Violence during pregnancy
Preliminary findings

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Domestic violence has been a highlighted concern for some years. This has resulted in governments now providing recurrent funding for a range of domestic violence service provisions. The funding of services has given rise to a significant shift in service delivery, moving from volunteers staffing services to the development of specialised professional expertise in a range of domestic violence service provisions.

A number of years practice experience in the field, together with a review of the literature, leads to the conclusion that pregnancy may be a vulnerable time for some women whose partners choose to use violence. This has grave implications for the short, medium and long term health and welfare of these women and children.

For most though, pregnancy is a time of joy and happiness, which can often inspire hope for the future. For many of us it is almost unthinkable and unimaginable that anyone, let alone the father of the child, would or could intentionally harm or injure a pregnant woman. However, a number of reports indicate otherwise. It is this most disturbing of issues that I wish to present to you today.

I will present a brief overview of some of the contentions around the issue of definitions in the area of domestic violence because of the implications these have on research and practice. I will share some research findings on the issue of domestic violence and pregnancy, which will lead into a presentation of my current research on the topic. I will conclude by sharing some of the dilemmas that have been highlighted by my research to date. Unfortunately the data is incomplete and no real conclusions can be drawn at this stage, so only a glimpse of what has been found to date can be presented here today.

DEFINITIONAL DILEMMAS IN RESEARCH AND PRACTICE

Researchers, practitioners and the community do not share a common understanding of domestic violence, each holding often very differing ideas and philosophies about causation and incidence, and resulting in very distinct social and political implications (Das Dasgupta, 2001:2). Many of our systemic responses are shaped by our understanding and our definition of what we think constitutes violence.

In much of the material available on domestic violence, one of the things that is observed almost immediately is the variety of terms used to describe this phenomenon – for example, wife abuse, domestic violence, battering, spouse abuse, family violence ... and the list goes on. Upon closer examination it is evident that these terms cannot be used interchangeably as they have very different meanings. As Weeks (2000:276) argues:

> Different terminology and concepts are not simply linguistic debates but contain different assumptions, perspectives and experiences and lead to different responses to the extent and nature of violence against women.

So definition is an issue.

It can be a challenge when reading research reports to establish the definition or the meaning used as writers often assume that the meaning is understood, leaving the reader without a clear understanding of what is being measured or discussed. A graphic example of the implications of not having a shared or consistent definition was reported by Hegarty & Roberts (1998), who found when reviewing a range of domestic violence prevalence studies that the prevalence varied from 2.1% through to 28% of the population. The variation was a result of the differences in the definition used in the studies. This is problematic.

RESEARCHERS/PRACTITIONERS

To find some answers to this perplexing problem one might turn to the literature only to find that there is division between feminist and other researchers and between the field of research and the field of practice. On one hand there are researchers, feminist researchers and activists who define violence as a pattern of intimidation, coercive control and oppression, contending that physical assault is sometimes used to consolidate a pattern of domination but is not always necessary to maintain control (Das Dasgupta, 2001:2). This view takes into account context and is considered to be the 'broad' definition (ibid) with many linking violence to violations of human rights (National Committee on Violence Against Women, 1992: 1).

On the other hand, the 'narrow' view is one that is considered to be the decontextualised view, seeing physical assault as the definition of violence, espousing the gender neutrality argument of the perpetrator and victim, maintaining there is sexual symmetry in intimate relationships (Dobash et al, 1992). This view is in stark contrast to the generally held understanding maintained by the vast majority of advocates and practitioners writing and speaking about domestic violence. However, the challenge is

that much of the research available on domestic violence utilised by workers is informed by the decontextualised or the 'narrow' view of violence. This issue has grave implications for the reliability of statistics and it adds to the confusion of 'what is domestic violence' which in turn has grave implications for the community.

THE COMMUNITY

Research will often inform practice and, in the main, physical assault occasioning injury is what is being measured, policed and most often understood by the general community as being domestic violence. The community's perception of what constitutes domestic violence is extremely problematic as a huge proportion believe that domestic violence is about some lunatic bashing his partner 'black and blue' on a regular basis. As a result there are many, many women who do not consider themselves to be experiencing violence as their experience sits outside the physical assault or 'narrow' view of violence. A further complication to this issue is the fact that there is a great deal of emphasis on the myth that violence is the product of 'out of control' anger, again negating all other threatening and controlling behaviours.

WHAT IS VIOLENCE?

This common misconception that violence is about anger leads onto the notion that anger management will fix the problem. It will not, however, and there is a huge problem with this depiction. Debates rage in the domestic violence arena about anger management versus attitudinal and behavioural change programs for violent men. (Not a topic that can be covered today but, in short, programs that work with violence need to adhere to very clear guidelines which anger management programs do not meet.)

In summary what we do know is that we need to be clear about our understanding of what violence is.

WHAT IS VIOLENCE?

- It is behaviour that establishes coercive control over others;
- it is often gender-based;
- it is much more than physical assault;
- it works to gain the perpetrator what they want when they want it, often with little or no direct negative consequences.

WHAT VIOLENCE IS NOT

- violence is not about anger;
- anger and violence are not the same;
- anger is an emotion;
- violence is a behaviour.

A person can be angry and not violent. A person can be violent and not angry. This depiction is often used as the excuse for violence and, while it is not acceptable, it is still frequently used.

OPERATIONAL DEFINITION FOR CURRENT RESEARCH

In order to clarify the definition issue, the following is the operational definition used in my research:

> Violence is defined as intentional violent, threatening, coercive or controlling behaviour in current or past intimate relationships. It encompasses not only physical injury, but direct and indirect threats, sexual assault, emotional and psychological abuse, economic control, property damage, enforced social isolation and behaviour that causes a person to live in fear.

DOMESTIC VIOLENCE IN PREGNANCY

WHAT THE LITERATURE SAYS

Overseas research suggests that 4 - 8% (Gazmararian et al, 1995; 1996) and possibly up to 21% of pregnant women experience domestic violence occasioning actual injury (Helton, 1986). One study found that trauma was the leading cause of injury for pregnant women (Poole et al, 1996). Frequent sites of injury were the abdomen, breast and genital areas, with injuries commonly caused by blunt trauma (or an assault without a weapon). These injuries were more frequent during the late second trimester and during the third trimester of pregnancy (Stark, Flitcraft & Frazier, 1979; Walker, 1979). Pregnant women who experienced physical assault were more likely to have multiple trauma sites than were non-pregnant women experiencing violence (Helton & Snodgrass, 1987). Some argue that violence in pregnancy may be more common than pre-eclampsia, gestational diabetes and placenta previa, conditions which women are routinely screened for (Gazmararian, 1996). It has also been found that between 40% and 45% of women who experienced violence reported that sexual assault accompanied physical abuse (Campbell & Alford, 1989).

In a Canadian study, 6.6% of the pregnant population surveyed had experienced violence during pregnancy. Of these, 64% reported an increase of violence, 78% remained with the perpetrator, 67% received medical treatment for the violence and only one woman told her doctor about the violence (Stewart & Cecutti, 1993).

A study in New York revealed that domestic homicide was the single most significant cause of death by injury for pregnant women (Dannenburg et al, 1995).

In addition, it has been found that:

- women who experience violence in pregnancy are four times more likely to have miscarriages, and are four times more likely to have low birth weight infants (Bullock & McFarlane, 1989; McFarlane, Parker & Soeken,1996);
- 16% of pregnant women experience violence and women who are physically abused during pregnancy are at an increased risk of substance abuse and deliver low birth weight infants (McFarlane et al, 1996);
- 10.9% of recently pregnant women had experienced violence (Cokkinides & Coker, 1998);

- where the mother has been physically assaulted there is a high level of infant mortality (Vasilanko et al, 1998)

Australian research on this issue falls behind that of our overseas colleagues but this is beginning to change. The Australian survey *Women's Safety Australia* (Australian Bureau of Statistics, 1996) found that in a national sample, 20% of women who disclosed violence from a previous partner stated that the onset of the violence began during pregnancy. There have only been two documented studies on domestic violence in pregnancy in Australia – one adult study in Brisbane (Webster et al, 1996) and the other a study of teenage pregnant women in Western Australia (Quinlivan, 2000). The Brisbane study found that women who experience violence in pregnancy experience more miscarriage, neonatal death, suffer more injuries to the abdomen, are more likely to abuse substances, and have increase of late trimester bleeding, infection and premature delivery resulting in poor maternal and foetal outcomes (Webster et al, 1996).

The Western Australian study (Quinlivan, 2000) found that the incidence of domestic violence among pregnant Australian teenagers to be higher than rates reported for the general community. It was also reported that babies born to the abused group of young pregnant women were diagnosed with significantly more neonatal problems than the non-abused group. These babies were also reported to have smaller head circumferences (ibid). This study confirms that domestic violence has a significant impact on the infant in utero.

CURRENT RESEARCH

The aims of the research are:

- To determine the nature, level and extent of domestic violence against women during pregnancy, in the context of their social support, economic and safety needs, within a highly diversified women's hospital population.
- To explore women's perceptions of an appropriate health professional response to disclosures of domestic violence.
- To develop and contribute to the knowledge base about the incidence of domestic violence in Australia.
- To contribute to the theoretical knowledge for the development of quality and ethical women-centred work practice in women's health.

The contentious issues around definitions have an enormous impact on research methodology. For example, if we were to recruit women to a domestic violence study, it would be likely that women who have already self defined their experience as violent would respond, resulting in a biased sample. In order to avoid some of these pitfalls, this research is located in a much larger study exploring the income, social support and safety needs of women during pregnancy. So when women are recruited, they are recruited to 'The Support and Safety Survey'. The details of what they will be asked are outlined once women have been introduced to the researcher. Having third party recruiters has had its own challenges, but that's a story for another day.

To achieve our aims we are currently collecting data through 400 structured interviews with women who are at 26+ weeks gestation. The structured interview contains a set of validated and reliable questions which have been specifically designed for a pregnant population. Our sample is stratified to include women who do not speak English and who use interpreters. To our knowledge there has been no other research of its kind conducted here in Australia.

To date 85% of the interviews have been conducted with approximately 25% of the sample indicating that their partners use some level of violent behaviour toward them. Of this 25%, 65% have declined information on services and assistance. Now we need to remember that the research is continuing and these statistics will vary, but this is an interesting theme to have emerged. It appears that women in this study are willing to discuss very sensitive issues in the context of the anonymity and confidentiality of the research environment but not in the broader context of the health care system.

In a number of examples women have clearly stated that they do not want information or referral options as they do not want to leave their partner, clearly reflecting a perception that help is available for them only if they wish to leave their partner. Other women have stated that they are fearful about disclosing to professionals, as their fear of the service system is greater than their fear of their partner. This is demonstrated by the following quotations from women when offered information and referral options:

> *He's not really violent, he doesn't hit me.*
>
> Stated one woman whose partner had pointed a knife at her pregnant belly, threatening to cut the baby out if it wasn't his (to demonstrate his point he scratched her with it):
>
> *But this is how men are. They can't help it.*
>
> Stated one women whose partner 'got aggro' every now and then but never did any real damage:
>
> *I don't need a referral to anyone. I have traded my happiness for security and it's been worth it because I know my kids will have the best and go to good schools and besides he's not bad all the time. In fact sometimes he's really nice.*
>
> *I know him and his moods and I can work around them. If I left him I'd have to manage on my own with the kids and I'd be scared that I couldn't cope and CSV [child protection] would come in and take them away. It sounds like he's real bad now that I've done those questions but he's okay mostly.*
>
> *He's a really good father and provider – I can't take my kids away from that.*

As a result of the themes emerging it appears that there are a number of barriers preventing women from disclosing that their partner is violent. These include:

- the lack of consensus about accurate definitions of violence with a community perception that leaves some women believing that some men's violent behaviour is normal;
- the fear of public authority for some women appears to be greater than the fear of the perpetrator of violence;

- the fear of social pressure that leads women to assume that once a man is violent the woman has no other option but to leave;
- a conscious pro-active choice by the woman to stay, no matter what happens.

In my experience, I have found that it is a sad reality that many, many women experience violence from an intimate male partner and, if they disclose this to a professional, the only intervention made available to them is to leave the relationship. What we know from experience in the field is that violence doesn't always stop when parties separate. In fact it is the most dangerous time for the safety of women and children. It has been noted by a number of studies that the risk for domestic homicide occurs on or around separation (Easteal, 1993; Women's Coalition Against Family Violence, 1994)

A number of the women I have interviewed have clearly stated that they love their partner and, while they do not want to leave, they would like the violence to stop. It was also my experience working in domestic violence services that women only left as a last resort after physical violence had escalated, and they often returned.

For me as a practitioner in the field, it has been disturbing and confronting to work with a second woman partner of the same violent man whose violent and abusive behaviour had continued. With this example together with the experience of hearing from so many women during this research, I guess I am wondering about the wisdom of only providing limited intervention options for women whose partners choose to use violence, and that is biased toward supporting the woman to leave.

Overall our domestic violence service system is targeted to those women who leave or are planning to leave and these services are critical, particularly our women's refuge system. But it is clearly not meeting all the needs of women who experience violence from an intimate partner as demonstrated by the women I am interviewing. They are clearly not disclosing because they do not want to leave.

Instead of an 'either/or' polarised position in terms of systems development, let's expand our thinking to a 'both/and' position. We can do this by being creative and visionary, by developing multifaceted helping systems that will meet a wider range of need. We can do this by building on what we have rather than developing one type of system at the expense of another. Because if we listen to women and actually hear what they say, 'one size' doesn't fit all.

How can we do this? I don't know what the answers are but I think we need to explore the evidence from the women themselves as to what works for them. One such example we can look forward to is the report from 'The Recovery from Family Violence Project'. This project – funded by the Victorian Government through the Department of Human Services Family Violence Unit, and conducted by Chisholm Institute – has consulted widely with women. The project has been completed for some time now, but the report has not yet been released.

In conclusion by supporting women and their families appropriately we ultimately support our children, and if we put energy into raising emotionally balanced and emotionally intelligent children, we are investing in our future. ♦

REFERENCES

Australian Bureau of Statistics (1996) *Women's Safety Australia*, Catalogue No. 4128.0, ABS, Canberra..

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

Campbell, J. & Alford, P. (1989) 'The dark consequences of marital rape', *American Journal of Nursing*, 89(7), 946-949.

Cokkinides, V.E. & Coker, A.L. (1998) 'Experiencing Physical Violence During Pregnancy: Prevalence and Correlates', *Family and Community Health*, January.

Dannenburg, A.L., Carter, D.M., Lawson, H.W., Ashton, D.M., Dorfman, S.F. & Graham, E.H. (1995) 'Obstetrics: Homicide and other injuries as causes of maternal death in New York City, 1987 through 1991', *Journal of the American Medical Association*, 172(5), 1557-1564.

Das Dasgupta, S. (2001) 'Towards an understanding of women's use of non-lethal violence in intimate heterosexual relationships', *Violence Against Women* Online Resources, access on line site 19.4.02: www.vaw.umn.edu/FinalDocuments/vawnet/towards.asp

Dobash, R.P., Dobash, R.E., Wilson, M. & Daly, M. (1992) 'The Myth of Sexual Symmetry in Marital Violence, *Social Problems*, 39(1), 71-91.

Easteal, P.W. (1993) *Killing the beloved: Homicide between adult sexual intimates*, Canberra: Australian Institute of Criminology.

Gazmararian, J.A., Adams, M.M., Saltzman, L.E., Johnson, C.H. & The Prams Working Group (1995) 'The Relationship Between Pregnancy Intendedness and Physical Violence in Mothers of New Borns', *Journal of Obstetrics and Gynecology*, 85(6), 1031-1037.

Gazmararian, J.A., Lazorick, S., Spitz, A.M., Ballard, T.J., Saltzman, L.E. & Marks, J.S. (1996) 'Prevalence of Violence Against 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 Journal of Public Health*, 22(1), 49-54.

Helton, A. (1986) 'Battering During Pregnancy', *American Journal of Nursing*, August, 910-912.

Helton, A. and Snodgrass, F.G. (1987) 'Battering During Pregnancy: Intervention Strategies', *Birth*, 14(3), 142- 147.

McFarlane, J., Parker, B. & Soeken, K. (1996) 'Physical Abuse, Smoking and Substance Use During Pregnancy: Prevalence, Interrelationships and Effects of Birthweight', *Journal of Obstetric and Gynecological & Neonatal Nursing: Clinical Studies*, 313-320.

National Committee on Violence Against Women (1992) *The National Strategy on Violence Against Women*, Commonwealth of Australia, October.

Poole, G.V., Martin, J.N., Perry, K.G. Jnr, Griswold, J.A., Lambert, C.J. & Rhodes, R.S. (1996). 'Trauma in Pregnancy: The role of interpersonal violence', *American Journal of Obstetrics and Gynecology*, 174(6), 1873-1876.

Quinlivan, J. (2000) 'Study of adolescent pregnancy in Western Australia', in *The Way Forward: Children, young people and domestic violence*, conference proceedings, Melbourne, April, 2000.

Quinlivan, J. & Evans, S.F. (1999) *Detecting Domestic Violence in Adolescent Pregnancy*, Department of Obstetrics & Gynaecology, University of Western Australia and Women's & Infants Research Foundation, unpublished paper.

Stark, A., Flitcraft, A. & Frazier, W. (1979) 'Medicine and patriarchal violence: The social construction of a 'private' event', *International Journal of Health Services*, 9(3), 461-493.

Stark, E. & Flitcraft, A. (1996) *Women at Risk: Domestic Violence and Women's Health*, Sage Publications, USA

Stewart, D.E. & Cecutti, A. (1993) 'Physical Abuse in Pregnancy', *Canadian Medical Association Journal*, 149(9).

Walker, L. (1979) *The Battered Woman*, New York: Harper and Row.

Weeks, W. (2000) 'Towards the prevention of violence and the creation of safe and supportive gender relations', in Weeks, W., & Quinn, M., (Eds), *Issues Facing Australian Families: Human Services Respond* (3rd Edition), Pearsons Education, Sydney, Australia, 273-287.

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

Women's Coalition Against Family Violence (1994) *Blood on whose hands? The killing of women and children in domestic homicide*, Arena Printing, Melbourne, Australia.

Vasilanko, P., Marshall, J., Fournier, R., Gwizdala, R., Lehman, L. & Bigelow, L. (1998) *Saginaw Fetal Infant Mortality Review Program*, Saginaw Michigan, Department of Obstetrics and Gynaecology, Saginaw Cooperative Hospitals Inc., unpublished paper.

DISCUSSANT

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This presentation is a courageous exploration of difficult and sensitive issues relating to violence against women during pregnancy.

It makes a number of useful contributions:

- The paper raises a series of questions, and explores the issues.
- It challenges us to professional reflection and debate, rather than showing us just one path.
- The paper reflects the complexity of the problem yet urges the need to address it.

DEFINITION

The paper raises concerns about the definitions used in the debate. The fact that there are diverse definitions of violence lead to confused responses, especially about incidence, understandings and debates. Myths associated with pregnancy and violence further obscure the real issues.

The research presented here has made its definition clear and chosen to use a broad definition of violence, where the perpetrator has intent to harm, and causes fear in the subject.

LITERATURE

There is an extensive survey of the relevant literature which identifies that:

- there is a wide range of incidence (4%-21%, 2.1%-28%), with the differences being largely attributable to differences in definition;
- there is a pattern in the nature of the violence, usually blunt trauma to multiple sites, often abdomen, breast, genital areas. Sexual assault is also often associated with violence in pregnancy;
- there is often an association with substance abuse and teenage pregnancy;
- violence often occurs in late second or third trimester of pregnancy;
- there is association with significant health risks for the baby – miscarriage, low birth weight, small head circumference, delayed development;
- there are also significant health risks for the mother with uterus rupture, ante partum haemorrhage, and death.

This study has taken a supportive approach by conducting a social support and safety survey, rather than only asking questions about violence. The results of 25% reporting some violence are consistent with the literature. Most of those reporting (65%) declined assistance or services which raises issues for us to consider. Most did not wish to leave their relationship, but wanted the violence to stop.

Most women reported they would not normally reveal the violence to a health professional but found it possible to tell in the context of research. This challenges us as social workers who think we are easy to talk to.

ADDITIONAL QUESTIONS

The system is presently failing to assist women and babies.

Is leaving the only option we offer? Are we (the system) more scary than a violent partner?

We know that when safety is compromised, serious outcomes result to both mother and baby, and there are significant cost implications to the system.

We need some lively professional debates about the juxtaposition of the social work value of client self determination and most workers' preference, which would be to see women leave and be safe.

We need to explore the place of our values, feelings and frustrations – as well as empowerment, empathy and judgement.

CONCLUSIONS

This is an important study exploring the current incidence and nature of violence experienced in Victoria by pregnant women. It is useful for reflecting women's own perceptions of violence and their views regarding action.

It will be a valuable catalyst to generate debate about options and future policy directions. ♦