ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/43509316

The Hidden Experience of Violence during Pregnancy: A Study of 400 Pregnant Australian Women

Article *in* Australian Journal of Primary Health · April 2008

DOI: 10.1071/PY08013 · Source: OAI

CITATIONS
21

READS
137

1 author:

Deborah-Anne Bernadette Walsh
The University of Queensland
9 PUBLICATIONS **116** CITATIONS

SEE PROFILE

All content following this page was uploaded by Deborah-Anne Bernadette Walsh on 06 December 2018.

The user has requested enhancement of the downloaded file.

The Hidden Experience of Violence during Pregnancy: A Study of 400 Pregnant Australian Women

Deborah Walsh

School of Social Work and Human Services, The University of Queensland
Deborah Walsh Domestic Violence Training Services

*This article will report on the results of research into violence experienced by women during pregnancy, undertaken at a large public tertiary obstetric hospital in Australia. Participants in the research included 400 women from diverse backgrounds, recruited from the Royal Women's Hospital Antenatal clinic in Melbourne. The methodology for the research included a structured interview framework into which was incorporated a modified version of the Abusive Behaviour Inventory (ABI). The instrument measured both physical and psychological abuse indicators. The study found that 20% (*n=*80) of women interviewed reported experiencing violence during their pregnancy and that they did not disclose this to their health care professionals, thus suffering the abuse in silence. An increase in physical violence was reported by 6% (*n=*25); however, the majority of women reported that the level of violence and abuse remained the same throughout the pregnancy. It was found that a range of abusive behaviours were reported by the women interviewed, which resulted in three very distinct profile groups emerging from the data. A greater awareness of the prevalence of this phenomenon in the peri-natal population, together with ongoing access to research in this area, will benefit health care professionals in developing sensitive practice strategies for working with women affected by violence during pregnancy. Through a deeper understanding of associated issues, practitioners can work towards creating an environment where women feel safe enough to break their silence and be confident that their disclosures will be responded to appropriately, without pressure to leave the relationship.*

Key words: *Domestic violence, Violence against women, Pregnancy*

Violence experienced by women from intimate partners is increasingly recognised as causing a serious threat to the health status of women (VicHealth 1999; Australian Bureau of Statistics [ABS] 1996, 2005). The potential impact includes long-term physical and psychological health consequences for the women themselves as well as enormous economic costs for the health care system (KPMG Management Consulting, 1994, 1996; Laing, 2001). In addition, such violence has adverse effects on the newborn. It might be assumed that such violence would cease during pregnancy; however, this assumption is not supported by research evidence. Overseas studies found that women who report physical, sexual or emotional abuse during pregnancy were more likely than non-abused women to give birth to a baby with low birth weight (Murphy, Schei, Myhr, & Mont, 2001). Research conducted in Australia by Quinlivan (2000) explored the connection between low birth weight and violence. This study demonstrated that repeated prenatal exposure to the stress hormone cortisol impacts on the developing foetus, causing a range of health problems and resulting in a negative impact on birth weight. The results confirm overseas findings that have also reported a link between violence in pregnancy, low birth weight infants, miscarriage and perinatal morbidity (Bullock & McFarlane, 1989; Newberger et al., 1992; Berenson, Weimann, Wilkinson, Jones, & Anderson, 1994; McFarlane, Parker, & Soeken, 1996; Quinlivan, 2000; Campbell, 2001; El Kady, Gilbert, Xing, & Smith, 2005). Thus, a clear link is established between violence in pregnancy and health problems for both mother and infant.

Hillard (1985) reported on the extent of physical violence in a sample of 742 pregnant women. It was found that 10.9% (81) of women reported experiencing violence in their relationship. Of the 10.9 % reporting violence, 3.9% (29) of women reported violence during pregnancy. Of these, 21% reported an increase, 36% reported a decrease and 43% reported that the violence stayed the same. The study focus was on physical assault, so the broader range of coercive tactics was not included. However, it is one of the few studies to explore the issue of a change in the prevalence and degree of violence during pregnancy.

While significant research has been conducted overseas, particularly in the United States, there has been a paucity of research conducted in Australia on violence during pregnancy. A literature review revealed only two dedicated studies. The sample populations surveyed in both these studies had a higher rate of Aboriginal and Torres Strait Islander participants than in the general community, which may have impacted on the overall prevalence rates.

Research conducted in Queensland by Webster, Sweett, and Stolz (1994), reported that 29.7% of the women surveyed disclosed a history of abuse, with 5.8% reporting violence during the current pregnancy. This figure rose to 8.9% when women were interviewed at 36 weeks' gestation (Webster et al., 1994). The study noted that women experiencing violence had low birth weight infants, suffered more injuries to the abdomen, were more likely to abuse substances, had an increase in late trimester bleeding, experienced more infection, and had more premature deliveries than the non-abused population (Webster et al., 1994; Webster, Chandler, & Battistutta, 1996). The Webster (1994, p. 468) study used a self-directed pen and paper questionnaire that included eight physical assault questions and one emotional abuse question. The one emotional abuse question included a limited range of behaviours described in brackets as verbal abuse, being allowed no money, and being kept away from family and friends (Webster, 1994).

The other study conducted in Western Australia by Quinlivan (2000), focused on pregnancy in adolescence. It found that 29% of young women experienced violence during pregnancy, a higher rate than that reported for the general community. The results highlight the fact that younger pregnant women are also vulnerable to violence.

The Australian Bureau of Statistics Personal Safety Survey (ABS PSS, 2005), included questions on the experience of violence during pregnancy. It was found that 14.6% of women reported experiencing violence during pregnancy from a current partner, while 36% of women reported experiencing violence from a previous partner (2005). Of the 14.6% of women who reported violence from a current partner, 7.6% reported the violence did not occur for the first time during the pregnancy, while 7% reported the violence commenced in that pregnancy. Of the women reporting violence from a previous partner, 18.3% reported the violence did not occur for the first time during the pregnancy and 16.8% reported the commencement of violence (ABS PSS, 2005). The ABS PSS (p. 5) defined violence as including any incident involving the occurrence, attempt or threat of either physical or sexual assault. The survey did not include questions pertaining to psychological abuse.

The aim of this current study was to determine the extent, level and nature of violence against women during pregnancy, and to contribute to the knowledge base concerning the incidence rates in pregnant populations in Australia. A number of reviewed studies measured the incidence of violence against women using physical violence as the only criteria, with Webster et al. (1994) a notable exception. This current study explored the extent, level and nature of violence using a broad definition of violence, which included both physical and psychological tactics of coercive control as the criteria for measurement.

The aim of this paper is to inform primary health care providers about the occurrence of violence during pregnancy and to highlight the fact that, of those women who did experience violence during pregnancy, only a small number took the option of referral to support services. Some women clearly indicated that they did not want to make life-changing decisions during their pregnancy while other women, when faced with severe increases, did leave, and, in the main, without support from formal services.

The extent of violence was determined by self-reports from women who indicated that their partner had used violence. Women who stated that the violence had started, increased, decreased or stayed the same since they had been pregnant determined the level of violence. The nature of violence is understood to mean the type of violence reported.

Methodology

Study design

In the area of interpersonal and family violence research and practice much debate exists about what constitutes violence. Definitions vary; this is reflected in the community's perception of what is considered interpersonal and family violence (Cook & Bessant, 1997; MacDonald, 1998; Weeks, 2000). To eliminate the potential difficulties that

varying definitions of violence pose, this research was nested within a larger study—the income, social support and safety needs of women during pregnancy—and the use of the terms "violence" and "abuse" were deliberately avoided.

The instrument "The Support and Safety Survey" (SASS) was designed as a structured interview schedule containing a range of questions inquiring about social and economic support, aboriginality, disability and safety. The results of the other components of the larger study will be published elsewhere.

The study reported here used a modified version of the "Abusive Behaviour Inventory" (ABI [Shepard & Campbell, 1992]) which was nested within the "Support and Safety Survey". The original ABI is a 29-item instrument using a 5 point Likert scale to measure the frequency of abusive behaviours experienced in an interpersonal relationship (Shepard & Campbell). The abusive behaviours are divided into two sub-scales that include psychological and physical abuse items. The modifications included the addition of six questions (see Walsh & Weeks, 2004, for a discussion on the justification for the additional questions), expanding the number of questions to 35. Of these, the physical abuse sub-scale contained 12 items and the psychological abuse sub-scale contained 23 items. In the interviews, women were asked: "How often has your partner done the following behaviours?" with the responses recorded as: "never", "rarely", "occasionally", "frequently" or "very frequently". If women responded affirmatively to a question, they were asked if the behaviour had "started", "increased", "decreased" or "stayed the same", since becoming pregnant.

This research was approved by the Royal Women's Hospital, Melbourne, Australia, and the University of Melbourne Research and Ethics Committee (Walsh, 2003; Walsh & Weeks, 2004).

Study population

The study population was comprised of pregnant women who attended the Antenatal Pre-admission Clinic at the Royal Women's Hospital in Melbourne and who were approximately 26+ weeks' gestation. The Antenatal Pre-admission clinic is administered by midwives and provides women with information that prepares them for their hospital stay and birthing experience. It includes a routine psycho-social assessment that assists in the early identification of any special needs, referral and support that women may require.

A total sample of 400 women was calculated as necessary to ensure adequate power based on the total antenatal population of 4600 (see Walsh & Weeks, 2004, p. 42; Walsh, 2004). Asking a random sample of women about possible violence was considered too intrusive by the Research and Ethics Committee of the Royal Women's Hospital. It was decided instead to recruit a significant sample of women attending the hospital who were interested and willing, and who self-selected to participate in the research. Our sample was one of convenience and not a random sample of the general antenatal population; however, it was of a substantial enough number that the results obtained could be considered meaningful.

Support and Safety Survey

The recruitment of participants was initiated by the attending midwife at the clinic once the preliminary psycho-social assessment was completed. Women were invited to participate in the Support and Safety Survey, and, if they agreed, were subsequently introduced to the researcher and interviewed with their consent.

Limitations

Limitations are inherent in any research, particularly where it is conducted in a busy practising clinic that cannot provide a specific level of control for extraneous factors. It is recognised that the hospital and obstetric population are not representative of the general population as a whole. In comparison to the general population, the hospital population has a greater representation of cultural and linguistic diversity and includes higher numbers of women from lower socio-economic backgrounds. An additional level of bias was created through the recruitment of participants by midwives and the self-selection of women to participate in the study. Not all midwives at the clinic were actively involved in recruitment due to workload issues.

It is also reasonable to assume that in an interview environment—for social desirability reasons—a number of women may have minimised the severity of the violence they were experiencing. Violence in intimate personal relationships is an intensely sensitive issue, and, for some women, is

difficult to discuss. It is therefore assumed that there will be some under-reporting in the sample.

The author recognises that the sample is not generalisable to the population as a whole, given the limitations highlighted. However, a sample of 400 women who have experienced violence from an intimate partner during pregnancy and who were willing to discuss their situation makes a substantial contribution to the Australian research literature.

Results

A total of 872 women were approached to obtain the 400 interviews for this study—a 46% response rate. One woman became distressed during the interview disclosing that she was at risk of becoming homeless and in crisis. As a result the interviewer suspended the interview and the woman was referred to a crisis social worker immediately. This survey was withdrawn from the sample as it was incomplete, and, as a result, *n*=399.

Sample characteristics

A summary of the demographic data is provided in the table below.

Table 1: Sample Characteristics

	Sample Population *n*=399
Marital status	
Married	274 (68.5%)
Living with partner	86 (21.5%)
Separated/ divorced	22 (5.5%)
Single	17 (4.3%)
Age	
<20	1 (0.3%)
20 - 24	66 (16.5%)
25 - 29	143 (35.8%)
30 - 34	117 (29.4%)
35 - 39	60 (15%)
40 - 44	12 (3%)
	399 (100%)
No. of Children	
Primiparous	176 (44%)
Multiparous	223 (56%)
Education	
Primary	5 (1.2%)
Partial Secondary	82 (20.5%)
Secondary	88 (22%)
Partial Tertiary	32 (8%)
Tertiary	159 (40%)
TAFE / Vocational	33 (8.2%)

Table 1 shows the distribution of marital status, age, number of children and educational attainment of the sample.

Cultural and linguistic diversity

Data was not collected on country of birth. The ethnicity of the group should not be confused with country of birth as a number of women may have been born in Australia of overseas-born parents and identified with that ethnic and cultural background. Any findings in relation to this question should, therefore, be viewed cautiously.

A breakdown of the cultural and linguistic diversity of the sample showed that 220 (55%) women where from English-speaking backgrounds. Of these, 193 (48.4%) stated they were Australian, 1 American, 1 Canadian, 5 Irish, 15 British and 5 women stated they were from New Zealand. There were 179 (45%) women who stated they were from a culturally and linguistically diverse background.

Only 14 (3.5%) of the women interviewed did not speak English and bi-lingual and bi-cultural research assistants interviewed this sample. The remaining women interviewed spoke English well enough to participate in the interview process.

The number of women in the sample who identified as being of Aboriginal/Torres Strait Islander background was four (1% of the total sample). During the data collection phase, 70 Aboriginal/Torres Strait Islander women attended the hospital for antenatal care and were identified by the hospital's Aboriginal Women's Business Health Unit (Sutherland, 2003).

The number of women who reported to have a disability was 23 (5.8% of the sample). The hospital does not readily identify this group of women so any wider comparison is not possible.

Responses to the "ABI"

The questions in the physical and psychological abuse sub-scales measure behaviours during the lifetime of the relationship, and do not reflect the pregnancy. Any change on the experience of violence during the pregnancy is reported in the next section.

Using the state of Victoria criminal assault criteria as the determination of the sample of interest (women reporting violence and abuse) from responses to the ABI, 106 (26.5%) women responded affirmatively to one or more of the behaviours in the ABI physical sub-scale.

Sixteen (4%) were excluded from the sample of interest as they reported instances of behaviour that occurred once or rarely, with minimal responses

to other abuse indicators, and who reported on instances of violence that did not relate to interpersonal conflict. For example, one reported that her partner threw a spanner at a wall when repairing a vehicle. This type of response was not included.

A group of 90 (22.5%) are the focus of this analysis and are referred to as the "Composite Group". From this group of 90 women, three very distinct profile groups emerged. These profiles are as follows:

- The "Violence Against Women Group" (VAW group) - 49 women who responded affirmatively to questions that included direct physical assault and a range of other psychological abuse sub-scale items.
- The "Separated Group" - 16 women who disclosed that they had left their partner during the index pregnancy because of the partners' physical violence.
- The "At Risk Group" - 25 women who responded affirmatively to at least one of the 12 physical abuse sub-scale behaviours that did not include actual physical assault. The women in this group were also required to respond affirmatively to two or more psychological abuse sub-scale items from the modified ABI.

Table 2: Demographic Detail for the Profile Groups

	Composite *n*=90	VAW *n*=49	Separated *n*=16	At Risk *n*=25
Marital status				
Married	48	30	0	18
Living with partner	23	17	0	6
Separated/divorced	16	0	16	0
Single	3	2	0	1
Age				
< 20	1	1	0	0
20 - 24	23	12	5	6
25 - 29	33	18	6	9
30 - 34	20	12	2	6
35 - 39	12	6	3	3
40 - 44	1	0	0	1
No. of children				
Primiparous	35	17	7	11
Multiparous	55	32	9	14
Education				
Primary	1	1	0	0
Partial secondary	27	16	5	6
Secondary	14	6	4	4
Partial tertiary	8	4	0	4
Tertiary	27	16	2	9
TAFE/ vocational	13	6	5	2

The majority of the women were currently married or living with their partner. The age range is reflective of women's reproductive years, with the exception of the under-20 age group. The Royal Women's Hospital has a dedicated clinic for young mothers, and, as the Quinlivan (2000) study reported on the issues for young mothers, this study did not target the specialised clinic.

It is interesting to note that in the Composite group 53% of women reported some post-secondary education (i.e., partial tertiary, tertiary and Tafe/Vocational) and 47% reported primary, partial secondary and secondary as their educational level.

For the Composite Group (*n*=90), 53% reported being Australian, with 47% from an ethnically and culturally diverse background. One woman from this group stated she was an Aboriginal woman.

The level of violence

For every affirmative response to questions on the ABI, women were asked if the behaviour had started, increased, stayed the same or decreased since they had become pregnant. From the Composite Group, 80 (20%) women reported that violent behaviours occurred for the first time or continued during the index pregnancy.

The profile group breakdown found that 42 out of the "VAW" group (*n*=49), all 16 women in the Separated group, and 22 women from the At Risk group (*n*=25) reported that the violence continued while pregnant. The total number who continued to experience violence during pregnancy was 80 women (20%).

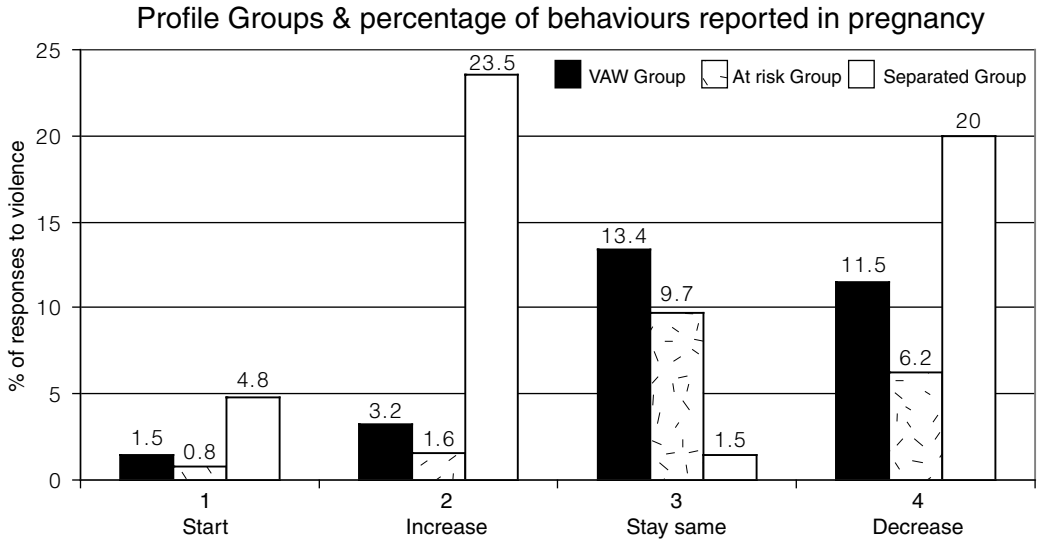
Figure 1 shows behaviours that started, increased, stayed the same and decreased. This table again demonstrates the trend that a significant number of behaviours are either staying the same or decreasing for a number of women.

In the VAW Group, 42 women described these behaviours starting, increasing or staying the same during the pregnancy and seven women stated that the majority of the behaviours had decreased.

The At Risk group reported that the majority of behaviours nominated had stayed the same and a number of behaviours decreased.

The group of women who separated from their partners during the index pregnancy clearly indicated that a substantial number of behaviours increased (23.5%), a number started (4.8%), and a high number stayed the same (20%), and very

Figure 1: Profile groups percentage of behaviours reported during pregnancy (VAW *n*=49; At Risk *n*=25; Separated *n*=16)



% of responses = the number of responses to questions about the partner's abusive behaviour

few decreased (1.5%). This particular group identified that a number of behaviours increased, and, in comparison, this was the only group that demonstrated this feature.

This group also reported the highest level of physical assault responses. The following table shows the responses to the most concerning physical assault questions.

Table 3: Percentage of responses to physical assault questions from the Separated group (*n*=16)

Physical assault question	No. reported
Pushed, grabbed or shoved	13 (81%)
Slapped, hit or punched	6 (37%)
Hit or hurt in abdomen or breast	4 (25%)
Threatened with knife, gun	4 (25%)
Threw, hit, kicked or smashed things	13 (81%)
Kicked	6 (37%)
Physically forced sex	5 (31%)
Threw you around	6 (37%)
Physically attacked sexual parts	3 (18.7%)
Choked or strangled	3 (18.7%)
Used a knife, gun or other weapon	3 (18.7%)

Referral rates

An offer of a referral to support services, domestic violence services and information was made to all women who responded affirmatively to abuse questions. Of the women in the Composite Group (*n*=90), 28% accepted information or a referral to services and 72% did not.

A breakdown of the referral rates for the profile groups found that 10 (20%) women from the VAW profile group (*n*=49) and 3 (12%) women from the At Risk profile group (*n*=25) accepted a referral. A large percentage of women-12 (75%) in the Separated profile group (*n*=16)-accepted information and referrals offered, with four women indicating they had existing support (one with formal support services and three with informal support).

Discussion

A number of studies have suggested that violence can start and/or escalate for women during pregnancy (McFarlane, 1993; Stewart & Cecutti, 1993; Webster et al., 1994). This study found that, in the main, violence remained constant throughout the pregnancy. It suggests that a history of violence in the relationship was a strong indicator for violence during pregnancy. There was one exception to this, which was found when the profile groups were analysed separately and the data for the separated group emerged. This group provided a very different picture, where 23.4% of violent behaviours increased, 20% of behaviours decreased and 4.8% of behaviours started during pregnancy. These results are comparable to those found by other studies and suggest that if women are already experiencing physical assault-level violence in their relationship, they are at risk of this increasing during pregnancy. For women whose experience of violence is less frequent, the violence and abuse continued in a "business as usual" format throughout the pregnancy.

More recent data published by the ABS PSS (2005) found that half of the women reporting

physical violence stated that the violence did occur for the first time during pregnancy. Approximately half reported that it did not. However, it is pertinent that the ABS survey did not include psychological abuse questions. In comparison to this current study, the group with the highest incidence of physical assault violence (the Separated Group) reported that only 4.8% of behaviours increased, whereas the ABS reported a higher incidence. This supports other research that found variations in definitions and methodology will yield very different results (Gazmararian et al., 1996; Hegarty & Roberts; 1998; Martin, Mackie, Kupper, Buescher, & Moracco, 2001).

Webster et al. (1994) suggested that as the education level of women increased the violence decreased. When reviewing the educational attainment levels of women in this study, our data did not support that finding. Irion, Boulvain, Straccia, and Bonnet (2000) also reported no difference in the prevalence of violence described by women with differing socio-demographic characteristics. This supports the findings in this study that education level and other socio-demographic differences was no barrier to or protection against violence.

Further, Webster et al. (1994) suggested that legal marriage may offer a degree of protection against domestic violence. This current study found differently, as the married women in the sample was greater than other reported marital status. We did not ask the Separated group about their marital status prior to separation. While it may have been an interesting outcome, it would not have altered the fact that legally married women were greater in number overall.

For 10 of the women in this study, all the violent behaviours reported decreased during pregnancy, suggesting that the pregnancy may act as a protective factor some women. For other women some of the physical assault behaviours decreased but the psychological abuse continued throughout the pregnancy. While some behaviour may have decreased, we did not ask if the behaviour had stopped completely. In retrospect, that question would have yielded some interesting data for comparison.

Following an extensive literature search, Hillard (1985) was one of the few previous studies to report on violence in pregnancy increasing, decreasing or remaining constant. Even though it is an old study by contemporary standards, it was included because of the unique similarity to this study. Hillard reported on the extent of physical violence in a sample of 742 pregnant women in the United States (Virginia). It was found that 10.9% reported experiencing violence in their relationship. Of the 3.9% of women who reported violence during pregnancy, 21% reported an increase, 36% reported a decrease in the violence and 43% reported that the violence stayed the same.

The prevalence rates of violence were considerably lower in Hillard's (1985) research (10.9%) in comparison to the present study (22.5%). The differences in findings could be attributed to a number of issues. These include the interpretation of the screening question in Hillard's study, which asked: "Has anyone at home hit or tried to hurt you?" which could possibly have attracted higher percentages of women who had experienced severe physical assault. Results from the study indicated that 49% of the women reported having attended an emergency room for injuries inflicted by a partner. In comparison, the present study utilised an in-depth structured interview that has been shown to increase disclosure rates (Gazmararian et al., 1996).

It is vital that care be taken not to mythologise assumptions from research findings, as has happened with the assumption that violence starts or escalates during pregnancy. In Australia, the dominant discourse on violence in pregnancy highlights this assumption without question. It is our experience that women who are being seriously assaulted reported that some violence had started and other behaviour escalated during the pregnancy, so much so that 16 (4%) of these women left the relationship. In the main, this study found that the violence being reported by pregnant women was decreasing or staying the same. It is critical to identify women who experience an increase of physical violence in pregnancy because of their increased vulnerability but it is also important to recognise the broader range of women's experience. One of the key issues for research is that measuring only the physical indicators of assault reinforces the notion that violence is only experienced as physical assault. Ignoring the range of ways in which women experience violence beyond physical assault contributes to a silencing of the voices and experiences of other women.

It is evident from the results that the issue of violence against women during pregnancy is a hidden phenomenon within the pregnant population. This is demonstrated by the fact that some women did not identify their partners' behaviour as being violent; while others acknowledged that their partners' behaviour was violent and actively chose to stay with them.

Many women commented, when offered information and referral options, that they did not need either as they did not want to leave. Thus, their perception of the helping system as being geared to those women wanting to leave is highlighted. This suggests that the construction of our domestic violence support systems, which are predominantly crisis intervention-oriented, are not meeting the needs of women wanting to stay in their relationships. It implies that one of the barriers to disclosure is the perception that if a woman discloses her partner is violent, there will be or is likely to be an expectation that she has to leave.

Conclusion

The results of this study indicate that the extent, level and nature of violence against women during pregnancy are serious issues in the pregnant population and issues that require the urgent attention of our health care system. The fact that some men choose to use violence against their intimate partners when they are pregnant is not an isolated event. This research and others have demonstrated that violence against women during pregnancy continues to be of concern in our community. Those women identified in this current study as being brave enough to leave did so, in the main, on their own without formal assistance. They were not identified in the health system as requiring extra support and assistance, and, given the vulnerability of this group of women, this finding is problematic. For others in the sample, the experience of violence was suffered in silence. De Bruyn (2001) argued that there is a general "tolerance" of violence in society, which both women and men internalise as a norm. This notion was confirmed in this research and gives rise to my concern that if this social tolerance is not challenged then violence is likely to increase over time.

A disclosure made to professionals about violence does not necessarily mean that women want or need assistance to leave the relationship. Women may be seeking assurance that the behaviour directed towards them by their intimate partner is considered by others as violent and abusive. Having their experience acknowledged and validated may be the first step in a long walk to safety.

Acknowledgments

First, I would like to recognise the Support and Safety Survey Advisory Committee members Anna Moo, Keran Howe, Marg D'Arcy and the late Associate Professor Wendy Weeks for the support and advocacy provided throughout this research.

Many thanks go to the Royal Women's Hospital for not only providing the site for the research but for the ongoing support it provided in so many ways. The tangible support made this research happen.

I am indebted to the Sir Robert Menzies Foundation for the award of the Allied Health Scholarship in 2001 for 2002-03—the only one awarded to date to a social worker.

To the women who were so willing to participate in this study, whose strength, bravery and survival continue to inspire my work.

Dedication

To the late Associate Professor Wendy Weeks, whose commitment to social research was outstanding, and who died suddenly on July 31, 2004. She was the supervisor and mentor for this research and is greatly missed by all who knew her.

References

Australian Bureau of Statistics. (ABS) (1996). *Women's Safety Australia*. Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. (ABS) (2005). *Personal Safety Survey Australia 4906.0*. Canberra: Australian Bureau of Statistics.

Berenson, A. B., Weimann, C.M., Wilkinson, G.S., Jones, W.A, & Anderson, G.D. (1994). Perinatal Morbidity Associated with Violence Experienced by Pregnant Women. *American Journal of Obstetrics and Gynecology 170*(6), 1760-1769.

Bullock, l., & McFarlane, J. (1989). The birthweight/battering connection. *American Journal of Nursing, 89*(9), 1153-1155.

Campbell, J. (2001). Abuse during pregnancy: a quintessential threat to maternal and child health - so when do we start to act? *Canadian Medical Association Journal 164*(11), 1578-1579.

Cook, S., & Bessant, J. (1997). *Women's Encounters: Australian Experiences*. Australia: Sage Series of Violence Against Women: 1-18.

de Bruyn, M. (2001). *Violence, pregnancy and abortion: Issues of women's rights and public health: a review of worldwide data and recommendations for action*. Chapel Hill, USA, IPAS.

El Kady, D., Gillbert, W.M., Xing, G., & Smith, L.H., (2005). Maternal and neonatal outcomes of assaults during pregnancy. *Obstetrics and Gynecology, 105*(2), 357-363.

Gazmararian, J., Lazorick, S., Spitz, A.M., Ballard, T.J., Saltzman, l.E., & Marks, J.S. (1996). Prevalence of Violence Against Pregnant Women. *Journal of the American Medical Association, 275*(24), 1915-1920.

Hegarty, K., & Roberts, G. (1998). How common is domestic violence against women?: The definition of partner abuse in prevalence studies . *Australian and New Zealand of Public Health, 22*(1), 49-54.

Hillard, P.J.A. (1985). Physical abuse in pregnancy . *Obstetrics and Gynecology, 66*(2), 185-190.

Irion, O., Boulvain, M., Straccia, A., & Bonnet, J. (2000). Emotional, physical and sexual violence against women before or during pregnancy. *British Journal of Obstetrics and Gynaecology, 107*, 1306-1308.

KPMG Management Consulting. (1994). *Economic Costs of Domestic Violence in Tasmania*. Tasmanian Domestic Violence Advisory Committee. Hobart: Office of the Status of Women.

KPMG Management Consulting. (1996). *The Financial and Economic Costs of Domestic Violence in the Northern Territory*. Office of Women's Policy, Northern Territory Government, Domestic Violence Strategy, Darwin, Northern Territory.

Laing, L. (2001). *Australian Studies of the Economic Costs of Domestic Violence*. UNSW, Sydney: Australian Domestic & Family Violence Clearinghouse: Issues Paper.

MacDonald, H. (1998). *What's In a Name? Definitions and Domestic Violence*. Melbourne, Australia: Impact Printing.

McFarlane, J. (1993). Abuse during pregnancy: The horror and the hope. Association of Women's Health, Obstetric and Neonatal Nursing: *Clinical Issues, 4*(3), 350-362.

McFarlane, J., Parker, B., & Soeken, K. (1996). Abuse During Pregnancy: Associations with Maternal Health and Infant Birth Weight. *Nursing Research, 45*(1), 37-42.

Martin, S. l., Mackie, L., Kupper, L.L., Buescher, P.A., & Moracco, K.E. (2001). Physical Abuse of Women Before, During, and After Pregnancy. *Journal of the American Medical Association, 285*(12), 1581-1584.

Murphy, C., Schei, B., Myhr, T., & Mont, J.D. (2001). Abuse: A risk factor for low birth weight? A systemic review and meta-analysis. *Canadian Medical Association Journal, 164*(11), 1567-1572.

Newberger, E. H., Barkan, S.E., Lieberman, E.S., Yllo, K., Gary, L.T., & Schecter, S. (1992). Abuse of pregnant women and adverse birth outcome: Current knowledge and implications for practice. *Journal of Obstetrics and Gynecology, 267*(17), 2370-2372.

Quinlivan, J. (2000). *Study of adolescent pregnancy in Western Australia. The Way Forward: Children, Young People and Domestic Violence*. Melbourne, Australia: Partnerships Against Domestic Violence.

Shepard, M. F., & Campbell, J.A. (1992). The Abusive Behaviour Inventory: A Measure of Psychological and Physical Abuse. *Journal of Interpersonal Violence, 7*(3), 291-305.

Stewart, D., & Cecutti, A. (1993). Physical abuse in Pregnancy. *Canadian Medical Association Journal, 149*(9), 1257-1262.

Sutherland, N. (2003). Verbal communication. Master of Applied Epidemiology (Indigenous Health), Royal Women's Hospital & National Centre for Epidemiology and Population Health, ANU: Canberra.

VicHealth. (1999). *Mental health promotion plan: 1999-2002*. Carlton South, Australia: Victorian Health Promotion Foundation.

Walsh, D. B. (2003). *Silent suffering: The extent, level and nature of violence against women during pregnancy: A study of 400 Australian women*. Unpublished PhD thesis, The University of Melbourne.

Walsh, D., & Weeks, W. (2004). *What a smile can hide: A report on the study of violence against women during pregnancy*. Carlton, Australia: Royal Women's Hospital.

Weeks, W. (2000). Towards the prevention of violence and the creation of safe and supportive gender relations. In W. Weeks & M. Quinn (Eds.), *Issues Facing Australian Families* (3rd ed.). Australia: Longman.

Webster, J., Chandler, J., & Battistutta, D. (1996). Pregnancy outcomes and health care use: Effects of abuse. *American Journal of Obstetric and Gynecology, 174*(2), 760-767.

Webster, J., Sweett, S., & Stolz, T.A. (1994). Domestic Violence in Pregnancy: A Prevalence Study. *The Medical Journal of Australia, 161*, 466-470.

Deborah Walsh
School of Social Work and Human Services,
The University of Queensland
St Lucia Queensland 4072
AUSTRALIA
Email: d.walsh@social.uq.edu.au

View publication stats