women attempting to leave or having just left a relationship are in

danger of violence from their partner and are more likely to be murdered than women who stay.[5]

**Knowledge and practice**

The current results indicated a consistent relationship between higher knowledge levels and frequency of asking women about IPV. This finding confirms previous research in other countries such as Canada[12] the UK[9,18] and Scandinavian countries[19] that found lack of knowledge to be an important barrier to the frequency of screening for physical, emotional and sexual abuse. The presence of a screening tool and protocols alone are insufficient to ensure screening and ongoing education should be provided. Barriers affecting screening practices must first be identified and then addressed prior to implementing new screening policies and procedures. A five year follow up study by Baird et al [9] which evaluated the degree to which midwifery practice changed in the Bristol Pregnancy Domestic Violence Programme (BPDVP) found IPV enquiry had been maintained. They concluded that training increased participants' knowledge of screening for IPV with 61% reporting 'a great deal' of knowledge compared with 42% in 2005. This suggests that on-going education and training results in a responsive and pro-active approach towards IPV by midwives.

Robust educational programmes are vital if midwives are to screen and support women experiencing IPV, midwives need to have developed knowledge about the topic and most importantly know how to communicate about this sensitive topic with women. Indeed, Roughton[24] argues that if health professionals do not know what to assess for, or how to ask a woman, they will miss important cues or not ask about issues related to IPV. The findings from the current study indicate the need for ongoing education on IPV to be provided to midwives.

Guillery et al[12] suggested that lack of knowledge about IPV may be due to this content not being addressed in undergraduate curricula. . In the current study one third of participants indicated that IPV was not addressed at all in their midwifery education program while half indicated that they received a "minimal amount" of IPV education. The results are consistent with a study conducted by Haagbloom et al[25] who found that very few nurses (22%) had received information about violence against women in their basic nursing education. Similarly, a study by Jackson & Fraser[18] found very few midwives

reported receiving education/training to identify and support abused women. Most midwives stated they would like more education and training on IPV.

Reported rates of workplace training were higher with nearly ninety percent of midwives in the current study reporting some training about IPV. Those with some training had higher knowledge scores compared to those who did not have any training. These findings are consistent with previous studies. Paluzzi et al[26] found an improvement in knowledge and attitudes regarding IPV among nurses who attended a 1-day continuing education session. Similarly, Protheroe et al[27] reported a greater awareness and understanding of IPV with an increased probability of midwives identifying women once they had undergone a training programme designed to increase their awareness and knowledge of violence against women.

It can be seen that education and training reinforce best practice guidelines in IPV.[28] Education and training also provide an efficient and effective method for midwives to understand and address IPV. Connor et al[29] found that education and training can also influence attitudes and behavioural intentions of nursing professionals and students by helping combat future negative feelings when dealing with situations related to IPV. There is evidence that midwives do not feel able to deal with victims of partner violence if there is a gap in their knowledge and practice.[13,30] In a UK study, Price et al[30] concluded that midwives require undergraduate and postgraduate education programs, combined with ongoing workplace support if they are to become knowledgeable, confident and effective in routine antenatal enquiry for partner violence.

**Conclusion**

There is no doubt that many midwives find discussing IPV with women during pregnancy challenging especially when they have received little or no education or training to support them in this role. Responding to IPV requires knowledge of the risk factors, signs and symptoms and consequences for a woman who may be trying to survive a violent relationship. Dealing with IPV can be complex and challenging and midwives must be alert to the signs of a woman who may be in a violent relationship.

Midwives must be able to ask women about IPV in a compassionate and sensitive manner. It is also important that midwives understand how living with violence can affect women and their children in order to routinely enquire and respond compassionately.

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**Table 1 Participant characteristic**

| **Demographic data** | **n** | **(%)** |
|---|---|---|
| **Gender** | | |
| Female | 148 | 98 |
| Male | 3 | 2 |
| Missing | 1 | |
| **Age** | | |
| Range 23-69 years | | |
| Mean 46.3 | | |
| SD = 10.15 | | |
| **Number of year working as a qualified midwife** | | |
| Range 0-45 years | | |
| Mean 17.16 years | | |
| SD = 11.09 | | |
| **Highest education level** | | |
| Certificate | 31 | 20.4 |
| Diploma | 31 | 20.4 |
| Degree | 53 | 34.9 |

| | | |
|---|---|---|
| Master's degree | 28 | 18.4 |
| PhD | 5 | 3.3 |
| **Current area of practice** | | |
| Public hospital | 123 | 80.9 |
| Community | 47 | 31 |
| Private hospital | 20 | 13.1 |
| Other | 12 | 7.9 |
| **Work frequency** | | |
| Part time | 81 | 54.7 |
| Full time | 67 | 45.3 |
| **The extent to which IPV was taught during their midwifery education** | | |
| Not at all | 48 | 33.6 |
| Minimal amount | 73 | 51 |
| Moderate amount | 13 | 9.1 |
| Great deal | 6 | 4.2 |
| Unsure | 3 | 2.1 |

| | | |
|---|---|---|
| **Having received any training about IPV** | | |
| None | 17 | 12 |
| Some | 125 | 88 |
| **Type of education/training about IPV** | | |
| Attending a lecture or talk | 77 | 61.6 |
| Reading the hospital policy | 55 | 44 |
| Attending a skill- based workshop | 49 | 39.2 |
| Other in-depth training (over 4 hours) | 41 | 32.8 |
| Watching a DVD | 40 | 32 |
| Other | 21 | 16.8 |

**Table 2 Participants' knowledge about IPV (n=152)**

| Questions | Answered correctly (%) | Answered incorrectly (%) | Unsure (%) |
|---|---|---|---|
| Being under 30 years of age increases your risk of experiencing partner violence | 39.1 | 35.3 | 25.6 |
| A women is more at risk of IPV if her partner abuses alcohol/drugs | 98.5 | 0.8 | 0.8 |
| Being female increases your risk of experiencing IPV | 93.2 | 4.5 | 2.3 |
| A family history of abuse increases a woman's risk of IPV | 95.5 | 2.3 | 2.3 |
| Perpetrators of violence have trouble controlling their anger | 80.5 | 12.0 | 7.5 |
| Perpetrators are violent because they drink or use drugs | 61.7 | 25.6 | 12.8 |
| Perpetrators of violence are aggressive with anyone | 78.9 | 9.8 | 11.3 |
| Chronic unexplained pain is a warning sign that a woman may have been abused by her partner | 11.4 | 60.6 | 28 |
| Anxiety is a warning sign that a woman may have been abused by her partner | 78.2 | 6.8 | 15.0 |
| Substance abuse is a warning sign that a woman may have been abused by her partner | 66.2 | 13.5 | 20.3 |
| Frequent unexplained injuries are a warning sign that a | 99.2 | 0 | 0.8 |

| | | | |
|---|---|---|---|
| woman may have been abused by her partner | | | |
| Depression is a warning sign that a women may have been abused by her partner | 69.9 | 8.3 | 21.8 |
| A women experiencing violence may not be able to leave a relationship because of fear of retribution from her partner | 98.5 | 0 | 1.5 |
| A woman experiencing violence may not be able to leave a relationship because of financial dependence on the perpetrator | 100 | 0 | 0 |
| A woman experiencing violence may not be able to leave a relationship because of religious beliefs | 99.2 | 0 | 0.8 |
| A woman experiencing violence may not be able to leave a relationship because of the needs of her children | 94.7 | 3.0 | 2.3 |
| A woman experiencing violence may not be able to leave a relationship because of the love she has for her partner | 90.2 | 2.3 | 7.5 |
| A woman experiencing violence may not be able to leave a relationship because of isolation | 100 | 0 | 0 |
| There are common, non-injury presentations of abused women | 72.7 | 3.0 | 24.2 |
| There are behavioural patterns in couples that may indicate IPV | 84.8 | 1.5 | 13.6 |
| There are specific areas of the body are most often | 66.9 | 3.8 | 29.3 |

| | | | |
|---|---|---|---|
| targeted IPV cases | | | |
| There are common injury patterns associated with IPV | 66.4 | 1.5 | 32.1 |
| Bruises and injuries in different stages of healing may indicate abuse | 96.2 | 0 | 3.8 |
| Survivors of IPV are at greater risk of injury when they leave the relationship | 66.9 | 12.8 | 20.3 |
| Even if the child is not in immediate danger, midwives in all states are mandated to report an instance of a child witnessing violence in the home to Children Services | 90.2 | 3.0 | 6.8 |