901 Recipient of Abuse

Definition/Cut-off Value

Recipient of abuse is defined as an individual who has experienced physical, sexual, emotional, economic, or psychological maltreatment that may frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, and/or wound the individual (1).

The experience of abuse may be self-reported by the individual, an individual's family member, or reported by a social worker, healthcare provider, or other appropriate personnel. Types of abuse relevant to the WIC population include, but are not limited to, the following:

- **Domestic violence**: abuse committed by a current or former family or household member or intimate partner (2, 3, 4).
- **Intimate partner violence** (IPV): a form of domestic violence committed by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner) that may include physical violence, sexual violence, stalking, and/or psychological aggression (including coercive tactics) (5).
- **Child abuse and/or neglect**: any act or failure to act that results in harm to a child or puts a child at risk of harm. Child abuse may be physical (including shaken baby syndrome), sexual, or emotional abuse or neglect of an infant or child under the age of 18 by a parent, caretaker, or other person in a custodial role (such as a religious leader, coach, or teacher) (6, 7, 8).

Participant Category and Priority Level

Category	Priority
Pregnant Women	IV or VII
Breastfeeding Women	IV or VII
Non-Breastfeeding Women	VI or VII
Infants	IV or VII
Children	V or VII

Justification

Abuse is a serious public health problem with numerous individual and societal consequences. Women and children who experience abuse often suffer from immediate and long-term physical and emotional health consequences. It has been estimated that the per-victim lifetime cost (including medical costs, lost work productivity, criminal justice, and other costs) is $103,767 for women who experience IPV and $830,938 for children who experience maltreatment (4, 9). Although abuse is prevalent, it is often under-reported for a multitude of reasons. Many statistics related to IPV are reliant on self-report by the recipient. Women may be hesitant to report IPV or seek help from health care providers due to reasons such as financial dependence on the abusive partner, fear of further abuse, fear of stigmatization, and shame (10, 11).

Additionally, screening and evaluation for abuse, particularly IPV, is often inconsistent in the medical community (11, 12).

Impact on Maternal Health

Data from the 2015 National Intimate Partner and Sexual Violence Survey (NISVS) indicate that about 1 in 3 women in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime (13). According to the National Center for Injury Prevention and Control, women in the U.S. experience about 4.8 million intimate partner-related physical assaults and rape each year (14). Between 2016 and 2018, the number of IPV incidents in the U.S. increased by 42% (15). The highest rates of IPV are generally experienced by women between the ages of 18 to 34 and nearly three quarters of all women recipients of IPV first experienced IPV before the age of 25 (13, 16). An estimated 11.6 million females between the ages of 11 and 17 years reported having experienced IPV (13). According to the NISVS, some ethnic minorities are disproportionately affected by IPV. The table below summarizes lifetime prevalence of IPV among women of various ethnicities (17):

Race/Ethnicity	Lifetime Prevalence of IPV
Multi-Racial, Non-Hispanic	57%
American Indian/Alaska Native, Non-Hispanic	48%
Black, Non-Hispanic	45%
White, Non-Hispanic	37%
Hispanic	34%
Asian or Pacific Islander	18%

Research suggests that the disclosure of IPV and seeking of services by certain racial/ethnic groups may be deterred due to a mistrust of the medical community, lack of cultural sensitivity, fear of stigmatization and inability to access services (10). Higher rates of IPV are experienced by immigrant women, especially among Latina and Asian women (18). Immigrant women are particularly susceptible to IPV due to poverty, social isolation, disparities in economic and social resources (between the woman and her partner), and immigration status (18). Other populations disproportionately affected by IPV include women with disabilities, LGBTQ women, women veterans, and women with substance use disorders (11). Research shows that:

- Women with disabilities have nearly double the lifetime risk of IPV (17).
- Women with physical health impairments and mental health impairments were 22% and 67% more likely to experience IPV than women without impairments, respectively (11).
- A greater proportion of gay/lesbian women (40%) and bisexual women (60%) report experiencing IPV compared to heterosexual women (35%) (11).
- The lifetime prevalence of IPV among transgender people ranges from 31-50% showing similar, if not higher rates of occurrence than other sexual minorities (11).

- The lifetime IPV prevalence for women veterans is 35% (11).
- Nearly 90% percent of women entering substance use treatment had experienced IPV in their lifetime (11).

While IPV during the perinatal period is more common than other maternal health conditions such as pre-eclampsia and placenta previa, it receives considerably less attention during perinatal care (19). Most studies have found that between 3- 9% of women experience abuse during pregnancy, with the rate increasing to as high as 12% after delivery (10). However, some studies conducted more specifically on low-income single women have estimated abuse rates up to 50% during pregnancy (12). Women living in low-socioeconomic conditions experience higher rates of IPV before and during pregnancy (10). Many of these women, who are at higher risk for adverse health outcomes, utilize WIC services (10). One study found that women who participate in WIC have higher odds of IPV during preconception and pregnancy compared to women who do not (10).

Women who experience abuse are at greater risk of a host of adverse physical health conditions including chronic pain (e.g., fibromyalgia, joint disorders, facial and back pain); cardiovascular problems (e.g., hypertension); gastrointestinal disorders (e.g., stomach ulcers, appetite loss, abdominal pain, digestive problems); and neurological problems (e.g., severe headaches, vision and hearing problems, memory loss, traumatic brain injury) (18). Moreover, women, who experience psychosocial stressors such as IPV, are more likely to partake in risky health behaviors (e.g., smoking, alcohol, and substance use) (16). Engaging in such behaviors puts women at an increased risk for unintended pregnancies and sexually transmitted infections (12).

Pregnant women who experience IPV are less likely to obtain adequate prenatal care and are twice as likely to miss prenatal appointments and not initiate care until the third trimester (12). One study found that women who experience abuse during pregnancy are less likely to gain the amount of weight recommended by the Institute of Medicine (IOM); specifically, excessive weight gain was associated with women aged 20 to 34, and inadequate weight gain was associated with women aged 35 years and older (20). Another study found that the pre-pregnancy BMI of women who experienced IPV before and/or during pregnancy was also more likely to be underweight or overweight compared to participants who were not abused (21). For more information about gestational weight gain, see risk #131 Low Maternal Weight Gain and risk #133 High Maternal Weight Gain.

Women who experience abuse during pregnancy may also suffer mental health consequences. Research has shown that IPV during pregnancy is associated with depression during the perinatal period. In fact, almost 40% of abused women report depressive symptoms, making it the most common mental health consequence of IPV. Women experiencing abuse while pregnant are 2.5 times more likely to report symptoms of depression than their non-abused counterparts. Post-traumatic stress disorder (PTSD) is also common among abused women, with rates ranging from 19-84%. (12) For more information about maternal mental health, see risk #361 Mental Illnesses.

Despite the detrimental effects of IPV, it is often under-reported and not commonly evaluated during pregnancy (21). In fact, research suggests that women are not routinely evaluated, and most clinicians only conduct screening when obvious warning signs are observed (10). According to a national survey, only 17% of providers routinely screen for IPV during the first visit and only 5% during follow-up visits (10). Researchers and caregivers agree that the ideal time to address IPV is during perinatal care because it is often the only time women have regular contact with health care providers; however, the consensus on how to approach IPV and which interventions should be adopted is unclear (19). The U.S. Department of

Health and Human Services and American College of Obstetrics and Gynecologists recommend that physicians screen all women for IPV during obstetric care, beginning at the first prenatal visit, at least once per trimester, and at the postpartum checkup (10).

Impact on Infant Health

IPV experienced by the mother can have severe impacts on neonatal health, putting the infant at higher risk of low birth weight (LBW), preterm birth (PTB), or being born small for gestational age (SGA). IPV has also been shown to contribute to increased likelihood of spontaneous abortion, fetal loss, and neonatal death. These complications may be caused by several mechanisms, including blunt physical trauma to the mother, negative maternal coping behaviors (e.g., smoking, drug use, or alcohol use), inadequate maternal nutrition, isolation, limited access to prenatal care, and elevated physical or psychological stress levels. (12)

Analysis of data from the Pregnancy Risk Assessment Monitoring System (PRAMS) shows a small but significant relationship between IPV either before or during pregnancy and LBW infants (22). One study found that women seen in the hospital for assault while pregnant and who delivered their infants during that hospitalization were more than three times as likely to have a LBW infant (22). The cessation of domestic violence also appears to have a positive impact on infant weight gain. One study indicated that newborns of women who reported an end to domestic violence had greater increases in weight from 6-12 months of age compared to infants of mothers who reported continued violence (23). For more information about LBW, refer to risk #141 Low Birth Weight and Very Low Birth Weight.

While the research on the association between IPV during pregnancy and delivery of a SGA baby is limited, one meta-analysis found that SGA outcomes were significantly increased among women who experience IPV during pregnancy compared to women who did not (24). Another study conducted in a low-income, urban, and predominantly African American sample found that infants born to mothers experiencing IPV were five times more likely to suffer an adverse neonatal outcome (e.g., SGA, LBW or PTB) (12). Research shows that babies who are SGA are at an increased risk of early childhood developmental and behavioral problems and of developing coronary heart disease, stroke, non-insulin-dependent diabetes mellitus, adiposity, and metabolic syndrome in adulthood (12). For more information about SGA, refer to risk #151 Small for Gestational Age.

Shaken Baby Syndrome (SBS) or Abusive Head Trauma (AHT) is the leading cause of physical child abuse death in the United States (25). According to the Center for Disease Control and Prevention (CDC), SBS is a preventable, severe form of physical child abuse resulting from violently shaking an infant by the shoulders, arms, or legs (26). Approximately 1,300 reported cases of SBS/AHT occur in the U.S. each year and most involve babies less than 6 months old (25). Babies from birth to 1 year, especially babies ages 2 to 4 months, are at greatest risk of injury from shaking because they cry more frequently and are easier to shake than older children (26). Factors that increase the likelihood of SBS are having unrealistic expectations about child development and child-rearing, having been abused or neglected as a child, being a victim or witness to domestic violence, and being a single parent (26).

<u>Breastfeeding</u>

When it comes to infant feeding decisions, the research on the relationship between breastfeeding and IPV against the mother before, during and after pregnancy is limited and findings are mixed. A review of 16 studies concluded that IPV exposure appears to associate negatively with breastfeeding outcomes, including decreased breastfeeding initiation, early cessation of exclusive breastfeeding, and shortened duration of exclusive breastfeeding (27). However, high-quality research remains limited. Because exposure

to IPV is not a strong predictor of breastfeeding outcomes based on existing literature, WIC staff should provide breastfeeding support to help participants meet their individual breastfeeding goals.

Impact on Child Health

There are many forms of abuse and neglect. Per the CDC, the most common forms of child abuse and neglect are (28):

- **Physical abuse** – the intentional use of physical force that can result in physical injury. Examples include hitting, kicking, shaking, burning, or other shows of force against a child.
- **Sexual abuse** – involves pressuring or forcing a child to engage in sexual acts. It includes behaviors such as fondling, penetration, and exposing a child to other sexual activities.
- **Emotional abuse** – refers to behaviors that harm a child's self-worth or emotional well-being. Examples include name calling, shaming, rejection, withholding love, and threatening.
- **Neglect** – the failure to meet a child's basic physical and emotional needs. These needs include housing, food, clothing, education, and access to medical care.

According to data from National Survey of Children's Exposure to Violence, approximately 1 in 7 children (0 – 17 years old) in the U.S. experienced child abuse and/or neglect in the reported year (29). Children in families with low socioeconomic status experience child abuse and neglect at a rate that is five times higher than children in families with high socioeconomic status (28). The CDC estimated the total U.S. population economic burden associated with child maltreatment was approximately $428 billion in 2015, rivaling the burden of other public health concerns such as stroke and type 2 diabetes (28). According to the National Child Abuse and Neglect Data System, 75% of the 3.4 million child and abuse neglect referrals in 2011 were classified as neglect, with the majority of children being under 3 years old (30). Neglect can affect children throughout their lifetime depending on the timing, how often it occurs and the severity (30). Children who are abused often have moderate to severe malnutrition due to having food withheld, which may lead to a compromised nutrition state and failure to thrive (FTT) (31). While neglect is often associated with children being underweight, the research is mixed (30). There is a small body of evidence regarding neglect and obesity, with some studies showing neglect being associated with a higher risk of obesity (30). Research has also shown that even when they are not the recipient of abuse, children who witness acts of aggression or IPV in the home can suffer symptoms of post-traumatic stress disorder, such as bed-wetting or nightmares, and were at greater risk than their peers of having allergies, asthma, gastrointestinal problems, headaches, and the flu (14).

Serious neglect and physical, emotional, or sexual abuse have short- and long-term physical, emotional, and functional consequences for children. Children who are abused and/or neglected may suffer physical injuries such as cuts, bruises, or broken bones, as well as emotional and psychological problems, such as impaired social-emotional skills or anxiety. (28)

Child abuse and neglect are considered adverse childhood experiences (ACEs), which are potentially traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. ACEs can have negative, lifelong effects on health, including disruption to healthy brain development, affecting social development, and compromising the immune system. Research shows that exposures to ACEs increases the risks of injury, sexually transmitted infections, including HIV, mental health problems, maternal and child health problems, teen pregnancy, involvement in sex trafficking, and a wide range of chronic diseases such

as cancer, type 2 diabetes, heart disease, and suicide. Child abuse and neglect are just a portion of potential ACEs that can occur in childhood. (32)

Implications for WIC Nutrition Services

WIC staff can provide the following nutrition services to participants who experience abuse:

- Provide a safe and supportive environment for participants who may be experiencing or have experienced abuse.
- Encourage pregnant women to attend all prenatal appointments with their health care provider and explain the importance of early and adequate prenatal care.
- Offer tailored breastfeeding support catered to the participant's specific needs and concerns.
- Encourage parents to attend local parenting classes or parent training programs (33).
- Refer the participant to their family case manager, if available, and/or to services and resources in their community that provide support to victims of abuse.
- Refer participants to national resources such as:
    - National Domestic Violence Hotline: 1-800-799-SAFE (7233). This hotline is staffed with trained counselors 24 hours a day and provides callers with crisis counselors, safety planning and assistance in finding resources, such as shelter. A secure, confidential online chat option is also available.
    - Directory of Crime Victim Services. This website provides a directory of programs and organizations that can help victims of crime.
    - Rape, Abuse and Incest National Network (RAINN): 1-800-656-HOPE (4673). This national hotline provides counseling and assistance to victims of sexual violence and their families and friends from trained counselors who are available 24 hours a day.
    - National Clearinghouse for the Defense of Battered Women (NCDBW): 1-800-903-0111 ext. 3. This national organization provides technical assistance to abused women facing charges related to their abuse.
    - Childhelp National Child Abuse Hotline: 1-800-4-A-CHILD (1-800-422-4453). This hotline offers information to parents seeking help for child abuse, individuals who suspect child abuse is occurring and those needing prevention tips. Professional counselors are available to provide support and referrals to emergency and social services. Their website also lists Child Protective Services in each state.

If State law requires the reporting of known or suspected child abuse or neglect, WIC staff must release such information to appropriate State officials. WIC regulations pertaining to confidentiality do not take precedence over such State law.

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