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**AN EXPLORATION OF WOMEN'S PERCEPTIONS  
AND LIVED EXPERIENCES OF DOMESTIC  
VIOLENCE AND ABUSE IN THE CONTEXT OF  
THEIR PREGNANCY**

**KATHLEEN MARION BAIRD**

**A thesis submitted in partial fulfilment of the requirements of the  
University of the West of England, Bristol, for the degree of Doctor of  
Philosophy**

**Faculty of Health and Life Sciences, University of the West of England,  
Bristol**

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## **Abstract**

This thesis reports on a qualitative study exploring women's experiences of domestic violence before, during and after pregnancy. The research employed a qualitative framework underpinned by feminist and phenomenological values and philosophy. Feminism and phenomenology were integrated in order to strengthen the philosophical foundation in an attempt to gain a richer and deeper understanding of the human lived experience.

Data were collected from seventeen interviews undertaken with eleven women who had been pregnant in the previous two years, using unstructured interviews. The interviews focused on the participants' unique accounts, appreciating their different experiences and interpretations of living with domestic violence. Thematic analysis of the data was used to identify common themes.

Findings suggest the women welcomed the opportunity to talk about their own personal experiences of violence, which they believed had been triggered by their pregnancy. Only two pregnancies were planned, with almost a third of the women being coerced into motherhood by their partner. Feelings of vulnerability about themselves and their unborn babies were intensified by their partners' continuing violence and abuse.

Responsive service developments were also explored in the interviews. The women described what they would have found helpful, from healthcare professionals and services during their pregnancies.

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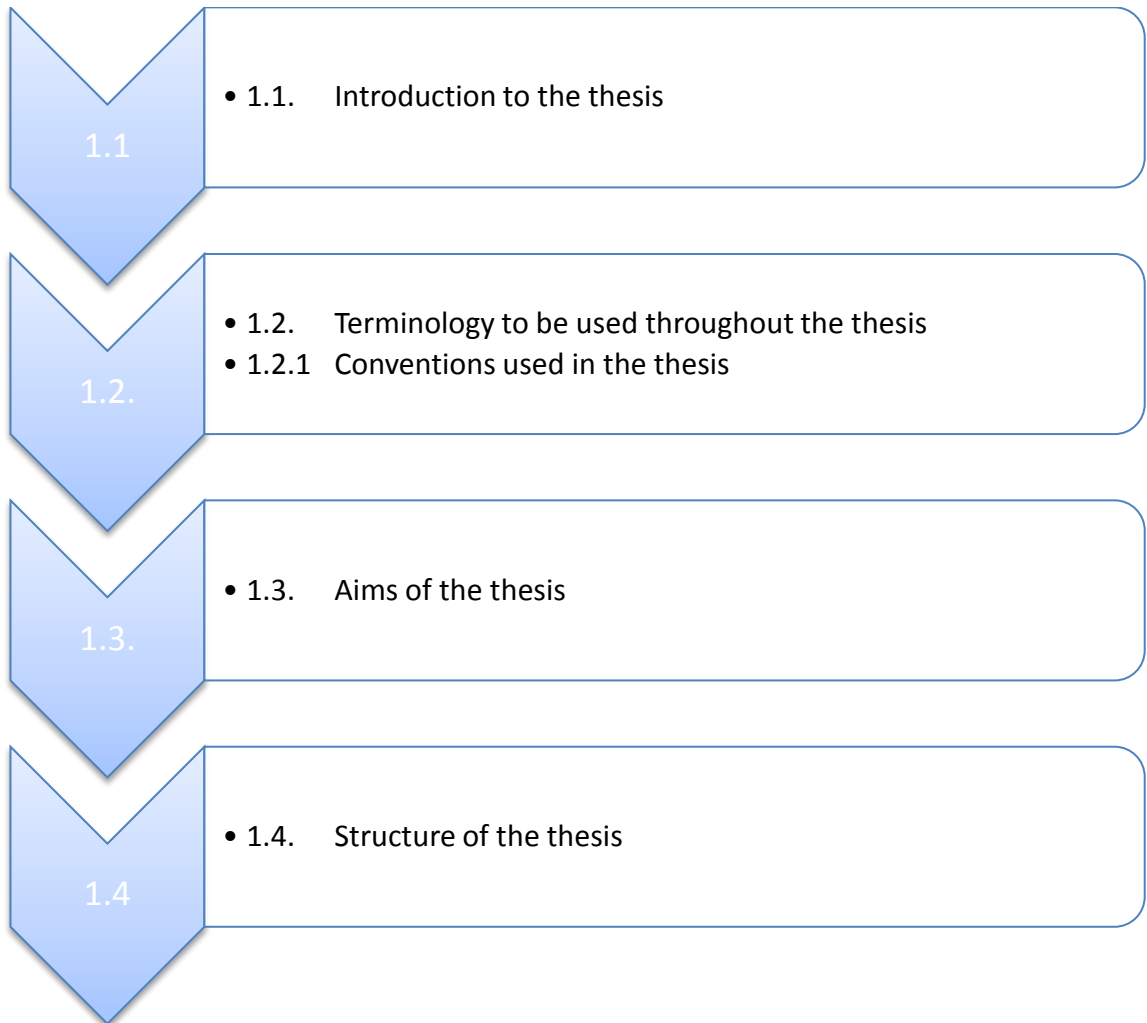
### ***Dedication***

*I dedicate this thesis to the memory of 'Nicola' who sadly died during the data collection phase of this thesis*

# **PART ONE**

## **Introduction**

### **Chapter One**



## Chapter One

### 1.1. Introduction to the study

Domestic violence and abuse against women is a global public health issue, (World Health Organisation, 2010) it is embedded in society and pervades all socio-economic, gender and cultural groups, having a devastating impact on the lives of survivors (World Health Organisation, 2005). In most cases, domestic violence occurs within the context of a relationship of a cohabiting couple and includes physical, sexual, emotional abuse as well as controlling behaviours. The World Health Organisation defines partner violence as:

Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Sexual violence – any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but limited to home and work.

This definition includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object – however the legal definition of rape may vary in different countries. (World Health Organisation, 2010, p.11)

Domestic violence is predominantly perpetrated by men against women, although it can also be perpetrated by women against men. However, Kufman Kantor and Jasinski (1998) identify that it is very different from the violence men perpetrate towards women, given that it is usually far less harmful, frequently carried out in self defence and much less likely to be motivated by an attempt to control, dominate or terrorise. Domestic violence also occurs in same sex relationships, although currently there exists a lack of knowledge about its extent and consequences or indeed an understanding about the differences between violence

in a same sex relationship and violence which occurs within heterosexual relationships (Harne and Radford, 2008) with most of the existing knowledge being limited to lesbian relationships (Hester *et al.* 2010). According to Hester *et al. (op cit)* this limiting evidence base can be attributed to a 'potential for a homophobic backlash from society' and because 'lesbians were becoming more visible as a domestic violence research group' (p 252). Researching domestic violence in same sex relationships exposes methodological problems for example obtaining a representative sample. Hester *et al. (op cit)* suggests the hidden nature of the lesbian, gay and bisexual and transgender population means that is virtually impossible to recruit a random or even a representative sample.

In response Hester *et al. (2010)* study explored a comparison of behaviours across both heterosexual and same sex relationships in the UK. The findings from the 746 surveys, 67 individual interviews which included 44 participants identifying themselves as either lesbian, gay, queer, bisexual, transgender, the remaining interviewees were heterosexual men and women. More than a third of the survey respondents reported experiencing domestic abuse in their same sex relationship, with the findings similar in both groups, women (40.1%) and men (35.2%). The main risk factors for abuse included young age, less than 35 years, low income and a lower educational attainment. Overall the findings of Hester *et al. (op cit)* revealed that individuals in same sex relationships experience an amalgamation of physical, sexual and emotional abuse.

Around 520,000 people die every year as a result of domestic violence (World Health Organisation, 2010). The World Health Organisation Multi-Country Study on women's health and domestic violence against women (Garcia-Moreno *et al.* 2005) collected data from over 24, 000 women between the ages of 15 and 49 in both rural and urban areas in ten different countries. The findings signified that 13% – 61% of women experienced violence by an intimate partner at some point in their lives and 6% – 59% of participants had experienced sexual violence by a partner.

Disturbingly, the same study reported rates of 1% to 21% of the women interviewed also reported having experienced child sexual abuse under the age of 15 (World Health Organisation, 2002, 2005). The findings of Garcia-Moreno *et al.* (2005) supported previous population studies which also indicated 10% to 69% of women aged fifteen to forty nine years had experienced physical abuse by a male partner at least once in their lifetime (Heise *et al.* 1999; Heise & Garcia-Moreno, 2002).

Living with domestic violence results in a poorer health status with reduced quality of life resulting in higher utilisation of health services (Williamson, 2000a; Hegarty, 2006; Baty *et al.* 2008). Health professionals now acknowledge the importance of responding to domestic violence, although the response from some sectors of the health service has been varied. 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, in an appropriate manner, to women and children who are subjected to domestic violence and abuse (Department of Health 2005, 2010a). Currently, however, there is a lack of strong well evaluated evidence to confirm the efficacy of such interventions (Ramsay *et al.* 2002, 2006; Feder *et al.* 2009).

The precise relationship between pregnancy and domestic violence remains unclear (Reilly *et al.* 2010). However, what is known is that the consequences of domestic violence during pregnancy include a higher incidence of neonatal death, premature labour, low birth weight infants and miscarriage (Campbell, 1992, 1998, 2001; MacFarlane *et al.* 1996; Shumway *et al.* 1999; Covington *et al.* 2001; Valladares *et al.* 2002; Janssen *et al.* 2003; El Kady *et al.* 2005; Martin *et al.* 2006a; Shah and Shah, 2010).

The impetus for this study developed out of a process that started many years ago, in 1999 when studying for my first degree at University. During a sociology lecture,

the lecturer made reference to violence against women, highlighting some of the statistics of domestic violence. This lecture stimulated an interest in the subject, motivating me to explore the topic in much more depth. Further exploration and my own personal professional practice led me to consider why there was a lack of responsiveness from health professionals and especially from maternity services who were, in the main, women caring for women. That awareness has resulted in several funded projects exploring and evaluating the impact of midwifery and primary health care interventions aimed at empowering clinicians, to support women experiencing domestic violence. Examples include: an audit of midwifery professional practice in 2003 with the purpose of exploring midwives' attitudes about the introduction of routine enquiry in the antenatal period (Price and Baird, 2003). This was followed by a Department of Health funded study in 2004 which supported the development and introduction of the Bristol Pregnancy and Domestic Violence Programme (BPDVP) aimed to equip in the first instance a group of community midwives with the knowledge and confidence to effectively routinely enquire about domestic violence during the antenatal period (Salmon *et al.* 2004, 2006). Involvement in these projects, together with my fervent interest in the topic itself stimulated the impetus for this research.

Whilst undertaking my PhD, I have continued to be involved in several other projects all related to domestic violence and health. These have included the development and evaluation of a drama workshop with a professional theatre company, with the purpose of facilitating multi-agency working and professional collaboration around domestic violence (Baird and Salmon, 2011). From 2008 to 2011, I was part of a research team which tested the effectiveness of a programme of training and advocacy support, within primary health care. The main aim of the study was to increase the identification of women experiencing domestic violence and their subsequent referral to specialist advocacy services (Feder *et al.* 2011). More recent research has included a follow up study of the Bristol Pregnancy Domestic Violence Programme (Baird *et al.* 2011).



Although researchers and academics have addressed the pervasiveness and epidemiological aspects of partner violence and abuse, very few have focused on women's perceptions and the lived experiences of abuse during pregnancy. Although such studies are vitally important, it has nevertheless resulted in the continued silence of the voices of pregnant women who have or are experiencing violence and abuse. Consequently, it was always my intention that the research would be built around the women's experiences as told by them. For that reason, and in accordance with my feminist principles, the women's voices shape the research, seeing them as experts in their own lives (Stanley and Wise, 1983; Kelly, 1988).

## **1.2. Terminology to be used throughout the thesis**

The women in this study endured many different types of violent behaviour including physical and sexual violence, psychological abuse, which included emotional and verbal abuse, intimidation, deprivation and isolation, all types of behaviours which allowed the men to control and dominate. I made the decision to use the terminology 'domestic violence' and 'domestic abuse' throughout the thesis as they are currently the terms most frequently utilised within the United Kingdom (UK). Other terms such as 'intimate partner violence' and 'partner violence' will be used when it is the terminology used by the author of the work I am acknowledging. The current discourse surrounding the appropriate use of terminology, when exploring the subject of violence against women, will be considered in more depth in chapter two.

### **1.2.1. Conventions used in the thesis**

Italicised format and indentation is used to identify direct quotes from all the study participants. The quotes from the participants are written verbatim, as spoken by them and this includes colloquial language. Direct quotations from the literature will also be set within quotation marks; quotations of ten or more words are

indented. All direct quotes are accompanied by the author/s date of publication and page number. Throughout this thesis, I use terminology that is accessible to a reader who is not a midwife; however, I am mindful the inclusion of some midwifery and obstetric terminology is unavoidable, especially within the context of maternal and perinatal outcomes. Therefore a glossary of terminology is included on pages 358-361.

### **1.3. Aims of the study**

The purpose of this research is to explore women's experiences of domestic violence within the context of their pregnancy as told by the women themselves. It also appears relevant to understand the effect the domestic violence had on their health and well being. In addition, an exploration of their interactions with health professionals will be considered. For that reason sub aims have also been employed.

#### **Principal aim of the study:**

'An exploration of women's perceptions and lived experiences of domestic violence and abuse in the context of their pregnancy'.

#### **Sub aims of the study:**

- (a) An exploration of the health and social consequences of domestic violence and abuse for women.
  
- (b) An exploration of abused pregnant women's perceptions of access to, and the responsiveness of, the maternity services and other health and social care professionals.

## **1.4. Structure of the thesis**

This thesis presents the findings of research undertaken between 2007 and 2012. The thesis is divided into four parts and the sequential flow of chapters follows a systematic approach commencing with an overview of the subject of domestic violence and concluding with recommendations for future research and practice considerations. Part one is comprised of chapters one and two, chapter one provides an introduction to the thesis. In chapter two I outline and critically evaluate an identified body of literature and research regarding a number of essential areas that inform the study aims.

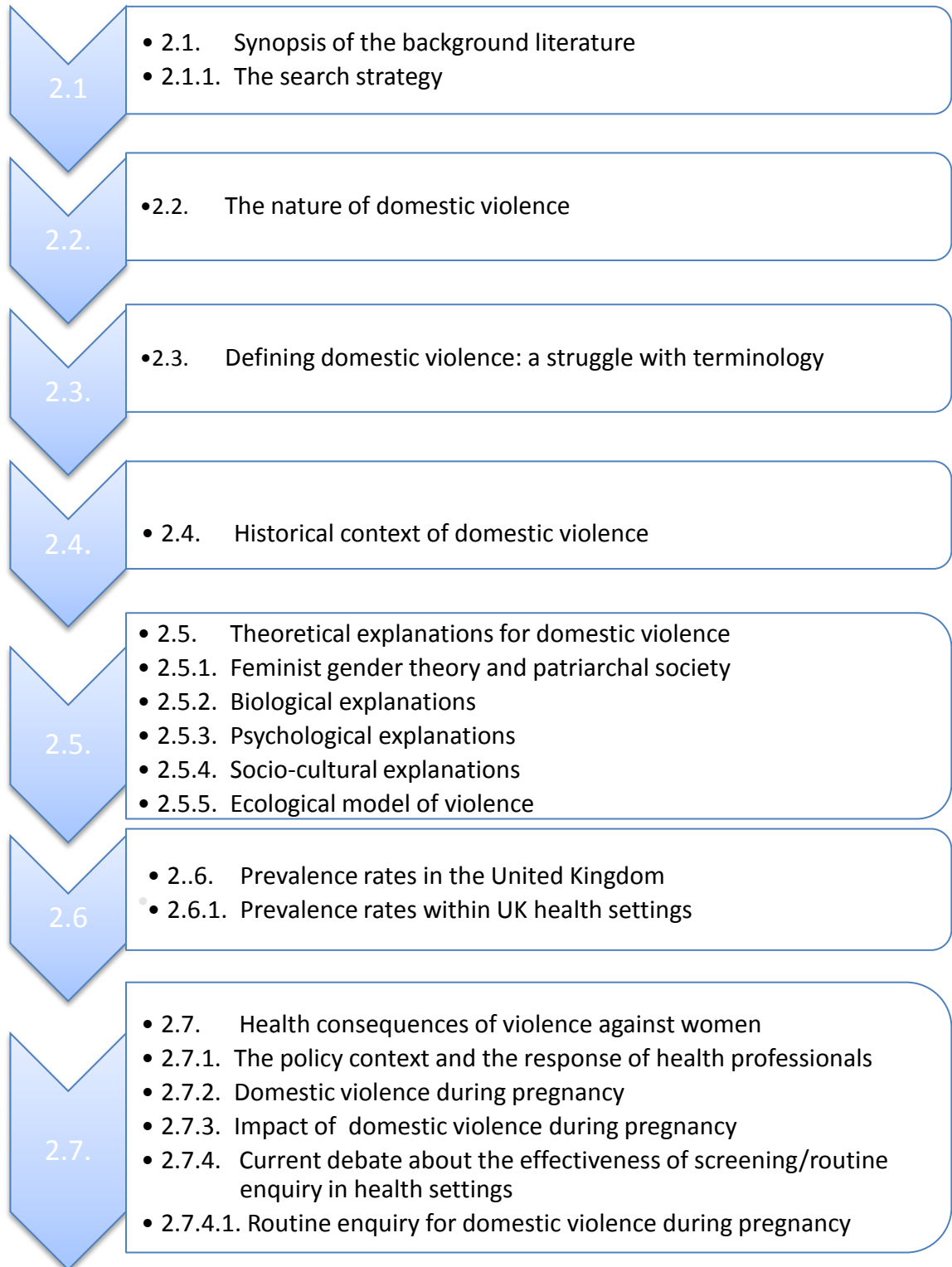
Part two comprises of chapters three and four: chapter three explores the critical thinking process that I embarked upon, to develop my philosophical orientation and the theoretical contributions influencing the strategies I employed during my research. In chapter four, I describe the methodological approach employed to justify my choice of methods for data collection and analysis of the women's stories.

Part three of the thesis comprises chapters five to fourteen. Chapter five provides a brief synopsis of the women's stories, providing a biographical outline of their life before, during and after their relationship with their partners. Chapter six sets the scene for the findings chapters, by offering an initial insight into the participant's lives and relationships and highlights the complexity of living within an abusive relationship. The remaining chapters in part three present the findings of the research and impart meaning to the voices of the women who participated in the study. The chapters are based on the result of thematic analysis of the women's accounts of their experiences of domestic violence during pregnancy. Within each of the chapters, the women's individual experiences are explored in a sequence of relational themes. Part four of the thesis comprises chapters fifteen to eighteen. Chapter fifteen to seventeen locates the overall findings of the study within

existing literature of domestic violence and domestic violence during pregnancy. Chapter eighteen is the concluding chapter of the thesis and it provides a summary of the study, a review of the key findings of the research, recommendations for policy and future midwifery practice and directions for future research based on the overall findings of the study.

## Chapter Two

### Literature Review



## **Chapter Two**

### **Literature Review**

#### **Introduction**

The purpose of this chapter is to present a theoretical background to the study and this will be achieved by providing a synopsis of the literature pertaining to the topic. The prevalence, nature, patterns of violence and health consequences for women who experience partner violence and abuse and the theoretical explanations that contribute to a better understanding of why violence against women occurs, will be explored in this chapter. The identification of domestic violence in the maternity services and the challenges of implementing routine enquiry and the ongoing debate about its effectiveness will also be considered.

#### **2.1. Synopsis of the background literature**

A key aim of the literature review was to critically appraise and synthesise current knowledge in relation to the main research question and the sub aims of the study. Searching for pertinent literature was an ongoing process during the study, thereby ensuring that the most up to date and relevant literature was used in underpinning my thesis. Owing to the word constraints, this literature review does not intend or claim to be authoritative in explaining or even conceptualising domestic violence. Instead, what this review is attempting to achieve, is to provide an overview of trustworthy literature relevant to domestic violence, and domestic violence in pregnancy including presenting some of the theories that exist.

##### **2.1.1. The search strategy**

A detailed literature search was undertaken in 2007 prior to starting my research and again in 2009 and 2010. Using both, books and electronic resources, such as ASSIA (Applied Social Sciences Index and Abstracts), Blackwell Synergy, Ovid Online

(Biomedical) Collection, SAGE Journals Online and Sciences Direct, PsycINFO, Community WISE and CINAHL and EBSCO, the searches uncovered an abundance of literature on domestic violence. Combination searches and truncation were also applied. The search terms used five components that included words associated with the subject: domestic violence; domestic abuse; interpersonal violence; intimate personal violence and couple violence, all terms which are used interchangeably in the literature. This uncovered more general literature pertaining to domestic violence, as intimate partner violence and interpersonal violence are terms frequently used in American literature and by academics working and researching in the field of domestic violence.

In addition to searching academic journals, information produced by key agencies working in the field within the United Kingdom (UK) were also identified and included organisations such as the Home Office, Department of Health, Women's Aid and Refuge. The search process was further aided by backward chaining which involves the processes of analysing reference lists from collected articles, thus ensuring that seminal and pertinent literature is not overlooked (Holloway and Wheeler, 2010). Significant books were also utilised throughout my study. These included any seminal works written by eminent researchers and academics in the field, to help aid my understanding and knowledge around the theoretical explanations of domestic violence, society and gender.

The literature review also incorporated an in depth examination around theory and methods most suitable for the study, including a review of the approaches taken by previous researchers in the field. A considerable amount of literature was collected over a period of time and cataloguing and reading all this literature was a necessary and lengthy process that was necessary to increase my knowledge and understanding. I excluded papers which were not written in English. Although an initial overview of the literature was conducted at the beginning of my research, this review was an ongoing process throughout the period of the thesis. Frequent

searches of the Internet, academic databases and any new books that were written for more up to date information were undertaken. This was a necessity as I was aware of the fast moving agenda of domestic violence from research and policy perspectives. Articles of non-British origin, if related to pregnancy and domestic violence and written in English were included in my literature search as there was not an abundance of literature pertaining solely to domestic violence and pregnancy available from within the UK.

The remaining sections of this chapter will include an overview of the nature and prevalence of domestic violence and pregnancy, the health consequences for a woman and her unborn baby and the current debate with reference to identification and responsiveness of healthcare services and professionals. To avoid unnecessary repetition within the thesis, where a deeper exploration and discussion concerning a specific issue occurs in more depth in the discussion chapter, then that particular issue will only be referred to briefly in this chapter.

## **2.2. The nature of domestic violence**

Domestic violence is a broad concept, which includes many forms of physical violence, sexual violence, and a range of behaviours and acts that may be used in isolation or together to control the woman. Physical violence can include the use of physical force such as slapping, hitting, kicking, punching, hair pulling, biting, using knives and weapons, burning, and scalding all of which can result in serious injury or death. Psychological and emotional abuse comprises of verbal threats, intimidation and coercion, isolation, deprivation of basic needs such as food, money, clothing, and the restriction of information, education, employment and social activities. Sexual violence incorporates behaviours such as rape, forced sexual contact, being forced to watch or take part in pornographic sexual activities (Department of Health, 2005; Harne and Radford, 2008; Women's Aid, 2011).



Within the context of the UK, domestic violence is usually regarded as violence between adults who are or have been in an intimate relationship or family relationship with each other (Hague and Malos 2005). Domestic violence occurs across society, regardless of age, gender, race, sexuality or wealth and it also affects men. More recently, the frequency of female to male violence has been brought to the fore, and whilst it is clear that women do abuse men, UK British Crime Surveys (BCS) (Walby and Allen, 2004) have demonstrated that it is mostly men who perpetrate the violence against women and it is predominantly women who suffer as a result of it (Hague and Malos, 2005). Currently, in the UK it is estimated that one in four adult women experience domestic violence at some point in their adult lives (Walby and Allen 2004; Department of Health 2005; Povey *et al.* 2008; Smith *et al.* 2011) and two women are murdered every week by a partner or ex partner (Walby and Allen, 2004). There is increasing evidence that during pregnancy a woman is at particular risk of violence and abuse, this supposition will be explored in more depth later in this chapter. Undoubtedly, experiencing domestic violence and abuse can lead to negative consequences in many spheres of life, including educational achievement and economic opportunities, increased uptake of risky health behaviours and reduced capacity to parent (World Health Organisation, 2010).

### **2.3. Defining domestic violence: a struggle with terminology**

The purpose in this section is not to arrive at a determined definition but purely to explore some of the varied terms currently being utilised. Domestic violence is recognised worldwide; however, the language used to refer to domestic violence varies from the gender-neutral terms such as spouse violence or partner violence to terms that are gender specific such as 'woman battering' or 'wife violence'. The use of such terminologies would suggest that the violence occurs in the background of a particular relationship. Radford and Hester (2006) suggest that such variations in the language used can reflect broader conceptual and ideological differences. For example, in the UK the term 'domestic violence' was developed within the context of feminist research and is the term that continues to be used today by women's

organisations such as Woman's Aid. Lavis *et al.* (2005) suggest that using the term 'domestic violence' is often utilised as it can be seen to convey the "brutality, breadth and depth of the behaviours and actions, which constitute the phenomenon" (Lavis, 2005 p15). However, using the term 'domestic violence' can also imply that the violence only occurs in a home when a couple are living together, and not when a couple separate, when in fact the latest British Crime Survey (BCS) identifies that women who had recently or were separated from their abusive partner have the highest risk of domestic abuse and stalking (Smith *et al.* 2011). Others suggest in relation to intimate partner abuse the term 'domestic violence', actually trivialises the various types of brutality which are multidimensional with social structural, political and economic foundations (Crenshaw, 1997; Sokoloff and Dupont, 2005).

Dobash and Dobash (1998) consider the term 'violence' elicits several issues, one being the breadth and the narrowness of the term, proposing that the word violence has been used to incorporate a long list of orientations and behaviours commonly referred to as 'violence against women'. They suggest a more narrow definition of violence may be much more beneficial, with each type of violence considered in its own right thereby increasing comprehensibility about a specific form of behaviour. According to Kelly and Radford (1998) the ongoing debate about suitable definitions to describe partner violence are actually struggles about meaning and conceptualisation; they are not static, but are in reality ongoing and will change through time, reflecting social awareness and recognition.

Within the British context, domestic violence is typically regarded as violence between "adults who are or have been in an intimate relationship with each other, usually a sexual relationship between a woman and man" (Hague and Malos, 2005, p. 4). More recently, the term 'domestic abuse' is frequently cited in UK literature, and is considered to symbolise the inclusion of behaviours and actions that are less visible to the human eye, involving psychological and emotional maltreatment

(Lavis *et al.* 2005). Survivors of domestic violence indicate that the term 'abuse' still tends to lessen the impact of the non – physical violence behaviours, which they consider are just to be as damaging as physical violence (Department of Health, 2010b). Aside from the terms 'domestic violence' and 'abuse', which will be used interchangeably in this thesis, other terms frequently used to explain violence against women include terms such as 'intimate partner violence' and 'gender-based violence'. Conversely, even though such terms highlight gender as being associated with the violence, at the same time they fail to acknowledge the complexity of the violence between individuals by ignoring contextual and socio-cultural factors (Heise, 1998). Another term widely used in North American literature is 'battered women'. However, this is not a term favoured or utilised within the UK context. Survivors of domestic violence feel unhappy about the use of this terminology, believing it to be labelling and judging of survivors, whilst giving the impression that all women who are subjected to violence are made feeble by the experience (Hague and Malos, 2005).

In 2004, the UK government introduced a single definition of domestic violence, with the purpose of replacing the varying definitions that were in use across the public sector. This is not a statutory definition but was introduced with the purpose of being used by all departments which inform policy development, for example, the police service, the Crown Prosecution Service and the UK Border Agency (Home Office, 2011). The current UK definition defines domestic violence as:

Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. (Home Office, 2011, p. 6)

This definition also includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, making it evident that victims are not confined to one gender or ethnic group (Home Office, 2011). Acknowledging ethnic and gender differences is important as Britain is multiethnic and previously

government bodies have been slow to acknowledge that some forms of violence and abuse may be culturally specific. Indeed some women's groups such as Southall Black Sisters and Brent Asian Women's Group in London began their own movement to bring attention to the specific experiences of domestic violence in Asian communities (Harne and Radford, 2008). However, other black and minority ethnic groups were initially more reluctant to bring attention to their plight; concerned that by speaking out about domestic violence within their own communities would be seen as condemning what they already considered what a stigmatised community (Harne and Radford, 2008). In the last decade four main issues for Black ethnic minority women have been deliberated in the media and public policy; forced marriage, female genital mutilation, honour based crime and women's Islamic dress. All four issues have helped fuel popular media representations of minority cultural and religious groups as being particularly oppressive to women (Dustin and Phillips, 2008). Dustin and Phillips (*op cit*) propose the management of these issues has been problematic, with initiatives to protect women becoming entangled with the anti-immigration agenda. Suggesting that inaction could be seen as racist but then so could action. This does little to support women who are exposed to ongoing coercion and abuse. A small number of women's groups particularly amongst Asian and African-Caribbean populations were actively campaigning and encouraging dialogue with the government and leaders of the minority communities for many years before it figured in the media representations (Gupta, 2003). However, it is important that the preoccupation of the exploitation of women from minority ethnic groups do not also feed a xenophobic agenda (Dustin and Philips, 2008). Within the UK recent indications suggest that policy is developing in a more mindful way, such encouraging outcomes are due to the tireless campaigning, and research of minority women's groups.

Currently, the debate continues amongst researchers, academics and women's groups concerning the most appropriate definition to use to define violence with an array of reasons why certain definitions should be considered. I consider there are

limitations with each of the terms as none of the terms fully take into account all the abusive acts the men perpetrated against the women in this particular study.

#### **2.4. Historical context of domestic violence**

Domestic violence has a long history and currently exists in many cultures throughout the world and is accepted as a part of everyday living (World Health Organisation, 2005), and until the late 20<sup>th</sup> century has gone mostly unchallenged. The question of what domestic violence actually is its prevalence and how best to confront it has been the subject of much discussion and debate since its identification as a social problem. Domestic violence is not a recent phenomenon, there is evidence of it in the Roman times and in the Bible, where the character and behaviour of Eve is portrayed as one of weakness and disobedience; behaviours which have formed the basis of how women are still viewed today (Hunt and Martin, 2001). Simone de Beauvoir proposed there was a strong link between Christianity and the law and the manner in which women were perceived:

Man enjoys great advantage of having God endorse the code he writes; and since man exercises a sovereign authority over women, it is especially fortunate that this authority has been vested in him by the Supreme Being (Beauvoir, 1953, p. 621)

Previously, policy makers viewed violence against women as a relatively minor social problem, especially when a husband or intimate partner perpetrated the violence. However, in the last thirty years a social change led by the efforts of feminist activists, women's organisations, academics and research institutions has been pivotal in creating awareness and leading change (Richie, 2005). What was considered as a private issue is now known to be a social problem which requires a social, clinical and political response. Such awareness raising and receptiveness has resulted in a transformation in public awareness (World Health Organisation, 2004), acknowledging that the magnitude and far-reaching consequences of the problem has led countries to pass laws and criminalise domestic violence, by providing legal,

health and social service services assistance to abused women (World Health Organisation, 2010). However, the World Health Organisation claims that regardless of such advances, there continues to be a limited effort to prevent violence and abuse occurring in the first instance (World Health Organisation, 2010).

## **2.5. Theoretical explanations for domestic violence**

Many theories have evolved in an attempt to explain the reasons for violence against women. Just as no single act of domestic violence is an accurate reflection of all violence that occurs within a relationship, no one theory fully explains what causes partner violence. Without empirical verification, theories remain speculations that remain unsubstantiated (Barnett *et al.* 2005). Historically, the prevailing attitude to domestic violence was the belief that it was a private affair between a husband and wife and that unless the violence was causing serious injury to women and children, then no one interfered. Explanations that a perpetrator may offer for his violence include resentment and jealousy against a woman, her relationship with friends and family, spending too much time away from the home, being a bad housekeeper, denying men the right to sexual intercourse or being too independent (Hague and Malos, 2005). Violence against women can also be attributed to a multifaceted collection of factors including gender inequality and social norms that exist around masculinity and economic inequality (World Health Organisation, 2010). In the absence of a single theory, an overview of several familiar theories will briefly be explored in an attempt to rationalise why domestic violence might occur.

### **2.5.1. Feminist gender theory and patriarchal society**

Male violence against women in intimate relationships is one of the most deliberate expressions of hierarchical rule and coercive control (Watkins, 2000). Hoff (1990) maintains violence against women occurs in a society which accepts the practice of socially structured inequalities, which epitomises not only the concept of patriarchy, but also sexism. Stark and Flitcraft (1996) concur with Hoff (1990), proposing that

previously little attention was paid to the interplay of macroevents such as equality and the microdynamics of male domination. In a social system where women's subordination to men is defined as natural, violence continues to be seen and accepted as a conventional means of controlling women. Even today, there is little doubt that in some countries men still have the power to kill, imprison, enslave and punish their wives and children without fear of punishment or recourse (Levesque, 2001). Several themes have been identified that may lead to domestic violence: men's possessiveness and jealousy; disagreements and expectations concerning domestic work and resources; men's sense of the right to punish their women for perceived wrong doing; the importance to men of maintaining or exercising their power and authority in their own homes. Until more recently, such traditionalist explanations have held credence with the legal system and still do in some countries where women are still expected to obey their husbands in marriage (Hague and Malos, 2005).

Feminist writer, Ann Oakley claims sex and gender is frequently used to women's disadvantage, where cultural expectations of what a woman can or cannot do is attributed to a biological law, which results in a woman being relegated to the status of a second class citizen (Oakley, 1972, 1984). This results in women being excluded from a range of activities (de Beauvoir, 1953) including sport (Young, 1990a) and to memberships of certain professions (Woodward, 2006). The roles that women play in society, unlike those of men, are determined by their biological sex (de Beauvoir, 1953). As a consequence of such beliefs feminists have sought to make a division between the biological characteristics of the female body and gender as a cultural concept (Woodward, 2008). For a long time, feminists have sought to critique essentialist understandings of gender and sex, to establish a body of research and theory in an attempt to realise how gender is connected to social, economic and cultural status and power in society (Richardson, 2008). They also reject the widespread use of so-called gender-neutral research methodologies that contain a patriarchal bias and are therefore damaging to women (Ylló, 1998). Previously, radical feminists agreed with the Marxist view that gender divisions are

primarily concerned with power and oppression. However, they did not believe gender divisions could be accounted for by capitalism and class alone. Therefore as an alternative, they started to consider whether patriarchy as opposed to capitalism was responsible for serving the interest of men above women (Hunt and Martin, 2001). Dobash and Dobash (1998) contend that violence against women has to be considered within the structure of a patriarchal partnership that exists within a patriarchal state. Alleging that the structure of society in itself is patriarchal and that neglecting to challenge gendered violence permits male violence to continue unchallenged by society (Dobash and Dobash, 1979, 1998). The World Health Organisation (2010) supports Dobash and Dobash's hypothesis by suggesting that it is often the traditional social and cultural norms that make women vulnerable to violence from their partners. Therefore, it is only by challenging and changing such social norms that domestic violence can be prevented from occurring in the first instance.

It is also important to realise that diversity and difference also exist amongst women, and that many differences exist between various groups of women, for example class, age, sexuality, ethnicity and disability. Kelly *et al.* (1994) allege some academics have neglected to recognise the differences that currently exist between women, thereby postulating that domestic violence may not be the only form of oppression that women have to endure:

Our goal now is to develop an anti-oppressive feminist praxis, which aims to both account for, and take account of, the complex interplay of multiple sources of oppression (and areas of privilege) in women's lives. (Kelly *et al.* 1994, p. 28)

Marilyn Frye (1990) supports Kelly and colleagues' inference by claiming that:

woman is not the only concept or social category that any of us live under, as no one enters the world simply as a woman. (Frye 1990, p. 176)



In her work exploring female oppression Frye contends that to recognise a person as being oppressed, one has to consider that person as belonging to a group, therefore it is necessary to assume a macroscopic rather than a microscopic view:

The experience of oppressed people is that the living of one's life is confined and shaped by forces and barriers which are not accidental or occasional and hence avoidable, but are systematically related to each other or penalize motion in any direction. (Frye, 1983, p. 4)

### **2.5.2. Biological explanations**

Biological explanations offer a collection of causal theories about domestic violence which are based on science; such justification includes chemical disruptions or hormonal imbalances of adrenalin or cortisone. Male testosterone and its relationship with an increase in aggression is often considered, suggesting such imbalances can be attributed to male acts of aggression, mood swings and deviant behaviour. Certainly, research on animals has shown that the male is much more aggressive than the female in many species. However this does not explain the high levels of violent behaviour in pre pubertal boys before their level of testosterone is significant (Hunt and Martin, 2001). Research findings which suggest a correlation between biological changes and violence have been conducted on very small samples of women rather than men. Williamson (2000a) proposes that by using the biological model to explain domestic violence repudiates the possibility of incorporating a social or political explanation for violence against women.

### **2.5.3. Psychological explanations**

Psychological explanations derive from the assumption that either one or both partners possess certain characteristics which increase their probability of experiencing partner violence (Hegarty, 2006). Such thinking includes men's loss of control and women's addiction to violence. Such explanations have derived from

medical research and are linked with deviant behaviour and mental illness (Hague and Malos, 2005). Critics of psychological explanations cite its limitations as an explanation, discounting poor mood control by suggesting that the majority of perpetrators do not have any difficulty controlling their mood in other environments outside the family home.

Another conjecture often deliberated is the belief that violent conduct can be a learned behaviour. Pertinent literature confirms the importance of childhood socialisation by establishing that male perpetrators and female victims are more likely to have come from homes where their father abused their mother (Gelles, 1991; Dobash and Dobash, 1998). At the core of such a hypothesis is the theory of modelling, suggesting that children learn social behaviour by simply imitating others. There is considerable evidence that witnessing violence on one's mother in childhood places boys at the risk of adopting similar behaviours as an adult (Hotaling and Sugarman, 1986; Johnson, 1996). This suggests boys who witness violence are taught a prevailing message about the rights of men over women, as well as the belief that men have the right to demand conformity and obedience, resorting to violence to enforce their power and control within an intimate relationship. Likewise, young girls see their mothers as powerless to prevent the violence and may carry such perceptions forward into their own adult relationships (Dobash and Dobash, 1998). Wilson *et al.* (1995) intimates that male sexual jealousy and possessiveness could be a possible explanation for men's violent behaviour against women and as such this theory may be especially salient for understanding violence against pregnant women.

Research has demonstrated that abusive partners are inclined to be sexually jealous of their partners compared to non – abusive men (Burch and Gallup, 2004; Pallitto *et al.* 2005; Bacchus *et al.* 2006). They demand exclusive ownership of their partner with the right to expect complete obedience (Dobash and Dobash, 1998). Bacchus and colleagues revealed that abused women reported increased levels of jealousy during their pregnancy from a partner who was emotionally insecure; such male

insecurities translate into an increase in violent behaviour during the woman's pregnancy (Bacchus *et al.* 2006). Taillieu and Brownridge (2010) propose the social learning theory may offer a partial rationalisation for the violence that is perpetrated against pregnant women, as several studies have identified a relationship between witnessing violence in the family home and the increased risk to becoming a perpetrator during pregnancy (Burch and Gallup, 2004; Faird *et al.* 2008). A criticism of this particular theory has to be that it does not allow for an explanation of individuals who are exposed to family violence but do not go on to emulate abusive behaviours, nor for the large number of perpetrators who are violent but were not abused themselves as children, nor came from a violent home.

#### **2.5.4. Socio-cultural explanations**

Theories which exist around socio-cultural explanations are frequently linked to social classifications, such as low income, minority status and gender, suggesting that violence stems from socioeconomic conditions such as lack of employment opportunities or poor work conditions, low wages and bad housing (Hague and Malos, 2005). In the late 1970s, poverty and unemployment, poor working conditions and excessive alcohol were frequently cited as explanations for domestic violence within a family (Hegarty, 2006). It is still considered that the presence of male frustrations caused by unequal opportunity and poverty can lead to high levels of personal frustration, which can increase the risk of aggression within a household (Barnett *et al.* 2005).

The difficulty with accepting social-cultural explanations as a possible origin of partner violence is that it can lead to an assumption that violence only occurs in poor families. Whilst a substantial amount of research has identified that living in poverty, youth and low educational attainment are all factors which can increase the risk of a women experiencing violence within an intimate relationship (Johnson, 1998; Bowen *et al.* 2005; Heaman, 2005; Martin *et al.* 2006b; Fanslow *et al.* 2008; Vieraitis *et al.* 2008; Barter *et al.* 2009), it is crucial to acknowledge that domestic

violence takes place in all social groups (Johnson, 1996; Dobash and Dobash, 1998; Hague and Molas, 2005). Indeed, Barter *et al* (2009) research involving 1353 young people demonstrated that a substantial number of young people will experience some form of domestic abuse, with one in six girls in their study revealing they had experienced some form of severe partner abuse in their relationship. Clearly demonstrating an association between domestic violence and youth. However, contrary to previous research in this field, Barter *et al* (*opcit*) study did not find an association between social deprivation and an increase in teenage partner violence.

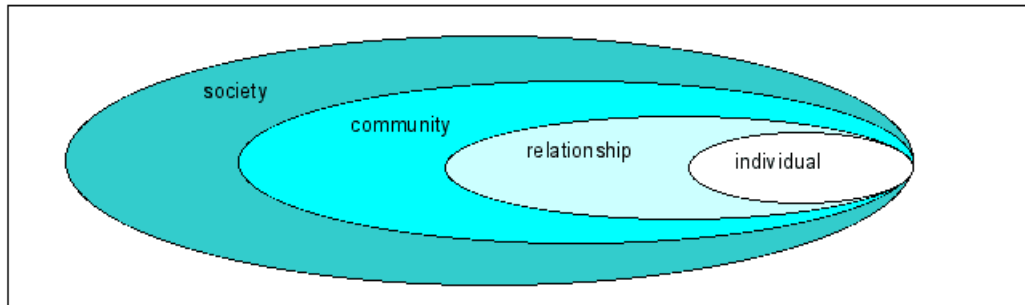
Domestic violence can remain hidden from all outside agencies for many years in professional families, because of the perception that it just does not happen (Hague and Malos, 2005). Theoretically, working outside the family home can have both a positive and negative effect for women, as it will assist to reduce isolation whilst at the same time provide a woman with a certain amount of economic freedom and may present her with the possibility of escape, although this is not necessarily always the case. Employment and income can be considered as sources of power for the woman, and therefore may be considered as threatening by the man. Refusing to allow the woman to work is one way of restoring that power (Johnson, 1996). However, the socio-cultural explanation remains inconclusive as the vast majority of men regardless of their occupation or social circumstances do not abuse their female partners.

#### **2.5.5. Ecological model of violence**

The World Health Organisation proposes the use of the ecological model as a conceptual framework for understanding the nature and causes of intimate partner violence. They consider the ecological model helps them to understand the personal, situational and socio-cultural factors that cause partner violence and abuse (Krug *et al*. 2002; World Health Organisation, 2005, 2010). Conceptualised as a set of four circles (see figure 1), the ecological model regards violence as the

result of interacting and overlapping behavioural influences that operate at four different levels of the social environment.

Figure 1: World Health Organisation Ecological Model (Krug *et al.* 2002)



The ecological model categorises risk factors for domestic violence at four distinct levels; the individual, the relationship, the community, and society (Krug *et al.* 2002; World Health Organisation, 2004; 2010). The ecological model espouses a public health approach, promoting and emphasising the multiple interactions between risk factors both within and between the different levels (World Health organisation, 2010).

### **Individual Level**

At the core of the model is the individual level and the personal characteristics which make women more or less at risk of experiencing violence. There are several factors which could be considered as increasing a woman's chances of being a victim of domestic violence. Such factors include their personal history which may influence how individuals behave and increase their likelihood of becoming a victim or perpetrator; other risk factors include alcohol or substance abuse, history of childhood abuse, psychological disorders or having experienced domestic violence and abuse in a previous relationship (World Health Organisation, 2004, 2010).

### **Relationship Level**

The relationship aspect of the model includes aspects that may increase a woman's risk of entering into an abusive relationship with an intimate partner. It includes

the persons closest to the woman who can influence her behaviour and her experiences. For example experiencing a poor relationship with a parent or having violent friends may influence whether a young person either engages in or is at risk of become a victim of violence (World Health Organisation, 2004; 2010).

### **Community Level**

The community level alludes to the community context in which social relationships are rooted and includes schools, neighbourhoods and work environments (World Health Organisation, 2010). Other risk factors include economic stress of unemployment, poor housing conditions, and economic and physical mobility (World Health Organisation, 2004).

### **Societal Factors**

Consideration of societal factors includes influences such as gender inequality, religious or cultural beliefs which create tensions between groups of people, especially in societies which sanction violence against women (World Health Organisation, 2010). Societies where women are economically dependent on men, or are dominated by men either in the home or the political arena, are inclined to have higher levels of gender violence (Heise *et al.* 1999).

The ecological model attempts to integrate a different perspective on violence against women, by suggesting there is not one single cause or explanation that predisposes a woman to becoming a victim of domestic violence. However, it must be acknowledged that risk factors are not the same as causes; violence against women must be considered within the context of structural inequality of the wider society in which it takes place.

## 2.6. Prevalence rates in the United Kingdom

Today, domestic violence continues to be one of the most common crimes that occurs in the UK. Past and current self-reporting figures from the British Crime Survey (BCS) pay testimony to this fact (Jansson 2007; Povey *et al.* 2008; Smith *et al.* 2011). The British Crime Survey is a large nationally representative victimisation survey and is considered to be the most robust method the UK currently has, for collecting figures on the extent and nature of domestic violence and abuse. It was designed to support police statistics by encapsulating violent incidents reported to the police, highlighting crimes such as domestic violence (Johnson, 1998). A selection of the UK population including women and men between the ages of 16–59 are now asked to complete a computerised self completion questionnaire on their experiences of domestic violence, sexual assault and stalking, during both their lifetime and the previous year (Povey *et al.* 2008). The findings discussed below originate from a computer assisted self-completion module on partner/intimate violence. Results from 2004/05, 2005/06 and 2006/07 BCS self completion surveys confirm that there is little evidence of any changing trends in the prevalence of partner violence between 2004 – 2007, concluding that women are generally at a higher risk than men to have experienced all types of abuse (partner abuse, family abuse, sexual assault and stalking), with 28% of women aged between 16 and 59 having experienced domestic violence (Hoare and Jansson, 2011; Smith *et al.* 2011) and for women who had been a victim of serious sexual assault since the age of sixteen, the perpetrator was a partner or ex partner (Smith *et al.* 2011). The self completion survey also indicated that on average 10,000 women are sexually assaulted and 2,000 women are raped every week (Walker *et al.* 2009a) demonstrating that despite any advances that have been made in awareness raising and policy development, the continued violence and abuse experienced by women in the UK remains an urgent and a pervasive concern. Johnson (1998) suggests that crime-victim surveys have a major flaw in their method of data collection, which is they were not designed to measure sensitive experiences of violence which predominantly affect women. The findings of the BCS almost certainly under

represented sexual and physical violence against female partners when compared to surveys which have specifically focused on these topics.

Radford and Harne (2008) support Johnson's inference by suggesting that there are several failings with regard to how data from population surveys such as the BCS are collected and interpreted. They believe such data collection methods do not provide an accurate representation of the situation, a case in point being, that only residents in private households are interviewed and provided with the opportunity to complete the questionnaire. Women who are in temporary accommodation or refuges are excluded from the data collection. As a result of focusing on private households, the BCS is very unlikely to include the considerable numbers of women who are actually experiencing domestic violence. Another anxiety about collecting domestic violence data from crime surveys is highlighted by Dobash and Dobash (1992) who suggest that collecting data in this manner does not truly reflect the social context in which the violence occurs.

### **2.6.1. Prevalence rates within UK health settings**

Higher rates of domestic violence have been reported in surveys conducted in health settings than in the general population, thereby indicating that female survivors are more likely to access health services than women who have not experienced partner violence. Women experiencing domestic violence will seek help by attending accident and emergency units approximately three times more than non abused women (Campbell, 2002). They are also much more likely to be frequent attendees at their General Practitioner Practice (GP) (Hegarty, 2002; 2006). A cross - sectional survey of women conducted in East London who were attending their general practice surgeries established that 41% had endured a lifetime of physical and/or sexual violence from a current or former partner and 17% had experienced violence within the past year (Richardson *et al.* 2002), demonstrating that healthcare services, and in particular GP's can be a source from which survivors are mostly likely to seek advice, support and help. Despite the



evidence which suggests that women are frequent users of the health service, thereby presenting ample opportunities for disclosure, in reality very few women are identified by healthcare professionals (Feder *et al.* 2005).

## **2.7. Health consequences of violence against women**

It is now widely accepted that violence against women is a major public health issue and according to the World Health Organisation (2010) is the main explanation of women's poor health. The physical and emotional consequences of violence are immense, as depicted by Heise *et al.* (2002)

It is a profound health problem, sapping women's energy, compromising their physical health and eroding their self esteem (Heise *et al.* 2002, p. 5)

The World Health Organisation survey in 2005 found that in the majority of settings, women who had experienced physical and sexual violence were at much higher risk of experiencing poor or very poor health outcomes (World Health Organisation, 2005). Domestic violence and sexual abuse against women and young girls can lead to serious injury, disability and death as well as indirect health consequences such as psychological disorders like post traumatic stress disorder, depression, sleep disorders, suicide, social withdrawal and eating disorders, self harm and substance abuse. In comparison to non abused women, women in abusive relationships report higher rates of sexually transmitted diseases, including human deficiency virus (HIV), unintended pregnancies, repeated abortions and gynaecological problems (Department of Health, 2010a; World Health Organisation, 2010). Women with an unintended pregnancy are at increased risk for pregnancy violence compared with women whose pregnancies are intended (Stewart and Cecutti, 1993; Goodwin *et al.* 2000; Jasinski, 2001; Saltzman *et al.* 2003).

Women who are physically assaulted by their violent partner are also at high risk of sexual assault and rape as part of the pattern of abuse (John *et al.* 2004). Sexual violence is considered to be highly prevalent among women who are physically abused and often results in serious medical and emotional health consequences (Campbell *et al.* 1995; Campbell and Soeken, 1999a; Kelly and Radford, 1998; World Health Organisation, 2004). Sexual assault is also associated with a range of gynaecological complications, including vaginal infections, vaginal bleeding, chronic pelvic pain and recurrent urinary infections (Golding, 1996). A woman may have very little control over her own or her partner's use of contraception and may often be fearful of insisting on the use of contraception or condom use (Campbell, 2002; World Health Organisation, 2002, 2005).

Living with sexual and physical violence can lead a woman to attempt suicide as a means of escape from the relationship (World Health Organisation, 2002). Stark and Flitcraft (1995) confirmed the link between pregnancy abuse and the risk of maternal suicide establishing, that 19.2% of pregnant women who experience abuse will attempt suicide, compared to 5% of non abused pregnant women. This worrying statistic brought an acknowledgement from the previous three UK confidential reports into maternal deaths, that a clear association between domestic violence, pregnancy and suicide can be established (Lewis, 2004, Lewis, 2007, Lewis, 2011). Living and surviving with continued physical, sexual and psychological violence may induce the woman to draw on high risk behaviours to help her manage the violence; such behaviours could include smoking and the harmful use of alcohol and drugs (World Health Organisation, 2010).

### **2.7.1. The policy context and the response of health**

It could be suggested that until recently the NHS has, for the most part, only dealt with the physical consequences of domestic violence and that proactive identification has been poor. Health care professionals should be practising within the remit of the Human Rights Act (HM Government, 1998a), Crime and Disorder

Act (HM Government, 1998b) and more recently the Domestic Violence, Crime and Victims Bill (House of Commons, 2003). Such Acts place an obligation on Primary Care Trusts and NHS Trusts to respond responsibly and effectively to domestic violence. Indeed, the publication of the 2002 World Report on Violence and Health highlighted that globally health was neglecting its role in preventing violence and instead was spending more time dealing with the consequences of domestic violence rather than preventing it (World Health Organisation, 2002). The financial costs of dealing with domestic violence within the UK are significant. Figures published by Walby in 2004 established the annual cost to the economy was approximately £22.9 billion, with the annual cost to the NHS alone for dealing purely with the physical consequences of domestic violence, equated to £1.2 billion (Walby, 2004). More recently, professionals have begun to focus their attention on domestic violence, although this has been more effective in some areas of the NHS than others (Lavis *et al.* 2005; Department of Health, 2010a). Despite the prevalent nature of abuse, there has been and continues to be, reluctance amongst professionals to enquire about or respond to domestic violence within personal and family relationships. This reluctance has been attributed to health professionals' lack of awareness, lack of training and feeling unprepared to deal with a woman's disclosure of domestic violence. In addition the fear of offending the woman and time constraints within clinical practice (Bacchus *et al.* 2007; Salmon *et al.* 2006; Baird *et al.* 2011) or their own biases regarding who is at risk, often resulting in selective screening (Bohn *et al.* 2004). One contributory factor is the misconceptions about the aetiology of domestic violence which contributes to victim blaming and decreases the willingness and motivation of professionals to be proactive in the identification of domestic violence and abuse as part of their role (Williamson, 2000a). Consequently, such beliefs and attitudes result in a woman being stigmatised, feeling judged and made to feel responsible for the violence.

In 2006, findings from a systematic review of 15 controlled studies demonstrated that the training of professionals and organisational change within health-care systems can make a difference, by increasing the identification of women

experiencing domestic violence (Ramsay *et al.* 2006). However, it also exposed uncertainty about the effect of such interventions in terms of referral to specialist services or indeed of any other outcome measure beyond identification (Ramsay *et al.* 2006). Recognition of the relationship between domestic violence and health has resulted in several UK professional bodies such as the Royal College of Midwives (2006) The Royal College of Nursing (2000) and the British Medical Council (1998) issuing guidelines and policies for tackling domestic violence. They have also highlighted the expected role of health professionals in addressing domestic violence. Government departments have also started to respond to domestic violence (Women and Equality Unit 2004; Department of Health 2005; Home Office 2008, 2011; The Crown Prosecution Service 2009). In 2005, the Department of Health updated their 2000 handbook for professionals, advocating that all Trusts should be working towards routine enquiry and providing women with advice about available domestic violence support services. The updated handbook endorsed that any implementation approach must also be supported by clear guidelines and training for health professionals (Department of Health, 2005).

There was a clear expectation from the UK government that local partnerships which were set up under the Crime and Disorder Act 1998 should now be working together, to identify domestic violence at a local level, and developing approaches for the purpose of reducing domestic violence, as a part of a wider crime reduction programme (HM Government, 1998b). In 2004, an amendment to the 1998 Crime and Disorder Act (HM Government, 1998b) extended the scope of domestic violence legislation to include recognition of domestic violence within same sex relationships, and non co-habiting relationships. Primary Care Trusts were given a statutory duty to work within Crime Disorder Reduction Partnerships. The amendment to the Act made clear the expectation for health services with regard to their identification and support of survivors. The extensive consultation, 'Together we can end violence against women and girls' conducted for the Home Office in 2009 identified that the National Health Service (NHS) had to do better in responding to victims of violence in terms of treatment and support of survivors.

The consultation also advocated that the NHS had to continue to foster strong partnerships with local statutory and non-statutory organisations (HM Government, 2010).

The Health Service Taskforce on Health was established by the Department of Health in 2009 with the purpose to explore what health services could do to prevent violence against women and girls. The taskforce identified that an integrated approach will best serve women and children who are experiencing domestic violence. In 2010 the taskforce published a report with 22 recommendations. This included amongst others, the requirement for training and education for all staff, the need for Primary Care Trust (PCTs) and NHS Trusts to promote partnerships with local third sector agencies, thereby ensuring that appropriate services are available for survivors of abuse. They also advocated the continuation and development of Multi-Agency Risk Assessment Conferences (MARACs) and Crime and Disorder Reduction Partnerships (CDRPs), stating that the continuation of such partnerships should be encouraged to further cultivate partnership working (Department of Health, 2010a). As a result of the findings from the taskforce the government published the Call to End Violence Against Women and Girls Action Plan, (HM Government, 2011). The plan focused on four key areas, these included: Challenging the attitudes and behaviours which foster domestic violence; providing adequate levels of support where violence does occur; working in partnership with the purpose of achieving the best outcome for survivors and families; taking action to reduce the risk to women and girls who are victims and to ensure perpetrators are brought to justice (HM Government, 2011). More recently, the Department of Health produced guidelines to support health commissioners to improve the commissioning of services for women and children who experience domestic violence. The Department of Health will encourage health commissioners to use the guidance when they are planning, reviewing, commissioning and evaluating local services. The guidelines also encourage the practice of commissioners engaging women in planning and evaluating the services (Department of Health, 2011).

### **2.7.2. Domestic violence during pregnancy**

Experiencing domestic violence at any time in a woman's life can result in a multitude of harmful health problems. However, violence during pregnancy is of special concern as the violence not only poses a threat to the woman but also to her fetus (Saltzman, 1990; Campell *et al.* 1998; Harne and Radford, 2008). Research findings suggest that pregnancy itself can act as a trigger for domestic violence or exacerbate ongoing existing violence (Helton *et al.* 1987; Campbell *et al.* 1992; Webster *et al.* 1996; Bewley *et al.* 1997; Valladares *et al.* 2002). It is estimated that for almost 30% of women who suffer from domestic violence in their lifetime, the first incidence of violence will occur during pregnancy (Helton *et al.* 1987; Women and Equality Unit 2004). Based on findings from interviews with women, Campbell *et al.* (1993) proposed four possible explanations why men may perpetrate violence against their partner during pregnancy: they included jealousy towards the unborn child, anger towards the unborn child, pregnancy specific violence not directed at the unborn child and 'business as usual'.

The World Health Organisation (2005) review of 48 worldwide studies established the incidence of physically abused women during pregnancy to be greater than 5% in eleven of the fifteen countries considered, with between 13% and 50% of the populations studied stating that they were abused for the first time during pregnancy (Stewart and Cecutti, 1993; Valladares *et al.* 2002; Janseen *et al.* 2003; Bohn *et al.* 2004; Renker and Tonkin, 2006). Yet, in contrast there is also evidence which suggests that for some women, a pregnancy may be a protector from domestic violence. Of those reporting a past history of abuse, 30% to 68.7% reported that the violence stopped whilst they were pregnant (Helton, 1987; Martin *et al.* 2001; Saltzman *et al.* 2003; Bohn *et al.* 2004; Guo *et al.* 2004; Renker and Tonkin 2006). Notwithstanding such findings, what is known is that a past history of violence and abuse is one of the strongest predictors of pregnancy violence (Martin *et al.* 2001). Between 60% and 96% of women who are abused during pregnancy were experiencing violence prior to their pregnancy, suggesting that violence during pregnancy is in fact a continuation of pre-existing violence for the majority of

women (Taillieu and Brownridge, 2010). However, studies reporting on emotional and sexual abuse were more likely to testify that a pregnancy was also associated with an increase in psychological and sexual abuse for women experiencing domestic violence, when compared to women without a similar history (Janssen *et al.* 2003; Martin *et al.* 2004). Therefore a decline in physical violence during pregnancy may result in an increase in psychological and sexual violence.

A review of prevalence rates of domestic violence from developed countries up to 1996, signified rates of partner abuse during pregnancy ranging from 0.9% to 20.6% with most of the literature supporting figures of between 3.9% and 8.3%. A similar review examining prevalence rates since 1996, including both developed and developing countries as well as considering multiple forms of violence, found prevalence rates of physical violence to be between 0.9% and 30%, with eleven of the eighteen studies reporting the rate of physical violence between 3.0% and 10.9% (Muhajarine and D'Arcy, 1999; Covington *et al.* 2001; Johnson *et al.* 2003; Bacchus *et al.* 2004a; Dunn and Oths, 2004; Saltzman *et al.* 2003; Heaman, 2005). Prevalence rates from developing countries ranged from 1.3 % to 12.6% for physical violence (Leung *et al.* 1999; Guo *et al.* 2004; Faid *et al.* 2008; Peralas *et al.* 2009). A number of studies also explored emotional and/or verbal abuse and reported higher prevalence rates ranging from 1.5% to 36% (Shumway *et al.* 1999; Janseen *et al.* 2003; Yost *et al.* 2005; Charles and Perreira, 2007). Unfortunately, the majority of studies did not report on sexual abuse. However, those that did reported prevalence rates of between 1% and 3.9% (Bacchus *et al.* 2004a; Peralas *et al.* 2009). It is thought that the wide variation of prevalence rates between countries can be attributed to the varying research study designs being utilised to explore the topic, the variability in definition, the population studied, and socio-cultural differences (Ellsberg, *et al.* 2001, Shah and Shah, 2010; Urquia *et al.* 2011). Taft (2002) proposes the difficulty in achieving an accurate measurement of prevalence rates can also be attributed to researchers from various disciplines and theoretical backgrounds using different definitions and different tools to measure the same problem.

Studies using very detailed multiple item violence measures in their analyses and screening of women on several occasions throughout their pregnancies, reported higher prevalence rates of physical violence during pregnancy. For example, a study conducted by Bohn *et al.* (2004) exploring the influence of socio-economic status, education, ethnicity and age in relation to prevalence, found the level of a woman's education emerged as the most significant predictor of both partner abuse and partner abuse during pregnancy, although Bohn's *et al.* findings are in direct opposition with Johnson's (1996) earlier work, involving 12,300 women in a survey in Canada. This concluded that for this particular cohort of women, education status was the only one of all the attachment and commitment predictors that was not a significant predictor of partner abuse. The level of a woman's education is understandably significant as it will affect her employment opportunities and income potential, potentially trapping her in a violent relationship if she is unable to support herself or her children.

Such disparities in prevalence rates demonstrate the challenge of estimating correctly the magnitude of the problem (Bacchus *et al.* 2007), which is extremely important when attempting to consider and promote arguments for the continuation of screening in health settings (Taft, 2002). Regardless of the variation in prevalence, the risk factors and incidence rates are still higher than for other common complications of pregnancy for which women are regularly screened during pregnancy (McFarlane *et al.* 1996a; Gazmararian *et al.* 2000). Several studies have specified that the risk of violence is much higher for younger mothers during pregnancy (Campbell, 1993; Parker *et al.* 1993; Parker *et al.* 1994; Stewart and Cecutti, 1993; Muhajarine and D'Arcy, 1999; Janseen *et al.* 2003; Saltzman *et al.* 2003; Bohn *et al.* 2004; Heaman, 2005). Indeed, Saltzman *et al.* (2003) found that women less than 20 years of age had a 4.3% increased risk of experiencing violence during pregnancy, when compared to women of more than thirty years of age. However, Taillieu and Brownridge (2010) advocate caution when interpreting such data, as analysis was limited to bivariate analyses and whilst the relationship



between age and an increased risk of pregnancy violence is significant in bivariate analysis, the association becomes non significant when controlled in multi-variate analysis (Gelles, 1988; Muhajarine and D'Arcy, 1999; Janseen *et al.* 2003; Bohn *et al.* 2004; Dunn and Oths, 2004). Consequently, it remains unclear whether young maternal age is in itself a significant risk factor for pregnancy violence.

Unfortunately, UK based prevalence studies examining domestic violence during pregnancy are in the main deficient in quantity. Nonetheless, the limited UK based studies that are available which have examined prevalence rates, report rates of between 2.5% and 5.8% (Richardson, *et al.* 2002; Johnson *et al.* 2003; Bacchus *et al.* 2004a, 2004b, Bowen *et al.* 2005). One UK study found that women were ten times more likely to experience domestic violence during their current pregnancy if they had been experiencing domestic violence in the previous twelve months (Bacchus *et al.* 2004a). Regardless of variations in prevalence rates, it is apparent that a substantial minority of women experience violence during pregnancy and for the majority of those women the violence will continue into the postnatal period (Mezey and Bewley, 1997; Martin *et al.* 2001; Charles and Perreira, 2007; Taillieu and Brownridge, 2010).

Taillieu and Brownridge (2010) suggest knowing the prevalence, frequency and severity of pregnancy violence is crucial because it demonstrates the extent to which pregnancy can be considered a particularly vulnerable time. Women who continue to experience violence during their pregnancy are much more likely to be at a higher risk of experiencing extreme violence than women who do not experience violence whilst pregnant (McFarlane *et al.* 1995, 2002; Campbell, 1999; Krulewitch *et al.* 2001; Burch and Gallup, 2004, Martin *et al.* 2007).

### **2.7.3. Impact of violence during pregnancy**

Regardless of the ongoing debate as to whether pregnancy acts as a trigger for domestic abuse or exacerbates existing violence, what is clearly identifiable is that violence and abuse is extremely detrimental to a woman and her unborn child. A

précis of the literature deduces that domestic violence during pregnancy presents a serious health problem; it causes physical injuries and psychological trauma to the pregnant women and poses a threat to the unborn child. More recently attention has begun to focus on pregnancy associated deaths (Martin *et al.* 2007; Lewis, 2004, 2007, 2011) which occur during pregnancy and in the postpartum period, and are referred to as maternal deaths. The current and previous two Triennial Reviews examining maternal deaths within the UK have reported on maternal deaths attributed to domestic violence (Lewis, 2004, 2007, 2011). The most recent 'Centre for Maternal and Child Enquires Report' (CMACE) (2011) testified that of the fifty deaths between the years of 2006 - 2008, thirty four of the women had features of domestic violence, for 11 of the 34 women, domestic violence was the actual cause of their death. In most cases the perpetrator was the woman's partner. This supports Campbell *et al.*'s. (1998) hypothesis which suggests that:

A woman abused during pregnancy is being battered by a particularly dangerous man. Therefore it is important to discuss potential long – term risk of homicide with women abused during pregnancy, even when their current abuse is not severe. (Campbell *et al.* 1998, p. 97)

As previously discussed, contributing factors which may increase the risk of pregnancy complications, include an unintended pregnancy, late entry into and inadequate antenatal care, miscarriage, antepartum haemorrhage, preterm labour, low birth weight for gestational age, maternal and fetal injuries and death (Shumway *et al.* 1999; Covington *et al.* 2001; Valladares *et al.* 2002; Janssen *et al.* 2003; El Kady *et al.* 2005; Shah and Shah, 2010). Shah and Shah (2010) conducted a systematic review of 30 studies reporting on the rates of low birth weight, preterm birth, and babies born small for gestational age. Their review identified that women who were exposed to domestic violence during pregnancy had a significant increased risk of low birth weight and preterm birth and babies born small for gestational age. During the pregnancy, the injuries focus on the centre of the body,

the abdomen, breasts and genitalia (Hedin-Widding and Janson, 2000). Such injuries can cause perinatal death due to placental abruption, and maternal uterine rupture. Boy and Salihu (2004) reported on one study which found that 88% of the female participants had been physically attacked during pregnancy, resulting in eight fetal deaths. A survey conducted by McWilliams and McKiernan (1993) of women living in Northern Ireland refuges found that 60% of the women had experienced domestic violence during their pregnancy, consequentially, 13% endured subsequent miscarriages.

There are also a number of high-risk harmful behaviours to both the mother and her unborn child which may occur as the woman seeks to escape from the violence. Such behaviours include smoking, alcohol abuse, drug taking, (prescribed and illegal), all described as a means of coping with the violence and abuse, (Bullock & McFarlane 1989, Mc Farlane *et al.* 1995, 1996b; Valladares *et al.* 2002; Neggers *et al.* 2004; EL Kady *et al.* 2005; Faramrzi *et al.* 2005; World Health Organisation, 2010). There is also some indication that violence during pregnancy is not a one off event, Martin *et al.* (2004) revealed that on average abused pregnant women experienced one violent attack resulting in one injury per month, signifying that pregnancy is not a protector against violence and abuse. Reproductive health outcomes are also associated with domestic violence, and these include the non-use of contraception leading to unplanned and/or unwanted pregnancies (Price *et al.* 2007). Women who experience violence during pregnancy are also at an increased risk of adverse mental health outcomes. Campbell and Lewandowski (1997) intimate that the psychological health consequences of experiencing domestic violence prompt women to seek health care services as frequently as for physical health problems. Controlled studies have consistently found that women who are experiencing domestic violence have more depressive symptoms than other women (Ratner, 1993; Mc Cauley *et al.* 1996). Dunn and Oths (2004) also report that women abused during pregnancy are two and a half times more likely to report being depressed. Despite such findings, the requirement to assess for the

association of domestic violence and depression has seldom been recognised amongst health care professionals.

#### **2.7.4. Current debate about the appropriateness of routine enquiry**

It is important to acknowledge that women may not ordinarily elect to self disclose about their abusive experiences to health professionals. However, the use of brief questions by professionals has been shown to lead to a higher rate of disclosure (Bacchus *et al.* 2002, 2007; Salmon *et al.* 2004). Within the context of the UK, there is evidence available which suggests women support routine questioning if they are asked in a sensitive manner and by a well trained professional (Bacchus *et al.* 2002, 2007; Baird *et al.* 2011; Feder *et al.* 2011). Yet, the debate is ongoing about the best way to identify and support women who are in abusive relationships. There remains an uncertainty whether routine enquiry for partner violence in health settings is appropriate or indeed effective (Feder *et al.* 2009). There have been several systematic reviews which report a lack of robust evidence demonstrating the effectiveness of health services intervention for routine enquiry for domestic violence (Ramsay *et al.* 2002; Wathen and MacMillan, 2003; Kataoka *et al.* 2004; Ramsay *et al.* 2006; Feder *et al.* 2009; O'Reilly *et al.* 2010).

A review by Ramsay *et al.* (2006) concluded that advocacy intervention for women who sought help from professional services, or were residing in refuges, could reduce the level of abuse and increase social support and increase their quality of life. However, Ramsay and colleagues also concluded that there was a lack of evidence supporting interventions in health settings. A more recent review by Feder *et al.* (2009) supported the findings of previous reviews, concluding there was a lack of evidence indicating improved morbidity or mortality outcomes from screening. As such, there is insufficient evidence to justify implementing screening programmes in all health care settings. Conversely, although routine enquiry has not been found to be effective, this may be because previous reviews included

broader populations of women which only included two studies specifically on pregnant women (O'Reilly *et al.* 2010). By contrast, the systematic review conducted by O'Reilly and colleagues specifically focused on pregnant women, and demonstrated that domestic violence routine enquiry is indeed effective in pregnant populations (O'Reilly, *et al.* 2010).

Bacchus *et al.* (2007) conducted a two year evaluation of a domestic violence intervention, in a maternity and sexual health service, in a UK hospital. The intervention incorporated guidelines, staff training, and inclusion of routine enquiry for domestic violence for all clients and a referral of women who disclosed a history of abuse to an on-site advocacy service, which was provided by a community organisation. Results of the study concluded that domestic violence training of maternity and sexual health staff resulted in changes in some professionals' knowledge and their practice in the short term. However, in the main, universal routine enquiry was not achieved. Feder *et al.* (2011) conducted a cluster randomised controlled trial in two urban Primary Care Trusts in England. The intervention included two practice based training sessions for all the primary care team, including GPs, practice nurses, midwives, a prompt within the medical record to ask about abuse and a referral pathway to a named domestic violence advocate. The primary outcome was the recorded referral rate of patients to local domestic violence advocacy services. A secondary outcome was a recorded identification of domestic violence in the patient records. Results demonstrated that one year after the GP practice's receiving their second training session, the 24 intervention practices referred 223 patients to advocacy services and the 24 control practices referred 12 patients. The intervention practice recorded 641 disclosures of domestic violence and the control practices recorded 236 disclosures. Such findings from Bacchus *et al.* (2007) and Feder *et al.* (2011) suggest that if healthcare professionals are provided with training and a support programme with a referral pathway to a specialist domestic advocacy service, referral rates will improve. There is a need for further research within maternity settings, to explore the long-term effectiveness of an advocacy intervention which can evaluate the implementation and outcomes of women centred interventions. Such studies must also include

qualitative studies examining what women want or what they think should be included in an intervention during pregnancy and the postnatal period. Without such evidence, professionals will fail to see the bigger picture of potential benefits of routine enquiry of pregnant women for domestic violence.

#### **2.7.4.1. Routine enquiry for domestic violence during pregnancy**

Professional and governmental bodies have advocated implementation of routine enquiry in the maternity services (Department of Health, 2000, 2005, Royal College of Nursing, 2000; Royal College of Midwives, 2006; Lewis, 2007, 2011). It is now considered a professional expectation that every midwife will routinely ask all unaccompanied women that attend for antenatal care whether they are experiencing domestic violence. It has been suggested that within healthcare, maternity services have led the way with regard to introducing routine enquiry for domestic violence, with the majority of maternity units in the UK promoting routine enquiry for all pregnant women (Bacchus *et al.* 2007). This change in practice has followed guidance and practice recommendations from the Department of Health, Confidential Enquiry for Maternal Deaths, and various other professional and policy documents. Such a change in policy and practice has to be dealt with cautiously, as it is imperative that before the universal implementation of such a strategy, clinicians are supported to implement such a change. Support mechanisms include the establishment of evaluated training, with clear systems identified for safe documentation and referral to other agencies, for all areas where routine enquiry occurs.

There is no doubt that domestic violence is a challenging and difficult subject for many professionals including midwives. However, due to the nature of the midwives' role and the intimacy of the relationship that can develop between a woman and her midwife, midwives may be the first professional to whom a woman may disclose her situation (Price *et al.* 2007). There is also some evidence which

suggests that although midwives are often considered ideally placed to identify and support women experiencing violence, some midwives may find it difficult to initiate a discussion about domestic violence (Scobie and McGuire, 1999; Morgan, 2003; Price and Baird, 2003; Lavis *et al.* 2005; Salmon *et al.* 2005). Midwifery remains a predominantly female profession and as such, many midwives may have been personally affected by domestic violence. Such personal experiences may inhibit a midwife's ability to provide support to a woman, who is also experiencing domestic violence. There are other difficulties within clinical settings that may prevent midwives from offering support. Attitudes, knowledge and confidence will also affect the midwives' ability and willingness to routinely enquire about domestic violence (Torres-Vitolas, 2010). A Scottish study undertaken in the late 1990s identified that midwives felt inadequately prepared to ask women about domestic violence and therefore were reluctant to do so (Scobie and McGuire, 1999). The findings of Scobie and McGuire were endorsed by Price and Baird (2003) who identified that midwives were unwilling to ask women about domestic violence on a routine basis without ongoing support and training. This view was shared and supported by Taket *et al.* (2003) who identified that although some health professionals recognise domestic violence, they cannot be expected to respond to such a sensitive issue without training and knowledge of available advocacy support services.

Salmon *et al.*'s. (2004) evaluation of the Bristol Pregnancy Domestic Violence programme (BPDVP) sought to evaluate the impact of an educational and support programme, which aimed to equip a group of community midwives with the skills, knowledge and confidence to effectively enquire about domestic violence in the antenatal period. The training was positively received and was associated with an increased confidence to raise and respond to the issue. There was also evidence of improvements in increased knowledge, changed attitudes and more efficacy at post-test and follow up.

Studies conducted by Salmon *et al.* (2004) and Mezey *et al.* (2003) identified that there were other barriers to routine enquiry, including organisational barriers such as lone working, practitioner safety, time constraints, language barriers for non English speaking women and a lack of opportunity to ask the question as it was difficult to organise time alone with the woman without her partner being present. Despite such organisational difficulties, a recent systematic review of nine studies conducted by O'Reilly *et al.* (2010) suggested that the implementation of screening tools during the antenatal period does increase the identification of domestic violence.

Previous work from the UK and overseas has established that the majority of women do find being asked about a history of violence by a health professional acceptable, especially when there is a recognised relationship between the woman and the health professional (Webster *et al.* 2001; Gielen *et al.* 2003; Bacchus *et al.* 2007; Renker and Tonkin, 2006; Baird *et al.* 2011; Feder *et al.* 2011). In contrast to the findings and recommendations of recent systematic reviews, academics and women's groups suggest that there are potential benefits to women when domestic violence enquiry occurs routinely. It provides a woman with the opportunity to talk about the abuse, thereby removing some of the feelings of isolation and may also result in her accessing specialised support services (Taket *et al.* 2003). Women can find routine enquiry helpful even if they decide not to disclose, as it helps to make them aware that support is available, should they wish to disclose the abuse at a later date. Following a comprehensive evaluation of all existing research exploring the prevalence of partner violence amongst the pregnant population, Taillieu and Brownridge (2010) advocate that universal routine enquiry in maternity settings is warranted and appropriate and therefore should be continued.

## **Summary**

In this chapter I have identified that violence against women is a serious social issue that erodes the very fabric of a woman's emotional and social world. This is a world that many others including professionals have limited or no access to, as much of



the harmful behaviour takes place behind closed doors. It is only in the last few decades that academics and researchers have begun to uncover the true costs of domestic violence and its impact on a woman's health. Studies on domestic violence during pregnancy have demonstrated that domestic violence is directly and indirectly detrimental to maternal and fetal well being. However, so far much of the evidence that is available has been focused on the prevalence and epidemiology of violence against women, resulting in the marginalisation of women's experiences.

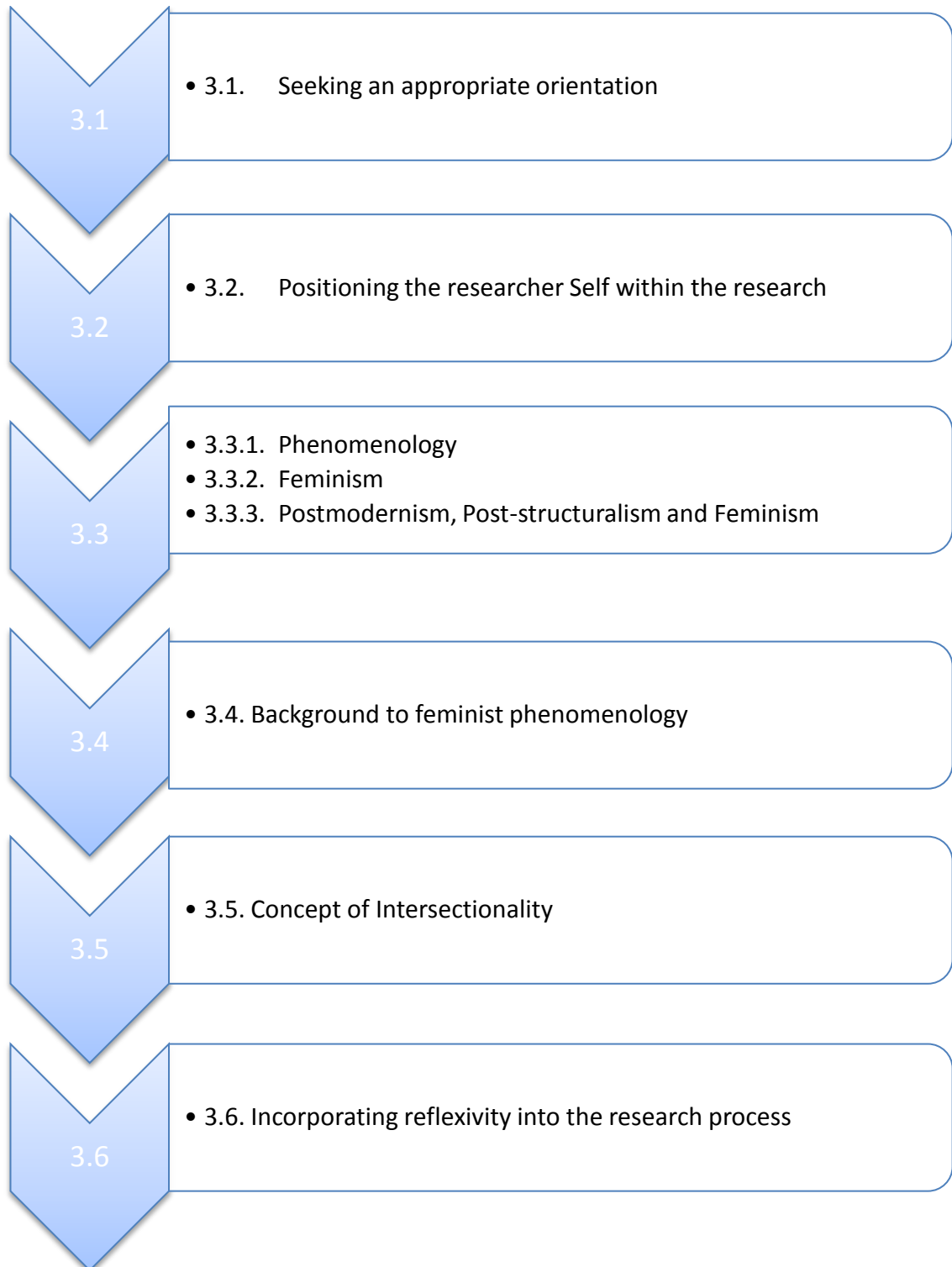
Most women in the UK will have an occasion to access the Health Service at some point in their lives, and women who are experiencing domestic violence will frequently seek out services for stress related ailments and treatment for their injuries. This provides health professionals with a unique opportunity to assess for domestic violence, and if identified, offer appropriate support and referral to specialist domestic violence advocacy agencies. However, a multitude of professional and structural obstructions have been identified as potential barriers to routine enquiry in settings.

It is anticipated that my PhD research will uncover some of the complexity of the hidden world of domestic violence within the context of pregnancy as told by the women themselves placing them at the centre of the analysis exploring men's violence and domination during pregnancy. Chapter three will introduce and justify my purpose for employing feminist phenomenology as an appropriate methodology.

## PART TWO

### Philosophical Orientation and Theoretical Contributions

#### Structure of Chapter Three



## Chapter Three

### Philosophical Orientation and Theoretical Contributions

#### Introduction

The purpose of this chapter is to justify my intentions for utilising feminist phenomenology as an appropriate methodology for my research question, whilst describing why phenomenology is philosophically compatible with some important feminist values and principles. To conclude, I will discuss how I depended upon a reflexive approach throughout the research.

#### 3.1. Seeking an appropriate orientation

There were several factors to be considered when I was deciding upon an appropriate orientation for my study. For example, as the main intention of the study was to explore women's experiences of domestic violence during their pregnancy, it was essential that any approach chosen would allow their voices to be heard. I was also aware of the very sensitive nature of the subject, which had the potential to be emotionally distressing, not only for the women but also for me. Therefore, it was essential that I considered my values and beliefs in relation to my philosophical position. Indeed, Liamputtong (2010) reinforces the importance of researchers examining their own ontological and epistemological position, as this may determine the manner in which a researcher conducts their research.

Liamputtong (2010) claims researchers who wish to consider the subjective nature of a phenomenon whilst also exploring the many realities of those involved in the research, should adopt an interpretivist paradigm. To this end, qualitative research is well suited to understanding the meanings and subjective experiences of individuals, and it is therefore appropriate to explore women's experiences of violence and abuse during their pregnancy. I sought to utilise an orientation which

would allow me to listen to and interpret the voices of the women who are marginalised and have often been denied the opportunity to have their voice heard or acknowledged. It was also important to empower the participants in the study to convey their own feelings and experiences in their own words (Liamputtong, 2007, 2010; Bryman, 2008). Bryman (2008) proposes that qualitative research, as a set of interpretative practices, privileges no single methodology over any other. However, according to Hitchcock and Hughes (1995) this can lead to qualitative research being difficult to define, often leading to the criticism that qualitative research in itself has no theory or paradigm (Hitchcock and Hughes 1995), nor does it have a distinct set of methods. Nevertheless, a common attribute that all interpretivists share is the philosophical belief that human nature can only be realised when the environment in which it takes place and the thinking processes that originate from it are studied together (Silverman, 2000; Parahoo, 2006; Bryman, 2008; Liamputtong, 2010). Indeed the methods used by qualitative researchers share a common belief in that they can bequeath a 'deeper' understanding of social phenomena (Silverman, 2000, 2011).

Sarantakos (2005) considers that qualitative methodologies are based on the premise that when it comes to understanding human experience, the separation between researcher and the researched, between subject and object, is a fiction with the researcher themselves becoming an apparatus of the data collection. This happens in as much as the researcher has to possess the ability to think about questions during the interview and be able to get as close as possible to the perception and experiences of the participant. Parahoo (2006) suggests an interviewer with personable skills is absolutely vital when conducting qualitative research, as a dispassionate or uninterested interviewer is very unlikely to build up a relationship of trust with the participants or empower them to relate their experiences. Without doubt, qualitative researchers appear to exemplify a common belief that they can provide a deeper understanding of social phenomena than would be obtained from using quantitative data (Parahoo, 2006; Bryman, 2008, Silverman, 2011).

### **3.2. Positioning the researcher 'Self' within the research**

In this section of the chapter, I intend to discuss my own philosophical position in relation to the research. I aim to discuss and emphasise the qualities and the suitability of the theoretical approach chosen.

Having decided to utilise the qualitative, interpretative approach which focuses on human experience, I then had to have a framework which would best suit the purpose of my research. Liamputtong (2010) suggests that researchers, based on their personal preferences should not favour one approach over another, it is important that they consider the research questions which they want answered. Regardless of the approach chosen, it was crucial that trustworthiness of the research could be achieved and Liamputtong (2010) refers to the work of Guba and Lincoln (1985, 1994) who present an exemplar of trustworthiness. Guba and Lincoln (1985, 1994) are critical of and oppose the view that, there are absolute truths about the social world and suggest that there can be more than one account. They propose that a simple application of reliability and validity to qualitative research is contradictory, as no single absolute of social reality is possible. However, at the same time, they are resolute that qualitative researchers must also establish ways of assessing the quality of qualitative research that provides an alternative to reliability and validity. The criteria they propose have four components, all of which are commensurate to quantitative research; creditability which equates to internal validity; transferability which equates to external validity; dependability which equates to reliability, and lastly conformability, which equates to objectivity (Guba and Lincoln, 1994; Bryman, 2008). I endeavoured to contemplate the four components at every juncture of the research from the planning stage to writing up the thesis and dissemination of the research. My aim is to make these processes transparent throughout the thesis.

I began this research with empathy for feminism. My awareness of feminist theories arose out of an interest in women's studies, and a quest to develop midwifery knowledge. I have always held the belief that the experiences of women are important, yet they are often ignored in what can be considered as a male dominated society (de Beauvoir, 1953, 1989; Yllö and Bogard, 1988; Bowles and Klein, 1989; Bulter, 1990a; Reinharz 1992; Ribbens and Edwards, 1998; Lockhart and Danis, 2010). Feminist tenets, with goals to inform social change whilst allowing for a gendered subjectivity (Maynard, 1994), were appropriate for my research. Previously, feminists have been critical of knowledge which has been constructed and dominated by men, regardless of whether they have been based in methodological positions which claim to be value free (McLaughlin, 2003; Maynard, 2004; Letherby, 2003). According to McLaughlin (2003) it is no longer acceptable for women's experiences to be considered as universal; instead they should be viewed as multiple and different. An example of this is offered by Amos and Parmar (1984)

The perception white middle class feminists have of what they need liberating from has little or no relevance to the day to day experiences of the majority of Black women in Britain and the ways in which they determine political choices, which have to be made. (Amos and Parmar, 1984, p. 5)

Feminist theoreticians and practitioners alike have emphasised the connection between the imbalance of power distribution within society and the family (Eisikovitis and Buchbinder, 2000). Attempts to question this unequal power balance are often viewed by men as a threat to their own social standing and privilege (Yllö, 1993). However, Eisikovitis and Buchbinder (2000) offer a word of caution when considering this assumption, as they believe gender inequality may not be an issue for everyone. They perceive that whilst there may be an awareness of gender inequality, it can lead to gender being taken for granted as a theory, so much so that it may have little explanatory power when considering the

client's experience. They also suggest that the majority of women who have experienced violence and abuse may not be aware of the impact of gender on their everyday lives.

Previously, I had avoided the theoretical and formal traditions such as phenomenology which I believed were what Edwards and Ribbens (1998) term as 'male stream'. I sought explanations which would bring attention to 'female or women's issues' but it is important to acknowledge that I am not without bias as I have always espoused a feminist point of view. Nevertheless, I considered it was important to attempt to capture the women's lived experience of the social world and the meanings that they ascribed to such experiences. Therefore, adopting a phenomenological framework to co-exist with feminism, would add strength and credence to the research. I believed such a partnership was creditable as both feminism and phenomenology aim to explore and understand the everyday world of women's experiences.

Accordingly, my ontological position and epistemological understanding were parallel to the interpretative paradigm, which focuses on understanding people and their everyday experiences (Sarantakos, 2005). I believed utilising feminist phenomenology would afford me the opportunity to explore the lived experiences of women who had encountered domestic violence during pregnancy.

### **3.3. Phenomenology and Feminist Theory**

In the next section of this chapter I will describe the strengths of each philosophical framework and consider their contribution to this study.

#### **3.3.1. Phenomenology**

Phenomenology occupies a prominent position in modern philosophy (Dowling, 2007). Essentially, interpretive phenomenology explores the lived experience or the

life world, with its emphasis on the world as lived by that person (van Manen, 1997) and it is often considered principal to the interpretive paradigm (Denzin and Lincoln, 1998). There is an endeavour to understand the fundamental nature of people's experiences and interpretations of key features in their life (Spiegelberg, 1982; Sarantakos, 2005; Bryman, 2008) and the approach has been described as a way to "break free and see the world afresh" (Crotty, 1998, p. 86). It is not possible nor is it my intention to describe all the distinctions of phenomenology in this thesis. Rather, I intend to provide an overview of the main tenets and acknowledge how these inform this research. Utilising phenomenological methods of enquiry to explore domestic violence is not novel; this approach has been used by several researchers to explore a variety of experiences of domestic violence and abuse (Denzin, 1984; Esikovitits and Buchbinder, 1999; Garko, 1999; Reitz, 1999; Shamai, 2000; Wesely, *et al.* 2000; Taylor *et al.* 2001).

The philosophical framework of phenomenology purports that to understand the world of meaning, one must interpret it and according to Stewart and Mickunas (1990, p.3) phenomenology is a "reasoned inquiry which discovers the inherent essences of appearances". It has emerged as a philosophical perspective casting a light on previously ignored human experience (Tymieniecka, 2003). As such, phenomenology was initially considered as a suitable philosophical approach for this study in that it would facilitate an understanding of the lived experiences of women who had experienced domestic violence, allowing for the exploration of the essence of the experience for women who participated in the study, including the meaning that they ascribed to their experiences.

Edmund Husserl, a German philosopher and mathematician is considered to be the creator of phenomenology (Morse, 1994). Husserl believed that the meaning of the lived experience may only be understood through one to one transactions including between the researcher and the object of research. Such transactions include attentive listening, interaction and observation, in order to create a true



representation of reality (Husserl, 1970a). The main focus for Husserl was the study of phenomena as they appeared through consciousness; he eliminated mind-body dualism, proposing that minds and bodies both occur within the experience (Lavery, 2003). Phenomenology strives to study:

The structure of various types of experience ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action and social activity, including linguistic activity. The structure of these forms of experience typically involves what Husserl called "intentionality", that is, the directedness of experience towards things in the world, the property of consciousness that it is a consciousness of or about something. (Stanford Encyclopaedia of Philosophy, 2003, p. 2)

Husserl believed conscious experiences have an exclusive attribute in that we all live through or perform them. This experiential quality is an essential part of the nature of conscious experience; yet, the debate amongst phenomenologist scholars is how we should study conscious experience. Classical phenomenologists such as Husserl (1970a) promoted pure description of lived experience, believing that we describe an experience just as we find it (descriptive phenomenology). Whereas, Heidegger suggests, we strive to interpret a type of experience by relating it to important features of context (Interpretive phenomenology). One of the main differences between descriptive and interpretive phenomenology is the role of the researcher's thoughts and prior knowledge of the phenomenon being studied (Simpson, 2007). Husserl's descriptive phenomenology offered an ideal of transcendental subjectivity where the researcher is required to discard their reality and describe the phenomenon in its purest sense. The researcher is asked to strip away any prior experiential knowledge and personal bias, so they do not influence the description of the phenomenon (Tymieniecka, 2003). This process is termed 'bracketing' and is used to create "objective

neutrality” (Simpson, 2007, p. 181) a stance not appropriate to this research. The concept of bracketing will be explored in more depth shortly in this chapter.

Heidegger (1889 – 1976) one of Husserl’s successors, did not follow Husserl’s theories of intentionality and reduction and over a period of time he modified and developed Husserl’s approach (Wojnar and Swanson, 2007). Heidegger focused on *dasein* meaning ‘being human’ (Lavery, 2003) to express how the world is encountered in everyday life from the view of the individual, rather than from what others conceptualise. Heidegger alleged that understanding of individuals cannot occur in isolation of their social context or the historical period in which they live (Wojnar and Swanson, 2007). In this sense Heidegger does not attempt to bracket; here, the focus is on the interpretation of what it is like for those participating in the study, which is felt to require some prior understanding of the topic to be investigated (Heidegger 1962). Heidegger believed that it is not possible for researchers to completely eliminate their preconceptions and as such they will unavoidably bring certain expectations and meaning to bear on their interpretation and understanding. Interpretation is crucial to this process of understanding, and is influenced by an individual’s background which cannot be eliminated (Heidegger, 1962). In view of this, I have been aware of my interpretive influences and have accounted for them accordingly (Lavery, 2003; Wojnar and Swanson, 2007).

### **3.3.2. Feminism**

Feminist methodology has its origins in feminist theory and it is suggested by Holloway and Wheeler (2010) that they are so closely entwined they cannot be fully separated. Feminism has developed into a research methodology in its own right and is underpinned by feminist theories and multiple constructions about women’s perspectives of oppression and consciousness (Holloway and Wheeler, 2010). As a social movement, there appears to be a distinctively feminist mode of enquiry although, some may intimate that it is unclear what a distinctively feminist mode of

enquiry means or involves (Maynard, 1994). Nevertheless, what unites different feminist strands is the overarching principles that gender is a key determinant of social status, and that the male gender is privileged and powerful compared to the female gender. Furthermore, research is owned by the powerful (men) at the expense of women and men and women differ in their perceptions of life, due to their social status (Reinharz, 1983, 1992; Stanley and Wise, 1993; Holloway and Wheeler, 2010; Sarantakos, 2005; Parahoo, 2008). Stanley and Wise (1993) propose feminist theory was initially considered at a macro level, involving society, institutions and power. However, they also advocate that it is important to consider the micro level which they relate to individuals in society and how they interact with each other. The latter is relevant and important to my work, where the focus as a researcher is to explore personal interactions between individuals. Feminist researchers intend to contribute to the improvement of the lives of women (Holloway and Wheeler, 2010). The uncompromising tenet of feminist methods is concerned with the importance of women's lives and their position, in the social structure of society. According to Reinharz (1992, p.241) "feminists are interested in women as individuals and as a social category". There is a conjecture that feminist research arose out of failure of conventional research (usually conducted by men on women) to serve women's interests (Parahoo, 2008). Levesque-Lopman (2000) concurs, stating that feminists in the last two decades have disputed the basic foundations of positivist social science. This suggests that feminist research rejects the possibility of "value-free research" (p 105) and instead promotes an allegiance to changing the position of women and society. Reinharz (1983; 1992) infers feminism had already partially corrected the pre-existing gender imbalance by validating the experience of women as important and relevant. This is supported by Maynard (1995) who suggests feminist theories allow for the exploration of women's gendered subjectivity and situates the 'sister relationship' at the centre of women's lives. Nevertheless, according to Watkins (2000) a dilemma facing feminism is an inability to arrive at a consensus of opinion of what feminism actually is. The assumed universality of Western feminism has been subjected to criticism, particularly by "women of colour" (Crenshaw, 2001). More recently, anti - violence activists have brought attention to the cultural and political partiality that currently

exists within the assumptions of feminism. They call on an extension of the patriarchal discourse to be expanded to embrace women from the margins (Crenshaw, 1994; Sokoloff and Dupont 2005; Lockhart and Danis, 2010). Intersectional theory will be discussed in more depth later in this chapter.

Watkins (2000) maintains that it is important that feminism is identified in political terms which promote collective as well as individual experiences. It should be defined in such a way, that it brings attention to and recognises the diversity of women's social and political reality, acknowledging the women whose social circumstances have been least studied or up to now, have not been influenced by the political movement. I concur with Watkins's (2000) explanation believing that feminism should not be viewed as a movement which considers men as the enemy, it is a movement which is about the struggle to end sexist oppression. Its main purpose and aspiration should be to benefit all women regardless of race or class and finally it should not strive to privilege women over men.

Bryman (2008) suggests the close affinity between feminism and qualitative research has come about, because quantitative research is viewed as incompatible with feminism due to its considered representation of a masculine convention of knowing (Maynard, 1994). Qualitative research is considered to be suitable as its focus is on the subjective experiences and meanings of those being researched (Maynard, 1994). It is also viewed as facilitating feminist sensitivity to come to the fore, where the social reality of women is considered through personal accounts that emerge from their shared experiences. Indeed, in most instances, feminist methodology focuses on questions related to the understanding of women's lives and oppression, conducted by a type of enquiry which starts with an open - ended exploration of women's experiences, allowing one to see how their life is organised (Reinharz, 1992; Maynard and Purvis, 1994; Oakley, 1998; Maynard, 1998; Parahoo, 2006; Bryman, 2008). Nevertheless, writers such as Oakley (1998) and Maynard (1994) suggest that, whilst the open-ended enquiry was without doubt beneficial to feminists in their early work, quantitative research which can also bring about social change and benefit women is justified. The rejection of quantitative

methodologies may mean that feminists overlook the contribution of such research to the knowledge and understanding of women's experiences.

Feminist research places an emphasis on two main purposes: increasing awareness and sensitisation, it advocates a change in the social, political and health policies that impact on women lives (Parker and McFarlane, 1991). It is a basic tenet of feminism that women suffer discrimination because of their gender, and challenging this discrimination would require a radical change in the social, economic and political domains (Delmar, 1986, Parker and MacFarlane, 1991). Writers such as Kelly *et al.* (1995) believe that feminism is based on the belief that gender is a fundamental controller of social life and that males influence all aspects of life, to the detriment of women. In a response to such thinking, researchers developed feminist theory. Maynard and Purvis (1994) suggest that feminists have illustrated the power that can be exercised over women and their "subjected knowledge" (p.129), by defining objective knowledge as superior to personal experience. They believe introducing women's narratives about their lives have demonstrated the subordination of women to men in almost every area of social life. Never is this more accurate than when studying partner violence against women. In point of fact, it was the feminist movement which brought attention to the need to address and put an end to male violence against women. It is assumed by feminist activists that violence against women must be considered in a different way from other forms of violence in society, because it is related to the politics of sexism and male domination (Watkins, 2000).

The main principles guiding this research are in accordance with feminist research as defined by Duffy (1985) in that the principal investigator is a woman; the purpose of the work is to study women with the focus of the research being that of women's experiences; the research has the potential to help the participants as well as the researcher. The work will be characterised by an interaction between researcher and subject, it will use non hierarchical relations with an articulation for feelings and a concern for values. The word feminism or feminist will be used in the thesis, with

non – sexist language being used, and the work will be supported by a wide range of feminist literature (Duffy, 1985).

### **3.3.3. Postmodernism, Post-structuralism and Feminism**

According to McLaughlin (2003) summarising postmodern ideals is notoriously difficult, because the ideals are very complex and they challenge many notions usually taken for granted. Indeed, McLaughlin claims postmodernism is now a “major source of uncertainty and scepticism within social and political thought” (p.91). The very term itself is also considered as ambiguous, as it is often used interchangeably with post-structuralism. In the main, post modernism is viewed as a form of sensitivity, in that it questions the notion of the dispassionate social scientist, viewing the social scientist’s account as one amongst many (McLaughlin, 2003). Postmodernists are suspicious of any concept that suggests it is possible to arrive at a definite account of any reality. They prefer instead to employ a belief that no forms of knowledge are absolute or superior, they are just different and all knowledge and practice must be understood within its discourse and culture (Burch, 2008). They also subscribe to the principle that reality can only be accessed through narrative representations (Bryman, 2008). Characteristically then, post modernists have less to say about data collection and more about the writing and representation of social science findings, favouring qualitative to quantitative research (Alvesson, 2002). Postmodernists contend that in our “post-industrial world, identities and ideas proliferate to create a pluralistic world” (Burch, 2008 p.189), and that each subculture and group will have a different viewpoint, of which each one is valid (Burch, 2008). Post-structural and postmodern feminists examine how gender and sexuality are constructed, through language and institutionalised ways of thinking (Hines 2008).

Sarantakos (2005) suggests there are in fact two types of postmodernism: radical and moderate, proposing that it is only radical postmodernism that articulates scepticism in the ontological foundations and epistemological principles of the social sciences leading them to pursue a strict anti-positivist objective. Moderate

postmodernists view reality, not as objectively given but as being created and interpreted in interaction, considering the world to be “plural, multiple with ever changing meanings” (Sarantakos, 2005 p.316). Postmodernists also submit to the philosophy that current social and cultural processes construct hierarchies within a social system that in turn construct structures of power, subjecting people to control and domination.

Despite such uncertainty and because one of its main purposes is to reposition claims to knowledge and truth, I believe postmodernism can be considered to have a strong allegiance with Feminist theories. For example, Simone de Beauvoir’s famous declaration that “one is not born a woman, one becomes one” (de Beauvoir, 1953, p. xvi) can be considered as an important precursor to postmodernism (Mc Laughlin, 2003). Early feminists heavily criticised de Beauvoir’s work for failing to acknowledge or address the patriarchal foundations of existing systems of power. However, Bryson (2003) suggested that feminists influenced by postmodernism have since revisited de Beauvoir’s work and now consider her philosophy was characterised by the same preoccupations that prefigures postmodern feminism. According to McLaughlin (2003) some feminists have now distanced themselves from postmodernism in its present form. They have developed their own postmodern viewpoint, one which is more aligned to feminist political principles. Indeed, feminists who question the role of postmodernism are apprehensive that its adoption requires the loss of important tools from feminist activity. They suggest that the adoption of postmodernism, would lead feminism to “lose the sense of the validity of the subject and the opportunity of political change” (Mc Laughlin, 2003, p.110). Butler suggests that treating ‘woman’ as a universal subject is not beneficial to feminism, because it does not allow for an interpretation of the differing social and economic roles of women. Maynard (1994) supports this view by suggesting that a postmodern perspective actually highlights the significance of difference and by doing so, has highlighted the problems which existed in the over simplification and generalisation of previous work by feminists.

Feminist researchers have begun to address the issue of power, not just in relation to women but also in relation to other oppressed minority groups (Etherington, 2004). This has called for a different way of collecting data, a way which is open and transparent. During the postmodern era, researchers were asked to regard all that has gone before as relevant 'stories' that were constructions of their time, and whilst such stories served a purpose, there is actually "no fixed and unchanging truth" (Etherington, 2004, p.27). Post modernist research provides representations of participants' stories without an objectivist stance. Accordingly, such research is recognised as being a re-presentation through a particular lens. To do this successfully calls for researcher reflexivity (Ribbens and Edwards 1998). However, Holland and Ramazanoglu (1994) suggest that in fact, postmodern methodologies which attempt to discover subjugated knowledge and analyse discourses, have a tendency to be less explicit than modern methodologies about the place of the researcher in the research. Holland and Ramazanoglu (1994) and Ribbens and Edwards (1998) suggest that whilst feminism has been successful in giving a voice to women's experiences, this does not necessarily entail sensitivity to where the 'knower' is situated.

Despite misgivings regarding its suitability with feminist ideology, I am drawn to postmodern feminism as I do believe its fundamental principles fit with my perspective and world view. I concur with Hague *et al.* (2003) who suggest that postmodernism and post-structuralism have emphasised that knowledge is "historically and culturally specific" (p. 39) suggesting that it is important that we listen to the voices of individuals who have been formerly silenced by dominant discourses of power. Drawing on postmodern feminism, and with a focus on representation and text, my overall purpose was always that the research be directed by the voices of women who participated in the study.

My main intention was to locate the most appropriate approach and method for my study, I required a method which would allow me to hear the women's voices,



would empower women and enable them to describe their experiences of domestic violence and abuse. Further exploration of the literature led me to consider the suitability of a feminist phenomenological approach. The following section will discuss the tenets of feminist phenomenology; provide a perspective on its joint relationship, whilst considering its suitability as an appropriate research method.

### **3.4. Background to Feminist Phenomenology**

Feminist phenomenology has developed out of the reconsideration and expansion of the work of some classical phenomenologists namely Edmund Husserl, Martin Heidegger and Maurice Merleau-Ponty. In addition, Simone de Beauvoir, Judith Butler, Iris Marion Young and Sandra Lee Barkty have all combined phenomenology with feminist theory (Schües, *et al.* 2011). Where their particular interest was to relate interpretive phenomenology to the issue of gender, this inference will be explored in more depth later in this section. Amalgamating two different frameworks is an alternative approach to traditional qualitative research in health (see figure 3.1. on page 69). Whilst each method has its own identity, both phenomenology and feminism can be integrated in order to strengthen the overall philosophical foundation and attempt to gain a deeper understanding of the experience of living with domestic violence and abuse (Fisher, 2000).

Fisher (2000) claims that there are various possibilities for a relationship of feminism and phenomenology, pointing towards a union termed 'feminist phenomenology' or 'phenomenological feminism'. In the past, phenomenology and feminism have been rarely associated and Studlar (1990) believes this is due to phenomenology standing as an exemplar of male philosophical observation, whereas feminism is focused on transforming a domineering system rather than being content to interpret it (Reinharz, 1992). Reinharz (1992) suggests that it is perfectly acceptable for feminist research to be used with a combination of

different methods. Undeniably, more recently, within feminism there has been a moderation of the rigid interpretations of what feminist research should look like. It is recognised that other research methods can be just as usefully applied as part of the feminist research endeavour. As Kelly *et al.* (1995) assert:

rather than assert the primacy of any method, we are now working with a flexible position: our choice of method(s) depends on the topic and scale of the study in question. (Kelly, *et al.* 1995, p. 35)

Fisher (2000) proposes that Simone de Beauvoir (1908 – 1986) can rightfully be considered to be the influential creator of feminist phenomenology. de Beauvoir's original work (1949; 1953) draws on the phenomenology of Husserl and Heidegger with a direct focus on embodied lived experience and the role of language in revealing the world's meaning. de Beauvoir's work added to the richness of interpretive phenomenological description, with first person accounts of the gendered character of experience that had been previously neglected in classical phenomenological texts. de Beauvoir's influential contribution to 20<sup>th</sup> century literature was her study of women. de Beauvoir's publication 'The Second Sex' (1949, 1953) whilst controversial, is also considered to be a seminal landmark in the history of feminism (Borde and Malovany-Chevallier, 2009) and credited with starting the second wave of feminist activism (Scholz, 2000). According to Bryson (2003) de Beauvoir's discourse drew upon:

philosophical, psychological, anthropological, historical, literary and anecdotal data in order to argue that a major obstacle to a woman's liberty is not her biology or the political and legal constraints or even her economic situation; rather it is the whole process by which femininity is manufactured in society. (Bryson, 2003, p. 129)

Suggesting that it is the manner in which femininity is constructed and conceptualised in society, which restricts freedom for women (Bryson, 2003; Borde and Malovany-Chevallier, 2009), de Beauvoir's description of a woman's situation in *The Second Sex* (1953) and other writings was not meant as "condemnation of women, nor is it a resignation to the role prescribed for women" (Scholz, 2000, p.45). Rather, it was an intention to highlight the socially constructed obstacles that inhibited a woman's freedom by exploring the historic situation of women. de Beauvoir alleged that women had been prevented from taking control of their lives, suggesting that women had become the 'Other' throughout culture, whereas the man has been the 'Self' (de Beauvoir, 1953). de Beauvoir's work provoked much discussion and debate amongst the feminist movement in the 1960s and it is fair to say that this discussion and debate continues today.

Heinamaa (2003) suggests de Beauvoir's work, which presented a philosophical description of women's experiences and the world as experienced by women, was in response to Husserl and his followers including Heidegger and Merleau-Ponty, assumptions that sexual difference is irrelevant to the descriptions of experience. Heinamaa (2003) proposes their assumptions have led to a limited understanding of human experience and an acceptance of universal and essential features, that only belong to the experiences of men. Fisher (2000) maintains that the work of de Beauvoir not only represents a crucial phase in the development of feminist thought, but also provides one of the earliest expressions of feminist phenomenology. Fisher (2000) also purports it was de Beauvoir's persistent enquiry into the physical, psychological and social aspects of female embodiment that actually made visible the wide-reaching effect of patriarchal customs within a western society.

However, it is important to acknowledge that beyond the writings of de Beauvoir, there has been limited exploration into the collaboration of feminism and

phenomenology. Within the phenomenology and feminist literature, de Beauvoir has been frequently promoted and cited as an existentialist and an existential phenomenological approach has been previously chosen as a method of inquiry in a selection of studies related to domestic violence (Kane, 2006; Eisikovitis & Buchbinder, 1999; Reitz, 1999; Garko, 1999). Garko (1999) proposes that such descriptive methods contribute to a deeper understanding of women's lives by providing them with a voice. The resulting rich, descriptive, subjective accounts can offer researchers insight into the particular aspect of human existence (Garko, 1999).

Alongside de Beauvoir, other feminist scholars who have utilised phenomenological methods include Judith Butler (1990a; 1990b) Sandra Lee Bartky (1990) and Iris Marion Young (1984, 1990a, 1990b, 2005). Their work focuses on being true to the phenomenon, the phenomenon being that of the lived experience. Sullivan (2000) suggests that a phenomenological approach which has a focus on embodiment, reflectivity and lived experience may in fact lend itself to feminism. However, Sullivan also voices caution, suggesting that not all phenomenological philosophies are the same, and therefore they are not all equally valuable to feminism (Sullivan 2000). Perhaps this explains why until recently, there has been little interest in phenomenology as a means of investigating the relationship with feminist thought. Fisher (2000) alleges feminists have led the deliberation around the incompatibility of feminism and phenomenology, maintaining that the debate concerning this underlying incompatibility stems from what is seen as the 'traditional' phenomenology especially transcendental phenomenology.

Whilst phenomenology can and does explore social or political experiences as in cultural phenomenology, it does not profess to be political itself. By contrast, feminism is inherently political, as feminism focuses on domination, inequality and gender difference between the sexes. However, within feminism itself, there is a debate over difference. Some feminists have attempted to minimise the theory of

gender difference, they have suggested that the long-established societal perception of women being seen to be different is due to their biology and this difference has been used as the justification for their oppression. Fisher (2000) supports this claim by suggesting that the lived experience, especially bodily lived experience, cannot be studied in a generic analysis, as bodies are sexed and individuals are gendered. Fisher (2000) suggests traditional phenomenology has for the most part ignored such important factors and it is this presumption which has led to many feminists contending that phenomenology and feminism are incompatible. However, notwithstanding or considering such beliefs, it is evident that phenomenology, like feminist theory, is committed to the theory of the lived experience and understanding the world, through subjective experiences.

Feminism can draw upon phenomenology in seeking an articulated framework for experiential accounts as well as a means of expression for the issues of sexual difference and especially for those that lie at the core of feminism. Feminist phenomenologists relate phenomenology to the issue of gender; Schüles *et al.* (2011) suggests central to this relationship have been the ontological question of the nature of space, time and the body. An example of such a piece of work is that of Iris Marion Young, *Throwing like a girl: a Phenomenology of Feminine Body Comportment, Motility, and Spatiality* (1990a), where Young utilises a framework combining the insight of the theory of the lived body experience with the theory of the situation of women developed by de Beauvoir (Young, 1990a). Young claimed to fill the gap that existed between existential phenomenology and feminist theory; she believed gender led to distinct differences of the lived experience (Young 1990a, 1990b).

Simone de Beauvoir in her work 'The Second Sex' (1949, 1953) interweaves Merleau-Ponty's views about the lived body into her analysis of women's experience of oppression. Another important feature of de Beauvoir's work is the way in which she integrates the foundational phenomenological concept of the

'situated subject'. de Beauvoir highlights the subject of freedom and ethics from the viewpoint of women who, she feels, are situated in particular circumstances, and have relationships with others that circumscribe their possible freedom. de Beauvoir cites Aristotle who depicts women as lacking qualities, literally believing that women as such are afflicted with a natural defectiveness, de Beauvoir blames this on the lack of woman's ontological position, her special kind of being, as relative to man for whom she is an object:

She is defined and differentiated with reference to man and not he with reference to her; she is incidental, the inessential, as opposed to the essential. He is the Subject, he is the Absolute - she is the **Other**. (de Beauvoir, 1953, p. xvi)

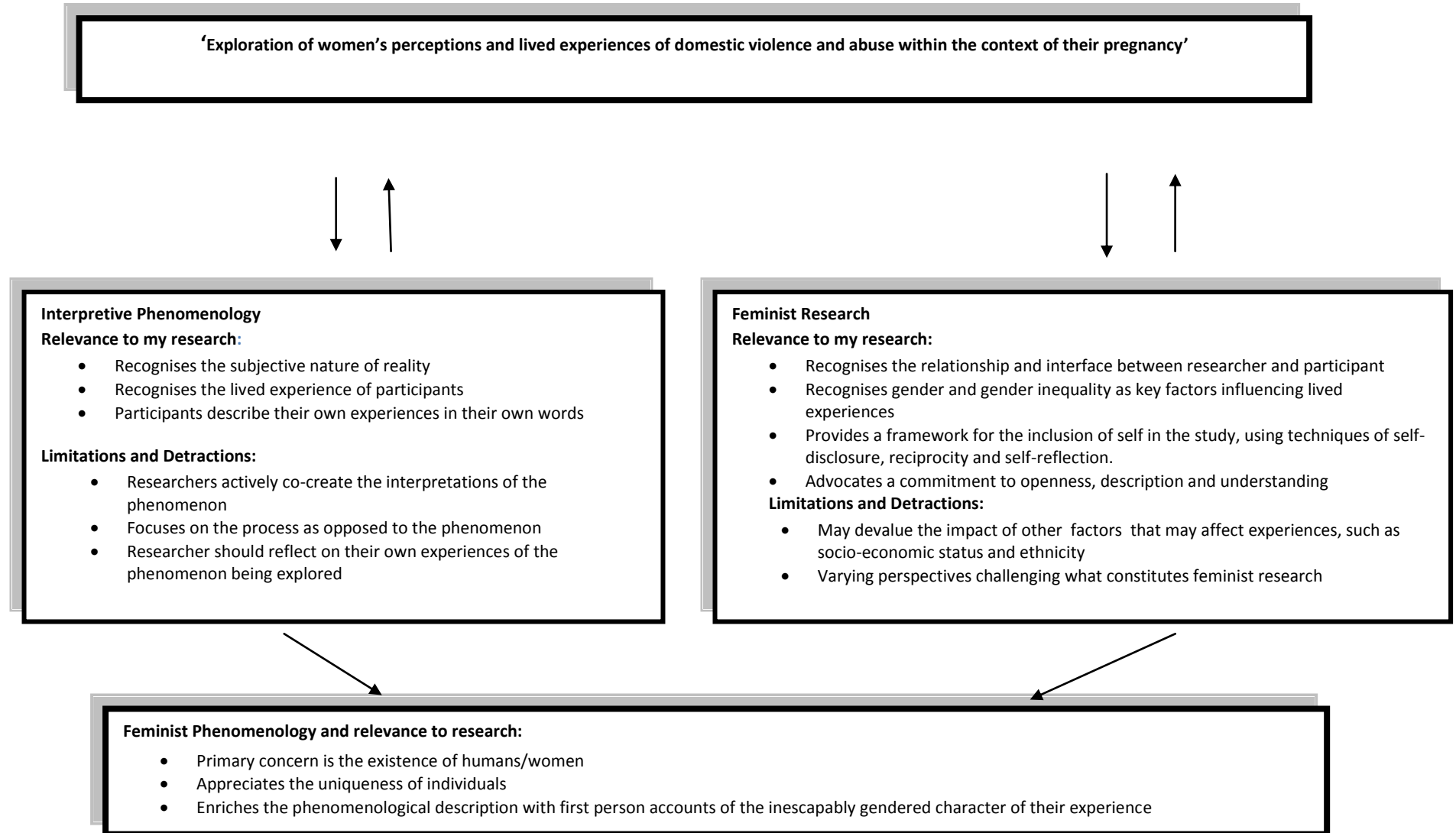
This definition from the introduction to her book '*The Second Sex*', (1953), de Beauvoir appears to be stating that she considers that a woman's position is considered relative to that of man, and perhaps it is this belief that lies at the very core of philosophical feminism gender difference.

Recognising that my work intended to reflect women's experiences, set against the milieu of patriarchal control, it is therefore appropriate to utilise the work of de Beauvoir to position the research in the exploration of meaning in the data. However, de Beauvoir's writings are not without criticisms or limitations. Whilst she unquestionably challenges the male cultural hegemony (Rowbottom, 2009) and questions male domination and patriarchy, I, alongside others, consider that her work is not without its limitations. For example, her discourse rarely refers to working class women or women of any colour other than white. Indeed, Rowbottom (2009) suggests de Beauvoir often focused on "women in her own image" (p xvi), proposing that her contemplation with patriarchy may have prevented her from considering differences in the level of women's subordination (Rowbottom, 2009). Therefore, I considered it necessary to research further

feminist and phenomenological sources through which my work could be situated. I studied the writings of Sandra Lee Bartky and Iris Marion Young (see figure 3.2. page 70). Bartky has examined studies in female oppression, gender and sexual differences whereas, Young by exploring issues of social justice and oppression has recognised women's experiences in the world are uniquely embodied by the very nature of their gender. Young (1984, 1990a, 2005) and Bartky (1990, 2009) both suggest that phenomenology has been developed with a male bias and in response Bartky's and Young's work offer representations of female embodied consciousness. Young's work explores female sexual differences on embodied experiences, raising an awareness of the social, political and economic structures of power that help create gender, racial and economic oppression (Bartky, 2009). Both their work focuses on female experiences of expression, whilst also considering how a woman's subordination can be embodied.

Although, I am mindful that de Beauvoir's work is quite controversial on topics such as mothering and marriage, she, nevertheless, provides an explanation of women's lived experience in a way never represented previously by male philosophers. Young supports some of de Beauvoir's work in her phenomenological accounts of pregnancy and breast experience (2005), turning to women's embodied consciousness as a vital part of that existence.

**Figure 3.1. Theoretical Framework: Integration of Feminism and Phenomenology**





**Figure 3.2. Feminist Phenomenology Philosophers**

<b>Feminist philosophers who have used feminist phenomenology to articulate women's position and role in society</b>	
<p><b>Simone de Beauvoir</b> <b>(1908 – 1986)</b></p>	<p>de Beauvoir provided a philosophy that recovered women's lived experience in ways unlike those previously represented by men. She believed that no biological, psychological or economic fate determines the figure that the human female presents in society. Rather it is civilisation itself that produces this creation, <i>'the intermediate between male and eunuch who is described as female'</i> (de Beauvoir 1953, p 295)</p> <p>de Beauvoir argues that because of a woman's lack of strength and their childbearing role, they have been excluded from the productive process. However, this does not mean that a biological or materialist explanation on its own could account for women's subordination; for this to occur, also requires the wish to dominate. Now, with modern technology and contraception, a woman's subordination is no longer based on physical necessity. The only thing preventing women from seeing themselves as subjects in their own right is the artificial idea of womanhood engendered by society, which still views women as secondary objects, acquiring meaning in relation to men (Bryson, 2003).</p>
<p><b>Iris Marion Young</b> <b>(1949 – 2006)</b></p>	<p>Iris Marion Young was a leading American political social scientist and a feminist phenomenologist. Resourcefully she employed the ideas of de Beauvoir and Merleau – Ponty to define elements of gendered embodied subjectivity in social and political context. Although descriptive in nature like de Beauvoir and Merleau – Ponty she evaluated women's rights, their opportunities, and constraints on freedom within a patriarchal society (Ferguson and Nagal, 2009).</p> <p>Young also recognised that women's experiences in the world are uniquely embodied by the very virtue of their gender; challenging us to see how embodied experiences position women in the world of patriarchy. For Young, women's oppression was structural. The agent of oppression was interwoven within the social structures that trap the people they oppress (Card, 2009).</p>
<p><b>Sandra Lee Bartky</b> <b>(1935 -</b></p>	<p>Bartky approaches feminist philosophy without a fixed methodology and so therefore she has used phenomenology, existentialism, post structuralism and Marxism to try to tease philosophical insights out of the feminine condition, as women live it. Bartky considers that men are situated differently than women within the ensemble of social relationships, and likewise, she argues that women's ways of knowing are different to men's (Bartky, 1990). Bartky considers <i>'women are stereotyped, culturally dominated and sexually objectified'</i>. (Bartky, 1990, p23) which she believes threatens their autonomy.</p>

### **3.5. The concept of intersectionality**

Feminist discourse on intersectionality has developed over the past two decades and whilst there are some differences in interpretation and application, intersectionality theory considers the ways in which hierarchies of power exist alongside several defined categories such as race, class and gender (Crenshaw, 1991; Sokoloff and Dupont, 2005). The feminist view on domestic violence is to acknowledge that women experience a higher and more frequently fatal rate of violence and abuse than men, due to a socially structured gender inequality which is embedded in society (Sokoloff and Dupont, 2005). Furthermore, Feltly (2001) proclaims that although violence against women happens within individual people's lives and is experienced at a personal level, there is no doubt that it is "culturally produced out of intersecting relations of gender, race, social class, and sexuality" (p. 365). Clearly, the overall contribution of feminism and feminists has been significant in challenging earlier sociological and psychological models of domestic violence that depicted domestic violence as simply a 'family problem' (Kurz, 1989). Conversely, Lockhart and Danis (2010) suggest that most of the social movements, academic literature and intervention strategies have been aimed at supporting the 'universal woman', leading to a 'one size fits all' approach (Lockhart and Mitchell, 2010). Such an approach is considered by some to be inadequate in illuminating the experiences and needs of women from diverse groups (Collins, 1998, Crenshaw, 1994, Sokoloff, 2005).

The term intersectionality arose out of feminism (Simpson 2009) and was centred on those who have the least amount of power, who are often women and girls (Morris and Bunjun 2007; Lockhart and Danis, 2010). It was the work of Kimberlé Crenshaw (1994) first introduced the theoretical concept of intersectionality to help explain the reality of abused women experiencing other diverse oppressions. These included, but were not purely restricted to, gender, racism and violence. Bograd (2005, p.26), suggests Crenshaw's hypothesis of intersectionality does not situate "domestic violence as a monolithic phenomenon". Instead she suggests that intersectionalities can colour the meaning and nature of the violence, how it is experienced by self and

likewise how it is responded to by others (Bogard, 2005). Sokoloff and Pratt (2005) and Lockhart and Danis (2010) have identified a theoretical perspective, the concept of intersectionality to explain the diverse experiences of abused women. From this perspective, the overall effects of violence and abuse are augmented by additional victimisations which may occur outside of the abusive relationship. These further factors suggest that no one facet is privileged as an explanatory construct of domestic violence and abuse.

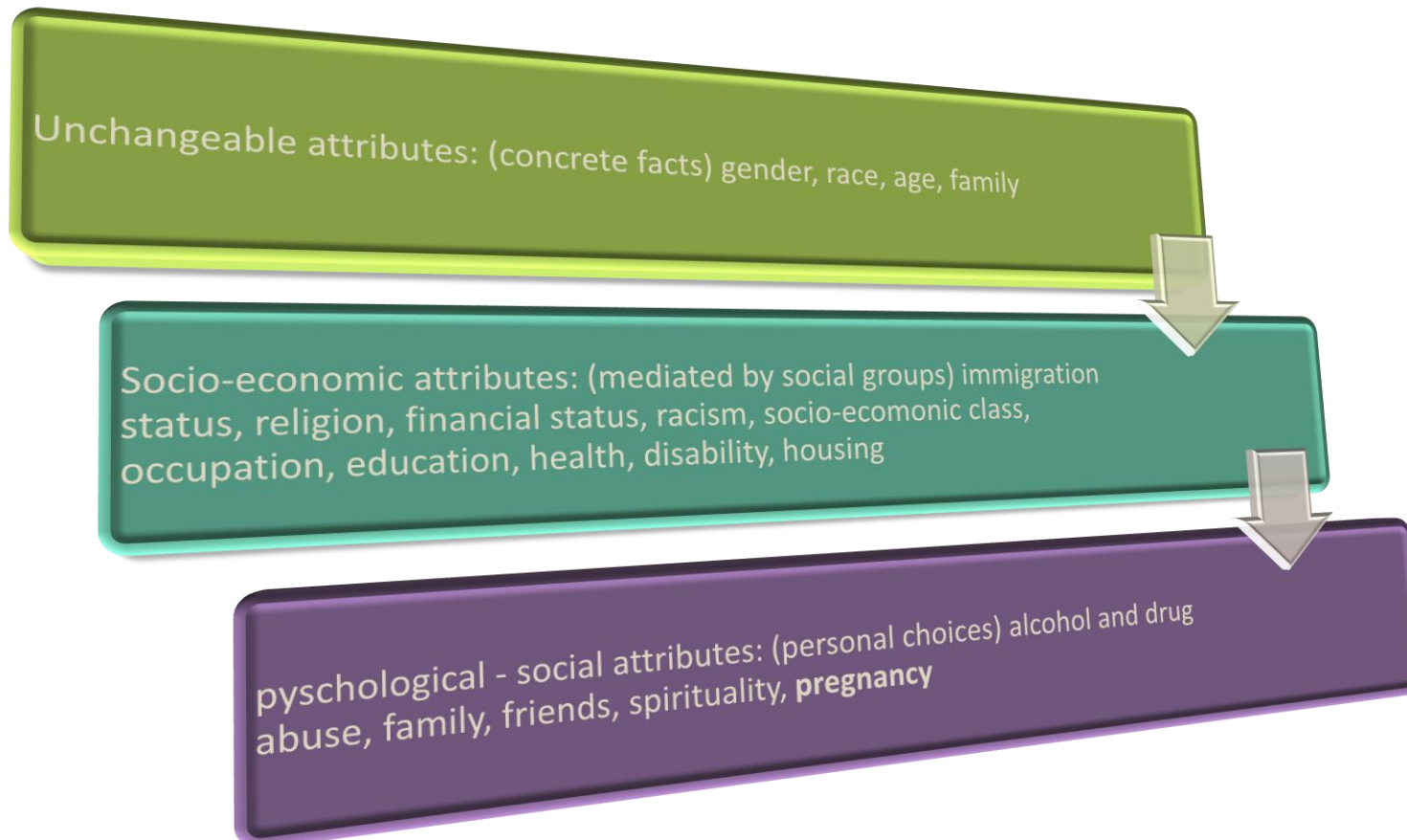
Crenshaw (1994) believes that gender inequality, although a major facet, is nevertheless modified by its intersection with other systems of power and oppression. Therefore, whilst all women are susceptible to violence and abuse by a partner, particular women's self image and how they are judged by others may differ depending on variables including, whether she is white or black, poor or wealthy, a sex worker or a teacher, a citizen of the country or an immigrant (Bogard, 2005). Lockhart and Mitchell (2010) propose the failure to understand the lived experiences of survivors of violence from within a more holistic contextual framework may result in significant consequences for those women who are already marginalised.

Up to this point, I had familiarised myself with the philosophy and discourse of de Beauvoir, Bartky and Young, believing that between them they offered a conceptual framework which would resonate with many of the women's individual and lived experiences, in terms of gender inequality and oppression. However, the women's narratives suggested there were aspects of their experiences which lay outside the discourse of de Beauvoir and others. Whilst I understood that gender as an explanatory model was important, I also believed the concept of intersectionality could provide a theoretical explanation for some of the spheres of victimisation or vulnerabilities which seemed to co-exist alongside the violence and abuse. Clearly, a woman's lived experience must make visible all the multifaceted realities which co-exist and interact, thus determining her overall experiences. Accordingly Lockhart and Danis (2010) purport:

An intersectional perspective suggests that to fully understand the oppression of women, it is important to understand the multidimensional, socially constructed categorisations that influenced the experiences of women in general. (Lochart and Danis, 2010, p. 8)

They propose that violence against women cannot be read through the lens of gender alone. It is also important to consider the intersecting factors that actually shape the living realities of the women affected. Such realities determine their needs and help seeking patterns (Lockhart and Danis, 2010). One could suggest that perhaps pregnancy in itself should be regarded as an additional living reality that should be considered as an internalised ideology alongside others. I believed that utilising an intersectionality conceptual framework would provide a deeper explanation, allowing me to unpack some of the demographic factors alongside the power relations and gender inequality. To demonstrate my understanding of the principles of simultaneous, multiple and interlocking oppressions, a modified version of Lockhart and Danis's (2010) diagram of intersectionality of cultural diversity is presented (see figure 3.3. page 74), the diagram outlines the main attributes of the women in this study. I considered some of the categories to be 'concrete' i.e. unchangeable attributes, including gender and ethnicity, which in turn influenced the more transient socio-economic attributes, where they lived, and their social status. These attributes in turn, then impacted on the woman's psychological attributes. Lockhart and Danis (2010) maintain that women must be considered as having multilayered, socio-political identities which stem from race, social class, employment, education, ethnicity, physical characteristics and geographical location.

Figure 3.3. Conceptual Framework: Intersectionality, Culture and Diversity



Adapted from: Lockhart and Danis (2010) Reference: Lockhart, L.L., Danis, F. S. (2010) *Domestic Violence Intersectionality and Culturally Competent Practice*. New York: Columbia University Press

### **3.6. Incorporating reflexivity into the research process**

Intersubjective reflection also known as reflexivity has developed significantly in the past decade and can be found across a variety of phenomenological and feminist research (Finlay, 2002; Etherington 2004). More recently, the use of 'Self' has become more and more legitimate in research (Finlay, 2003a). To be reflexive is to be aware of the personal, social and cultural contexts in which we live and work and to understand how these can impact on the way we interpret our world (Etherington, 2004). Finlay (2002) considers reflexive activities to be integral to the interpretive process, suggesting that reflexivity is a continuous process of reflection by the researcher where they consider their own values and prejudices.

Phenomenologists focus on the manner in which the subject and object entangle in a "pre-reflective existence" (Finlay, 2003b, p. 107), suggesting that researchers must look within to attempt to disentangle perceptions and interpretations from the phenomenon being studied (Finlay, 2003b). Likewise, feminist theory and feminist methods generally include an acknowledgement to reflexivity as a method to transcend the differences of power, ethnicity and class in the research field (Stanley and Wise, 1990). Whilst supporting Stanley and Wise's (1990) and Finlay's (2003b) suppositions, I also consider reflexivity is not a simple activity, as I believe it is not always possible to stand back and examine the effects of one's preconceptions, especially if one is not aware of what they are. Finlay and Gough (2003) claim that as an activity reflexivity is challenging, as it requires a huge effort on the part of the researcher to identify and interrogate personal and professional practice. In fact, Holland (1999) suggests that the word 'reflexivity' is used in so many different senses, that it often sustains confusion rather than clarifying any underlying issues.

I was fully aware that the inter-personal relationships and the dynamics that might emerge from the data might be complex for both the participants and me. A reflexive approach accepts that the researcher is a central figure, who influences the collection, selection and interpretation of data (Finlay, 2002). When I started the research

journey, I was aware of the importance of reflexivity to the research process. Indeed, I consciously and purposely sought out a research design which would place reflexivity within it. Yet, in the early days of my work I grappled with the concept of reflexivity, often considering my own personal thoughts, feelings and experience an unworthy perspective. I struggled to fully understand how my own subjective experiences could have such an impact on the research data and analysis. I considered time spent deliberating and writing about my own feelings and experiences, to be self indulgent and egotistical. I wanted to avoid what Finlay (2002) refers to as "opportunity to wallow in subjectivity" or "engage in legitimised emoting" (Finlay, p. 215). I also had to acknowledge that domestic violence was not part of my own personal experience, and as such, I knew I was unable to truly place myself inside the women's experience. Nonetheless, feelings of empathy with the participants were experienced during the study. Such feelings were based on my ability to empathise with the women, due to a shared gender identity. This subject will be explored in more depth during the data collection and data analysis sections in chapter four.

The more familiar I became with feminist phenomenology, the more evident it became that reflexivity was essential and central to its meaning and purpose. Accordingly, it was important to consider how my own personal experiences and knowledge could affect data collection and analysis. As mentioned previously, Husserl (1970b) asserts that it is important to identify, examine and '*bracket out*' any presuppositions and pre-understandings, in order to enter the lived experience of the participants and appreciate their perspectives. Husserl's philosophy required the researcher "to withhold all judgements during the study which had not been obtained from his own active seeing and describing" (Faber, 1967, p. 211). However, Husserl's successors which include Heidegger, Sartre, and Merleau-Ponty modified and further developed Husserl's approach (Wojnar and Swanson, 2007). Heidegger (1889-1976) attempted to answer the question of the meaning of being, believing that humans are interpretive beings. Therefore the understanding of individuals could not occur in isolation of their culture and their social context. Heidegger (1962) introduced the concept of *dasein*, (human way of "being there") to give emphasis to the actuality that individuals cannot

remove themselves from the various factors that influence their choices, thereby giving meanings to the lived experience. Heidegger also suggests that "dasein is essentially temporal in that it looks ahead; it surveys its life a whole in its conscience and resoluteness" (Inwood, 1997 p. 11). Heidegger's phenomenology attempts to understand the situation of an individual in relation to their wider social and cultural position. For instance, when considering a woman's experience of violence, according to Heidegger, we cannot ignore the life that women has outside the violence. Indeed, their very experience of violence must be considered within the context of family traditions, community values and the broader socio-political context (Wojnar and Swanson 2007). For that reason Heidegger (1962) argues that it is not possible or even desirable to bracket out personal beliefs during the philosophical process. Conceptual understanding of bracketing is considered complex and can be challenging especially when we already know too much about the issue being studied (van Manen, 1997).

I had been exploring and writing about the subject of violence and abuse and its relationship to pregnancy for many years, and as such I could resonate with van Manen's conjecture, acknowledging the difficulty I would experience at any attempt to bracket out my previous knowledge and experience on the subject. Phenomenologists such as Merleau-Ponty (1962) and Gadamer (1976) agree with Heidegger (1962), in that they both suggest the bracketing interview, like other bracketing procedures, is not intended to completely eliminate a researcher's preconceptions. Its purpose is to alert the researcher to their existence, allowing the researcher to take steps to limit the effect that such biases may have on the descriptions offered by the participants. They simply intimate that the most important lesson that the bracketing process can teach us, is that complete reduction is actually impossible to achieve. They propose that what is important is that the researcher should attempt to make their position explicit, thus allowing for a better contextualisation of their own understanding. For that reason, I have attempted to apply such values to my work as I recognise that to completely bracket out would be impossible and undesirable to achieve: in that I cannot deny my gender, my experiences, nor can I eliminate my knowledge of the topic. According to Reitz (1999),



the researcher can take two steps in an attempt to remove bias from their research, they are: the use of open, rather than leading questions during the interview and using the participants' own words to describe the experiences. Both these steps were taken during this study.

It is now accepted that the researcher is a principal figure, who actively constructs the collection, selection and finally the interpretation of data. According to Finlay (2002), qualitative research no longer seeks to abolish the researcher's presence; the challenge, Finlay (2003b) proposes, is for researchers using introspection to draw on their personal revelation not as an end in itself, but as a catalyst for interpretations and to provide further insight. I realised that conducting sensitive interviews, with the intention of exploring women's experiences of violence and abuse, would call for integrity within a reflexive framework. Therefore, I intended to take a reflexive approach to all aspects of the study; this included the topic, the recruitment of participants, data collection, analysis and writing up. I have endeavoured to represent a true interpretation of participants' stories. Reflexivity within data analysis will also be considered in chapter four.

## **Summary**

This chapter has focused on the practical aspects of the study, by considering the ways in which the theoretical assumptions that have underpinned this study have translated themselves into the epistemological and methodological aspects of the research. I have discussed the empirical considerations that have supported the research, by justifying the choice of a qualitative methodology. I have also provided an explanation demonstrating that interpretive phenomenology is philosophically compatible with some important feminist values and principles. The chapter has also substantiated my intention to utilise feminist phenomenology as an appropriate methodology to position my research question.

The following chapter will describe the methodological approach employed within the study and explain and justify my choice of methods for data collection and analysis.

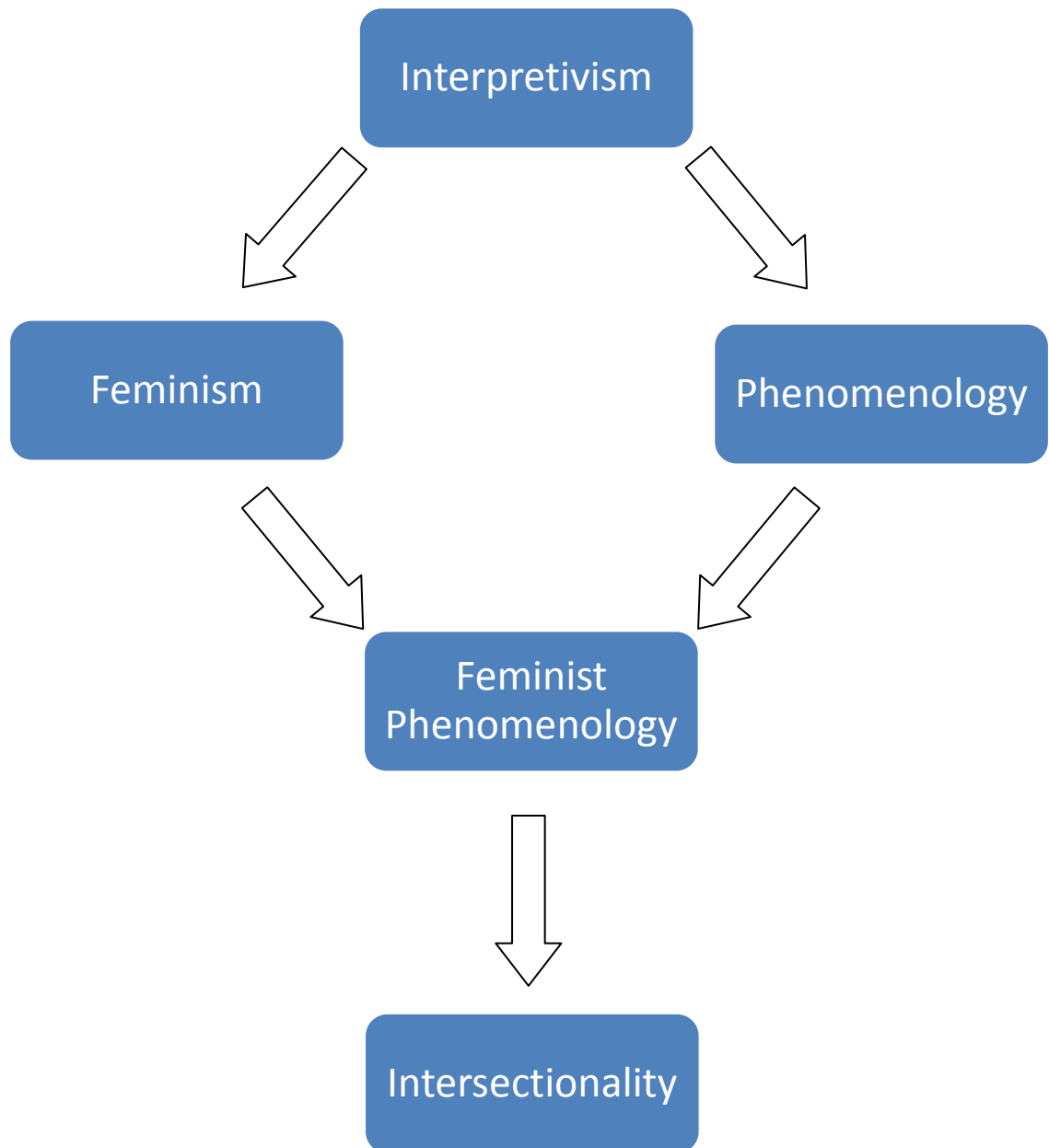
## Chapter Four

### Methodology

#### Structure of Chapter Four

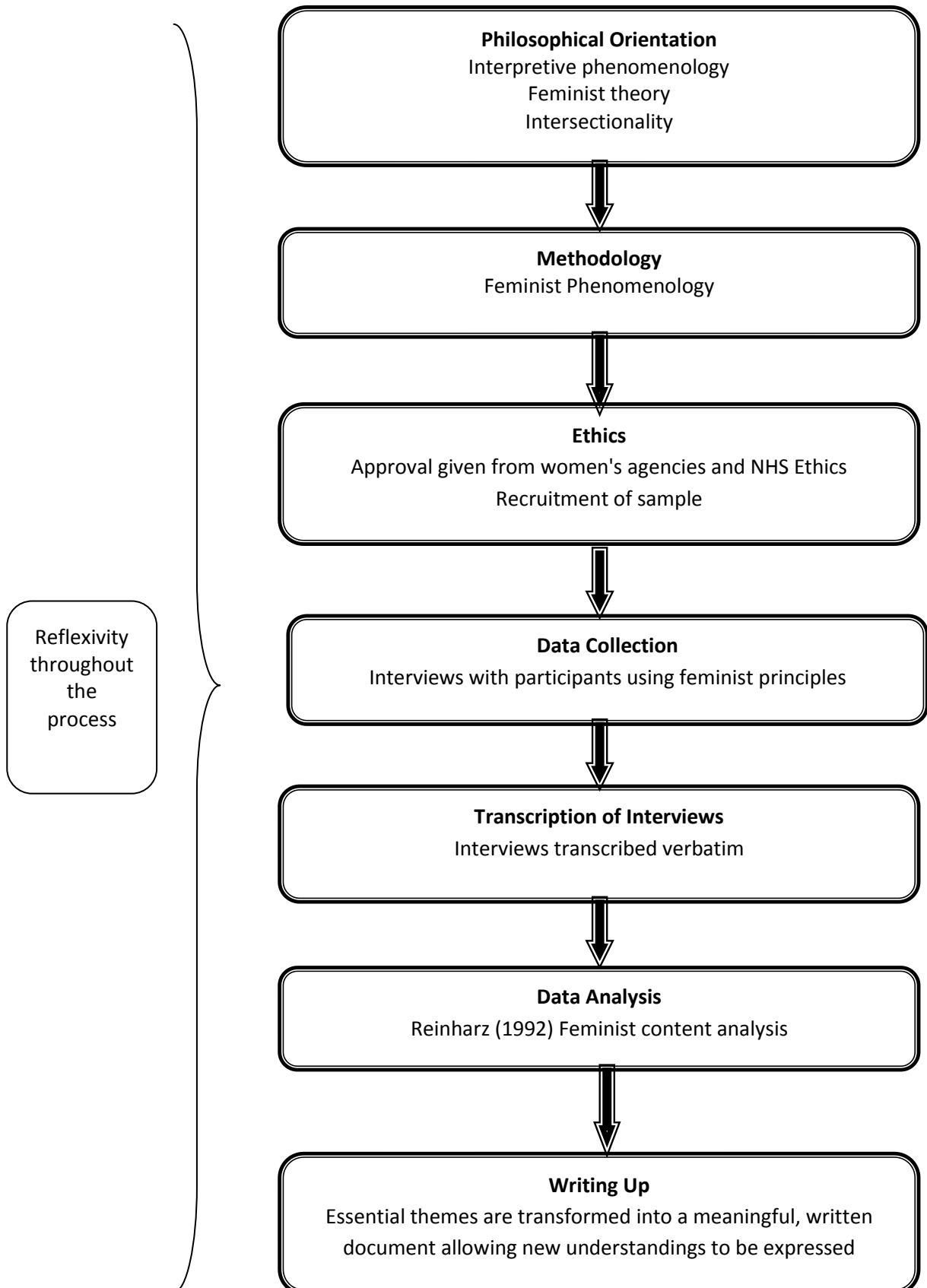


## Philosophical Orientation



## Chapter Four: Methodology

### Overview of the research process



## **Chapter Four**

### **Methodology**

#### **Introduction**

My intention in chapter four is to describe the methodological approach employed within this study and to explain and justify my choice of methods for data collection and analysis. In this chapter, I will also consider the importance and particulars of ethical research practice; gaining access to and the recruitment of participants. I will also make clear the process of conducting the interviews, data collection and clarify the importance of my researcher diary. Finally I will describe the process of analysing the women's stories.

#### **4.1 Negotiating access to participants**

One of the most difficult challenges, when conducting interviews with vulnerable people is gaining access to participants. Gaining access to participants can often take much longer than originally planned for, or indeed, it just does not happen (Baker, 2008). In the spring of 2008, I began discussions with two women's support service agencies in the local area where the research was conducted. Both organisations provide support for women who are or have been victims of domestic violence.

I approached the Directors of both organisations, to enquire whether they would be willing to meet me. These negotiations were protracted, but I considered this process essential in building a respectful and trusting relationship between myself, the refuge staff and more importantly the residents. I was very fortunate that both these local organisations agreed to meet me, allowing me to discuss the aims and objectives of the study. Their priority, quite rightly, was to ensure that the research would not be exploitative or cause harm to participants. It was imperative that they felt able to trust me and have confidence in my personal attributes, research abilities, my motivation

and commitment to the research. I realised that the first meeting with Directors of the organisations would be significant in terms of gaining access. Having worked previously with these organisations my request was given due consideration. I viewed these women's agencies as gatekeepers to participants; I was therefore fully aware that the success of the research was dependent upon the enthusiasm and involvement of the staff in the women's refuges.

Gaining access to women's refuges can be difficult in practical and safety terms, because of the need to keep the location secret, with the overall aim of protecting women and children and offering them a place of safety (Hoff, 1988; Abrahams, 2007). Safe houses and refuges were established by women for women, with a strong element of self-help and collective activity by survivors themselves (Hague and Malos, 2005). Currently, emergency and long-term housing, advocacy, help lines and women's support groups continue to be established by women's organisations. Many of the services provided are supported and administered by survivors of domestic violence. This has resulted in services that are responsive and sensitive to abused women's needs (Mullender *et al.* 2003). Such sensitivity has included being cautious of being 'used' or exploited by outsiders, including academics (Abrahams, 2007).

I was invited to attend several team meetings, to discuss the study face to face with some of the team leaders. Here, I was given the opportunity to explain the study in depth. During these meetings, I felt the study was well received by the majority of team leaders, with some of them voicing their support for the research. Several of the resettlement workers also offered to approach women they were currently supporting in the community. These women were separated from their partners and attending the 'Freedom Programme'. During the meetings, I felt I had been able to express my commitment to both the research and the participants, conveying a sense of responsibility for the welfare of any of the women who might agree to take part in the study. Following the staff meetings, I was informed that the team leaders thought the study was a good idea and they were willing to support the study. They all agreed to

place a recruitment poster in the refuge advertising the study (Appendix 1) and hand out information sheets to any of the residents who appeared interested in participating in the research (Appendix 2). In effect, they acted as a conduit, liaising with me and allowing me to arrange meetings to take place in the refuge. Some of the team leaders also discussed the proposed study with residents of the refuge at their weekly house meetings, acquiring their views about the study; thankfully, the study also received a positive response from residents.

I decided to approach both women's organisations in the city, as there was always a possibility that one of the organisations might have decided to deny me access. However, I was fortunate that both organisations decided to support the work. This process demanded a great deal of energy and time. In spite of this, I am certain that such preparatory work facilitated mutual confidence and understanding between me and the directors and support workers, and this relationship continued to develop during the research.

Having successfully gained NHS Ethical approval, refuge staff introduced the study to the residents by offering them an information sheet, which contained further details of the study and the level of commitment required of anyone who might be considering taking part. My contact details were available both on the poster and information sheet, to allow for personal contact (see appendix 1 and 2). However, all contact was via a third party, either a support worker from the refuge or the Freedom Programme. The refuge staff were always very hospitable whenever I visited the refuge. Below is an extract from my research diary, which was written following a visit to one of the refuges.

**Extract from research diary**

(Names have been changed to protect anonymity)

February 11<sup>th</sup> 2009



*The staff and the women at the refuge always make me feel welcome and I find myself feeling more relaxed with each visit. I have come to realise that the refuge will always be a hectic and noisy place, with children running around in the playroom, older children running up and down the stairs and the women often in the kitchen, making tea and cooking. I am starting to feel more accepted now, not that anyone was unpleasant previously, far from it. I just felt at first there seemed to be some suspicion about me, which of course is understandable. Thankfully, some of the women appear to be very interested in the research, often asking me lots of questions about the research. Once they find out I am a midwife, they often recite their birthing stories to me. I believe being a midwife has helped me to be accepted by the women. As with previous visits, I left some biscuits and fruit for the staff, women and children with Sue (refuge manager).*

#### **4.1.1 Ethical considerations**

I recognised that it was important to obtain ethics approval and negotiate access to the research sites. Obtaining NHS ethics approval was a lengthy but essential process, given the nature of the work. The proposal with accompanying consent forms, information sheets and supporting letters from the women's agencies and the University was submitted for review in August 2008, Appendix 2,3,4,5,6. The Ethics Committee reviewed the application on the 17<sup>th</sup> September 08; the ethics committee requested my attendance at the committee meeting. I was accompanied by my Director of Studies, who was supportive and reassuring. I was concerned that appearing before the panel would be an intimidating experience. It actually proved to be a valuable exercise allowing for a sharing of ideas around some aspects of the study, attending in person allowed me to respond immediately to any concerns and reservations the committee members had about the study. This was the case when a lay member of the committee voiced unease about the vulnerability of the women; her concern was that asking women to recall and describe abusive and violent behaviour would be detrimental to their wellbeing. However, once I was able to assure them that participation would be entirely voluntary, that no coercion would be involved in the recruitment and that adequate support mechanisms would be in place for any of the study volunteers, they appeared to be reassured. I was also reassured by

several members of the ethics committee who understood my reasons for conducting the research, in that this particular group of women are rarely given the opportunity to tell their story.

According to Liamputtong (2007) it is ethically correct that there are ongoing debates about the morality of conducting research with vulnerable populations, but it is not immoral or exploitative to include vulnerable groups if it is carried out ethically. Indeed, Morse (2000) strongly suggests it is in fact immoral not to conduct research with vulnerable groups in society, stating that it is often the most vulnerable in our society that we are in most need of understanding. When conducting this sensitive research, I tried to consider all the ethical implications. I was aware that I had a moral and ethical responsibility to all the participants, and as previously mentioned I was conscious that for some of the women, participation in the study could lead to unintentional emotional harm. I knew I was unable to provide a guarantee to the ethics committee or indeed to myself, that participation in the research would improve their lives. Nevertheless by following the principles of ethical behaviour and conduct it was hoped that participation in the study would not cause them distress. The dilemma of conducting sensitive issues will be considered in more depth later in the chapter.

The NHS Ethics Committee agreed to the study, subject to some minor amendments in the study design (see appendix 7). The amendments included removing my professional qualification as a midwife from the information sheet, designing a poster to be placed on the refuge notice boards to help with recruitment and offering to place the findings of the study on the women's agencies website. I did not consider the suggestions presented by the NHS Ethics Committee to be unreasonable, nor were they lengthy. In fact, I found the experience to be helpful and reassuring that my study has undergone and stood up to ethical scrutiny. Following submission of a suitable response to their suggestions, the study received a favourable opinion. The Committee designated the study exempt from the site-specific assessment (SSA) as the

recruitment and data collection would not take place on NHS property, nor would it involve NHS staff or patients.

It is also important at this point to acknowledge that for the NHS Ethics Committee stipulations, I needed to provide a structured schedule of interview questions. However, in accordance with feminist principles, my aim was to allow the interviews to be free-flowing and iterative and conversational in nature. I envisaged that the semi-structured interview guide would only be necessary if any of the participants were shy or reluctant to talk to me about their experiences and required prompting. However, the majority of the women were very open and talked about their stories with just one lead in question, which then flowed into the next question. The semi structured interview guide was only used with one participant, a young woman called Lisa. Lisa appeared very quiet and shy and was living in the woman's refuge with her baby son. During the interview, Lisa's replies to my questions were often short responses and any elaboration on her answers was only obtained through further probing questions. However, on reflection, I now recognise that perhaps the restricted rapport of the interview may have been the result of my own anxieties and insecurities. Lisa's interview was my first and I was anxious and nervous about how the interview would proceed and I now believe my own nervousness and apprehension may have affected the process.

## **4.2 Sample and recruitment**

### **About the women**

All the women had experienced domestic violence during their pregnancy in the previous two years. A total of fourteen women agreed to participate in the interviews. However, only eleven women were interviewed. Three women withdrew from the study, following consent. The ages of participants ranged from 21 to 38. Eight of the women were White British; one was Black British and two, Indonesian, now currently residing in the UK. Two of the participants were married to their partners, and nine

were co-habiting. They came from a range of backgrounds, including owner - occupied housing, though most of them from local authority or rented accommodation. Their occupations were also varied please see, Table 4.1. on page 90.

The women varied in age, and the number of children they had varied. The ages of children ranged from thirteen years to eight weeks old. All the women residing in the refuge were accompanied by their children. The experiences of abuse ranged from sexual, emotional and controlling to extreme physical abuse. In many instances several different types of violence were experienced. The length of time spent with an abusive partner varied from fifteen years to three years. In two of the relationships, women had children from previous relationships, which had broken down before meeting their abusive partner. Further contextual information about each particular participant is also available in chapter five.

**Table 4.1 Biographical Data of Participants**

<b>Name (Pseudonym)</b>	<b>Age</b>	<b>Occupation</b>	<b>Education – highest level achieved</b>	<b>Children</b>	<b>Ages of children</b>	<b>Ethnicity</b>	<b>Types of violence experienced in relationship</b>
<b>Tracey</b>	23	Full time mother	Secondary school	2	22 months & 8 months	White British	Physical, verbal, sexual, controlling, emotional and financial
<b>Julia</b>	35	Full time mother	Secondary school	3	13, 11 years & 19 months	White British	Physical, verbal, controlling, financial and isolation
<b>Sarah</b>	34	Full time mother	Secondary School	1	2 years	White British	Physical, verbal, emotional and financial
<b>Jane</b>	36	Health care assistant and student	Degree	3	10 years & twins 13 months	Indonesian	Physical, verbal, emotional, sexual controlling and financial
<b>Susan</b>	32	Home Carer	Secondary school	2	(13 years previous relationship) & 8 weeks	White British	Physical, verbal, emotional, controlling and financial
<b>Nicola</b>	22	Full time mother	College	2	2 years & 9 months	White British	Physical, verbal, emotional, controlling, sexual and financial
<b>Wendy</b>	38	Office manager	Degree	2	5 years & 20 months	Indonesian	Physical and verbal
<b>Kirsty</b>	24	Full time mother	College	1	2 years	White British	Physical, verbal, emotional, controlling, sexual and financial
<b>Louise</b>	25	Part-time waitress	Secondary school	1	22 months	Black British	Physical, verbal and emotional
<b>Tamara</b>	34	Full time mother	Secondary school	4	(12, 8, 5 years previous relationships) & 14 months	White British	Physical, verbal, emotionally and controlling
<b>Lisa</b>	20	Full time mother	Secondary school	1	13 months	White British	Physical, verbal, emotional, controlling and financial

Informed consent was obtained from every participant prior to starting the interview. Once a woman agreed to take part in the study, I returned to conduct the first interview a week later, thus allowing the participants seven days to reconsider. The women were aware that they could telephone me to cancel or re-arrange their interview. Should they wish not to speak to me directly, they were also aware that the refuge worker would be willing to contact me on their behalf. The principle of ongoing negotiation was always respected. The participants were aware that they could withdraw from the study at any time. When meeting the women for the first time, I discussed why I was conducting the study, taking time to fully explain the study and answer any questions. I always checked with the individual support workers that the participant's English and reading ability would allow for them to fully understand the information and consent sheet. This initial meeting allowed the women to ask me questions about the study. Eligible participants were women, eighteen years and older, currently pregnant or had been pregnant within the last twenty four months, separated from their partner and accessing support mechanisms.

At all times I was aware that I wanted to avoid what is referred to as 'smash and grab' interviews, meaning getting in, doing the interview, and getting out without any real interest in the participants of the study (Liamputtong, 2007). This is sometimes referred to by Reinharz (1983) as the 'rape' model of research. According to Dickson-Swift (2005) for some vulnerable participants, it may be the first time they have shared these experiences with anyone. With this in mind and purely from a personal and ethical stance, it was very important to me that I made an effort to build up a rapport with all the participants, before conducting the first interview. With this in mind, I met with all participants at least once before conducting any of the interviews. This not only provided me with an opportunity to explain the study in more depth, it also enabled me to arrange suitable date and time to conduct the first interview. It also allowed the women to meet with me in a non threatening way and afforded them the time to ask me questions or try to eliminate any anxieties they might have about participating in the research. I believe it also presented them with the opportunity to decide whether I was someone they felt they could talk to. I was very fortunate as the

women I met with, agreed to meet with me again and to participate in the research. Notwithstanding, three of the participants who had consented to take part were unable to be interviewed. One woman had to be re-located very quickly to another refuge for safety reasons, while another participant was asked to leave the refuge before our interview could take place. The third potential participant decided to return to her partner before the interview could take place, so it was deemed unsafe to make any further contact with her.

Additional support was available to residents of the refuge via an independent counsellor, with whom the women meet on a weekly basis. Prior to the interviews, I met with the counsellor and introduced her to the research. The counsellor offered to be available for the participants following interviews. Interviews conducted in the Children's Centre were only with women who were currently participating in the Freedom Programme. This group met on a weekly basis, which permitted me time to conduct one interview for 45 – 60 minutes on the morning before the group met. This ensured the participants had access to support and a supportive environment following each interview. The interviews were conducted in a private office in the refuge, or a quiet room in the Children's Centre. Every participant was aware that they could have their support worker present during the interview, however, none of the women chose to. For the participants who had their young children with them, the refuge manager organised a play worker for the children, thereby occupying them whilst I conducted the interview. The Children's Centre also provided space in the crèche for the children, allowing all the interviews to be conducted in a more relaxed environment.

The interviews with some of the women did not always go according to plan. For instance, I sometimes arrived at the refuge for an arranged interview to discover that the woman was out, or had made arrangements to meet with other people or organisations including housing officers, solicitors, school visits, or they had simply forgotten about our appointment. Twice, I arrived at the refuge for a pre-arranged

meeting to conduct an interview, only to discover the woman was upset and distressed. On such occasions, I considered it would have been uncaring, unethical and very intrusive to ask the women to participate, when they were so visibly upset. On both occasions, the interviews were rearranged for another day and time. During the data collection phase, I quickly realised how important it was for me to be as accommodating as possible in my approach to the interviews as the women's lives and circumstances were so complex. I also quickly realised that no visit to the refuge could or should be considered a waste of time, as I was always made to feel welcome, regardless of whether the interview took place or not. I often stayed long enough to enjoy a cup of tea and have a chat with some of the residents and staff. The residents appeared interested in the study and often asked me questions about my background and the purpose of the study. I believed this helped to develop and foster relationships with the residents and the refuge staff.

Contrary to my anxiety that the women might be re-traumatised when talking about their experiences, the women were very open and honest. This did not mean that the women did not become upset when recalling some of their experiences. This was especially relevant when they were describing the sexual abuse and rape that occurred in their relationship. When this occurred, I tried to be supportive, and acknowledge their distress. According to Dickinson-Swift *et al.* (2007) demonstrating empathy during research is crucial when acquiring information from participants, especially when the topic being explored is sensitive. During the interviews, when a participant became visibly upset, I offered to discontinue the interview, or stop the interview temporarily, providing them with some space and time to re-gain composure. I openly acknowledged their distress and respected their periods of silence. None of the women wished to discontinue their interview. The women freely offered intimate detailed information concerning the violence and abuse without being prompted, suggesting that they wanted their voices to be heard.



### 4.3. Data collection

My decision to use the interview as a method of data collection stems from my epistemological and ontological position that knowledge and reality can only be obtained from those who experience it (Reinharz, 1992; Crotty, 1998). I believed using in-depth interviewing would allow me to explore the breadth and nature of participants' experiences. Talking to women about their experiences of violence and abuse clearly raises ethical issues (Hoff, 1988; Williamson, 2000b), and feminist researchers have previously acknowledged that talking about the effects of experiences of violence can be distressing but cathartic (Kelly *et al.* 1995). Opie (1992) claims that there are several ways in which a participant may feel empowered and benefit from personally participating in research. These include making a social issue more visible by their participation, and the therapeutic effect of being able to reflect and perhaps re-evaluate their own experiences through the process of being interviewed. In-depth interviews are favoured and widely used by feminists as the method allows for a more sensitive approach to research (Maynard 1994).

Regardless that the women had given written consent the previous week, verbal consent was obtained from every participant prior to starting the interview. I also took this opportunity to highlight the limitation of confidentiality and anonymity, and checked once again that the women were happy to have the interview recorded. Minichiello *et al.* (2008) proposes extra vigilance is required when the interview is held over several meetings, suggesting that multiple interviews can bring about further ethical issues for the researcher. Such ethical issues include the level of rapport that may be built up between the researcher and the participant leading to a '*delusion of alliance*' (Stacey, 1988). Unquestionably, I can relate with Minichiello *et al.*'s. (2008) words of counsel; from a personal perspective, I felt I developed a closer relationship with the women that I was fortunate enough to meet on three or four occasions, in comparison to the women I only met with twice. With each follow-up interview, verbal consent for the interview was obtained.

In an attempt to help the women relax during the interview, the first question I asked was *'Tell me a little bit about you'*. I always used this as a preamble to the interview with dual purpose. By allowing the participants time to talk about themselves it was hoped that this prelude would help to relax the participants, indeed, Miller and Tewksbury (2001) suggest:

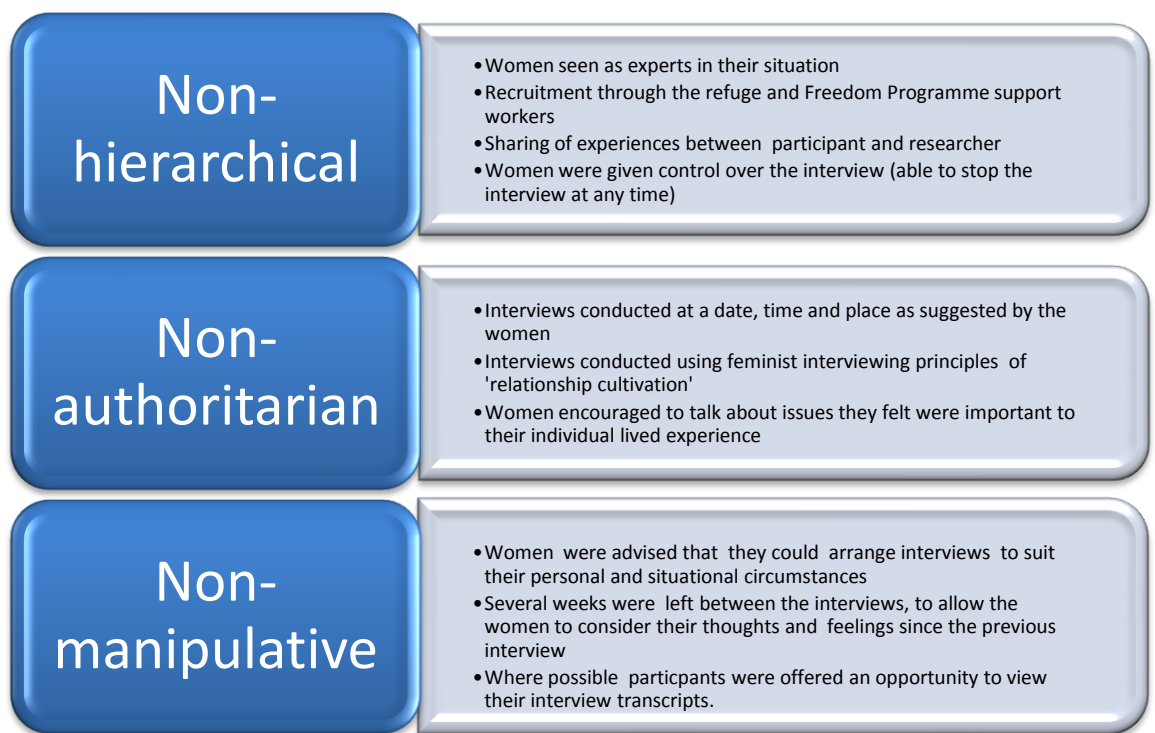
Becoming trusted and seen as someone with whom research participants are comfortable spending time, talking and sharing their lives is called 'establishing rapport'. In order for a researcher to truly understand the world, from the perspectives of those being studied and to see how persons being studied think about their world it is critically important for rapport to be established. (Miller and Tewksbury 2001, p. 55)

In an attempt to ensure an ethical and 'woman centred' approach, I engaged with feminist methodologies to conduct the interviews. I recognised that the women who agreed to participate in the study had to be able to trust me and this had to be developed in a short space of time and as a consequence sensitivity and respect towards the women was vital.

Adhering to feminist principles throughout the study, the women were considered as the 'expert' in relation to their experience of domestic abuse. It was also essential that I endeavoured to incorporate, throughout the data collection and analysis stage of the study, what Shulmit Reinharz (1983) terms a collaborative relationship. Reinharz considers that the traditional terminology of 'researcher' and 'subject' is cumbersome and renders the subject as "powerless and passive and in essence an object" (Reinharz, p.180). Also in accordance with Reinharz's (1983; 1992) principles of conduct, I wanted to avoid being viewed by the women as the person in the position of power, with control over the research setting. I also aimed to prevent the participants feeling manipulated and overwhelmed. Reinharz (1992) recommends that the researcher

include some simple measures to help the 'subject' feel like a 'collaborator' in the research process. Developing such openness needs to be fostered, as in most instances the two parties will start their journey as strangers (Reinharz, 1983). With this in mind, I considered Reinharz's Experiential Framework for Collaborative Research in conjunction with the World Health Organisation Ethical Code of Practice (1999), in an attempt to ensure safe and ethical practice during the recruitment and interview stages of the study. Reinharz's (1983) framework endorses principles of non-hierarchical, non-authoritarian and non-manipulative behaviour on behalf of the researcher.

**Adapted 'Experiential Framework for Collaborative Research' (Reinharz, 1983)**



Framework adapted from: Reinharz's Experiential Analysis. A Contribution to Feminist Research In: Bowles and Klein Theories of Women's Studies (1983).

According to the World Health Organisation (1999) researching domestic violence and abuse involves significant risks to the wellbeing of participants:

Researching abuse is not like other areas of investigation – the nature of the topic means that issues of safety, confidentiality and interviewer skills and training are even more important than in other forms of research. It is no exaggeration to say that the physical safety and mental well-being of both the respondents and the research team can be put in jeopardy if adequate precautions are not taken. (World Health Organisation, 1999, p. 2)

In response to their concerns the World Health Organisation published guidelines in an endeavour to raise awareness of some of the ethical issues in conducting research on violence (see table 4.2). The recommendations urge researchers to only undertake research involving women if they could guarantee complete privacy during the interview, provide information and referrals to all respondents and provide special training and support for the interviewers.

**Table 4.2. World Health Organisation Ethical Considerations for Conducting Research**

1. The safety of respondents and the research team is paramount and should infuse all project decisions.
2. Prevalence studies need to build upon current research experience and how to minimise the underreporting of abuse.
3. Protecting confidentiality is essential to ensure both women’s safety and data quality.
4. All research team members should be carefully selected and receive specialised training and ongoing support.
5. The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research.
6. Field workers should be trained to refer women requesting assistance to available sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.
7. Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development (World Health Organisation, 1999).

Paradoxically, the issue of 'power' was something I tried to avoid with this particular cohort of women. It was important to remember that all the women had been subjected to violence and abuse by a person who had taken control over their lives, including eroding their confidence and self esteem. As a consequence, I wanted to be aware of any aspects of my own behaviour that could be considered as controlling and manipulative. My purpose was to encourage a reciprocal relationship, thus challenging the traditional researcher and participant hierarchy (Oakley, 1981; Reinharz, 1983, 1992; World Health Organisation, 1999).

### **Considerations when conducting sensitive interviews**

I was conscious that the interviews conducted would be of a very sensitive nature, and this provoked much thought and concern. I was especially aware that conducting such sensitive interviews had the potential to trigger and provoke anxiety and distress for participants. My concerns were supported by King and Horrocks (2010), who suppose that any qualitative interview has the potential to raise questions and bring back thoughts that an interviewee might find distressing. During the interviews, some of the women became noticeably upset and tearful, or angry and frustrated when recalling some of the experiences they had endured at the hands of their abuser. According to Williamson (2000b), although traumatic for participants as well as the researcher, the interview process provides participants with choice and freedom to express their experiences and opinions of the abuse they have endured. This is supported by Abrahams (2007) who suggests that giving time to listen and understand women's experiences of violence can in itself be a validating and supportive process.

It was impossible to remain detached when listening to the women's stories. Initially, I was concerned that I would not be able to respond appropriately or effectively to their emotions and possible distress. The openness, honesty and revelations of intimate feelings by the participants presented me with a tremendous responsibility, which at times made me feel apprehensive and inadequate. However, the women trusted me

with their experiences; in point of fact, some of the women told me during or after the interviews that they found me easy to talk to and had told me things that they had never told anyone else. Nevertheless, if I am to be completely truthful, whilst I was pleased that the women felt they could be entirely honest with me, this trust added to my feelings of immense responsibility towards them and their narratives. It was very important to me that I was able to truly represent the women's thoughts and feelings whilst maintaining personal integrity. At a recent celebration on the contribution of Dr Ellen Malos and Professor Gill Hague to Research and Activism on Gendered Violence (2011), Liz Kelly, described women's openness and disclosures about abuse in an interview situation as a '*gift of trust*', in that women display their confidence and faith in you; they '*trust you to do good*' with their stories. The women in this particular study wished their stories to be told, in the hope that it would help other women in similar situations.

There was no doubt whatsoever, that I learned a great deal from the women I met. I went wherever the women led me; I saw them as the experts in their own experiences. Talking to the women as a female researcher made me appreciate and realise what Yllö (1988) acknowledges, as a woman I am part of what I was studying and "that as a woman, I am also vulnerable to such violence within our society" (p34). However, as Yllö (1988) so eloquently testifies, any subjective understanding gained was not, and should not be considered as an obstacle or hindrance to the work; rather it should become an important part of the analysis.

Due to the sensitivity of the topic, thorough consideration was given to the appropriateness of the venue and environment used to conduct the interviews. I considered how I would cope if anyone became distressed or disclosed something which would make me feel uncomfortable. Being a practising midwife, currently registered with the Nursing and Midwifery Council (NMC) I am bound by my professional and ethical code (Nursing and Midwifery Council, 2004). This personal and professional dilemma initiated a lot of thought about my position within the research.

I was concerned that by informing the participants of my professional obligation to disclose any child protection or safe guarding concerns to the appropriate agency, I ran the risk of affecting the quality of our relationship and the woman's trust, thereby preventing them from being completely honest with me.

Another important deliberation was the avoidance of potential exploitation of the participants. It has been a concern for feminist researchers that by encouraging women to disclose private and upsetting events in their lives, an interview might distress or traumatise the women (Edwards, 1993; Maynard and Purvis, 1994). However, this concern is contradicted by participants, who often claimed that the interview was helpful and cathartic and in some cases empowering (Kelly, 1988; East *et al.* 2010) Some participants felt proud that they had contributed to research and that their views were finally being acknowledged (Kelly, 1988; Renzetti and Lee, 1993; Morse and Field, 1995; Baker *et al.*, 2005; Abrahams, 2007, East *et al.* 2010). This is especially relevant when conducting research in domestic violence, where women are likely to have felt excluded or ignored for many years. Certainly, in this study, several of the women found the process cathartic and expressed their appreciation, commenting that they found the interview helpful and thanked me for taking the time to listen to their experiences. Three of the participants, Kirsty, Wendy and Julia, found the experience empowering and positive and offered to help with any future research.

Some of the women had concealed the abuse from their families and friends for many years. In these cases, the participants expressed a great relief to be finally given a opportunity to talk about the abuse they had experienced. The women all responded differently when recounting the violence and abuse. Some of the women became very animated and spirited, raising their voice in anger when discussing the behaviour of the perpetrator. One participant Susan became very vocal, angry and upset, during our interview. She wanted to make a cup of tea, so we continued to talk in the kitchen of the refuge, as she prepared the tea, where Susan talked about her partner's abusive behaviour towards her. When describing his behaviour towards her, she banged the

utensils onto the work top; closed all the cupboard doors with a loud bang, and slammed the fridge door with a thud; all these actions were carried out in anger and frustration. Yet in between all this anger, her tone would soften when she spoke directly to me; for instance, when asking how I took my tea. At the time, I thought nothing of this, however, when listening and transcribing Susan's narrative, I marvelled at her ability to move backwards and forwards between emotions.

### **Part of a transcription from Susan's interview (verbatim)**

*R: he was just as bad to his mum as he was to me. Do you want coffee or tea?*

*I: Tea please. (Susan slams cupboard door)*

*R: It was a case that you dread him coming in from work, that's when he worked of course! You didn't know what mood he was going to be in, if you didn't speak to him you were in the wrong, and if you did speak to him that was still wrong. You were constantly stepping on egg shells with him all the time, God it makes me so angry to think about what he did to me, do you have sugar? (Container slams onto work top)*

*I: No thanks just milk. (Fridge door slams)*

*R: Sorry, I didn't mean to do that (referring to slamming of the fridge door) this whole thing, this situation still makes me so fucking angry.*

Ribbens (1989) suggests that "one of the most important qualities for a researcher is the ability to listen and hear to what is being said" (Ribbens, p. 586). However, Parr (1998) suggests that whilst this is very important, it is just as significant to listen and hear what is not being verbalised. Parr (ibid) implies that carrying this out can be very demanding and tiring for the researcher. Listening to, and concentrating on, the women's narrative on some occasions for up to ninety minutes was emotionally tiring. Later when listening to the interview recordings, I would sometimes feel frustrated for failing to follow up on an important detail or aspect that the woman had mentioned. This was personally exasperating, especially when I knew that I was unable to meet with that particular woman again.



As intimated previously, individually the women exhibited varying and shifting emotions during the interviews. Unlike Susan, others became very quiet or distressed when recalling some of the ways in which the men behaved towards them. Yet even though the women found recounting their experiences distressing, especially when this involved disclosure around sexual violence, I was often taken aback by just how willing the women were to share such intimate experiences. At the same time I admired their strength to endure and tolerate the sexual abuse, wondering how they managed to carry on with their daily living when they had endured such extreme abuse. For some, this had been over a period of many years. Whilst listening to the women recall their experiences, I felt a mixture of emotions. I found listening to such experiences distressing. Sometimes their narratives were so explicit, it almost felt as if I was actually there, positioning myself in their experience. I also felt immense anger towards the men who had perpetrated the abusive behaviours. Occasionally, this anger and frustration was directed towards a particular organisation such as the police or health. Occasionally, individual woman offered accounts of how they had asked for help from a person or organisation, but their appeal for help or support was not acted upon. In such instances, I struggled to suppress my own feelings, trying to control my verbal and non verbal responses, in retrospect, there were times, when I was not very successful at doing either.

Using the women's voices to shape the research was always my objective; thereby allowing me to explore the subject, as reported by the women who had experienced the violence and abuse. Consistent with feminist ethics and principles, it was important to consider the impact of obtaining knowledge from participants while ensuring that the process was not oppressive or abusive. I always strived to adhere to the ethical principle of non maleficence and strived to ensure that the data collected were not obtained under coercion. All the women who participated in the research received a £10.00 High Street voucher. The voucher was not seen as an incentive to take part; it was purely a small token of thanks in recognition of their willingness to give up their time to speak to me; a gift.

As the interviews progressed, I found myself adopting a more relaxed approach as I became more confident in my own abilities as an interviewer. As a result, I found myself having to refer to the semi-structured interview schedule much less than I had during the first few interviews. I used open questions such as ‘tell me about the abuse you experienced during your pregnancy’. This allowed the women to discuss their personal experiences of violence and abuse during pregnancy in their own words. On reflection, the women made my role as the interviewer very easy. They were very responsive and prepared to share their experiences. At the end of each interview, I experienced a variation of emotions; this was sometimes happiness because the woman concerned had moved on and had a positive outlook about their future. At other times there were feelings of sadness and concern for the women. Although the women experienced feelings of relief and were extremely grateful to the refuge staff, it was also evident that some of the participants were struggling to adjust to their life in the refuge. They were missing their home and belongings. Some of the women had left behind family and friends in another city; some had no access to immediate funds and were struggling to see a way forward. Following each interview, my own emotional well being was dependent on how distressed the participant appeared during the interview. Even though I thought I was prepared to hear some horrific experiences, I often found myself struggling with my own composure and emotions whilst listening to them. However, despite being deeply distressed and moved when listening to what they had experienced, it was impossible not to feel inspired by their strength and their fortitude to survive and determination to make a new start in their life. For some, this included going back to college, or starting a job. All the women inspired me with their spirit and resilience.

### **Personal considerations of conducting sensitive research**

I was aware that conducting sensitive interviews might cause emotional upset, stress and anxiety to me as the researcher. When this happened, I drew on the invaluable support from my PhD supervisory team, and I made use of the opportunity to meet at regular intervals with an external counsellor. I also spoke to various colleagues who are

very experienced researchers with excellent knowledge of the topic being studied and understanding of feminist ethical approaches. Having access to such supportive mechanisms proved invaluable in helping me to alleviate my anxieties when they arose. I was very fortunate to have the support of a supervisory team who have been encouraging at every juncture of this research study. Their encouragement and support were invaluable; they listened, supplied moral support and on occasions cried with me when I needed to debrief, when embarking upon the data analysis stage of the research. Although I have undertaken domestic violence research before my supervisors had not and the effects of my story telling and disclosure often provoked sadness, anger, frustration and then consolation.

#### **4.4. Analysing the stories**

In the following section, I will describe the process of how data were analysed from the in-depth interviews. I will also provide a rationale for the particular framework chosen whilst describing the process of analysis. The significance of trustworthiness and researcher reflexivity during the analysis process will also be considered.

By its very nature, qualitative research normally produces an enormous amount of data, which requires researcher interpretation, which can only be achieved by actively engaging with the text (Reinharz, 1992; Miles and Huberman, 1994; Burnard, 1996; Davidson *et al.* 2010). Pope *et al.* (2000) suggest that there are a few well-established broad guidelines that should be followed during the data analysis process. Such guidelines should be considered alongside the researcher's ontological and epistemological position. In addition, Ribbens and Maynard (1998) suggest that whilst there is significant feminist literature devoted to issues of gaining access and reflexivity within the data collection process, much less is dedicated to the process of retaining participants' voices in the data analysis and writing up stages. In an attempt to avoid such a happening, I purposely sought an analysis process which would be sympathetic to my epistemological position whilst also having the capacity to describe, interpret

and appreciate the narratives of the women. Therefore, I drew on what has been described as a subjective, interpretative process (Reinharz, 1992).

Fisher (2000) believes it is possible to consider a phenomenological approach to understanding individual experience as a means of framing feminist experiential discourse, highlighting de Beauvoir's work in 'The Second Sex' as an example where she assumes a descriptive analysis of women's lived experience and their situation. According to Reinharz (1983), data analysis is an activity which is "reflective and solitary, in which recorded experiences are compiled, reduced and examined for their interactions and basic themes", where the "more significant is extracted from the less significant within a system of meaning" (Reinharz, 1983, p.182). Parts are then brought together to "make new wholes - simplicity is sought beneath the complexity" (Reinharz, 1983, p. 182). Reinharz (1983) believes there are no rules for data analysis except one, that the analysis stays true to the persons studied, drawing heavily on their spoken words. The language of the researcher should be "evocative and communicative" (Reinharz, 1983). Indeed Rapley (2011) intimates that in their basic terms, all qualitative data analysis frameworks share similar characteristics, in that they seek to move from the particular to the abstract.

#### **4.4.1. Experiential data analysis**

Experiential data analysis was chosen, as it is compatible with the constructionist paradigm in that it is ideal for identifying, analysing and highlighting themes within written data and as such it is considered as a "foundational method for qualitative analysis" (Braun and Clarke, 2006). By utilising experiential analysis, I hoped to be able to realise and acknowledge the individual meaning of the women's experiences, whilst also considering how the broader social context impinged on such meanings (Braun and Clarke, 2006). This is because the analysis did not aim to focus so much on individual philosophy but to consider the constructive contexts that enabled the individual accounts to be understood.

Phenomenology and feminism both share a commitment to experiential analysis (Fisher 2000), in that they examine and articulate the lived experience, alongside the researcher's theoretical inference, as a basis for reflective discourse. I required an analytical framework concerned with in-depth and personal accounts of women's experiences of violence and abuse within the context of their pregnancies. Interpretive thematic analysis was employed alongside Reinharz's experiential data analysis framework as illustrated in table 4.3. on page 107.

**Table 4.3. Reinharz (1983) Experiential data analysis framework**

Stages	Reinharz Data Analysis Framework	How data were incorporated in the analysis process
<b>Stage One</b>	Participants transform their private experiences into language which is taped and transcribed, leaving a large space on the right hand side for written interpretations.	<i>All the interviews were transcribed verbatim. A space was left down the left hand side. Transcribing verbatim was a lengthy and time consuming process, but I did not want to lose any sense of meaning from the individual experiences.</i>
<b>Stage Two</b>	Repeated and careful listening of the experiences and reflections allows the researcher to gain a general idea and meaning of these experiences. As you listen, visualise the conversations with the participants so that their emotional state is noted and interpretations become more personal. Re-read and reflect upon the transcripts several times over a period of weeks.	<i>All the transcripts were read through once; I also listened to the recording of the interview allowing me to visualise the interview with each participant. This took me back to the place and time of the interview. During the course of two to three weeks I re-read each transcript, reflecting upon each one.</i>
<b>Stage Three</b>	This understanding is then transformed into conceptual themes which capture the essence of each participant's experience. The themes will emerge from a dialectical process of moving between a background of intersubjective or shared meaning and one of meanings focused on, specific to participants' experience. This is the hermeneutic circle. As the researcher's interpretations become clearer, similar themes may merge into larger essential themes.	<i>Once again, the transcripts were re-read. This time I started to make very brief notes down the side of the transcripts. I focused on the intersubjective meaning of the experience for each woman. This process was repeated for each transcript. The transcripts were then re-read. This time I highlighted each theme with a coloured pen. This allowed for the shared meaning and basic themes to emerge from the collective data, allowing the initial themes to be generated. I then made a list of all the themes.</i>
<b>Stage Four</b>	The essential themes are then transformed into a meaningful written document that enables new understandings to be publicly expressed.	<i>Using Microsoft Word, I placed the individual sections of the text which had been read and coloured coded and related to an essential theme together, forming independent files. Once completed I read them to confirm they had a shared meaning.</i>
<b>Stage Five</b>	The final process of understanding is performed by the reader, when interpretations are created out of the experiences of the participants.	<i>Each essential theme was saved printed and re-read. Readings of individual transcripts continued, ensuring no important information had been missed. This is referred to by Braun and Clarke (2006) as the recursive process where you often move backwards and forwards throughout the phases as needed.</i>

The main themes were then further developed and reviewed. As a result another set of major themes were then developed and reviewed, and consequentially, another set of sub themes emerged (Braun and Clarke, 2006).

On completion of the data analysis, I presented the main themes to my PhD supervisory team; all of whom were experienced qualitative researchers. I wanted to avoid only seeing what I wanted to see, so I used the team to verify that these themes were real and relevant. Finally, I chose the quotes for inclusion in the findings chapter based on their ability to truly represent the main concepts as they emerged from the women's stories, see figure 4.5 on pages 109 and 110.

**Figure 4.5. Data Analysis – Emerging Themes**

Main themes in **bold** – sub themes in *italics*

<b>Sub themes</b>	<b>Main Theme</b>
<p><i>a) Violence before pregnancy</i></p> <p><i>b) Violence during pregnancy</i></p> <p><i>c) Violence following pregnancy</i></p>	<b>1. Link of pregnancy and violence</b>
<p><i>a) Physical, sexual, emotional, isolation, financial and control</i></p> <p><i>b) Continuation of violence</i></p> <p><i>c) First experience of physical violence</i></p> <p><i>d) Mobile phone to control, isolate and harass</i></p>	<b>2.Types of violence experienced during pregnancy</b>
<p><i>a) Male indifference to pregnancy</i></p> <p><i>b) Postnatal depression</i></p> <p><i>c) Infant feeding choices</i></p>	<b>3. Effects of violence during the postnatal period</b>
<p><i>a) Unplanned pregnancy and the link with violence</i></p> <p><i>b) Bullied into pregnancy</i></p> <p><i>c) Pre-term birth</i></p> <p><i>d) Miscarriage</i></p> <p><i>e) Men’s indifference to pregnancy</i></p>	<b>4. Effect of violence on pregnancy</b>
<p><i>a) Male alcohol use leading to an increase in violence</i></p> <p><i>b) Male drug use leading to an increase in violence</i></p> <p><i>c) Financial Difficulties</i></p>	<b>5. Substance abuse</b>



<b><i>Sub themes</i></b>	<b>Main Theme</b>
<i>a) Control of movements</i> <i>b) Isolation from family and friends</i> <i>c) Control over finances</i> <i>d) Roles within household</i>	<b>6. Power and control</b>
<i>a) Midwife</i> <i>b) General practitioner</i> <i>c) Health visitor</i> <i>d) Other services (Children's Services, police and women advocacy services)</i>	<b>7. Role of health professionals</b>
<i>a) Reluctance to disclosure to healthcare professional</i> <i>b) Lack of opportunity to disclose to healthcare professional</i> <i>c) Continued presence of partner</i> <i>d) Shame of being in an abusive relationship</i> <i>e) Fear of reprisal from partner</i> <i>f) Fear of social services</i> <i>g) Failure of health care professional to ask</i>	<b>8. Failure to disclose to health professional</b>

#### **4.4.2. Using a data analysis package**

All the individual transcripts were also imported into NVivo 8. This is a specialist software package that can be used to conduct data analysis (Bazeley, 2007). It was never my intention to utilise a computer assisted data analysis software package to actually analyse the data. Its main purpose was to help me manage a large quantity of data. According to Serry and Liamputtong (2010) and Bryman (2008) Computer Assisted Qualitative Data Analysis Software (CAQDAS) is a useful appendage which can be used to assist the researcher to find, categorise and retrieve their data. However

CAQDAS cannot analyse the data on its own merit. This is reinforced by Gibbs (2007) who affirms that analytic knowledge has to be produced by the researcher. In terms of my own data, using CAQDAS certainly assisted me in managing and organising the large amount of data generated from all the interviews. It provided me with an uncomplicated way to organise the relevant data into the identified themes, (Bazaley, 2007) allowing me to view all the various fragments within the context of an individual theme.

#### **4.4.3 Reflexivity and trustworthiness in data analysis**

It is only recently that researchers have come to fully appreciate the full meaning of reflexivity within the context of their own research and develop an understanding of the extent to which a researcher's own theoretical position can affect the theoretical accounts of their participants (Ribbens and Edwards, 1998). According to Finlay and Gough (2003), being reflexive during data analysis can be problematic. This proposition is supported by Ribbens and Edwards (1998) who believe that reflexivity in feminist research has always addressed two aspects of the research process with ease: firstly, the nature of the research relationship between the interviewee and researcher, and secondly, reflexivity in relation to issues of theory construction and epistemology. However, Finlay and Gough (2003) propose that little attention has been paid to reflexivity and power in the data analysis stage of research, cautioning researchers that immersing themselves in their own data can prove to be a painful and sensitive experience. They suggest that fixations with personal experiences and emotions can take the research down an unwelcome track, advising researchers not to privilege their own voice at the cost of their participants (Finlay and Gough, 2003). I was aware that I had to fully engage with the analysis process, regardless of how painful this might be.

I expected to experience and encounter sorrow and anguish during the data collection phase of the research. However, I was not prepared to experience such feelings during the data analysis phase. Liamputtong (2007) counsels caution as he believes the

feelings experienced during the data collection stage will probably re-emerge during the data analysis period. This may be because as the words are once again listened to and transcribed, the distressing and powerful words of participants come alive again (Dickinson-Swift, 2005). Re-visiting the women's narratives evoked strong emotions in me and I found myself re-living their nightmares. I found I had difficulty falling asleep at night as the women's stories stayed with me long after I had been actively engaged with the analysis. I experienced feelings of anger and distress and became emotional all over again, when listening to and transcribing the women's account of their experiences. Beyond doubt, I felt and re-lived the women's anger, pain and hurt. For several days following a period of transcribing and data analysis, I felt extremely sad. In short, I found it impossible to remain as untouched during data analysis, as I was by the data collection.

Morse (2000) proposes that when researchers conduct sensitive research, they run the risk of encountering and becoming engulfed with a shared suffering. Morse and Mitcham (1995) refer to this as the "compathy phenomenon" (p.650), which they describe as the "acquisition of the distress of another" (p.650). They suggest the compathetic response may arise from listening to distressing stories. Dunkley and Whelan (2006) support Morse and Mitcham's (1995) conjecture. However they identify shared suffering as vicarious traumatisation, which can occur when the researcher also starts to develop feelings of anguish and trauma, during the research. Liamputtong (2007) suggests researchers must try to prepare themselves and attempt to block the compathetic response, so that the participant's pain is not shared. However I know from personal experience how hard or indeed impossible this is to achieve. Compathy was experienced during the course of my own research. One of the participants, Nicola (pseudonym) died during the data collection phase of the study. Her death was unexpected and was due to an undiagnosed terminal illness. Nicola died the day before we were due to meet for her second interview. Following her death, I found it very difficult to revisit the interview. In fact it took several attempts before I was able to listen to more than a few minutes of the recording. As a consequence of her death, her words took on a special meaning. This great sense of

loss was heightened as I listened to her ardently telling me about her plans to start a new chapter in her life. She had seemed happy and was looking forward to moving on and making a new life for herself and her two young children. During the data analysis phase, I was extremely grateful that I had access to both formal and therapeutic supervision which helped me cope and come to terms with my personal feelings.

My purpose and overall aim during the data analysis phase of the study was to be as faithful as possible to the participants' stories. However, Holland and Ramazanoglu (1994) suggest that whilst feminist researchers interview women with the primary intention of producing feminist knowledge, they cannot simply allow the experience to speak for itself. To do so would leave the researcher unable to reveal how they came to any conclusions. They suggest women's accounts have never just spoken for themselves, they have always been interpreted and conceptualised by feminist researchers. Upon reading this, I was worried that I would be unable to confirm trustworthiness in any real sense. I considered the women in my study to be individuals, all very different and distinctive, and their narratives were unique to them, within their own social and cultural context. However, I was reassured by Liamputtong (2010) who suggests qualitative research data cannot be tested for trustworthiness using standards based on objective reality. Instead, he suggested principles that qualitative researchers could follow, to demonstrate the trustworthiness of their data.

One such principle is credibility. Lincoln and Guba (1985) suggest credibility can be achieved by accurately interpreting the participant's experience. Clayton and Thorne (2000) support Lincoln and Guba (1985) by claiming the research is considered trustworthy when the data have been presented precisely and honestly and reflect the experiences of the participants. Participant validation whereby interviews are returned to participants to be verified is one technique frequently used by researchers. Therefore, all the participants were offered the opportunity to review their transcripts following the interviews thereby offering participant validation. However, only one of the participants (Kirsty) took up this opportunity and asked to view her three

transcripts. Kirsty did not request any changes to her transcripts. Where multiple interviews occurred, it was possible at the beginning of subsequent interviews to provide a brief synopsis of our previous interview, as well as providing me with an opportunity to revisit any subjects which required clarification. This provided some of the women with the opportunity to validate my interpretation of our previous interview.

#### **4.4.4. Writing a research diary**

Writing a personal reflective research diary is considered to be an important part of one's research. Finlay (2002) suggests that the research diary is an important tool in qualitative research, which can be used by all, whether their primary interest is research, professional practice or social change. I aimed to write in my diary as and when necessary, I did not want the diary to become a resource, which I felt obliged and forced to maintain. Nevertheless, I always strived to ensure that I entered notes and details of what I considered were important events such as attending the ethics committee, visiting the refuges and attending meetings and conducting interviews. I also found it helpful to talk into a handheld digital recorder about my feelings, immediately after the completion of an interview.

#### **Example extract from personal research diary**

**February 11<sup>th</sup> 2009** (Name changed to protect anonymity)

*I arrived at the refuge to conduct an interview with Priscilla. However, Priscilla has decided she would prefer go out shopping with a friend rather than participate in our interview. It was very obvious that she was irritable and disconcerted about something. When talking to her, she tells me that she is angry with the refuge staff as she had just received a written warning from the manager of the refuge. This warning was for inappropriate behaviour towards other residents living in the refuge. Due to Priscilla's body language, I felt pursuing an interview with her at that point in time would have been pointless. I also felt ethically, she had the right to refuse to participate in the*

*interview. Although, to be perfectly honest, I was feeling slightly disappointed and frustrated, as Priscilla knew she could phone me to cancel or re-arrange the interview. However, we rearranged the interview for the following week, although I have a feeling Priscilla may have left the refuge by the time next Thursday comes round. I will also have to wait and see if the refuge manager (Sue) can arrange for a play worker to be available to take care of Priscilla's little girl before I can confirm the interview with Priscilla. On the plus side, I managed to have a cup of tea and chat with Lisa and check she was feeling alright following our interview on Monday afternoon. She was very chatty and showed me the outfit she bought for baby J... with her £10.00 voucher She also told me that she had an appointment with a advisor from the local college as she was thinking about going back to finish her hairdressing training. It was really nice to have the opportunity to chat with her and check she was OK following our interview, as I had been worrying about her as she had been a bit upset during our interview. I was also able to confirm with Sue (refuge manager) that Lisa had been OK following our interview.*

Sometimes, after leaving the refuge, I would sit in my car for five or ten minutes before driving off, in an attempt to try and organise my own thoughts and feelings. During such times, I found it very helpful to write some brief notes in my reflective diary or record my thoughts and feelings into the digital recorder. By so doing, I managed to capture my immediate responses following each interview. Following each interview, the women and their narratives stayed with me for a long time. According to Liamputtong (2007) this is referred to as researcher trauma and occurs when researchers explore sensitive topics. Roberston (2000) claims research is considered sensitive when the research includes the private sphere of an individual and involves deep and meaningful conversations about their life experiences which they may never have voiced before. Wellings *et al.* (2000) suggests that if the matter being explored requires the participant to disclose behaviours which would normally be kept private and personal, then disclosure will cause some discomfort to the participant. Lee (1995) claims such feelings and emotions are just as applicable to the researcher who is

conducting the research. This subject will be explored in more depth later in the data analysis section.

## **Summary**

In this chapter I have outlined the research process as I have understood and experienced it. I have described and justified my research methods and my research practice. I took inspiration from the qualitative tradition. In particular, I have sought to illustrate the way in which this research can be understood as feminist phenomenology research, reflecting the interests and orientation of a politics concerned with the way in which gender experiences and relations of power impact upon, and shape women's lives. In the following chapters I describe and discuss the findings of my research.

## Chapter Five

### Women's Stories

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## Women's Stories

### Introduction

This chapter presents the women's biographical profiles, reflecting on their life before, during and after the violence. Their accounts provided me with a much broader perspective than could have been achieved by simply focusing on the violence during pregnancy. The five women I was fortunate enough to meet with, on several occasions, were more open in subsequent interviews and I felt I was able to develop a deeper understanding of their lived experiences and Self. All names used are pseudonyms and any particularly distinguishing features have been removed.

### 5.1. Jane

Jane was thirty when we met. She had three children, a son aged ten and twin girls aged thirteen months. Jane was born and educated in the Philippines and had a degree in banking. She was the oldest girl in a family of several children. The family did not have much money and so in her mid twenties, Jane decided to move to Hong Kong, where she worked as a cleaner for a family in order to earn enough money to buy her own house in the Philippines.

It was during her time in Hong Kong that Jane met her husband A. A. was employed as a private teacher for the same family that Jane worked for. A. was twenty years older than Jane. Jane described her husband as charming and caring when they first met, she agreed to marry him two months after meeting him. Following their marriage his behaviour towards her changed; he became increasingly abusive and controlling, insisting she gave up her job to stay at home and look after him. He controlled the family finances and her movements. He became physically and emotionally abusive towards her. The physical abuse started with the occasional slap, if he became angry. This progressed to more severe abuse; kicking and beating her. He would frequently wake her at night to shout abuse at her. His behaviour was always worse when he had

been drinking. Jane became pregnant soon after their marriage. The abuse continued throughout the pregnancy and included sexual violence. Jane and A. returned to the UK, where the abuse continued, however, Jane was too frightened to tell anyone about the abuse and she felt very isolated, as her family lived in the Philippines, A. controlled her movements, confining her to the house, denying her the opportunity to socialise and meet new friends.

Shortly after returning to the UK, A. had a stroke and was unable to work. He insisted that Jane find a job and she worked at three part-time jobs; working as a shop assistant, cleaner and health care assistant. Although A. recovered from his stroke, he refused to return to work. During this time, he continued to drink, often drinking up to a bottle of whisky a day. The physical, sexual and psychological abuse was always worse when he had been drinking. The abusive behaviour continued throughout their eleven year marriage. During Jane's twin pregnancy the violence continued, but with an increase in the emotional and sexual violence.

A. refused to acknowledge any of the pregnancies and did not take any interest in the children. He refused to accompany Jane to hospital when she experienced a premature twin labour at 34 weeks gestation, or to visit the twins when they were in the Special Care Baby Unit (SCBU). Jane believed A. was jealous of the babies and felt forced to give up breastfeeding, as he became very angry if she spent too much time tending to the babies.

When the twins were a year old, A. decided to go on holiday to America, without Jane and the children; he left without saying goodbye. Before leaving he withdrew all their funds from their bank account. During his absence, Jane decided to leave him, telling him via the telephone that she had decided to divorce him. A. threatened to return to the UK, find her and kill her if she left him; she believed his threats and decided for her own safety, to seek a place in a women's refuge. A month after moving into the

refuge, Jane heard nothing more from her husband, either by phone or e-mail. Several weeks later, Jane was informed by the police that her husband had died of a heart attack in the Philippines. Following her husband's death, Jane talked about feeling 'free'. She did not have the funds to recover his body back to the UK and his family refused to pay. As a result, her husband was buried in the Philippines.

## **5.2. Kirsty**

Kirsty was 22 when we first met, she had one daughter aged two. Kirsty was attending college, studying for a diploma in child care and was seventeen when she met her partner B; he was nineteen. Throughout her teenage years, Kirsty cared for her single and partially disabled mother, and described herself as being very unhappy in her childhood. Kirsty believed attending college and obtaining a qualification in child care would be a means of escaping poverty and securing a career for herself. Kirsty met B. at a party and he told her he was working as a doorman. Kirsty described her partner as charming and friendly when they first met. Kirsty's family and friends advised Kirsty of B's. criminal record for violent behaviour. However, Kirsty believed his violent behaviour was in the past, believing that with her support, he would change his lifestyle.

Weeks after their first meeting, B. convinced her to move into his family home, which she agreed to, seeing it as way of escaping the responsibilities that overwhelmed her at home. However, his behaviour towards her changed once she started to live with him; he became more controlling, bullying her into leaving college, so they could spend more time together. The first violent incident occurred two months after she moved into his parent's home. He attacked her because she was late getting home from work. At the time Kirsty was working part-time as a waitress in the restaurant. Following the violent attack, he insisted she give up her job. The violent attacks and controlling behaviour became more frequent and intense as the relationship continued. They moved into bed and breakfast accommodation as his family insisted he leave the

family home, due to his violent and abusive behaviour. B. continued to control every aspect of Kirsty's life, from her right to meet with friends, to controlling her right to take contraception, although she continued to try and take it without him knowing. However, this was haphazard as she had to keep hiding her pills in different places, so he would not find them.

Kirsty became pregnant at 19: her partner refused to acknowledge the pregnancy. The physical violence and abuse continued throughout Kirsty's pregnancy, resulting in a spontaneous miscarriage at eighteen weeks gestation following a particularly violent attack. Following the miscarriage Kirsty was forbidden by B. to ever talk about the miscarriage to anyone. Despite taking contraception, Kirsty became pregnant again a few months later and as before her partner refused to acknowledge the pregnancy. Physical and emotional abuse continued throughout the pregnancy. Kirsty's partner refused to work; drinking to excess and took drugs most days.

Kirsty's pregnancy progressed to term and she gave birth to a baby girl. Following the birth B. promised to stop the abuse. However, in spite of his promises to change B's violent behaviour continued as before. B. refused to acknowledge their baby daughter. Shortly after the birth, Kirsty was diagnosed with postnatal depression. She struggled to feed herself and the baby, relying on her family to help buy items for the baby, as B. controlled the finances, using the majority of the household income for alcohol and drugs. When her daughter was three months old, Kirsty sought help from Women's Aid, after B. attacked her, when she was holding her daughter in her arms. This attack was the catalyst to escape from the violence.

### **5.3. Julia**

Julia was 35 when we met. She describes her childhood as happy and normal. She was 19 when she met her partner C. in Julia's words, *'he charmed and swept me off my*

*feet, by behaving like a perfect gentleman*'. C. was 22 and was employed as a mortgage advisor. Within six months of meeting, they moved in together against Julia's parents' wishes. They lived together for fifteen years. Julia and C. had three children together, two sons aged 9 and 1 and one daughter aged 13.

The first incidence of physical violence occurred in the postnatal period, following the birth of their first baby. However, during the pregnancy, C.'s behaviour towards Julia started to change. He started to control her movements, told her she had to stop working in the pub and he convinced her to start a family much earlier in their relationship than she had planned. During the pregnancy, he made hurtful comments about her weight gain and her pregnancy related body changes. He demanded that she complete a long list of household chores daily, when he was at work and would frequently check the chores had been completed, upon returning home. The first instance of physical violence occurred two weeks after the baby's birth; following this incidence, the violence became more frequent and more aggressive. The violence continued during her subsequent pregnancies. Indeed, following a brutal physical attack Julia suffered a miscarriage at 16 weeks gestation during her second pregnancy and experienced a premature labour at 26 weeks gestation with her third pregnancy.

C. had a history of recreational drug use and alcohol abuse, and had a criminal record for drunken and disorderly behaviour. He had also been dismissed from several jobs, due to his aggressive behaviour towards colleagues. He was particularly physically violent towards Julia when he had been drinking, taking drugs or both. Julia had made several unsuccessful attempts to leave him during their relationship; however, she returned to him when she felt she had overstayed her welcome at her parent's home. Each time she left him he always promised to change his behaviour. However, after a few months, he would return to his normal abusive behaviour. Julia desperately wanted their relationship to work for the sake of their children, and stayed hoping he would change his behaviour. Alongside the physical violence, there was also a lot of control in their relationship. For example, he would call her up to ten times a day, to

ensure she was doing all the household chores that he had told her to do. He also controlled all the finances, deducting money from the housekeeping if she did not complete all the chores he had tasked her to do. Julia suffered many severe injuries throughout her 15 years with C. including a broken jaw, broken fingers, cracked ribs, broken teeth, black eyes, spontaneous abortion and premature labour. There had been no sexual violence in their relationship. C. was frequently unfaithful during their fifteen years together.

Julia finally found the courage to leave him after 15 years of abuse, with the support of local domestic violence advocacy agencies, who found her and the children a place in a local women's refuge. Julia was eventually re-housed. However, her partner still had regular contact with her, because of his wish to have access to the children, Julia found this very difficult to deal with, as he continued to intimidate her in front of the children and she admits to still feeling very scared of him. At the time of our meeting Julia still had regular contact with the women's advocacy services and the support of a named support worker.

#### **5.4. Nicola**

Nicola was 22 when we met and she had been separated from D. for nine months. Nicola had a twin sister and had been raised in a close and loving family. She admitted to being very shy and found it difficult to make friends, relying on her twin sister for companionship. Nicola had missed a lot of schooling, as a child and a teenager, due to recurrent chest infections. Nicola was 17 when she met D. at college and he was her first boyfriend; he was the same age as Nicola. Nicola was studying health and social care and D. was studying car mechanics. Although Nicola loved attending college, she admits to being very shy and lacking in self confidence, and because of this she found it hard to develop new friendships. Nicola had a part-time job to supplement her income whilst she attended college; working in a local supermarket. However, she felt forced to leave her job as D would turn up whenever she was working and refuse to leave her

alone, generally being a nuisance. His behaviour frustrated the management team of the supermarket, and as a consequence Nicola felt forced to leave her job.

Whilst growing up, Nicola had been protected by her parents due to her shyness and illnesses. She believed that as a consequence, she rebelled against her parents when she met D. They tried to advise Nicola not to become too involved with him. However, she refused, she opted to ignore them, she enjoyed the attention D. was paying her. He was always attentive, insisting they spend all their time together. At 18, Nicola became pregnant with an unplanned pregnancy. However, she never considered a termination and her family, although very disappointed, supported Nicola in her choice to continue with the pregnancy.

Nicola started to realise that D. had a temper and he became more controlling of her movements; he demanded to know where she was, all the time. He decided to leave college without completing his course and was often in trouble with the police for fighting and other criminal behaviour. Indeed, unknown to Nicola until much later in the relationship he already had a criminal record for grievous bodily harm. As the pregnancy progressed, he persuaded Nicola to move in with him. However, this allowed his controlling behaviour to intensify, insisting that she did everything he told her, as she was pregnant with his baby and that made her his property. She was forbidden from meeting or visiting family or friends without his permission. His abusive behaviour included verbal and sexual abuse and intimidation. He habitually demanded sexual intercourse, sometimes several times a day and if Nicola refused, he would rape her; additionally, she was forbidden to use any form of contraception.

The physical abuse started after the birth of her first baby. B. became even more demanding; he denied her family access to the baby and checked her phone register daily to see who she had called. He used her mobile phone to send her family abusive messages, leading them to believe that she had sent the messages. D. ignored the

baby, refusing to provide any care. Nicola was only allowed out if he was with her. He controlled all the finances, using their money to buy alcohol and drugs. His violent behaviour towards Nicola intensified when he had been drinking. D. collected knives, frequently using them to threaten Nicola. On a couple of occasions Nicola or the neighbours phoned the police; however, he was never arrested, and only on one incident did the police remove some of his knives.

Following the birth of her first baby, a second pregnancy followed very quickly during which the abuse intensified. Nicola finally found the courage to leave D. when her second baby was 8 weeks old, when he threw a knife at her when she was holding the baby. Nicola and the children returned to her parents' home. Between our interviews Nicola was admitted to hospital with what her family thought was another chest infection; sadly, in fact it was the advanced stage of leukaemia. Tragically, Nicola died four days after being admitted to hospital.

## **5.5. Susan**

Susan was aged 32 years of age, when we met and had two daughters, a daughter aged 13 from a previous relationship and a baby daughter eight weeks old with her partner E. Susan met E. when she was aged thirty, and described him as very caring and attentive when they first met. E. was a friend of a friend and Susan considered him 'a nice guy'. A few months into their relationship Susan invited E., to move into the family home. It was around this time that Susan started to notice a change in his behaviour. He left his job without telling her and began to invite his male friends into their home, where they would spend the day drinking alcohol and smoking cannabis. As the relationship progressed, E. became controlling. He attempted to isolate Susan from her friends and family. Susan found herself having to account to E. for all her movements and was only allowed to go out without him, to go to and from work.



Verbal and physical violence became a regular occurrence in the relationship, with each attack becoming more and more vicious. The violence frequently took place in front of her thirteen year old daughter and occurred all the way through her pregnancy. Susan gave birth to a baby girl at thirty five weeks gestation. The baby weighed 2.3Kgs and was admitted to the Special Care Baby Unit (SCBU). E. blamed Susan for the premature birth because she had continued to smoke during her pregnancy. During a visit to SCBU, E. lost his temper in front of the nursing staff and was overheard threatening to cut Susan and her daughter's throat. The nursing staff reported his abusive behaviour to social services, which resulted in social service involvement with the family. Susan was offered support to leave the relationship and was provided with a place in a refuge in another area, as there was genuine concern for her safety.

## **5.6. Sarah**

Sarah was 36 when we met and had a daughter aged two. Sarah met F, when she was 34. Previous to meeting F. she had had two long term relationships and both these relationships had also included domestic violence. F. was 10 years younger than Sarah and was unemployed, when they met through mutual friends. Sarah asked F. to move in with her when he found himself homeless. When they met, Sarah was aware that her partner was a recreational drug user, regularly smoking cannabis. However, during their relationship, he began to use crack cocaine and sell the drug to source his own drug and alcohol habit.

Sarah became pregnant quickly into their relationship; although not planned Sarah never considered a termination, due to her maternal age. During her pregnancy, F. was verbally and physically abusive, the abuse was always worse when F. had been drinking. F. frequently demanded that Sarah 'get rid of the baby' insisting he had never wanted a baby, suggesting that Sarah had deliberately planned her pregnancy to trap him. During one ferocious argument in the street, F. pushed her violently from her

bike. As a consequence of the fall, Sarah suffered a miscarriage at 12 weeks gestation. However, a few months later, Sarah was pregnant again, and once again the violence increased in intensity and severity during the pregnancy. F. was very domineering and controlling; this included calculating the amount of food Sarah was allowed to eat, especially when there was limited money available to buy food. The lack of money was due to his growing drug habit.

During her pregnancy Sarah developed gestational diabetes. Therefore, it was important that she ate appropriately to manage the diabetes and control her insulin intake. F. would frequently deliberately withhold food from her. This made it almost impossible for Sarah to control her diabetes, resulting in several antenatal admissions to the ward. Sarah was too embarrassed to tell the midwifery and obstetric staff the real reason behind her repeated admissions for uncontrolled diabetes. As a result, she felt she was labelled by staff as being non-compliant. The violence continued throughout the pregnancy and their relationship, until Sarah escaped when her little girl was two years of age. Sarah found the strength to escape from her partner when her home was broken into and she was violently threatened by a gang in front of her daughter. The gang were demanding payment for her partner's drugs. Sarah was offered a place of safety at a women's refuge.

## **5.7. Tamara**

Tamara was a mother to four children and was 34 when we met. Tamara returned to her parent's home to escape from a previous violent relationship. It was during this time that she met her current partner G. G. was 34 and unemployed when Tamara met him. Four months after meeting G. Tamara was pregnant with an unplanned pregnancy. By this time Tamara and her children had moved into a home of their own and Tamara invited G. to move in with them when she realised she was pregnant. It was only when G. moved into the family home, that she realised the extent of his dependency on alcohol.

The physical violence began shortly after they started living together. G.'s violent behaviour was always much worse when he had been drinking and G. drank excessively most days. Tamara was frightened to answer back or disagree with anything he said; she quickly realised confronting or disagreeing with him would result in a violent assault. On several occasions, Tamara asked him to leave, but he refused. However, following a particularly violent assault, Tamara called the police. With the help of the police, he was 'persuaded' to leave. However, ignoring warnings from the police, he frequently broke into her home at night when Tamara was asleep; she frequently woke up, to find him standing over her, verbally threatening her. G. also constantly besieged Tamara by phone, some nights calling up to thirty times, shouting threats down the phone; his behaviour was more unpredictable when he was drunk. The police arrested him several times for harassment.

Once the baby was born Tamara agreed to allow him some access to visit their baby son. However, these visits provided G. with further opportunities to verbally threaten Tamara, using his right to see the baby as a way to see Tamara and gain entry into the house. He frequently threatened to kill Tamara if she ever tried to stop him seeing the baby. As a consequence, Tamara was too frightened to tell him to stop coming round to the house or stop him seeing their son. In spite of this, because she believed his threat to kill her, Tamara found the courage to contact the women's advocacy agencies for help. They offered her and the children a place of safety in the refuge.

## **5.8. Tracey**

When I met Tracey she was 23, with two children, a son aged 22 months and a daughter aged 8 months. Tracey had experienced a difficult childhood; she had a history of depression and self harming. Tracey had known her partner H. for many years before they started a relationship, as he was an older brother of a close friend. He was fifteen years older than her. Tracey started a physical relationship with H. when he returned home to his parent's home to live, following the breakdown of his

marriage of sixteen years. H. had three children from this marriage. Their relationship progressed very quickly and within four weeks Tracey and H. decided to move in together.

Tracey described H. as charming and caring when they first met. When he drank, however, he would sometimes become verbally and sexually aggressive, demanding Tracey perform sexual acts with him, which she found demeaning and offensive. She quickly learned not to refuse him though as he would get outraged and she quickly learned that she would be forced to carry out his demands anyway.

Most weekends the children from his previous relationship stayed with them and Tracey believed this caused extra stress and friction in their relationship. Gradually the verbal and sexual violence intensified and also started to include physical violence. H. would often wake her up at night by punching her, demanding sex. After a particular violent incident, Tracey found the courage to report him to the police. The police arranged for her to stay at a women's refuge and he was arrested for assault. It was during this arrest that Tracey was informed of his previous criminal record for assaulting his ex-wife. However, after six days, Tracey agreed to speak to him on the phone. Over a few days he managed to convince her that he wanted to change, he promised to stop drinking and seek help for his anger. Nonetheless, after a few weeks, his violent and abusive behaviour returned to its normal pattern. During this time, Tracey discovered she was pregnant. This was not a planned pregnancy but nevertheless Tracey was pleased and hoped the pregnancy and impending fatherhood would change his behaviour. However, the violence continued throughout the pregnancy.

During her pregnancy Tracey was informed by Social Services that there was an ongoing investigation against H. H.'s sixteen year old daughter was accusing her father (H) of sexually assaulting her during her childhood. Tracey considered leaving the

relationship, but felt trapped because of the pregnancy. The sexual and physically abusive behaviour continued throughout the pregnancy. When H. was drunk, he frequently threatened to perform a caesarean section on Tracey and flush the baby down the toilet. Despite social service involvement with the family, Tracey was too frightened to tell them about the violence in the relationship. One night following a heavy drinking session H. became very violent, his anger was fuelled because Tracey had refused to have sexual intercourse with him; he tried to strangle her, threatening to kill her if she ever tried to leave him. Unsurprisingly, Tracey was so frightened she promised not to leave him, believing he would carry out his threat to kill her.

Tracey was very depressed. She was too frightened to sleep and was struggling to cope with the demands of a new baby; she sought advice from her GP and was diagnosed with postnatal depression and started on medication. The violence continued to escalate in frequency and severity, and included H. attempting to set fire to her dress whilst she was wearing it, and holding Tracey down and pouring bleach all over her legs. It was following this attack Tracey escaped into the bathroom, locked herself in and phoned the police. The police arrived and arrested H. and Tracey sought safety in the women's refuge. Her partner was charged with grievous bodily harm and despite having a previous criminal record for assault he received a community service order. H. is now on the sex offender's register and is forbidden to have any contact with Tracey or their baby.

## **5.9. Wendy**

Wendy was 38 with two children; a son aged five and a girl of twenty months. Wendy was born in Jakarta, Indonesia and described her upbringing as poor but happy. Wendy attended University in Jakarta, graduating with a degree in accounting. She met her husband I., when he was on holiday in Jakarta. I. was the same age as Wendy and worked in information technology. Wendy describes falling in love with I. during their holiday romance, so when he asked her to return with him to the UK for a holiday, she

agreed without any hesitation. The holiday in the UK became an extended visit and Wendy agreed to marry I. six months after meeting him. Within a year of marriage, Wendy was pregnant with her first child; this was a planned pregnancy. Wendy described the first year of their relationship as happy, describing her husband as kind and caring. She also admitted being a little bit scared of him at times, as he liked to have his own way and had a tendency to lose his temper over the smallest thing. During her first pregnancy, there was no physical violence, although it was around this time that I.'s behaviour towards her began to change; he became verbally abusive and more controlling. He would often intimidate her and threaten her, frequently making fun of her in front of his friends and family.

The first instance of physical violence occurred during the postnatal period. Following the first physical attack, a pattern of abuse emerged and continued during her second pregnancy. Despite Wendy going to work and earning a respectable salary, I. insisted on controlling the family finances, refusing Wendy any access to their bank accounts. During Wendy's second pregnancy I. was made redundant and he decided he was going to stay at home and look after the children. During this time, he met someone else on the internet and frequently taunted Wendy about his new love, yet refused to move out of the family home. If Wendy threatened to leave I. or go to the police, he would intimidate and threaten her by telling her that she would be deported and the children would stay with him.

The violence continued until I. physically assaulted her in front of their son and baby daughter; the children became very distressed witnessing the violence. Wendy described this as the turning point in the relationship. During the attack I. broke her wrist and when she went to the Accident and Emergency department, she decided on this occasion to answer them truthfully when they asked how she had sustained the injuries. The nursing staff helped her to access support and also called the police. Her partner was arrested and charged with assault and the women's agencies helped her to find somewhere safe to stay, until her partner was removed from the family home.

## **5. 10. Lisa**

Lisa was 20 with a baby son aged thirteen months, when we met. Lisa had experienced a very unsettled and unhappy childhood and spent a lot of her childhood running away from the family home and school and had been homeless since the age of 16. When she was 17, Social Services found Lisa accommodation in a young person's shelter. It was here that she met her boyfriend J. who was also homeless and used to visit the hostel to visit friends. Lisa was very flattered by his attention and she found herself attracted to his cheeky humour and his confidence. This attraction quickly developed into an intimate relationship.

Lisa was very happy being with J. for the first four months of their relationship; he was very attentive and she felt cherished when she was with him. However, slowly his behaviour towards her started to change: he became controlling, verbally abusive and threatening and was very jealous of anyone who paid Lisa any attention especially if they were male. Lisa became pregnant and although the pregnancy was not planned, she decided she wanted to continue with this pregnancy, as she had had a termination previously and had always regretted it. The first physical attack occurred during her pregnancy, with subsequent attacks increasing in severity and frequency. Lisa's partner did not work and he frequently took drugs and sold drugs to allow him to fund his own drug habit. J. was well known to the police for his criminal activity.

Once Lisa's baby son was born J. showed no attention to the baby and he became more and more controlling, by preventing her from seeing her friends and family. He also removed the sim card from her phone and cut it up, so she could not communicate with anyone. The violence and abuse continued until her partner was arrested by the police and questioned about his involvement in a gang murder. Lisa took this opportunity to break away from J. by seeking help from the women's agencies.

### **5.11. Louise**

I met with Louise at the refuge; she was 25 with a daughter aged 22 months. Louise had a difficult upbringing. Drinking, drug abuse and poverty were a normal pattern in Louise's life; her mother had been an alcoholic and her father had used heroin all through her childhood. Louise has been in and out of foster care as a young child and had experienced extreme mental health problems as a young woman. As a consequence, she had smoked cannabis intermittently since the age of twelve, only stopping when she discovered she was pregnant.

Louise had known her partner K. for many years before their relationship developed, as they had grown up on the same street. K. had served in the British army for seven years until he was dishonourably discharged for cocaine use. Although Louise did not know this was the real reason for his discharge, as he had lead her to believe that it was his decision to leave the army. Louise describes their relationship as never being anything too serious on account of his career in the army. She described him as being motivated, smart, and a national champion in karate. Following his discharge from the army, Louise started to spend more time with K. they decided to move in together. However, Louise was shocked when she discovered she was nearly four months pregnant with an unplanned pregnancy. This was not a planned pregnancy, due to their unpredictable relationship; nevertheless, Louise decided to continue with the pregnancy despite her concerns for the relationship and her own mental health. After confirmation of her pregnancy, Louise decided to stop taking her prescribed anti-depressant medication and smoking cannabis.

It was around this time that Louise noticed a change in K.'s behaviour. His behaviour became aggressive and erratic. He frequently disappeared for days, and he stopped caring about his appearance. Louise did not really mind his absences from the home as he had become very moody and he was becoming more aggressive towards her. Louise suspected he had started to take heroin, recognising the behavioural signs from her own father. Once Louise found the evidence to confirm her suspicions, she asked him to leave the house. After her own upbringing, she was adamant that she would



not bring a baby into the same house as someone who was taking heroin. However K. refused to leave and became physically aggressive towards her. The physical violence continued throughout the pregnancy and to avoid a beating Louise would often give K. money so he could buy drugs. K frequently trashed the house searching for money and took Louise's personal belongings to sell, to buy heroin.

During her pregnancy, Louise managed to escape to a friend's house, when K. was arrested for attacking his sister when she refused to give him money to buy drugs. During this time, K. frequently sent Louise abusive texts, telling her to have an abortion threatening to track her down. Within a few days he had managed to locate Louise. K. threatened Louise, telling her if she ever tried to leave him again, he would kill her. Believing his threats, Louise felt compelled to return to him. Nevertheless, despite such threats, Louise was adamant that she would not bring up a child in a home where heroin was being used, calling the police several times to have K. removed from the home. Nonetheless, K would frequently stalk Louise, demand entry to her home. He also made threats to kill Louise via her phone and text messages. Louise became more and more afraid of K.'s erratic behaviour. Fearing for her safety, Louise contacted the local women's agencies who arranged for a place in a women's refuge.

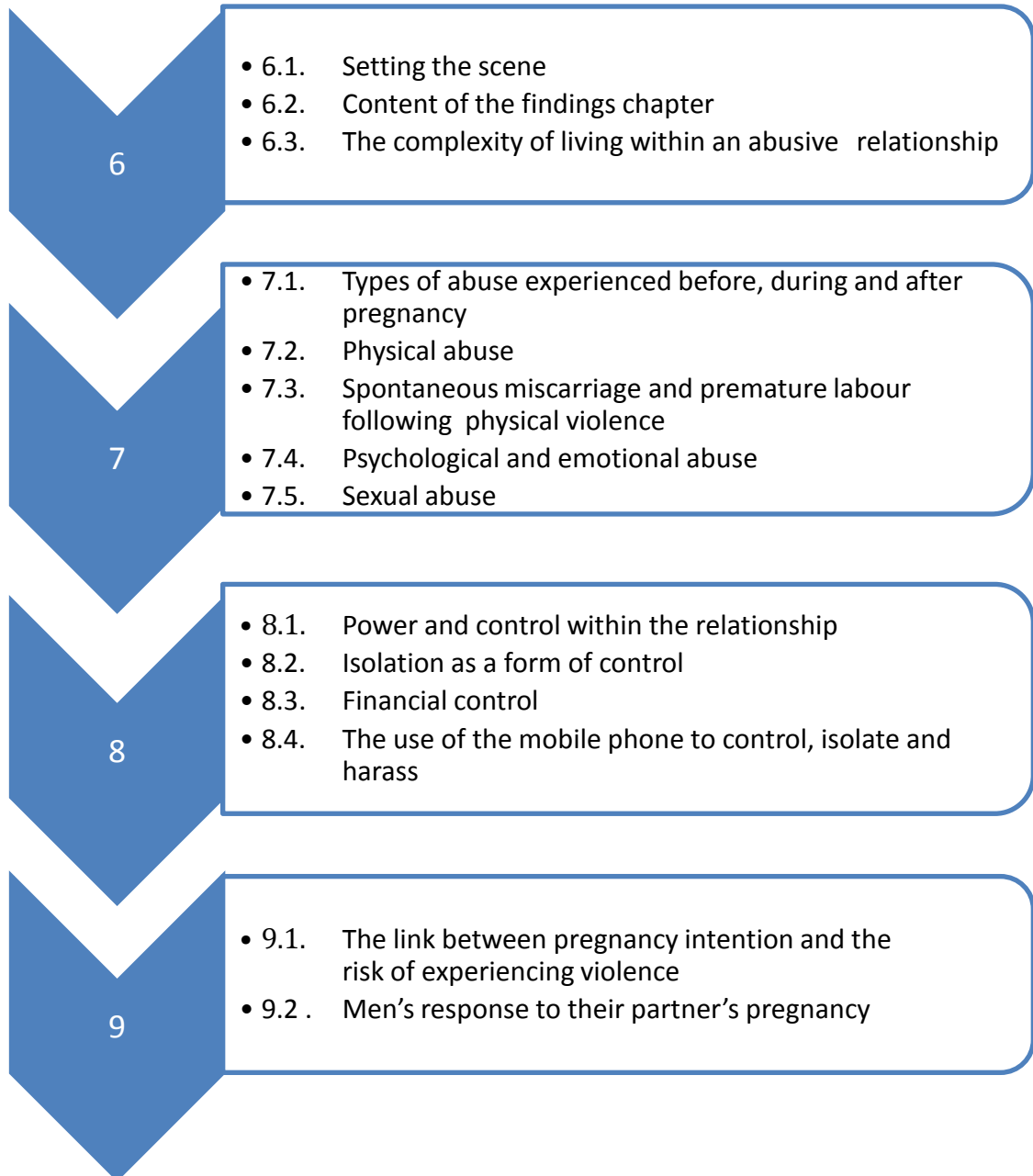
## **Summary**

This chapter has provided a brief snapshot of the women's lives. There were many similarities between them: for example, the violence they all experienced was frequent, brutal and brought them all devastating despair and low self esteem. Listening to the women talk about their experiences, it became clear to me that a man does not have to physically imprison a woman to keep her prisoner; there are unseen chains which can keep her shackled to an abusive relationship: these include children, finding alternative housing, a lack of funds, her own personal safety and a sense of shame.

Many of the women also had a deep rooted optimism during their pregnancy that the men would change, once the baby was born. As made clear, such hopes did not come to fruition. Hoff (1990) suggests women will often find themselves in a contradictory situation when assaulted by a partner. She will feel a deep shock and sense of shame that the man she loves and trusts would treat her this way, but believing that she is held responsible for the success of their relationship, she may consider the man's treatment of her as her fault. This was apparent in the women's narratives; it appeared that the responsibility of a pregnancy added to the perceived cultural norm of making their relationship a success regardless of the personal cost to them. Paradoxically, women can often find themselves in a 'no- win situation', in that they are expected to be carers and nurturers of the family, yet at the same time they are considered by many to be foolish if they choose to remain in a violent relationship.

## PART THREE

### Structure of the Findings Chapters



10

- 10.1. Violence and abuse in the postnatal period
- 10.2. Caring for a new baby in the postnatal period
- 10.3. Infant feeding choices and its relationship to domestic violence

11

- 11.1. Depression during the postnatal period

12

- 12.1. Partners' use of drugs and alcohol and its association with domestic violence

13

- 13.1. Health services' response to women's experiences of violence during pregnancy
- 13.2. Being asked about domestic violence and abuse
- 13.3. Disclosure of abuse to a health professional
- 13.4. Disclosure of abuse to the midwife
- 13.5. Barriers that prevent women from seeking help and support

14

- 14.1. Coping with and surviving domestic violence

## **Chapter Six**

### **Findings**

#### **6.1 Setting the scene**

Chapter six will set the scene, prior to the findings chapters. Chapters seven to thirteen will present the findings from the interviews conducted with the eleven participants. The interviews were conducted between 2009 and 2010. The number of interviews with each participant varied, ranging from a single interview with some participants, two interviews with others and three interviews with one participant. The number of interviews with each participant depended upon individual personal circumstances and their availability at the time of the data collection. All the women were separated from their partner at the time of the interviews.

The interviews were conducted at several locations, including a women's refuge, and the offices of a woman's support organisation. The majority of interviews were conducted in the woman's refuge. A total of seventeen interviews were conducted. All interviews were digitally recorded and transcribed verbatim. The ages of women interviewed, ranged from 20 to 41 years. Eight women who took part in the study were white British, one was black British, and two were Indonesian by birth but now permanently residing in the UK.

The participants in this study talked of their experiences of abuse disclosing their own stories, which emerged from their varied cultural social, economic and political backgrounds.

## 6.2 Content of the Findings chapters

The following six chapters are based on the experiences and perceptions of eleven women, who participated in the research and had experienced violence and abuse during their pregnancy. The purpose of the chapters is to attempt to contextualise the violence they experienced. It is important to acknowledge that during the interview process, the aim was to focus on events that occurred at the time of their pregnancy, and in the subsequent postnatal period. However, as might be expected, the women often spoke about other times in their relationship when abuse was present. It became apparent that such periods were just as important to them; therefore, where appropriate, some of those findings are also included throughout the chapters.

The Findings chapters are arranged as follows; chapter six aims to describe the range and nature of the violence and abuse experienced by women both during and outside of their pregnancies. Chapter seven portrays the various types of abuse experienced by the women and chapter eight illustrates the strong link between domestic abuse, power and control. Power and control resonated throughout all the women's narratives and as such, is also threaded throughout all the themes. Chapter nine explores the relationship between an unplanned pregnancy and its association with violence. A sub-theme of this chapter will be the women's perceptions of their partner's response to the pregnancy, and fatherhood. Chapter ten will explore the violence and abuse experienced by women during the immediate postnatal period, whilst considering how living with violence and abuse influenced their ability to care for their new baby. Maternal depression in the postnatal period will be discussed in chapter eleven, and chapter twelve will attempt to explain the link between the male use of drugs and alcohol and exploring the consequences for the women's existence. Chapter thirteen will focus on the women's interactions with the health service, specifically the maternity services. Concluding the findings section, chapter fourteen will explore the strategies the women developed to help them cope with the violence and abuse.

### **6.3 The complexity of living within an abusive relationship**

The women appeared to find it extremely difficult to separate the violence they experienced during pregnancy, from their experiences of violence when they were not pregnant. They communicated the need to talk about meeting their partner, the relationship prior to becoming pregnant, the pregnancy, birth and becoming a new mother when living with violence and abuse. With hindsight, such disclosures were extremely helpful, as these facilitated a fuller understanding of the context of their lives. It seemed important for the women to be known as individuals who went beyond being caught in the cycle of an abusive relationship. They wanted me to have an understanding of some of the specific aspects of their lives, so I could view their individual circumstances within a larger context. In a sense, the women were trying to provide me with an explanation for what had happened to them and what role culture played in their story. Nonetheless, for the purpose of this thesis the findings chapters will focus specifically on the period when the women were pregnant and the immediate postnatal period. In accordance with the theory of intersectionality, this thesis recognised that the women's individual perceptions of and how they coped with the abuse were all very different. They were influenced by their own subjectivity, and their own cultural factors, which influenced how they viewed the world.

Themes to emerge from the data included: power and control; domestic violence and its link to pregnancy; the male partners' responses to the woman's pregnancy and types of abusive behaviour experienced by the women including before, during and after pregnancy. The women's experiences of encountering and managing their depression; their partner's involvement in caring for the baby, the effect of paternal substance abuse and the overall response of the maternity and health service. The following eight chapters will present the findings from this study. The women's voices will resonate throughout all the chapters.

## Chapter Seven

### Findings: Types of Abuse Experienced by the Women

#### Introduction

This chapter will explore the women's experiences and the various categories of domestic violence and abuse during pregnancy and the postnatal period. I will begin by identifying the various types of violent abuse the women experienced. Some of the women described their experiences of domestic violence as being worse after the baby was born. Therefore, the women's experiences of domestic abuse during the early postnatal period will also be included.

#### 7.1. Forms of Abuse experienced before, during and after pregnancy

All the women interviewed experienced some form of domestic violence during their pregnancy. This was to varying degrees and included many different types of abuse, ranging from emotional and controlling abuse, sexual abuse to severe physical violence. Not all the women experienced physical abuse during the actual pregnancy. Of the eleven women interviewed, eight had been subjected to physical violence during their pregnancy, with the remaining three women experiencing physical violence for the first time in the postnatal period (See table 7.1). The violence was always perpetrated by a current or former partner. All the women gave accounts of being frightened of their partner during their pregnancy, regardless of whether or not physical violence was inflicted during their pregnancy. For the three women who had not endured physical violence during their pregnancy, other types of abuse were present in their relationship, including controlling behaviour, verbal, emotional and sexual abuse. The physical violence experienced pre - pregnancy, during the pregnancy and in the postnatal period included strangulation, burning with bleach and other cleaning agents, bone fractures and broken teeth. One partner attempted to set his partner on fire, following an argument. Some of the men used weapons including



knives to threaten the women. In most instances, the perpetrator used their fists and feet to physically abuse the women.

In this sample of eleven women, three women suffered a miscarriage as a result of their partner's behaviour. Two of the three women endured a spontaneous miscarriage following a violent physical assault and another experienced a miscarriage when her partner violently pushed her off her bicycle. The women frequently talked about the regularity of verbal abuse and name calling. Alarming threats to 'kill' occurred frequently for the majority of the women. The threat to kill during pregnancy is not an idle threat: research evidence has demonstrated that women in such circumstances have been murdered by their partner during pregnancy and in the postnatal period (Lewis 2004; 2007; 2011). As a result, domestic violence was the subject of discrete chapters in previous reports (Lewis, 2004; 2007), which clearly established a link between domestic abuse and maternal death. Within the context of the UK, a maternal death is defined as:

The death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. (Lewis, 2011, Centre for Maternal and Child Enquires p. 2)

The most recent report (2006 – 2008) identified that thirty four women who died also had features of domestic abuse in their relationship. For eleven of these women, the violence was fatal, with the violence being the actual cause of their death (Centre for Maternal and Child Enquires, 2011).

The physical violence women experienced comprised of many types of physical injury. The physical assaults were usually followed by commitments from the men that the attack would never be repeated. In reality, evidence demonstrates that once a man

carries out a physical attack on his partner, it is extremely rare for it not to happen again (Hague and Malos, 2005). This was also true for the women in this study.

## **7.2. Physical abuse**

It became apparent during the interviews with the women, that there were a number of health implications resulting from the ongoing physical violence experienced. All eleven women had been physically abused in the past twelve months. The women talked openly about their experiences of physical violence and abuse before, during and after the birth of their baby. The table on page 142 demonstrates that two participants had experienced physical violence before their pregnancy, with a continuation and an increase in the severity of physical violence during their pregnancy. Six of the participants were subjected to physical violence for the first time during their pregnancy and the remaining three participants experienced the first incident of physical violence in the postnatal period. However, it is important to acknowledge that Julia, Nicola and Jane, although not subjected to physical violence in their first pregnancy were physically abused in subsequent pregnancies by the same partner, see table 7.1 on page 144. All the women who were physically abused either before or during the pregnancy, continued to experience physical abuse during the postnatal period.

**7.1 Table: Women’s experiences of physical violence prior to their first pregnancy**

<b>Name Pseudonym</b>	<b>Types of violence experienced during the relationship</b>	<b>Physical Violence Before the 1<sup>st</sup> Pregnancy</b>	<b>Physical Violence During the Pregnancy</b>	<b>Physical Violence During the Postnatal Period</b>
<b>Lisa</b>	Physical, verbal, emotional, controlling & financial		•	•
<b>Tracey</b>	Physical, verbal, sexual, controlling, emotional and financial		•	•
<b>Julia</b>	Physical, verbal, controlling, sexual, financial and isolation			•
<b>Sarah</b>	Physical, verbal, emotional and financial		•	•
<b>Jane</b>	Physical, sexual, verbal, emotional, controlling and financial		•	•
<b>Susan</b>	Physical, verbal, emotional, controlling and financial	•	•	•
<b>Nicola</b>	Physical, verbal, emotional, controlling, sexual and financial			•
<b>Wendy</b>	Physical, verbal and emotional			•
<b>Kirsty</b>	Physical, verbal, emotional, controlling, sexual and financial	•	•	•
<b>Louise</b>	Physical, verbal, emotional		•	•
<b>Tamara</b>	Physical, verbal, emotional and controlling		•	•

The literature suggests that physical violence towards a pregnant woman is often aimed at the abdomen, breasts and genitalia (Radford and Hester, 2006). These parts of the female body are closely related to childbirth, protecting the unborn child and very much viewed as part of the female embodiment. In this study, six of eleven women reported being physically hit in the abdomen, the violence aimed at the abdomen, included being kicked and punched. Any breast injuries sustained, resulted from the random lashing out by men, or as a result of forced sexual intercourse. Nicola was the only participant in the study who openly talked about injuries to her genitalia area: these injuries were sustained following rape immediately after childbirth. However, Nicola was not alone in enduring sexual violence within the context of this study. Four of the women in the study frequently endured rape as part of the repertoire of abuse, therefore trauma to genitalia and the vagina was highly likely. Another consequence of experiencing physical violence during pregnancy was the risk of miscarriage. This will be explored in the next section of this chapter.

### **7.3. Spontaneous miscarriage and premature labour following physical violence**

Sadly, three of the women interviewed, suffered a spontaneous miscarriage following physical assaults. Two of the women had suffered an extremely physical assault prior to their miscarriage, and the third experienced a spontaneous miscarriage, after being thrown from her bicycle by her drunken partner.

Julia's partner had not been physically violent during her first pregnancy, with the first incidence of physical violence occurring at two weeks postpartum following the birth of her first baby. However, he became extremely violent and this behaviour continued during subsequent pregnancies. One attack was so ferocious that it resulted in a spontaneous miscarriage at fourteen weeks gestation. Julia also experienced a premature labour at 26 weeks gestation, following another violent attack. Both times, the injuries she sustained were aimed at various parts of her body, with her partner frantically kicking out at her, without any regard for her pregnant abdomen:

*I fell pregnant in February 2007 completely out of the blue and I was a bit stunned by it. Then one night he came home drunk and he was on cocaine and he was extremely violent, attacking me all over, kicking me everywhere and I miscarried three days later. I did have him arrested for that but the CPS (Crown Prosecution Service) were unable to press charges they didn't have enough evidence so he was bailed back to my address so that was a waste of time. (Julia: interview 2)*

Subsequently, Julia's husband carried on abusing her, often taunting her to call the police and report him as he was confident that they would not have enough evidence to charge him with anything:

*No, he had been arrested many times but he was never charged and he became quite cocky about it, quite arrogant that they weren't going to do anything so he would taunt me by saying do what you want, ring the police they aren't going to arrest me. (Julia: interview 1)*

As a consequence, of the non prosecution by the Crown Prosecution Service (CPS), it was several years before Julia was courageous enough to report the violence to the police again. The failure of the CPS to prosecute him encouraged his arrogance and a belief that he could behave in whatever manner he pleased, without redress. The police and legal profession have been criticised for failing to respond appropriately to domestic violence incidents, sometimes with tragic circumstances (Hague *et al.* 2003). Kirsty also regularly experienced violent attacks from her partner; following a violent assault, Kirsty too, suffered a spontaneous miscarriage at 18 weeks gestation:

*Um well I got to being 4 and a half months pregnant, I was really looking forward to it, although still not believing it was happening as it was not planned. Although we were having a really bad time, and he was regularly hitting me when we were living in the B&B. He would hit me all over, kicking me, punching me, pushing me around, this one time he was punching me in*

*my back and stomach, and that's how I lost my baby. (Kirsty: interview 2)*

Following, her miscarriage, Kirsty's partner forbade her to mention the pregnancy or miscarriage again, resulting in feelings of deep despair for Kirsty, who firmly believed his indifference to her miscarriage, prevented her from grieving for her lost baby:

*Well the next day it was as if nothing ever happened do you know what I mean he was expecting me to do the housework and go out walking with him and stuff like that and I didn't want to be doing things like that do you know what I mean you just want to curl up in bed, sleep, rest and cry. But, you know he woke me up in the morning, sending me downstairs to make his breakfast. The baby or the violent attack was never mentioned again. (Kirsty: interview 2)*

Sarah also experienced a miscarriage. This was not the result of her partner physically attacking her, per se; nevertheless, Sarah believed he was responsible for her miscarriage:

*I followed him on my pushbike looking for him, eventually I found him. He got so angry with me and pushed me off my pushbike causing me to have an accident on my pushbike, and I believed that what was caused me to miscarry. (Sarah: interview 1)*

None of the women interviewed experienced physical violence at the start of their relationship; they all appeared to be emotionally and physically attracted to their partner. However, they all produced a similar narrative. As the relationship progressed, the violence began to move stealthily into the relationship. It appeared to start with a similar pattern of verbal abuse and intimidation, which included shouting and name calling, throwing things at them, cornering them in a tight space, proceeding to punch past them into the wall. Such intimidating behaviour was frightening for all the

women, leaving them in no doubt of their partner's ability and willingness to physically harm them, if they stepped out of line. This bullying behaviour eventually progressed for all the participants into physical violence. Several participants experienced physical attacks during pregnancy, but they were fortunate enough not to experience a miscarriage as a result of the violence. They were, nevertheless, extremely traumatised by the physical violence:

*I just wanted to sleep and he wanted me to stay awake but I didn't want to. So he started getting nasty then and he pulled me down... not all the way down the stairs but some of the way down the stairs and at the bottom of the stairs he was wearing boots he just started kicking me at the bottom of the stairs. I was scared for me and my baby. (Tamara: interview 1)*

Julia's, Tamara's and Kirsty's narratives make it clear that the embodied experience of physical violence was not only directed at them but also at their unborn child. Lisa experienced physical violence prior to her pregnancy as well as other types of abusive behaviour, including emotional and controlling behaviour supported by extreme verbal violence. However, she felt there was an escalation in the physical violence during her pregnancy, with the violence becoming more frequent and more brutal:

*Yeah it got worse, after I was pregnant, he became much more physical, and it was as if being pregnant didn't make any difference to him. (Lisa: interview 1)*

Lisa endured many physical assaults during her pregnancy, and on one occasion, when she was five months pregnant, her partner attacked her when she was standing at the top of the stairs, violently punching her in the head, causing her to fall down the stairs:

*Yeah, like the one time he punched me around the head when I was at the top of the stairs, I can't remember what it was about now but he like punched me really hard and I fell all the way down the stairs, so I had to have an ambulance called out for me because I went all funny, I think I was knocked out for a couple of minutes and I was worried that I may have hurt the baby falling down the stairs. (Lisa: interview 1)*

Despite this violent attack, which resulted in an admission to the Accident and Emergency Unit (A&EU), Lisa protected her partner by lying to the ambulance crew about how she sustained her injuries. Women are often reluctant to be honest about how they sustained their injuries. This can be due to fear, shame and sometimes to protect their abusive partners. Lisa's partner often tried to convince Lisa that the violence was her own fault, because she had changed during pregnancy:

*He just used to say the violence and his bad temper was my fault because of my hormones...and it used to annoy me because I knew it wasn't my hormones. (Lisa: interview 1)*

Several of the women talked about the reluctance of their partner to take any responsibility for their actions; in fact they often blamed the women for causing the violence that the men perpetrated against them. For some of the women, the physical attacks became more extreme increasing in frequency and brutality, as was the case for Julia:

*Up until about 2004 he had always been very careful where he hit me um he would never hit me in the face it was always to the body or you know several occasions he had bit me and again he would never bite me anywhere where it would show and then 2004/2005 we moved and the violence got much worse and then that was when it started, I would regularly have a black eye, split lip, I have got a dislocated jaw, um I have had a number of teeth cracked, broken fingers, that was when it seemed he didn't really care then, he just lost all interest... whether that or he just lost his mind I don't know. He just*



*stopped thinking about the consequences and it became the norm for me to have a black eye or split lip. (Julia: interview 1)*

Many of the women in the study elected not to disclose about the violence and abuse for many years. This is not unusual, due to the shame and personal responsibility that they may feel for being caught up in an abusive relationship. This silence allows the perpetrator to continue to conduct his abusive behaviour without challenge. The question 'why doesn't she just leave' is often cited by family members and professionals, who may get frustrated when women decide to remain in a violent relationship. However, it is important to acknowledge that leaving a violent perpetrator is not that straightforward (Harne and Radford, 2008). It is also important to understand that living with the daily intimidation of domestic abuse can cause long and lasting psychological effects, including fear (Barnett *et al.* 2005). There is also an assumption that all women will be safe once they leave the violent relationship, but this is not correct. Most homicides occur when the woman tries to leave the relationship (Kelly, 1988; Walby and Allen, 2004; Hague and Malos, 2005; Walker 2009a; Walker 2009b).

#### **7.4. Psychological and emotional abuse**

Emotional and psychological abuse was integral to the women's narratives. Whilst each woman had their own unique experience, they all talked about living through feelings of fear and described being withdrawn. The women talked about the long-term psychological effects of living with abuse: for example, for the majority of the women there was no set pattern to the abuse. Some of the women experienced abuse daily; for others the physical and sexual abuse occurred once or twice a week and for one or two participants a physical or sexual assault took place fortnightly. Regardless of the frequency of the assaults, what was constant amongst all the women was their perpetual state of alertness to the imminent abuse. Mullender (1996)

associates a woman's constant state of alertness with the psychological abuse that prisoners of war experience, in that they never know when the next beating will occur. It is often the threat of physical and sexual violence which serves to keep the women in their place (Pence and Paymar, 1993). Barnett *et al.* (2005) stress that emotional abuse is very common and very harmful to victims, with a number of survivors claiming that living with emotional abuse is much more challenging than living with physical abuse. It was very uncommon for any of the women to experience physical violence that was not also accompanied by intimidation and emotional abuse. It was apparent that whilst the physical injuries they sustained were damaging to their physical well being, the women clearly identified that more damaging was the psychological and sexual abuse. Julia described how her partner would deliberately make her feel unattractive, by always telling her how much weight she was gaining during her pregnancy. He would comment on everything that she ate; counting the calories, constantly telling her that she had to lose weight after the baby was born. Julia admitted that this resulted in her hating her body when she was pregnant, with her weight gain causing her great distress. It also left her feeling very apprehensive about how her partner would behave towards her, if she did not lose the weight immediately following the baby's birth:

*When I became pregnant, I did become concerned that he didn't show any interest in the pregnancy although he was totally concerned about my weight, he went on about my weight a lot. I gained four and a half stone when I was pregnant and it really bothered him, he did go on about it a lot. He didn't like it. Um he made it quite clear he didn't like it, he kept going on about it to make sure I lost it afterwards. Um he was always watching what I was eating, telling me the calories of everything, yeah he became quite difficult in that sense um so he made me feel quite anxious I can remember because I kept thinking I knew of other women that had had babies young but didn't lose the weight and I would be thinking oh my god what will he do to me if I don't lose this weight. (Julia: interview 1)*

Jane's narrative clearly epitomises the tension that women living in a violent relationship endure. She describes how she learned to be aware of the signals when her partner was becoming angry and would attempt to diffuse the situation by not answering him back:

*I just don't respond when he is shouting at me, because when I respond to him I know it will get worse, he would shout about everything at me so I would just keep quiet. I would never ever answer him back I couldn't say anything about what he said to me because I know that if I answered him back he would just get worse yet, if I am not answering him he would then just kick me as I am lying on the floor. (Jane: interview 1)*

*I learnt to know when I feel that there is something not very good; I make it all nice and smooth so his attitude does not go off. I have to go along with what he wants because if you go against him even when he is driving, he will get very angry and I know that he's getting angry; yes, everybody goes quiet, everybody is very quiet. (Jane: interview 2)*

Lempert (1996) describes the processes that women sometimes use to stop, change, or deal with the abuse. The main strategy chosen is passive resistance; Lempert refers to it as "becoming an invisible presence" (Lempert, 1996, p281). Eisikovits and Buchbinder (1999) established that abused women made decisions to silence themselves when their partners appeared to be on the verge of losing control. In this study, the women's perceptions of control and beliefs about danger were often related to their partners' mood changes and using their own intuition. Wendy highlighted how her partner had developed the skill and power to control her behaviour, by his mannerisms. For example, in the presence of friends or family, he liked to clearly indicate who was in control and in charge of the relationship by the way he behaved towards her. This form of psychological abuse and controlling behaviour had been present in Wendy's relationship before the physical violence. Wendy was born in Jakarta and English was not her first language. She felt her husband used this to deliberately taunt and embarrass her, which made her feel inadequate, despite the fact that she was educated with a degree in business management. In the early days of

their relationship, she was not always sure of the true meanings of her husband's language, especially if he used local colloquialisms and slang. However, she quickly learnt to recognise his non-verbal communication cues. Once she had agreed to marry him and remain in England, she realised he had a temper and always liked to have his own way. In the early days of their relationship, he was not physically abusive towards her, although he was often openly disrespectful towards her when they were out with his friends or work colleagues:

*It was really hard for me as well because it's like a different culture and also different language and I mean I can speak English but I don't understand when they start to talk in slang language do you understand? Like sometimes, he took me out to his work parties. Sometimes he would talk in slang language and I knew he was being disrespectful towards me, often his friends would say to me oh you will have to slap him and I said why, and they would say, because he said something rude about you. But because I didn't understand and I just didn't say anything I just didn't make any comments or anything and I was thinking at the time it was just a joke and but then it happened more and more. I felt everyone was laughing at me (Wendy: interview 1)*

Tracey had a similar experience to Wendy, where her partner used his non-verbal body language to ensure that Tracey understood that she had to behave a certain way when they were out:

*It was more mental abuse to begin with um (pause) he just had certain ways of saying things especially in public, where I would know exactly what he meant but other people thought he was joking, but I knew he wasn't. (Tracey: interview 1)*

As previously highlighted, the pregnancy was also used as a means to emotionally injure some participants. Some of the women were frequently told by their abusive partners to have an abortion, indicating that they no longer wanted the pregnancy. Tracey explained:

*Um a few days later, pissed as normal he turned round and said I don't want this baby, I never wanted this baby, I am only with you because you are pregnant, I don't love you. (Tracey: interview 1)*

At the age of 30, Sarah discovered she was pregnant for the first time with an unplanned pregnancy. Despite this, she was pleased to be pregnant. However, her happiness was short lived, as within a few weeks her partner was telling Sarah to have an abortion:

*When I got pregnant with H.... he was taking cocaine; and we were at an engagement party for his brother he started telling me to have an abortion and everything in front of everyone. (Sarah: interview 1)*

However, Sarah made the decision to continue with the pregnancy and remain in the volatile relationship, enduring extreme psychological and physical abuse during her pregnancy.

The women's narratives referred to the constant fear they felt not only for themselves, but also for their unborn baby. They felt personally responsible for ensuring the complete safety of their unborn baby, against the violence. Some of the men appeared to use this fear, to threaten and control the women during the pregnancy:

*He did threaten to push me down the stairs um and he threatened that he was going to give me a caesarean and throw the baby down the toilet and things like that. There were times he would say oh if you did fall down the stairs it would be a blessing and all this um... it was the constant threats he made towards me that scared me the most. (Tracey: interview 2)*

The next section of this chapter will focus upon the verbal abuse and the various types of intimidation that the women experienced.

## **7.5. Verbal abuse and intimidation**

All the women endured extreme verbal abuse from their partners. Verbal abuse and intimidation are other types of emotional abuse (Hague and Malos, 2005). The men regularly used verbal abuse towards the women, using this to frighten and intimidate them. They were frequently sworn at, called degrading names, described as fat, a cow, stupid and an unfit mother. For all the women, this abusive behaviour included being subjected to criticism and belittlement in front of their children, friends and family.

Jane's partner would be verbally abusive to her not only during the day. He also regularly woke her during the night to continue his barrage of verbal abuse, standing over her and denigrating her by calling her disgusting names. This often occurred when he had been drinking. Depending upon on how much he had to drink, physical abuse often followed his tirade of abuse. This behaviour continued when Jane was pregnant:

*He would kick me when he came into the room at night. Sometimes, I would pretend that I am sleeping, but then he put the light on and would take off all my blankets and everything. So that would mean that you have to do something because you can't pretend to be sleeping, or sometimes he would just turn on the light, really bright lights so that you can't go to sleep and then he would stand there and he would just be shouting and saying anything what he want, sometimes he would beat me, especially if he had been drinking.(Jane: interview 2)*

It appeared that part of the anguish for the majority of women, was the relentless worry about what would happen to them next. The women talked about the continual guarding and awareness of their responses and actions when they were around the

men and the unpredictability of subsequent violent behaviour. There is some limited evidence available which suggests that verbal aggression is the most common form of abuse to occur in pregnancy (Cloutier *et al.* 2002). The women in this study found living with heightened awareness of potential threats of danger to them, their unborn baby and children, exhausting.

One participant decided to leave her partner when his drug taking habit caused his behaviour to become more erratic. His aggression was extremely difficult to live with. Louise had previously smoked cannabis with her partner. However, she felt that once he had started to take heroin, he had 'crossed the line'. Louise's father had been a long term heroin user when she was growing up. Because of her childhood experiences she decided that she would not stay in a relationship, where hard drugs were being used. Louise escaped to a friend's house. Even though Louise had left her violent partner, she still felt in constant terror of him. He would often wait outside the homes of family and friends, trying to see her. As a result, Louise lived in a state of constant alertness and fear of meeting him unexpectedly:

*He would often find out where I was going, or be hanging around outside my house, the house of my family and friends with the excuse that he wanted to see the baby, but it was all lies. He did not care about ..... He would just wait there for me to turn up, then he would be really threatening, asking me for money for drugs and I knew, I knew sometimes when you can tell when he means it. Like he is not just going to flip and he is not going to just slap you or punch you he would annihilate you like in front of who ever there. Yeah I was really scared of him.*  
(Louise: interview 1)

Louise clearly demonstrates that separation from an abusive partner does not necessarily mean that the woman is free from violence and abuse.

## 7.6. Sexual abuse

Sexual coercion has been identified as a frequent characteristic of abuse during pregnancy and following delivery (Coggins and Bullock, 2003). Sexual violence is a broad term used to describe rape and a range of humiliating, coerced and forced sexual activities (Kelly, 1988). For some of the women, the partner's abusive behaviour extended into their sexual lives. Four of the eleven women discussed being forced to have sex by their abusive partner on a regular basis. For several others, agreeing to sex was sometimes effective in countering the violence, but left the women with feelings of disgust. As previously described as a phenomenon, domestic violence covers a wide range of abusive behaviours. However, it could be argued that rape of a woman by her partner is the gravest form of sexual assault due to its damaging psychological, emotional and physical impact upon the victim (Goodman *et al.* 1993; Campbell, 1998b; Baker, 2008). It is believed that violence against women is often played out through sexual violence, where the assault is directed at the genital area and it goes hand in hand with rape, buggery and having objects inserted into the vagina or anus (Radford and Hester, 1998).

The trauma of partner rape played a significant role in the violence of some participants in this study. Sexual violence is often perpetrated following a physical assault (Johnson, 1995) and because of its '*intimate and intrusive violation of self*' (Harne and Radford, 2008 p. 5) is often the most difficult aspect of the abusive behaviour to discuss, confirming the suggestion by Jasinski and Williams (1998) that partner rape is not rare, it is just rarely talked about.

In this study pregnancy was not a protection against sexual violence and rape. Four participants were regularly forced to have sex including anal sex, regardless of whether they consented or not. The women recounted stories of rape as a form of violence, control and punishment. In the main, the general descriptions of their sexual relationship were negative, with no mention of love or tenderness. Interestingly, three



of the four women did not use the words 'rape' instead choosing to verbalise the rape that had occurred within the co-habiting relationship as 'being forced to have sex' and 'sexual violence'. Kirsty was the only participant to use the actual word 'rape':

*Yeah, he raped me on quite a few occasions, even when I was pregnant. Um he would try and have sex with me whilst I was asleep. He would do awful things to me. No meant yes to him.*  
(Kirsty: interview 2)

Kirsty went on to describe how she felt unable to emotionally or physically connect with her partner in an intimate way:

*Well, because he treated me so badly, making love with him was well horrible, and I would find it disgusting to be honest with you. Being through what I went through with him, I found it pretty gross. I was brought up to believe making love to someone is not about doing it, just for the sake of it. So I found it pretty disgusting with him, but I had no choice, if I did not agree he would just force himself on me.* (Kirsty interview 2).

Nicola was also subjected to rape in her relationship and this continued throughout her pregnancy:

*It was mainly verbal abuse when I was pregnant and sometimes even sexual abuse. This carried on all the way through the pregnancy. Even at the end, when my tummy was huge and he said I will have to force you to have sex with me and sometimes I was crying because I wanted him to stop but he just ignored me and carried on, he did not care that I was crying.* (Nicola: interview 1)

It can be particularly difficult for a woman to admit she has been sexually abused by the man who is supposed to love and cherish her:

*He wouldn't get violent as such but he would be very aggressive in his voice um there were certain times where he wanted to do something and (pause) basically he wanted anal sex um and I kept telling him no but he would try it anyway. Um most of the time I managed to get him off of me, sometimes I didn't so of course I was screaming because I didn't want it and all he would say to me is shut up, you stupid cow it don't hurt [crying]..... (Tracey: interview 2)*

Tracey believed that the more she struggled against sexual violence, the more aroused her partner became, and he would become more violent, the more she resisted him. According to Stark (2007) forcing women to engage in anal sex against their will is another form of coercive control.

Like Tracey, Nicola found it impossible to say no to her partner, as he would just rape her anyway, regardless of her refusing his demands for sex:

*He would just demand sex, whenever he wanted it, and if I said no he would force his weight on me he never took no for answer. (Nicola: interview 1).*

This was similar for Jane:

*Sometimes he sexually abused me even when I was really, really big because of being pregnant with the twins, my tummy was big. He said I will just force you anyway and sometimes I was crying, but he just forced himself on me, he did not bother him if he was hurting me [crying]..... (Jane: interview 2)*

The sexual violence was not only limited to pregnancy, but continued into the postnatal period for one of the participants. Nicola's partner raped her on the very afternoon she was discharged from the maternity ward. He showed a total disregard of her feelings or the fact that she had sustained a second degree vaginal tear during childbirth, resulting in the suturing of her perineum. Nicola was extremely distressed when recounting the experience of the sexual assault:

*The day I got home from the hospital he demanded sex. Well I said no I said you know I am really sore and bleeding and I don't want to have sex and I kept trying to push him off me but I am like 4 foot nothing you know I am really short and he is like 6 foot 4 so he is really tall, I was crying trying to push him off, as it was really painful, but he did not care, he just carried on, it was awful. (Nicola: interview 1)*

Understandably, all of the women who encountered rape within their relationship became very emotional and distressed during the interviews, when they were recalling the sexual violence. However, all the women wished to continue with the interview, strengthening my belief that they wished their story to be told and heard. Following disclosure, a few of the women required a few minutes to compose themselves before continuing with their stories. It can be very difficult for a woman to admit that she has been sexually abused by the man who is the father of her unborn child or children and whom she may still love (Hague and Malos, 2005). Braun and Wilkinson (2001) suggest that the vagina often socially and culturally symbolises the place where "a woman is most known to be vulnerable on a psychological and physical level" (p.23). They describe it as "vaginal vulnerability" (p. 23).

The four women who were frequently raped within the relationship were left, with feelings of emptiness and disgust; the disgust was obvious in the way they talked about the assaults. Some of the women cried whilst being assaulted, but this seemed to sexually arouse the men more. For some of the women sex was seen as a way of

countering the violence. They felt that agreeing to sexual intercourse, even when they did not want to participate, would avoid further confrontation.

Pregnancy in itself was not viewed as a form of protection against sexual violence. Several of the participants were worried that the violent sexual acts they were forced to engage in, might bring about a spontaneous abortion:

*The whole time I was with him I didn't... I was very unhappy at parts of our relationship, most of the time especially when he had been drinking, I was scared, I always felt dirty because of everything that he wanted to do when he was drunk. Um I had nightmares when I was with him, I couldn't sleep properly, most of the time when I was pregnant I was worried that he would do something to make me lose the child. (Tracey: interview 2)*

Stark (2007) believes that in general, when women are trying to survive in a violent relationship, as with other aspects of their life, they have limited control over their sex life. The control of sex is often linked to other types of gendered control and obedience. According to Hague and Malos (2005), there is no simple division between physical and sexual violence for women, when they are abused by their male partners. The two are linked, with rape being part of the overall physical assault, with women frequently being forced to have sex with her abusive partner after suffering a violent attack (Kelly, 1988; Johnson, 1995; Hague and Malos, 2005). The threat of sexual violence and sexual humiliation allows an abusive partner to dictate when, and how often, he will demand sexual intercourse with his partner.

## **Summary**

In this chapter I have focused on the various types of abuse the 11 women experienced during their pregnancy and this has included all the violence and abuse that the women spoke about. The violence included sexual, psychological and

physical abuse, isolation and financial control. Sexual abuse included treating the women as a sexual object, demanding sexual intercourse by coercion, and forcing them to perform sexual acts against their will. Psychological and verbal abuse included derogatory name calling, threats to kill, belittling the woman's feelings and her appearance and intelligence and preventing her from sleeping. The physical abuse involved punching, kicking and strangulation. The following chapter will draw upon the women's stories of power and control within their relationships.

## **Chapter Eight**

### **Findings: Power and Control**

#### **Introduction**

This chapter presents the specific theme of power and control. I considered power and control to be dominant and integral to the thesis, because all the women clearly communicated issues of power and control within their relationships. The men perpetrated various types of violence within the relationship, because ultimately they had the control and power to do so. Jasinski and Williams (1998) suggest that the way the family is structured, in terms of male dominance versus equality, contributes to the way in which families function. Literature supports the conjecture that control and oppression is a key characteristic of domestic violence and abuse. Therefore it was not unexpected to emerge as a major finding from the women's experiences. Stark (2007) and Yllö and Straus (1990) suggest that violence and abuse is more widespread in households where the male has the unequal concentration of power. Some of the tactics, actions and overall conduct of the partners, can be described as a means of coercive control, which according to Stark (2007) have the overall purpose to undermine the autonomy of a woman.

#### **8.1. Power and control within the relationship**

The extent of power and control within each of the women's relationship varied, and it is important to acknowledge and recognise that pregnancy itself did not seem to alter the behaviour of the men. In fact, if anything, the pregnancy allowed them to become more controlling within the relationship. The controlling behaviour included women having to ask permission to visit family and friends, or being prevented from developing any independent social networks outside the home. For the majority of the women, this control included financial control. The majority of the women were not allowed to have any independent access to money having to seek permission to buy personal items, including toiletries for themselves. Other controlling behaviours included denying the women any choice or control in relation to contraception. They

were frequently told what to wear and when they could speak. For some of the women in the study the control included having their phone calls monitored, being locked in the house when the perpetrator went out and being told what household chores had to be performed when their partner was out at work.

The majority of the women indicated that the emotional and controlling behaviour developed insidiously within the relationship. Many of them described how charming, caring and attentive their partners were towards them at the beginning of the relationship. Julia described how her partner had swept her off her feet at the beginning of their relationship. As indicated by Harne and Radford (2008), many men who control their partners are often very charming at the start of the relationship. Once the relationship is established, the controlling behaviour begins to emerge. Such controlling strategies are then used to entrap the woman in a violent relationship. This change in manner and behaviour can be a gradual transformation, as the perpetrator attempts to gain and reinforce their control. It has been suggested that once this transformation occurs, the women will begin to lose their self-confidence and self-belief in themselves and their capability to function as an independent person outside the relationship (Hague and Malos, 2005; Stark, 2007; Harne and Radford, 2008). Julia's illustration below portrays how her partner's behaviour changed, once they moved in together:

*He swept me off my feet, yeah he did, he is Scottish you see, so he spoke differently to everyone else which was quite appealing at the time, it annoys me now but when we first met I did find it very appealing. Um he was a nice looking guy and he worked and he was quite charming you know the perfect gentleman he was very, very nice. Um and most of the time when we first were together he was the same he was quite charming, generally quite considerate um and when we first started living together he still did most of the things in the property and he did his own washing and cooked meals um it sort of crept up on me I think his behaviour, um... it just sort of changed... I didn't see it for a long time. (Julia interview: 1)*

Some men already had criminal records and long standing drug and alcohol problems prior to meeting the women. Yet, when participants discovered the extent of the men's substance abuse, they did not attempt to leave the relationship. Instead, several of the participants believed they could change the conduct and activities of their partner's by just 'loving them'. However, their aspirations and belief in the men was not rewarded. Kirsty truly believed she could change her partner and that all he needed, was someone to believe in him. She explains how she ignored anyone, including family and friends, who tried to warn her about his reputation:

*I used to say to people I know the real P..., I know the true P... you know he's not that bad you know all that sort of stuff is in his past. I used to cover up for him, you know he's not that bad he's a good bloke really you know and he is lovely, you've just got to get to know him, that sort of stuff but... God they were right and I was so wrong... (Kirsty: interview 1)*

However, she acknowledged that seven months into their relationship, the honeymoon period was over. As his controlling behaviour gained momentum, he managed to completely isolate her from her family and friends. The repertoire of his controlling ways included dictating what clothes to wear:

*Yeah, everything was OK to start with, yeah, everything was OK, it was what I call honeymoon period um yeah we were really good for about 7 months and then it started getting to the stage where he was trying to control everything I did. He was just on my case the whole time about leaving home and moving in with him. He stopped me seeing my friends even started to tell me what to wear. (Kirsty: interview 1)*

None of the women discussed experiencing physical violence at the very start of the relationship and they all appeared to be emotionally and physically attracted to their partners. However, they all revealed a similar narrative, highlighting that as



the relationship developed; the men's controlling behaviour began to creep surreptitiously into the relationship:

*When I was in a relationship with him, yeah, it was all right to start with. In fact it was lovely. We were friends to start with, and I thought he was such a nice person, that I was really pleased it moved on to boyfriend and girlfriend. However, once our relationship moved onto more than friends... I don't know things changed, he wasn't the person that I thought he was, he didn't like me going out, he didn't like my friends, he didn't like my family, he just seemed to want me and him and that's it. He didn't want no-one else, no-one else getting involved and when he had a job and he was working nights, he would text me all through the night and ring me up to 10 times a night. He would also quiz my daughter to see if I had anyone in the house and then like things got slowly worse, he just got more controlling and dominating and in the end one day I had enough of it and I asked him to get out and he had been drinking while I was at work and he got violent, really violent. I gave him my phone so I could get out, he smashed my phone up and we got into like a physical fight and he had me on my lounge floor by my coat and throat and he smashed my head off the table and he kept doing it and doing it. (Susan: interview 1)*

## **8.2. Isolation as a form of control**

For most women, being isolated from family and friends was customary and seemed to be intertwined with controlling behaviour, with the partners having the power to dictate who the women could socialise with. In some cases, the women were prevented from seeing their family and frequently threatened with violence if they disobeyed their partners. Some men's behaviour was so appalling and demeaning towards the women's family and friends that they stopped visiting. As a result, many of the women had limited social contact with the outside world, whilst some of the women were only allowed out of the family home if accompanied by their partner. This continued during and following the pregnancy. Controllers will often attempt to isolate their partner to prevent disclosures about the abuse and to inculcate dependence. Stark (2007) believes that by cutting women off from friends, family and

alternative sources of support, “perpetrators become their primary source of interpretation and validation” (p.263). Eventually, the woman becomes completely controlled by the perpetrator and she develops feelings of insecurity about her own identity and unique personhood (Stark, 2007). Such social and spatial restriction was evident in my research, with partners exercising tight control over the woman’s movements both inside and outside the home. This lack of identity is portrayed by Nicola, who was only allowed to venture outside the home if accompanied by him. Nicola’s movements continued to be controlled by her partner during her pregnancy and following the birth of her baby:

*The only way I was allowed to go out was if he came with me or if I went to his family and friends. If it was anything to do with my family he would go really mad, I was too scared to disobey him. (Nicola: interview 1)*

Nicola was an identical twin and described how inseparable she and her sister had been when growing up together. She verbalised feelings of great sadness and a sense of loss when her partner forbade her to visit or communicate with her twin sister:

*Yeah she tried to stay in contact, she did try and visit me you know, she had visited at first when I was first living with him, but then she stopped coming because you know she felt too stressed being around him. Just like anyone would about going in someone’s house and seeing it done to your own sister, your own family you know it’s hard for anyone to come round and see it, eventually she stopped coming, he was happy then. (Nicola: interview 1)*

Susan was also purposely isolated from her family and friends during her pregnancy. During this time, she was forbidden to visit her family without her partner. Whenever any of her family or friends visited her at home, her partner made them

feel so unwelcome, they eventually stopped visiting. The extent of his control included accompanying her to and from work, thereby ensuring she did not meet with any family or friends on route:

*I wasn't allowed to visit my mum's no more, he made my friends feel so uncomfortable that they eventually stopped coming to visit, they didn't want to come round, he also walked me to and from work. The only time I saw my mum was when she came down to visit, however, once again he used to make it really uncomfortable when she was there because he never liked any of my family. I was only allowed out with his mum and allowed to see his family. (Susan: interview 1)*

Isolation and control were common for all of the women. Many of the women who were abused during pregnancy gave an account of their partner's attempt to isolate them from their family and friends. It has been reported that abusive men can be jealous of any close relationship that the pregnant women may try to make or maintain (Bacchus *et al.* 2006). Although not necessarily considered as a criminal act, isolation and control strategies by partners can be constituted as false imprisonment (Harne and Radford, 2008). Susan was frequently locked in the house when her partner went out:

*In the end I couldn't go without him, he would either get his mum to come and sit with me or he would leave me in the house but I wasn't allowed to let anyone in and he would lock the door until he come back. (Susan: interview 1)*

Kirsty did not fully recognise the extent of her partner's controlling strategy until he had successfully isolated from her family and friends.

*I just thought that he behaved that way because he cared but it wasn't, no it was because he was possessive and he didn't want me going off with anyone else, he didn't want me going out with my friends and stuff like that. He used to say to me you don't need any of those friends now that you are with me now and like a fool I thought ah that's sweet like you do, but that's the way he worked. He just messed with my head. (Kirsty: interview 1)*

Stark (2007) suggests controllers endeavour to make a woman's relationship with her family, a primary target of isolation. It is not uncommon for abusive men to forbid calls or visits to families, forcing the women to choose between them and their families. To enforce isolation during a woman's pregnancy and birth seems particularly brutal and vindictive at a time when families usually share in the joy of a new baby. Campbell *et al.* (1992) report that women assaulted by a partner during their pregnancy, were the least likely to have received any help from family and friends or indeed to ask for help when compared to non – abused women.

Three of the women continued to work throughout their violent relationships. For these women, the extent of the controlling behaviour did not include forbidding them from going to work or contributing to the household income. However, a contributing factor in the men's decision to tolerate the women working may have been attributed to their own unemployment status. In the relationships where the women continued to work, the male partner was either out of work or in and out of work periodically, with the women's income being viewed as essential to family resources.

### **8.3. Financial control**

Another indicator of control within a relationship which can limit a woman's independence and sense of worth is controlling her access to money. Pregnancy is associated with increased financial pressures and an increase on a woman's

dependency upon her partner (Bacchus *et al.* 2006; Pallitto *et al.* 2005). Several of the women talked about the increase in financial pressure in their relationships during pregnancy, suggesting that the lack of financial funds added to the tension within the relationship. Financial control was evident in nearly all the participants' stories, regardless of whether the women were employed or not. Only one of the participants interviewed did not allude to some form of financial control during our interview. During the interviews, financial control was presented as anything from a lack of access to funds, theft and acts of violence and intimidation by the partner to allow him to either withhold money for housekeeping or demand money from the women which she needed to buy food and pay household bills. According to Janinski and Williams (1998), abused women are often economically dependent, and are kept dependent deliberately by their abusive partner, as a means to maintain power and control over them. Leaving an abusive relationship is much easier when a woman has financial means of her own.

Jane first experienced her partner's violent reaction to her expenditure on their wedding day. Previously, her partner had been financially generous towards her:

*He was always kind to me but then on our wedding day and I needed to have white shoes, so I went to buy some white shoes and then he was shouting at me, you have used and lost all my money. I was frightened by his temper, but I couldn't do anything else but marry him as the wedding was planned. So I just had to ignore his behaviour and everything. I just cried and cried, even on my wedding day. (Jane: interview 1)*

It was clear talking to some of the women, that they associated the financial control within their relationship as another means of strengthening their partner's control over them. Julia explained upon returning home from work her partner would check that she had done all the household chores that he had instructed her to do.

Any jobs which were not completed as per his instructions resulted in a deduction in her housekeeping money:

*Yes he was very textbook as well you know he was very um manipulating, he lied about everything, quite controlling you know he had rules and I'd get lists of things that I had to do. He'd check the house for things to make sure that jobs were being done, if they hadn't been done then that was an argument and anything I hadn't done he would deduct the money out of my housekeeping, it was a long line of very strange behaviour. (Julia interview: 1)*

For some of the women, a lack of access to finances had a direct impact on their pregnancy. For instance, Kirsty had no access to money during her pregnancy; her partner had complete control of their limited finances. Kirsty found it very difficult to buy any items of clothing for herself or her baby; she relied upon her family to buy these. Kirsty clearly remembered an incident early in her first pregnancy when she wanted to buy a pregnancy test to confirm the pregnancy:

*I knew I was pregnant because I had morning sickness, I was really ill all through the morning, all through the day I was being really ill., I just didn't feel right in myself, I felt pregnant. Um and I kept saying to him I'm pregnant, I'm pregnant, I know I am pregnant, but he kept saying, no you're not, you're not pregnant. Um he wouldn't let me have any money to buy a pregnancy test (Kirsty: interview 1)*

Eventually, Kirsty went to visit her GP to have her pregnancy confirmed, yet despite this confirmation, her partner still refused to acknowledge the pregnancy.

Some of the men kept control of the finances to secure money to fuel their drug habit, refusing to allow their partners to spend money on food and vital baby items:

*All of his priorities were just getting another fix and he didn't seem to care that we were starving and that I used to have to cut up towels to use as nappies, when I bought the baby home because I couldn't afford to buy any nappies. Um because he would take every penny and if I tried to argue with him he would be oh we are not skint because of the drugs and I would say but we are and he would continuously deny it and turn it around blaming it on me, telling me all our money went on buying things for the baby. (Sarah: interview 1)*

Jane had three part-time jobs, because her partner refused to work following an illness, preferring to stay at home; this usually involved him drinking whisky most of the day. Jane was the main provider, working as a full time healthcare assistant and part-time as a cleaner and shop assistant. In spite of this, she had absolutely no access to money. Their bank account was in their joint names, allowing her salary to be paid automatically into the bank. However, her partner forbade her to have any access to the account. She was prevented from owning a cheque book or a bank card. Her husband had total control of the family finances, only he was permitted to withdraw money from their joint bank account, allocating her a budget to buy groceries for the family. Returning home from shopping, Jane had to present her husband with an itemised receipt so he could check how much money she had spent on the family groceries:

*No he dealt with anything to do with money, he dealt with it all. He controlled the money, even though I worked and he did not, I have no access to money. He would not allow me to have any money. Even when I went shopping he wanted to see the shopping list to check what I had used the money on. (Jane: interview 1)*

According to Stark (2007), controllers often gain access to a partner's money by restricting their access to resources, regardless of their contribution to the family income. The distribution of money within an abusive relationship is usually biased in the man's favour, permitting him to have more power within the relationship. Kirsty's partner insisted in moving them so far away from her place of work that it was impossible for her to carry on working, as Kirsty was reliant on public transport to get to and from work. She wanted to continue with her job, as she valued her independence; however, her partner bullied her until eventually she gave up work. Kirsty recollected how the loss of personal income made her feel very vulnerable and more dependent upon her partner:

*It wasn't our money; yeah it would be his money. Um if I never gave it, him he would just steal it off me. Where he would be like I need this, this, this and this. Um so I had no money, I never had any money, so I was dependent upon him for everything. (Kirsty: interview 2)*

Nicola's situation was slightly different from some of the other participants in the study. Nicola did have access to some money; her partner would give her money for housekeeping. However, what little money Nicola had, she would give to her partner to buy drugs, even though it meant going without food. She believed that by giving into his demands and handing over any money she had, she was preventing him from breaking the law to get money for his drug habit. Substance abuse was another common theme which emerged from the data and will be explored in more detail in a subsequent chapter.

Sarah experienced gestational diabetes during her pregnancy and was required to inject herself with insulin. However, she was powerless to control her blood sugar as she was regularly unable to eat a balanced diet, as there was no money to buy food. This resulted in several admissions to the antenatal ward during her pregnancy, in an attempt to control her blood sugar levels. Sarah was too embarrassed and frightened to inform the midwifery or obstetric staff why she was



unable to control her blood sugar levels. During our interview, Sarah indicated that she felt the staff considered her stupid and casual about managing her diabetes, implying she was being neglectful of her unborn baby. Eventually she decided to move in with her mother for the last few weeks of her pregnancy, as her concern grew for the health of her unborn child. It was only this concern and anxiety that overcame her fear of her partner's reaction about her moving temporarily, out of their home. For her own safety, she had to reassure him that the decision was only a temporary measure until the baby was born:

*it was very difficult um because I was having to deal with the insulin and of course because there was no money for food, I was not eating because we didn't have the money to spend. I couldn't take the insulin and I had to try and keep my sugar levels down and you have to be able to eat to do that. The staff frightened me about the damage I might be causing to my baby. So I went to stay with my mum for the last few weeks of my pregnancy so I could eat properly, because I knew the higher my sugar levels were, the more damage it would do to her.*  
(Sarah: interview 1)

Sarah felt utter despair at times during her pregnancy, when she was unable to get enough food to eat. The ultimate controlling mechanism by her partner was to regularly control the amount of food she would eat, dictating the portion size and the type of food she was allowed to eat, even though this could result in Sarah experiencing a hypoglycaemic episode. When an attack did happen, he would disappear from the house, leaving Sarah to call for help herself:

*He would do everything to keep the control um like even when it came to food and that, he had to have his big plate of burgers and stuff whereas I had to cope with like a tin of tomatoes on toast anything that was cheaper. He was so cruel, he knew I had to eat because I had to inject my insulin; he would make me have small amounts so I couldn't do a lot of insulin. Then if I had a hypo and things like that he didn't care, he would just look at me and laugh... I would be on the floor trying to tell him I needed sugar, I would be like I need sugar or something and it*

*would be oh well ring an ambulance yourself then, well he wouldn't even do that he would go out and leave me to it.*  
(Sarah: interview 1)

Such cruel actions and conduct from a partner demonstrates an extreme indifference not only towards Sarah but also to their unborn child. Sarah's daughter aged two at the time of the interview was born with minor disabilities, which Sarah believes were the result of her unstable blood sugars during her pregnancy:

*Yeah, well because of the diabetes and unstable blood sugars , H.... had fluid on the brain and I had to make all the decisions myself whether to have an abortion or to keep her, obviously I decided to carry on with the pregnancy, but I had endless scans to check on her development.* (Sarah: interview 1)

#### **8.4. The use of the mobile phone to control, isolate and harass**

The mobile phone can be used by men as an instrument to control and isolate women. In this study, mobile phones allowed men to monitor the movements of the women even, when they themselves were not physically present. It was also skilfully and cunningly used as a means to further isolate the women from their families. Several of the men dictated whether the women could actually use their mobile phones and if they were allowed to use them, the men would then monitor the calls.

Stark (2007) discusses the aspect of spatial and temporal extension of coercive control. He describes how men deploy coercive control through a spatially diffuse pattern of rules, by using stalking, cyber stalking and mobile phones that effectively erase the difference between confinement and freedom. It was evident that several of the women felt stalked by their partners, even when they were not in the same room or house. For some of the participants, their partners successfully achieved this by the means of the home telephone and personal mobile.

Susan described how her partner would use her mobile phone as a method of monitoring her calls. This included who she was calling; he was able to do this by regularly checking her call register:

*He used to go through my phone constantly checking it, looking at my call register and if I put it on silent then he would accuse me of talking to someone or if I deleted anything it was because I was hiding something. (Susan: interview 1)*

Lisa described how her partner would get agitated and angry, if her friends or family called or texted her, on her mobile phone. He would become so angry that he frequently took her phone from her and would hide it. One incident resulted in him snapping her sim card, so she could not talk or call anyone. By destroying her sim card, he was able to remove any record she had of her family and friends' phone numbers:

*He used to get annoyed about people texting me. He used to take my phone off me and hide it so I could not call anyone. He snapped my sim card so I could not talk to my friends. (Lisa: interview 1)*

Susan also explained how her partner would frequently use her mobile phone to check up on her movements. Part of his controlling behaviour included giving her an allocated time to get to and from the local shop:

*When he had a job and he was working nights, he would text me all through the night and rings me to check up on me. He would also use the phone to check up on me when I was out. If I went to the shop he would phone up the shop because he knew the owners and he said do you have a new extension, as it is taking her longer to walk round. (Susan: interview 1)*

The mobile phone was also used as a tool to isolate one participant from her family. In a vindictive act, her partner used her mobile phone to send cruel and rude messages to her family, hoping that the family would believe she had sent the messages, thus increasing her isolation and her dependency upon him:

*He kept like sending text messages to my family, from my phone, like really nasty ones, like saying we don't care about you, but he was writing it from me and you know making them turn against me. Hoping they would stop caring about me and he kept sending like horrible like sex jokes and horrible...he just did not want them to be around. (Nicola: interview 1)*

The mobile phone was a useful device for continued control and intimidation even when separation had occurred. Three participants described how their partner used the mobile phone to constantly harass them, following separation:

*Yeah it's just the constant harassment up to 300 phone calls a day all through the day, all through the night until about 6 in the morning. (Tamara: interview 1)*

*The phone calls were just terrible, they were constant, I felt like I had to answer my phone because if I don't answer my phone I just knew what trouble I would get. It's been constant for the last year, even when we were separated it's been like that. I feel I have to be friends with him for the sake of peace and the sake of the children. It's like they are constantly controlling you, even when they are not with you. (Julia: interview 1)*

*One time, he phoned me up, he was drunk and there was music blaring in the background, he was rapping and it didn't make any sense I couldn't fully understand what he was saying as he was saying it in rap, although I could make out enough to understand that he was saying I am going to cut you up and put you in my wheelie bin. Other times he would leave messages on my voice mail and just like you're a bitch, you are this, you are that just... (Tracey: interview 1)*

Such accounts reinforce women's narratives that separation from a violent partner does not guarantee safety or non contact with the perpetrator. The mobile phone and the internet were useful tools for the men, allowing them to continue to harass and frighten the women.

Following a particularly violent assault during her pregnancy, Louise made the decision to leave her partner. However, despite the separation, he still continued to threaten and harass her by continually sending her abusive text messages, which included telling her to abort the baby:

*I don't even know why, but he just sent me text message after text message saying get an abortion you cunt over and over again. (Louise: interview 1)*

Julia's partner managed to control her movements and domestic arrangements during the day by using the phone. He would constantly ring her at home from work. Julia believed the calls were used, not only as means to check up on her whereabouts, ensuring she was at home, completing the list of household tasks that he had instructed her to do that day, whilst he was at work:

*Yeah and he used to ring me up to 10 times a day, have you done this, have you done that, check this, check that, where are you it was just so stressful... He did not care that I was pregnant. (Julia: interview 1)*

## **Summary**

Controlling behaviour by the partners seemed to resonate throughout the women's individual experiences. It is known that such violence and control can develop from the need to enforce power and control within a relationship (Pallitto *et al.* 2005; Bacchus

*et al.* 2006; Stark, 2007). Yet, it is thought that pregnancy can symbolise a woman's independent embodied control over her body and according to Bacchus *et al.* (2006), such violence during pregnancy may stem from a continued need to reinforce power and control within the relationship, when a pregnancy can significantly change the family dynamics. Presently, there remains limited research available on the overall impact of patriarchal control and the risks of increased violence during pregnancy. Although not a criminal offence in itself, there is no doubt that for the women in this study, the power and control that existed within their relationships had an overwhelming psychological effect on wellbeing including anxiety, depression, eating and sleeping disorders, taking prescribed medication. These were all behaviours that were not only detrimental to the women but also to their unborn fetus. The overall influence of psychological abuse will be explored in more detail, in the following chapter.

## Chapter Nine

### Findings: Pregnancy Intention and Partners Attitude to Pregnancy

#### Introduction

The women who agreed to participate in the study included women whose pregnancies were both planned and unplanned. Eight of the participants in this study had an unintended pregnancy. Unintended pregnancy has been considered as a risk factor for physical violence during pregnancy (Gazmararian *et al*, 1995; Pallitto *et al*, 2005), suggesting that there is a need for a better understanding of the potential relationship between pregnancy intention and domestic violence.

#### 9.1 The link between pregnancy intention and the risk of experiencing violence

For the majority of women in the study, their first pregnancy was unplanned, (see table 9.1. page, 181), yet they all made the decision to continue with the pregnancy. This included women who were already experiencing physical violence before the pregnancy. Whether this decision to continue with an unplanned pregnancy could be attributed to compromised decision-making, regarding their ability to interact with family planning decisions, or was due to the fear of reprisals by their abusive partner is unknown (Miller *et al*. 2011) .

**Table 9.1 Participants' Relationship to Pregnancy**

<b>Name (Pseudonym)</b>	<b>Pregnancy planned</b>	<b>Decision regarding the pregnancy</b>
<b>1. Lisa</b>	No	Unplanned pregnancy, but decided to continue with the pregnancy.
<b>2. Tracey</b>	No	Unplanned pregnancy, but decided to continue with the pregnancy.
<b>3. Julia</b>	Yes	Bullied into agreeing to the pregnancy, after relentless pressure from her partner.
<b>4. Sarah</b>	No	Unplanned pregnancy. However, pleased to be pregnant due to her age.
<b>5. Jane</b>	No	Unplanned pregnancy, but decided to continue with the pregnancy.
<b>6. Susan</b>	Yes	Felt pressurised by partner, however, believed agreeing to a pregnancy would show her commitment to the relationship.
<b>7. Nicola</b>	No	Unplanned pregnancy, but decided to continue with the pregnancy.
<b>8. Wendy</b>	Yes	Planned 1st pregnancy due to her age.
<b>9. Kirsty</b>	No	Unplanned pregnancy, but decided to continue with the pregnancy, despite her partner refusing to acknowledge pregnancy.
<b>10. Louise</b>	No	Unplanned pregnancy, unaware of pregnancy until 16 weeks gestation.
<b>11. Tamara</b>	No	Unplanned pregnancy, but decided to continue with the pregnancy.



Several of the women's partners practiced birth control sabotage and overt pregnancy coercion, by placing undue pressure on the women to commit to motherhood, before they themselves felt ready. This behaviour included active bullying tactics by some of the men. Some participants openly acknowledged they did not take control of their own contraceptive use. Unintended pregnancies encompass two categories of pregnancy intentions: mistimed pregnancies that would be planned and wanted at a later date and unwanted pregnancies that were not wanted then or at any time (Butler, 2003). For seven women in the study, their pregnancies were not planned but once the pregnancy was confirmed, it appears the baby was wanted. None of the women sought, or considered a termination of pregnancy. However, this cannot be assumed as implicit, as a limitation of the study is that such confirmation was not sought or clarified. Sadly, for both the women whose pregnancies were planned, the pregnancy did not offer them a respite from their partners' violent outbursts and controlling conduct. The men did not alter their behaviour towards the women during pregnancy and the women did not feel cherished by the men during their pregnancy. However, it is worthy of note that of the three women who planned their pregnancy, two were not subjected to physical violence by their partner; the first physical attack for both women was early in the postnatal period. In the main, whether the pregnancy was planned or unplanned did not appear to make any difference to the chances of violence during pregnancy.

The findings from this study are supported by Campbell *et al.* (1995), who used focus groups of women in the United States (US), to explore abusive behaviour during pregnancy. Some participants in the study discussed male control over their contraceptive use and their forceful behaviour of eventually coercing them into an unplanned pregnancy. Goodwin *et al.* (2000) suggest another potential mechanism between abuse and unintended pregnancy is due to male dominance and fear, both of which could impact on a woman's ability to control her fertility, thus leading to unintended pregnancies. This was true for some participants in this research.

Jane admits she was very naïve about sexual behaviour and contraception. In fact, following her marriage, she only discovered she was pregnant when a friend advised her to attend a family planning clinic for contraception. Upon attending the clinic, she discovered she was already four months pregnant. Jane's husband had not discussed any future plans for a family as he was 20 years older than Jane, with neither of them taking responsibility for contraception:

*No, the pregnancy was not planned because I was so naïve when I married my husband and so I didn't know anything about becoming pregnant. I had not even thought about becoming pregnant, but although shocked, he also seemed pleased, he bought me vitamins. (Jane: interview 1)*

However, Jane did not receive the same response from her partner when she was pregnant again nine years later, with another unplanned pregnancy. Jane talked about how angry he was about the pregnancy and blamed her for becoming pregnant. He refused to acknowledge the pregnancy, telling her not to expect any special treatment, that she was making it up to avoid doing the household chores. Despite the pregnancy, his violent behaviour towards Jane continued. For Jane being pregnant with twins did not provide any protection from his continued abusive behaviour:

*He was so angry, Oh he said oh not again he said and then um it was very difficult to cope with because he was angry really, really angry and he shouted at me a lot, and I was crying and I was so scared that I would lose the babies. I was so frightened to tell him it was twins. He would just say to me oh you cry, and we'll see what happens to you because he said that I was crying for nothing that and I am just pretending because I am not really pregnant I am only using it as an excuse to avoid the work, yes that is what he used to say to me. He just carried on with his life; he did not care about me or the babies. (Jane: interview 1)*

His lack of interest in the pregnancy continued once the twin girls were born. Jane experienced a premature labour at 32 weeks gestation, but even then, Jane's husband refused to acknowledge the birth of the twin girls. He refused to visit them whilst they were in the Special Care Baby Unit. This indifference continued once the twins were discharged home, where he refused to provide any care for them, or show any interest in their wellbeing:

*When the babies were in SCBU for nearly two months he wouldn't drive me down there. He used to make me take the bus, even though he did not work, he did not want to visit them or offer to drive me to SCBU. When they came home and they cried, he would say to me 'you wanted them, you care for them.'  
(Jane: interview 1)*

Tracey's pregnancy was not planned and she blamed herself for becoming pregnant, when she and her partner had such a violent and volatile relationship. She was also very anxious about telling him about the pregnancy, as she was unsure how he would react, as he already had three children from a previous relationship:

*I didn't know whether I was happy or whether I was really angry at myself for getting pregnant and bringing a kid into that situation. (Tracey: interview 1)*

Several of the women voiced similar feelings. They appeared to blame themselves for not only the pregnancy, but also for being pregnant and remaining in the abusive relationship. They construed themselves as being weak for 'allowing' themselves to become pregnant. However, none of the women I interviewed could be considered weak; neither did they 'allow' the violence to happen. Indeed, they were all resilient and demonstrated great courage and strength, to have survived the extreme violence and trauma they all faced, which for some of the participants was on a daily basis.

Nicola's partner was very happy when she told him about her pregnancy. However, Nicola herself admits to having mixed feelings about the pregnancy, as she believed she had been pressurised into motherhood, prematurely. Nicola believed he used the pregnancy as a form of coercive control. The pregnancy provided him with the excuse he was looking for, to convince her to move out of her family home and move in with him. Nicola's use of contraception was sporadic and indiscriminate, as her abusive and controlling partner would become very irate if he thought she was trying to avoid conception:

*Well he um like forced me to get pregnant because he didn't only want 2 children he wanted like a football team he wanted like 12 kids; he wanted loads of children. He knew once I was pregnant, he could convince me to move out of my parent's house and move in with his family. I tried to use contraception but it was haphazard, as it always resulted in a big fight. But I was only 18 and did not really want a baby. Although when I was pregnant, it was OK, I just dealt with it. (Nicola: interview 1)*

Kirsty's situation was another example of male control of female contraceptive use. During her relationship with her partner, Kirsty experienced a nervous breakdown, leading to a short admission to hospital and long term medication. Upon her discharge, her partner decided to take control of all of her medication not only for her depression but also her contraceptive pill:

*Well, I had a nervous breakdown and I was in hospital for quite a while and when I came home from hospital and I was still a mess, so he was kind of in control of my medication and things like that. I had to ask him for my medication and because I was very depressed I could not always remember things. Later on in the day I thought to myself I don't remember taking the pill and I said to him oh did I take the pill today, yeah, yeah, yeah you took it, you took it, when he knew I hadn't and that went on for*

*a couple of weeks him saying that I had took it and I hadn't and he knew I hadn't taken it and that's basically how I ended up pregnant. (Kirsty: interview 2)*

Kirsty's partner appeared to be acting in a contradictory fashion. In spite of withholding her contraceptive pills, which would seem to suggest he wanted her to conceive, however, once she was pregnant, he refused to acknowledge the pregnancy. An explanation for such behaviour is given by Jasinski (2004) who suggested that a pregnancy may appear threatening to the partner. This results in an increase of his anger thus fuelling the violence. Valladares *et al.* (2002) reported a strong link between women who experienced violence during their pregnancy and an unwanted pregnancy, with two of the most frequently cited reasons for an unwanted pregnancy being involvement in a violent relationship or financial hardship.

The literature exploring the relationship between violence and contraceptive use, implies that a woman's lack of choice and control regarding her contraception is linked with her overall vulnerability and fear of her partner (Pallitto and O'Campo, 2005). However, there is a lack of evidence explaining how domestic abuse and violence are related to contraceptive use and non-intended pregnancy. This supposition will be considered in more depth in the discussion chapter.

## **9.2. Men's response to their partner's pregnancy**

There was a mixed response from the men when the women revealed they were pregnant. The majority of participants reported that their partners were initially pleased, when they were confronted with the news of an impending pregnancy. However, the pregnancy seemed to be the channel the men were seeking to help them intensify the control they already had over the women:

*I can remember he was obsessed with having a family um he couldn't wait to be a dad that was all he talked about and the day I turned 20... yeah just after my 20<sup>th</sup> birthday and he was really pushy about it he just went on and on and on, um you know he just really wanted to be a dad some of his friends were quite young when they became a dad and he just thought it would be brilliant. I was never that sure because up until that point I had never ever considered having children it was something I just never thought about. I remember some young girls when they were at school were oh I want a baby... it really didn't interest me I had no... you know I never felt that way at all I had never given it any thought and so it sort of threw me. He just kept on and on, talking about it all the time, he kept saying, oh we can have a baby it will be great you know. (Julia: interview 1)*

Some of the women in the study spoke about the mixed emotions they personally experienced, during their pregnancy. Some felt these feelings could be attributed to living in a violent relationship. They wanted to enjoy the prospect of motherhood, but the violent situation they found themselves living in seemed to prevent them from looking forward to the impending birth and parenthood:

*Um... when I was pregnant, it was harder to actually distinguish the feelings that I had, between you know the happiness of feeling those first movements and everything else to the fear and um frustration of the situation I was in. Um but you know now I am out of that situation obviously, I can look back and say yeah that was that and that was that, that was totally separate but at the time when you are there in that situation it's hard to um understand your feelings yourself, let alone explain it to anybody else and most of the time I wasn't angry with him, I was angry with myself, I don't know why. (Tracey: interview 1)*

Regardless of the male partners' show of enthusiasm when they initially learned about the pregnancy, many men showed no paternal interest or involvement as the pregnancy progressed:

*However, once I was pregnant, he wasn't very nice you know for someone that had gone on and on and on about wanting to be a dad when it actually happened and I actually fell pregnant he actually treated me no different he was not interested in antenatal appointments, he didn't want to read any books, he didn't want to go baby shopping he just had no interest in the pregnancy, the only thing he worried about was my weight gain. (Julia: interview1)*

*Yeah he was happy at first, but then sometimes he wasn't, he told me to get an abortion, so I did not know where I stood. (Lisa: interview 1)*

Tracey professed to being surprised by her partner's positive reaction to the news of the unplanned pregnancy: his delight was unexpected. At the same time, she recounted how she believed he shrewdly used the news of her pregnancy as another means to control her decision-making. Tracey was unsure whether to continue with the pregnancy; however, she felt constrained once her partner told everyone, including her parents, that she was pregnant:

*He could not wait to tell everyone about it, he rushed to tell my parents. Even if I wanted to have an abortion I could not, not when he had told everyone. Although, to be honest, I probably would never have had an abortion as I wanted to be a mum. (Tracey interview 1)*

Even when the pregnancy was planned, some of the women described how the initial euphoria seemed to diminish quickly. Within the context of Susan's story, who had experienced psychological and emotional abuse from her partner, there had never been any physical violence until she was pregnant. Susan's pregnancy was planned even though she had misgivings about becoming pregnant. Her partner's girlfriend in a previous relationship had experienced a stillbirth and he constantly talked about his grief for the lost baby, using the grief to explain his erratic and cruel behaviour towards Susan. Susan had assumed by giving him what he wanted his cruel behaviour towards

her would stop. She genuinely believed he would become more thoughtful, considerate and loving once he felt more secure within their relationship. However, this did not happen. In actual fact, once Susan was pregnant, his abusive behaviour towards her intensified in terms of isolation, controlling and for the first time, physical violence was introduced into the relationship:

*Even though I was not quite ready, I thought if we had a baby that would sort his life out, hoping that he would start to think about the way he behaved, I hoped he would become more caring and considerate, if I was pregnant, that would make a man of him. Initially, he seemed really overjoyed about it, although he didn't support me with the fact that I wanted to give up smoking though. He was a nightmare all through my pregnancy he was so paranoid, he said things like the baby is not mine, you were seeing someone else, and how do I know it's not their baby. He said he wanted the baby but he didn't change, he was still smoking the weed, still having all his friends round and I wasn't allowed to talk to his friends and they weren't allowed to talk or even to look at me. (Susan: interview 1)*

It seems that such behavioural traits and actions were a common theme running through the men's conduct. Sarah's partner frequently changed his mind about whether he wanted her to continue with her pregnancy:

*No the pregnancy was not planned, Um I fell pregnant with S..... and his first reaction, was great I am going to tell everyone and it was really great and then about 2 days later the novelty wore off, he started telling me he wished I would miscarry or go and have an abortion. (Sarah: interview 1)*

Kirsty's partner responded to the news of her pregnancy with anger and violence:



*Yeah, he accused me of sleeping with other people, kept telling me to get rid of it... he just was cold, yeah, told me to get rid of the baby, he didn't want nothing to do with her... or it as he called her at the time. Um He actually whacked me one, when I told him about the pregnancy, he is just a nasty piece of work.*  
(Kirsty: interview 2)

According to some of the women, their partners' behaviours were not motivated by their burning desire to have children. Rather, they were associated much more with increased domination and control, whilst attempting to bind the women deeper to what was an abusive and violent relationship. This would seem to suggest the men perceived the pregnancy as a means of increasing the women's vulnerability and reliance on them. Campbell *et al.* (1993) suspected that even when a pregnancy was planned, it still had the possibility to cause jealousy within the relationship, and that it was possible for a man to feel jealous of an unborn fetus. The man's perception that the fetus may come between him and his partner whilst obstructing her ability to care for him can be a catalyst for violence. This was exactly the situation for Jane, whose partner expected her to be a dutiful and devoted wife, considering his every want and need. He often demonstrated his anger, when she was attending to the baby:

*Yeah, he doesn't like it when I came home with the baby; he said that I had no more time for him.* (Jane: interview 1)

## **Summary**

When women are living in a relationship where violence and abuse is present, there is evidence to suggest they have very limited control over their sexual relationship and their fertility. Therefore they could become unintentionally pregnant more often than women living in non violent relationships (Gazmararian *et al.* 1995, 2000; Campbell *et al.* 2000; Pallitto and O'Campo, 2004).

## Chapter Ten

### Findings: Immediate Postnatal Circumstances

#### Introduction

The previous chapters have illustrated the types of abuse the women experienced during their pregnancy. However, for some of the women in the study, the abuse they experienced intensified during the postnatal period. This included physical, sexual, emotional and psychological abuse. For two of the participants the first incidence of physical violence did not occur until after their babies were born. For both the women in question, there were other types of abusive behaviour already present within the relationship which included verbal, emotional and controlling actions.

#### 10.1. Violence and abuse in the postnatal period

Wendy's partner was regularly verbally abusive to her before and during her pregnancy, although he had never physically abused her. Wendy described being very shocked when her husband hit her for the first time, when their baby son was only a few weeks old. Not only did he physically strike her, he also attempted to strangle her whilst she was holding their baby son. Wendy was shocked, physically and emotionally hurt by the violent incident:

*Yeah so basically the physical abuse happened to me when N... was a baby; he was only a few weeks old. This was the first time he hit me, he tried to strangle me, he got so angry with me and then he put his hand around my throat. I had N... at that time in my hands and he was shouting at me it was quite a shock. (Wendy: interview 1)*

Wendy decided to discuss the violent incident with her mother in law, whose response to Wendy's disclosure was to confess that she herself had experienced domestic violence from her son's father. However, instead of being appalled by her son's

behaviour, she tried to excuse her son's behaviour, blaming it on learned behaviour, as he had grown up witnessing his father being abusive towards her.

This cycle of violence theory is depicted as 'Intergenerational Transmission of Violence' (Hague and Malos, 2005). Such a theory provides an explanation for the transmission of violence by means of learned behaviour which is passed down through generations. Whilst there is some evidence that violence can be a learned behaviour, Hague and Malos (2005) questioned the validity of such a theory. They believed it did not explain why some people who grew up in violent homes elected not to conduct themselves in the same manner when they themselves become an adult. Such an hypothesis as the Intergenerational Transmission Model would seem to suggest that all boys who witness their fathers being violent to their mothers, will become perpetrators of violence and young girls who witness their mothers being abused, will go on to choose violent partners. Yet there is no evidence to support such an assumption. Indeed, research has shown that 80 per cent of abused children do not become abusers themselves (Frude, 1997).

Shocked, following a physical assault by her husband, Wendy decided to e-mail Women's Aid for advice. However, she decided not to seek any further help at that particular time from the women's agencies, choosing instead to believe her husband's apologies and promises to change his behaviour. This is not an uncommon response, as most women admit to feeling shocked by the first physical assault by their partner and want to believe that the assault is a one off event:

*He was so sorry afterwards, so I thought you know it's just like a one off perhaps he just has a temper so I'll just leave it there, as I wanted things to work because of the baby. (Wendy: interview 1)*

Sadly, however, this was not to be the case, Wendy's husband continued to physically abuse her until she eventually left the relationship.

Available literature clearly demonstrated that once a male partner physically abuses his partner, it will become a normalised pattern of behaviour which will intensify in frequency and potency. Centering her research with women Walker (1979, 1984) characterised the process of repeated tension build up, violent attacks and remorse as a cycle of violence. Her research established that the repeated cycle of violence that that women experience leads to severe psychological symptoms such as sleep disturbances, eating problems, fatigue and depression. Walker (*op cit*) also established that women who frequently encountered the cycle of violence also experienced a pattern of psychological consequences, which developed as the repeated violence in the relationship became more serious and uncontrollable. Walker alludes to a syndrome called 'Battered Woman Syndrome' which she believes, describes the learned behaviour which affects women who frequently experience the cycle of violence such as learned helplessness, low self esteem, social withdrawal, anxiety and re-experiencing the anxiety. Several of the women in the study expressed how the violent behaviour became more frequent and more severe during their relationships with the cycle of violence becoming more frequent with the honeymoon periods become shorter. This pattern of conduct confirms Walker's (*op cit*) suggestions where the repentant and remorseful period by the perpetrator becomes shorter and shorter, until it does not exist.

As previously discussed, Julia's first experience of physical violence also occurred following the birth of her baby daughter. Like Wendy, she had also endured other types of abuse during pregnancy, including verbal, controlling and emotional abuse. The first physical incident a few weeks into the postnatal period followed an argument, over the non payment of a household bill:

*We got into a disagreement over some bills that hadn't been paid, they should have been paid but obviously we had the baby and everything was up in the air and they were now late and we got into this silly argument over it and I was saying oh it doesn't matter we just pay them late but I can remember he was sat at the table and we were just arguing and then out of nowhere he just hit me um and that was it that was the first time he ever hit me and after that that became the norm and that was it. (Julia: interview 1)*

After this first episode of physical violence, for Julia, the physical abuse became a weekly occurrence, with each attack becoming more and more violent, supporting the findings from Walker's (1984) study:

*It was as if once he did it and nothing was really said about it, it became almost a weekly occurrence, every time we had an argument he would you know it first started off it was more shoving, pushing, dragging me around by my hair, things like that um. You know it was as the years went by he got more vicious then the kicking and punching started and yeah he used to spit in my face but he has done that for I don't know a good 12/13 years of our relationship. But that started around the same time as the pushing and the shoving the spitting just came with it that became like another part of abuse.(Julia: interview 1)*

Nicola, although experiencing other types of violence and abuse during her pregnancy did not experience any physical violence until the postnatal period. Nicola rationalised her partner's physical violence as jealousy towards their new baby daughter:

*Although he had been horrible to me, in terms of telling me what to do, who to see, the physical violence started like after B... was born, yes, after B... was born he started hitting me because he didn't get attention you know because all the attention went on the baby which you know it should do*

*because you have got to you know... a baby takes up a lot of work, you have got to change her nappy, feed her, get up in the night and he didn't like it because the attention went on B.... and not him, he was so jealous of a new baby. (Nicola: interview 1)*

Tracey also believed the birth of her baby exacerbated the physical violence in their relationship. Her partner not only physically abused her with his own body; he also used other means including a cigarette lighter and household cleaning products to abuse her:

*Well, after the baby was born his behaviour got worse, the violence was more worrying. One night after a long night of fighting, he got a lighter and he was trying to set fire to my dress. Um I got that off of him and he then went out to the kitchen got a bottle of bleach, opened it and poured it down the side of me and then tried to set fire to me again. (Tracey: interview 2)*

The risk of moderate to severe violence appears to be greatest in the postnatal period (Campbell, 1992; Gielen *et al.* 1994). The explanation offered for this increase in violence is associated with increased tensions that a new born baby can bring to an already volatile relationship. The lack of sleep, decreased sexual activity and financial and emotional difficulties can all add to the stress of becoming parents.

Some of the male partners physically assaulted the women when they were holding their babies in their arms. For the women, being physically abused whilst holding their baby was very frightening. They not only had to try and protect themselves but also their baby:

*After I had A..... he hit me when I had her in my arms and I won't ever forget it because I have been abused so much you*

*get used to it you know and you just kind of put a block on it you kind of try and shut yourself down, let him do what he got to do, get it over and done with and deal with it after. But I will never forget the time when he hit me numerous times when I had A..... in my arms; I was so scared for her. (Kirsty: interview 3)*

Nicola's partner had a fixation with knives and kept several regimental knives in the house: he would often use them to threaten and intimidate Nicola. However, these idle threats turned into reality after the birth of their first baby. Following an argument he threw a knife at Nicola whilst she was feeding the baby. The police removed some of his knives from the family home, but did not arrest or charge him with assault.

*He loved knives and he collected all these different knives, but I was really scared that the knives were in the house. I was scared, what if he ever used a knife on me. I was just terrified all the time and then when B... was born we had an argument and he just went mad and was shouting at me, really scaring me. And then he actually chucked the knife through the sofa and it nearly went through both of us. I was really scared because you know he chucked that knife and it nearly went through his own daughter and I was really petrified. I ran actually out of the house to my neighbours and I rang the police and I got his all his knives taken off of him. (Nicola: interview 1)*

The findings in this chapter have highlighted that for some of the women in the study the physical aspect of the violence exacerbated in the postnatal period. For three of the participants, the first incidence of physical violence did not occur until after their baby was born, indicating that the postpartum period can be considered as a contributing factor to an escalation and proliferation of violent conduct by the partner.

## 10.2. Caring for a new baby in the postnatal period

All the women interviewed, believed that living with violence had considerable consequences on how they adjusted to motherhood. The majority believed that living with violence and abuse increased their risk of developing postnatal depression. Their self-esteem was eroded by their partners repeatedly criticising their mothering skills. The women were constantly told that they were useless as a mother and were not able to care for their new baby, until they believed it be true.

Although the men were disparaging of the women's mothering skills, the majority of the men showed no genuine interest in physically caring for or bonding with their new baby, leaving the women to provide the majority, if not all, of the care. There appeared to be a paternal ambivalence to the welfare of the new baby. Interestingly, this was also true for the men who had forced the women into early motherhood, by persuading them that they desperately wanted to be a father. Due to the reluctance of the male partner to take an active role in parenting or participating in the physical aspects of providing care, the women in this study found caring for a newborn baby demanding. Indeed, some of the men demonstrated jealous and resentful behaviour towards both the women and the baby. The women also believed the men struggled to understand that it was now impossible for them to dedicate the same amount of time and attention to caring for their partners as they had done before the birth of the baby. This seemed to add to the men's jealousy and antagonism towards the baby. In general the women's narratives appeared to highlight that there was very little opportunity for family bonding. It seemed, for some of the men, there was a reluctance to accept that the women's bodies required a period of recovery from their birth experiences:

*He wouldn't do anything for H..... I had to do everything night and day he wouldn't let me rest. Of course I wouldn't have sex with him as I was bleeding in the postnatal period, this was not helped that every time he wanted me I was always doing*



*something like feeding H.... or changing her or just trying to be with her, he was so jealous of his own baby. (Sarah: interview 1)*

Lisa was another of the participants who had hopeful aspirations that her partner would be more caring to her once she gave birth. This was due to the fact that her partner insisted that she leave the postnatal ward earlier than she had planned so she could come home where he would look after her and the baby. However, on her first day home, her illusion of a loving caring partner and father was quickly crushed. The violence included her newborn son who was also hurt during a violent attack:

*Well I thought he would be more caring towards me and baby..... , especially as he told me to come home early, but I knew it was only because he didn't want to stay on his own, so I left the ward early to come back home. However, there was an argument and he started screaming round the house and baby ..... well the baby's head got banged on the door frame. The next morning he started again, he hit me; he hit me for like an hour. He did not care if I was holding the baby he would just continue to shout, scream and hit out at me. (Lisa: interview 1)*

For some of the women a crying baby would cause feelings of anxiety as they knew their partner would become agitated by the baby's crying:

*Sometimes, he would get mad when the baby cried, especially when he needed something and then obviously I am busy with the baby, he would get mad and shout why do you have to go to the child first, but you have go to attend to the child but he doesn't like it. (Jane: interview 2)*

Kirsty's partner would also become uptight and angry if he felt the baby was crying too much. To avoid upsetting him, she would watch over the baby when she was sleeping, ready to pick her up straight away after waking, to avoid her crying:

*...I used to sit in her bedroom a lot of the time and like I'd be going, if she started crying, and I'd be going shush please don't cry and like um... and stuff like that and he'd come running in what have you done, just shut her up for god's sake. (Kirsty: interview 2).*

As well as providing care for the baby without any help, or family assistance, the women were also expected to continue to fulfil their household tasks and chores without any help. The birth of a baby did not affect the men's attitudes in terms of accepting or allowing the women's family back into the home. The women and their newborn infants remained isolated from their families, at a time when the woman would have benefitted from family support.

Following the birth of Julia's baby, there was a clear change and distinction in traditional roles within their partnership. Her partner had always been demanding but she felt there was an escalation in his demanding behaviour, especially in terms of his desire that she looked after his needs:

*After the baby was born he just got worse, um there was more of him telling me what to do and how to do it, when he wanted his dinner ready, it always had to be ready at a certain time. And then he started waking me up on a morning to do his suit and his shirts he had never done that before um and you know it was if he decided that right well I work now and you don't and so this now your role and this is mine but without any consultation, as if he just made his mind up that's how it was going to be. He forgot that I had a crying baby to look after. He just seemed to get more violent and controlling after the baby L... was born. (Julia: interview 2)*

### 10.3. Infant feeding choices and its relationship to domestic violence

It is considered that breastfeeding is a major aspect of the postpartum experience (Kendall - Tackett, 2007) and currently within the UK, there is an active campaign to promote breastfeeding for all newborn infants in light of the health and nutritional benefits to baby and health benefits to the mother. However, although limited current literature seems to suggest that there is a strong relationship between a mother's abusive relationship and her choice around breastfeeding (Benedict *et al*, 1994; Prentice *et al*. 2002; Bair-Merritt *et al*. 2006).

In this study, only four of the eleven participants decided to breastfeed their newborn baby. However, three of the four mothers decided for a variety of reasons, to stop breastfeeding quite soon into the postnatal period. Interestingly, Kirsty, one of the youngest mothers in the study, decided to persevere with breastfeeding for six months even though she described the breastfeeding process as "very difficult" and "tiring". She was determined to prevent her abusive partner from formula feeding her baby, as she did not trust him to care for the baby because of his temper and drug habit:

*Yeah I always wanted to breastfeed do you know what I mean, don't get me wrong, I always wanted to breastfeed but part of that was I just didn't want him feeding my daughter. (Kirsty: interview 3)*

Jane also decided to breastfeed her new baby son. Jane was born and raised in the Philippines, where breastfeeding is viewed as natural. However, after a few months, she decided to change to formula feeding to appease her partner, who would get very angry with her when she was breastfeeding. Sometimes, his anger would result in physical violence. He would come into the room and kick her, if he considered the baby had been crying for too long. Due to his behaviour, Jane changed to formula feeding, believing that this would prevent her baby from crying too much, that he would also sleep for longer periods, therefore preventing her husband from losing his temper:

*Yeah, yeah he doesn't like it; he said that I had no more time for him. But obviously when a child is breast feeding he needs more attention and sometimes I had to bring him to the bed. But then he would get angry and start shouting at me and tell me to sleep on the floor in the other room, the baby was too much trouble. Then he would follow me into the room if J... was still crying and kick me and tell me to make him shut up. (Jane interview 1)*

When Jane later give birth to her twin girls ten weeks prematurely, she made the decision to only breastfeed them whilst they were in the special care baby unit. Once they were discharged home, she decided to give them formula milk to avoid a repeat of her previous experience.

There currently appears to be a lack of evidence exploring the link between domestic abuse in pregnancy and the impact on breastfeeding. In a recent review of ninety four studies, Bair-Merritt *et al.* (2006) examined the impact of childhood exposure to parental violence and explored whether women abused by their partners were less likely to breastfeed and concluded that there was insufficient evidence to draw a conclusion. There was no difference between abused and non-abused women, either in the initiation or duration of breastfeeding.

## **Summary**

This chapter has highlighted the extent and consequences of the continuation of domestic violence and abuse in the postnatal period. All the women interviewed believed that living with violence and abuse had a detrimental effect on their adjustment to motherhood. Criticism of the women's mothering skills by some of the partners eroded the women's self esteem. The following will explore the link between domestic violence and postnatal depression.

## Chapter: Eleven

### Findings: Domestic Violence and Postnatal Depression

#### Introduction

Adjusting to motherhood can be overwhelming for any new mother; however, when you also include the strain of living daily with violence, there is always the potential to increase the feelings of despondency and isolation. It was, therefore not surprising that a key theme to emerge from the data was that many of the women had experienced postnatal depression.

#### 11.1. Depression during the postnatal period

Postnatal depression is possibly an important association of domestic violence, and whilst some research studies have identified a clear correlation between domestic violence and depression, much less is known about its actual relationship with postnatal depression (Zlotnick *et al.* 2011). Only a small number of studies clearly demonstrate an association between, violence and its relationship with postnatal depression (Stewart, 1994; Campbell, 1998a; Cohen *et al.* 2002; Certain, *et al.* 2008).

In this study, seven of the participants discussed feelings of deep despondency and depression, following the birth of their baby. Five of the seven women were prescribed anti-depressant medication by their GP, with one of the women being hospitalised for treatment. During their consultations with various health professionals about their depression, none of the women was asked about their home circumstances, or whether they were living with domestic abuse. This could be attributed to health professionals assuming that the depression was probably linked with the birth of a new baby, the 'baby blues' or 'postnatal depression'. Believing this may prevent them from considering whether they should be probing further, into the home or relationship situation of the women. The role of the health professional in

acknowledging and supporting women who experience domestic violence during and after pregnancy, will be explored in more depth in the following chapter.

It is unclear how many of the participants may have already been experiencing depression, prior to giving birth, as this was not explored in the interviews. This could be considered as a limitation of the research, and it is now difficult to determine retrospectively. What is known is that the period following the birth is a particularly under-researched area in terms of domestic violence literature, yet this time is so crucial for the development of the newborn (Charles and Perreira, 2007). Martin *et al.* (2006a) suggests that we should not be surprised that women who suffer domestic abuse around the time of their pregnancy, will also experience depression during pregnancy and in the postnatal period.

Several women described how, after giving birth they were kept locked in the house, not allowed to see their families and were not able to access extra support to help them adjust to motherhood. They were also made to feel that they were a 'bad mother' or 'not coping' with the new baby, by their male partners:

*I couldn't see my family and my friends you know so I was like kept like a prisoner yeah ... I felt like a prisoner just having you know babies you know and I had... I think I had depression because I felt really low and felt like I couldn't cope. (Nicola: interview 1)*

From the interviews, it was clear some of the partners used the women's depression both as a means of punishment and as a weapon against them. The depression was used to reinforce feelings of inadequacy and in Susan's situation, her partner was able to berate Susan even though they were not living together, using the social networking site to inform everyone about her depression:

*He's put things on Face book and he's making out that he's the victim and I'm the asshole. Basically he's going around telling everyone that I've got postnatal depression, telling people that I was an unfit mother and I've lost the plot. (Susan: interview 1)*

Julia was diagnosed with severe postnatal depression following the birth of each of her three children. However, on reflection, she now appreciates that it was her situation that was responsible for her depression and not the pregnancies or adjustment to motherhood per se. It was only when Julia saw a female locum GP for the first time, following her third pregnancy that the GP asked her to consider whether it was in fact her current living and personal situation and not childbirth, that may have caused, or at least contributed towards, her depression. Following the birth of her first baby, Julia was admitted to hospital as an inpatient for treatment for her depression:

*He used to put me down and blame me for her behaviour because she never slept you know she was sick a lot, she just cried and cried and cried and I didn't really know what to do, the health visitor at the time wasn't very helpful she was always oh babies cry you have got to get used to it. Yeah he continued to say it was me, my fault, obviously I was a bad mother to which point by the time A..... was 10 months old I was doing a 10 week therapy course at ..... Hospital with the Mental Health Team I couldn't take it, I just couldn't take any more and listening to him continuously telling me it was me, I wasn't any good, I couldn't look after her that I couldn't look after her and I had a breakdown and I was sent to the mental health unit at .....Hospital. (Julia: interview 2)*

At the time of their depression, the majority of women in the study had not considered that the violence and abuse may have been a contributing factor to their deteriorating mental health. They assumed that their postnatal depression had been caused by the birth and their failure to adjust to motherhood:

*I didn't really see it being this... I didn't really see it as being part of the problem. Um I just knew that I was upset all of the time and I cried for no reason and it was like that so I didn't see it as being part of the problem. Which now looking back obviously I can, but nobody mentioned it, I just thought it was good old postnatal depression, but now um...(Tracey interview 2)*

Kirsty was the only participant who was actively taking anti-depressants prior to the birth of her first baby. However, Kirsty believed despite taking the prescribed medication her depression seemed to exacerbate, following the birth of her daughter:

*I think the depression started before my pregnancy to tell you the truth because I didn't feel right or happy, he always said I changed, like I was really bad for a little while. I think it had been bad... I had yeah... it had happened before I had her as I was already on tablets from the doctor, but then it just got worse when she was born. (Kirsty: interview 2)*

Nicola articulated that even though her partner forced her to engage in sexual intercourse prior to the birth of her baby, the sustained and continuing sexual abuse immediately following childbirth seemed more degrading and humiliating following the birth of her baby. Nicola clearly saw this as a contributing factor in developing postnatal depression:

*Because, you know I kept getting forced into sex, you know he didn't care if I bled, he didn't care if I cried through sex um you know it was like he didn't really care about me and the baby, I felt worthless, he did that kind of thing before I had the baby, but somehow after she was born, it seemed worse. I think I had postnatal depression, yeah, like I said before, I felt really low and felt like I couldn't cope. (Nicola: interview 1)*



## Summary

This chapter has presented the association between postnatal depression and domestic violence. In this small sample of women, seven of the eleven participants openly verbalised their experiences of postnatal depression. This would, therefore, seem to indicate that women who are experiencing violence and abuse in their relationships are potentially at an increased risk of developing postnatal depression (Taft, 2003). Many of the women in the study hoped, and assumed that the birth of the baby would improve relationships. They believed they would become a family; the partner would change his violent behaviour. Some of the male partners had pledged at the birth that they would change their behaviour, with some demonstrating emotion and love during the childbirth process. However, in reality they were unable to fulfil those promises. In fact, for some of the women the violence intensified following the birth. It could be suggested that when such promises remained unfulfilled, deeper feelings of despair ensued.

It has also been suggested that women's overall perceptions of their place in the world, including the consciousness as the 'other' (de Beauvoir, 1953) as well as the awareness of being considered a lower social being, can be the underlying cause influencing the rate of depression (Brown and Harris, 1978). I would also propose this awareness is heightened as a woman tries to embrace her new role as a mother. Indeed, some of the women stated that being pregnant and giving birth had strengthened the abuser power and control within the relationship.

The following chapter intends to focus on the partner's use of alcohol and drugs, highlighting the effect substance abuse had on the relationship before during and after pregnancy.

## Chapter Twelve

### Findings: The Effect of Partner's Substance Abuse

#### Introduction

The interview data suggests the use of illegal drugs and alcohol was not problematic for the women themselves. Only one of the women interviewed disclosed about their own personal use of illegal drugs or alcohol dependency prior to pregnancy. It was decided to include partners' use of drugs and alcohol as a theme in its own right, as so many of the participants discussed the men's excessive use of alcohol and drugs. The majority of the women believed that their partner's reliance on substances had a devastating effect on their relationship and often fuelled the violent attacks.

#### 12.1. Partners' use of drugs and alcohol and its association with violence

The violent behaviour of the majority of men became much more volatile when they were either drunk, high on illegal drugs, or could not find the means to source the drugs. Tamara's partner frequently used alcohol as an excuse for his abusive behaviour towards her:

*When he has been drunk he would hit me, he then tells me he doesn't know what he's done and he can't remember what he's done until I tell him but I don't think that's always the case because ok I have had the experience sometimes myself when I have gone out and drunk excessively and not known what I have done in the morning but then I don't think he can use that excuse every time. I used to think, OK, maybe he does not remember, you know, but then other times he does because he can remember things but he slips up and it is obvious he does know and he using being drunk as a excuse for hitting me.. So I don't know. I now realise he is just a cruel person, with or without the drink; he is just being himself, just being nasty. (Tamara: interview 1)*

The domestic violence literature acknowledges that the abuse of alcohol and drugs appears to be one of the most common risk factors for domestic violence within a relationship (Mc Farlane *et al.* 1995; Parker and Auerhahn, 1998; Muhajarine and D'Arcy, 1999; Phillips *et al.* 2007). Despite such findings, it is also important to acknowledge that one cannot assume a causal link between the violence perpetrated and the dependency on alcohol and drugs. The presence of alcohol or drugs does not necessarily mean that the substance abuse is the cause of the violence (Field *et al.* 2004). It is also true that not every man who drinks alcohol or takes drugs will be abusive towards their partner as a consequence. Yet alcohol and drug misuse is often cited as the cause of violent behaviour and as highlighted earlier can be the cause of financial hardship within a relationship. Alcohol abuse and drug abuse existed in ten of the relationships. The drug use included a variety of drugs, from cannabis to crack cocaine and heroin. Excess drug abuse was present in seven of the relationships, with some of the men abusing both alcohol and drugs.

Sarah would modify her behaviour in an attempt to try and placate her partner's needs to avoid confrontation, when she knew he had been taking drugs:

*Yeah I was scared of him, he managed to control me because of fear, I was always more frightened around him when he had taken cocaine, especially crack cocaine, he always seemed more ready to lose his temper over anything or nothing. You see, he used to do a lot of weight training and seeing him thump things and not feel the pain his knuckles would be bleeding and everything and he would just be smacking the walls and things like that and denting fire doors and things like that and it's like I knew that if he did hit me he could cause some serious damage. Um so I tried to appease him all the time, especially when I knew he had taken drugs. (Sarah: interview 1)*

The small number of women who had some access to funds were regularly forced to hand over their housekeeping money to their partner, so they could buy drugs

and alcohol. This resulted in the women having to go without basic essentials and necessities in their lives. The use of drugs and alcohol clearly added extra tensions to a relationship which was already volatile. Several of the women talked about having no money to buy food or to pay the household bills, with two of the women having to move home during their pregnancy, because of unpaid bills and rent arrears. The lack of financial support appeared to be due to their partner spending the household budget on drugs and alcohol. This was more noticeable in the relationships when the male partner did not work and was receiving Government benefits.

Substance abuse has been associated and identified as a means of women coping with living with violence and abuse (Golding, 1999; Humphreys *et al.* 2005, Barnett *et al.* 2005). Although this was not a common feature in the sample of women interviewed for this study, however, more than half of the participants discussed taking prescribed medication during the relationship, to help them cope with feelings of depression and anxiety. Personal consumption of alcohol was mentioned briefly by some of the participants, but overall, alcohol did not appear to be used as a means of coping with the violence in their lives.

There has been a considerable debate about the causal role of drugs and alcohol in domestic violence (Bacchus *et al.* 2007). It is believed that the use of alcohol and drugs may allow for feelings of anger to be expressed (Field *et al.* 2004). Whilst this may be true, it is also important to acknowledge that for some women in the study, although they reported that their partners were more physically and verbally abusive when they were intoxicated, these same men were also abusive when they were sober and not under the influence of drugs:

*When he was on crack he was more violent but then he was violent throughout the relationship, because like when he was smoking the cannabis if he couldn't get any that was my fault if*

*you see what I mean. So if no-one had anything for him to buy, that was my fault, and he'd take it out on me, or if someone had a reaction because he had been given bad gear, that would be my fault because... I don't know why but it was always my fault. Even if it was nice and he was mellow and he was chilling out and then I would say something to him, and then he would be cross, because it was my fault that he was now having a bad reaction because I was talking to him. (Kirsty: interview 2)*

## **Summary**

The findings from this current study suggest that frequent binge drinking and drug abuse increased the risk of domestic violence and abuse. The pregnancy was not viewed as a protective factor, with an increase in abusive behaviour when the male partners were either intoxicated or taking drugs. The women clearly believed that excessive consumption of alcohol and drug addiction was the catalyst for the violence they experienced, both before during and following their pregnancy. The next chapter will consider the women's experiences of using the health service, when they were experiencing domestic violence and abuse.

## Chapter Thirteen

### Findings: Women's Experience of Using the Health Service

#### Introduction

A sub aim of the study was always to explore women's perceptions of and their access to and the responsiveness of the health and social care professionals. Therefore a line of enquiry pursued during the interviews was the women's experiences of the responses from professionals, working in the health service. Participants identified examples of both indifferent and caring responses from some of the healthcare professionals they encountered.

#### 13.1. Health services' response to women's experiences of violence during pregnancy

Without question, the health services can perform a pivotal role in supporting women and children who are living with domestic violence and abuse. In some areas of the health service, support and care have improved significantly in the last decade, (Williamson, 2000a; Hague *et al.* 2003; Roberts *et al.* 2005; Department of Health, 2010a, 2010b). Within the context of the health service, failing to respond is no longer an option, consequently many front line healthcare professionals have had to acquire new knowledge and skills to respond effectively to disclosures around violence. All the women in the study came across a wide range of health professionals during the course of their violent relationships including midwives, accident and emergency staff, nurse practitioners, practice nurses, health visitors, general practitioners (GPs) and obstetricians. This chapter will present some of the women's personal encounters with health professionals, whilst also considering the responses of the professionals to their disclosures of abuse. The personal experiences and feelings around disclosure will also be considered. The women's narratives explain why some made the decision not to disclose the abuse.

### **13.2. Being asked about domestic violence and abuse**

Of the eleven women interviewed, six of the women disclosed the abuse to a healthcare professional. Disclosure to a health professional occurred at various junctures in the women's journeys. Some of the instances of disclosure to various healthcare professionals included two women disclosing about the abuse to their GP, another participant divulging details to her health visitor following the birth of her second child, whilst another informed her named nurse practitioner about the abuse. Two of the women disclosed about the abuse to their named midwives, whilst another participant openly disclosed about her situation to a doctor in the Accident and Emergency Unit. Sadly, not all of the women who disclosed details of violence to a professional received a favourable response; such findings will be explored in more depth presently. The women's narratives seem to suggest that some of them did not receive the essential advice and support they sought. Furthermore, several participants had been involved with several different healthcare professionals for long term ongoing mental health concerns, yet none of them had been asked about abuse in their personal lives. The following section will consider the generic response of some of the healthcare professionals the women encountered.

### **13.3. Disclosure of abuse to a health professional**

All the women in the study had regularly visited their GP before, during and after pregnancy. Interviews revealed that for all but two of the women, the GP failed to directly enquire about the presence of partner violence in the relationship, despite several of the women being seen regularly for depression and being prescribed anti-depressant medication. However, this lack of assessment, prior to prescribing medication could be attributed to lack of education about how to approach a woman whom a GP suspects is being abused. Of the two disclosures, one told of safe and supportive practice, whilst the other demonstrated dangerous practice with no follow up care provided. A further explanation of such practice will be explored at a later point in the chapter. Some midwifery staff offered the rudiments of supportive and

women-centred care, but there was also a disinclination to fully embrace routine enquiry into domestic violence, in the antenatal period. Wendy had suffered many types of abuse since her arrival to the UK with her British partner. Initially his abusive actions started out as controlling actions and verbal abuse. However, following the birth of their first child, her partner's abusive behaviour extended to include physical abuse. His abusive behaviour increased in frequency and severity until one physical attack resulted in a broken and dislocated hand. Wendy attended the local Accident and Emergency Unit. Whilst waiting to be seen, she made the decision to disclose about the violence with the purpose of leaving the relationship:

*In the end when the doctor called me in and I had just went by myself and I told him the truth and then the doctor said we can help you to call the police, and I said yeah I have already rang the police but I didn't make a full statement because I didn't get time to do that and I said to the doctor I will call the police again when I get back home. So um yeah and then we came back home quite late because I had to get an x-ray and see another doctor so it was long hours in the hospital and they want me to see a consultant. Um so and when I got back home it was 11 o'clock in the night and I was so tired, for me it was such a long day. I just cried all night long... (Wendy: interview 2)*

Wendy did in fact leave the relationship following this particular incident and believes this was helped by her partner being arrested and charged by the police for the assault.

Julia found the courage to disclose abuse to her new locum female GP who provided her with support, whilst she made the decision to leave the relationship. This disclosure followed her GP questioning her about her postnatal depression and the use of antidepressants following the birth of her third baby. Julia had not always received such a supportive response from healthcare professionals. Several years previously,



she openly disclosed to her health visitor that she was living with a violent partner; however, this disclosure received a hostile response:

*She said if I came in and told her again she would put the children on the at risk register, she was really matter of fact, yes, that was exactly what she said she said if you come in again because of an abuse incident I will have to put the children on the at risk register. (Julia: interview 2)*

Julia admits to being shocked by this response when she had finally found the courage and strength to reveal the truth of her situation. By disclosing details to her health visitor, she believed that she was divulging these facts to a trusted professional, who would offer her support and guidance. Receiving such a retort may explain why Julia chose not to talk again about the violence and abuse until many years later. Health visitors, like midwives, are in an ideal position to identify and offer support to a woman who is experiencing abuse. This attitude highlighted in Julia's testimony, reflects testimonies of other women who have highlighted their unfavourable interactions with health professionals and statutory bodies (Mc Williams and Mc Kiernan, 1993; Williamson, 2000a; Hague and Malos, 2005). Without doubt, the uncaring manner and attitudes of staff are massive barriers to women disclosing domestic violence. Healthcare professionals need to address their own feelings before they can actively listen, offer advice and support to women in a constructive manner. This is to lessen the continuation of the social discourse of domestic violence, which blames women for the abuse they experience (Williamson, 2000a).

Julia had also been admitted to a psychiatric unit for postnatal depression six months after the birth of her first baby. At no point during her stay in the unit nor during the follow up appointments, did any of the team directly ask her whether she was experiencing violence in her relationship. Regardless of the evidence which clearly demonstrates the clear correlation between domestic abuse and a woman's

psychological and emotional wellbeing, it seemed they were happy to assume it was due to postnatal depression:

*They assumed it was postnatal depression, the only questions they asked about anything that had happened previous to having A..... and my childhood. Yeah, so somebody did come in and we went all through my childhood, what my childhood was like um and all that type of thing. But that was it, no one actually asked me how my life was now, what was my life like at home now, they never asked about my relationship with my husband... (Julia: interview 2)*

During a consultation for unexplained chest pain, Jane made the decision to discuss the abuse with her GP when her GP told her the chest pain could be due to stress.

*I think she asked me about things at home and I managed to tell her something about it but we did not go much in deeper she just said if you want to get in touch with domestic violence head office something like and then she gave me a small leaflet. She then also sent me leaflets into the house. I didn't say anything to my husband, I just told him everyone got them sent through the post. (Jane: interview 2)*

Such unsafe practice could have endangered Jane's life, as in many controlling relationships, the male partner will open all the mail which is sent to the home. Jane's husband took the leaflets and threw them into the bin, warning her not to tell anyone about their business. Such actions by health professionals are not only disconcerting but extremely dangerous, as available evidence from crime surveys has clearly established that women are often murdered when their husband/partner suspects they may be planning to leave the relationship (Coleman *et al.* 2007, Women's Aid 2006). Alarmingly, the GP then neglected to follow Jane up or refer to the violence again at any follow up appointments. English was not Jane's first language, yet no

attempt was made to fully explain the various services or options available to her. She truly believed her GP could not help her and never raised the issue again.

Susan's full disclosure of the extent of her partner's abuse occurred by chance and was not instigated by her. Nevertheless, it was intervention by a health professional which led to her escape from her partner. A nurse in SCBU had overheard how her partner spoke to her during a visit. Her partner blamed Susan and her daughter from a previous relationship for the re-admission of their baby to baby unit. Her partner threatened to cut the throat of her thirteen – year old daughter:

*Well he just lost the plot because my daughter had impetigo, he then blamed my daughter and me for baby M.... condition. He turned round and said what is stopping me from going and slashing her fucking throat and the rest of the fucking idiots you hang around with. (Susan: interview 1)*

The special care nurse was so concerned by Susan's partner's abusive manner, that she immediately involved Social Services and the police. With their support, Susan managed to leave the abusive relationship, and for her own safety she was moved into a refuge. However, this meant leaving behind her home, family and friends. At the time of our interview she was living in a women's refuge with both her daughters. Baby M was only 6 weeks old and Susan admitted she was feeling very isolated and struggling to cope with a new baby without the help of family and friends. However, she knew for the well being of both her children and herself, she had to make a new life for her and the children, away from her abusive partner.

Kirsty had visited the Accident and Emergency Unit several times due to the injuries she had sustained during violent attacks. However, she admits she was too frightened

of her partner to be completely honest with the staff about how she had sustained the injuries:

*I often had to go up to A&E, but I would come up with the excuses, you know, I fell down the stairs you know the excuses we use..... They never really quizzed me about them and I was too scared to be completely honest. Plus he was always there, what could I say? (Kirsty: interview 2)*

It appears that the staff decided not to scrutinise the true origins of Kirsty's injuries. The reasons and explanations for such practice will be explored in more depth in the discussion chapter. It has to be acknowledged that in many instances the partners/husband were present when the women met with their health professional, including the midwife. Such behaviour demonstrates not only the men's control over their partner's movements, but also the power they possessed, by reducing the woman's ability and opportunity to disclose the abuse. As a result, any information the women were able to share with any health professional was limited. However, this chapter demonstrates the professionals' lack of knowledge and awareness associated with controlling behaviour of perpetrators of violence and abuse. The next section will consider disclosure of the abuse to the midwife.

#### **13.4. Disclosure of abuse to the midwife**

Of the 11 women in the study, only five of the women in the study admitted to feeling comfortable with discussing violence with their community or hospital midwife. The women received a range of responses from midwives. Wendy was not routinely asked by a midwife about domestic violence during her pregnancy. In spite of not being asked, the presence of a domestic violence poster in the toilet, at the clinic, prompted her to reconsider her current position in the relationship and raised her awareness of support agencies. Wendy conceded that had the midwife found an opportunity to ask her about domestic abuse, she might have been tempted to disclose about the

violence. However, Wendy's opportunity to disclose was also hindered by the presence of her partner at her appointments. Nevertheless, the importance of having posters and leaflets visible and available at all consultations is reinforced:

*No, no the midwife didn't ask me but at that time, when I was pregnant with S.... However, I found it really hard to talk to her, because personally we didn't have much time together on our own, if any. At the time he was saying to me that I was going to lose him that he will leave me he would not be around when S... was born and I was so worried at that time. I remember one day in the clinic, when I went for my scan, I looked on the wall in the toilet, and I looked at the poster about domestic abuse and this got me thinking at the time. I was thinking should I tell the midwife or not. If the midwife had asked me, I think I might have told her, yeah, I might have.... (Wendy: interview 1)*

Following Julia's admission to the hospital with premature labour at 26 weeks gestation after a violent attack, Julia disclosed about the violence to the midwives caring for her:

*I had been going to work for about 3 years without telling anyone about the violence. That was the first time I ever told anyone and I told the midwives at the hospital. (Julia: interview 1)*

According to Julia, the midwifery staff were very supportive and understanding offering to contact Women's Aid, and the police. However, Julia decided to go home without any agency help. Julia's partner begged for forgiveness and she believed him, when he promised he would never harm her again, which of course was not the case.

Louise decided to be completely honest about her relationship with the midwife. However, she was only able to do this as her partner was not present during her first consultation with her midwife:

*Yeah I was really honest about everything because I told them he was like an intravenous drug user, he has got Hep B, um I told her that I smoke weed, told her that I smoke cigarettes, um I think she could see like the state I was in, it wasn't... I suppose it couldn't have been that long after I had had a nervous breakdown anyway. Um and then I called the police a couple of times because I was so scared of what he was going to do, so yeah when I was pregnant, I was honest with them, I told the midwife everything, so then I had to have a social worker, but that was OK. (Louise: interview 1)*

During Louise's stay on the postnatal ward, the midwifery staff were also aware of her violent partner. Louise felt the midwives were very supportive, preventing her partner from entering the maternity unit and offering various contacts with support groups:

*Yeah, yeah, we had had some conversations about it various support groups. They were nice, like they were helpful, like I really liked all the midwives at..... (Louise: interview 1)*

Tracey experienced physical violence for the first time during her pregnancy, and visited the midwife with a black eye, the morning following a drunken physical attack. Tracey had decided to be honest with the midwife when she asked how she had sustained the injury. Once again, she was able to be open because her partner had not accompanied her to the appointment:

*I was either 6 or 7 months pregnant. I can't remember how it happened, but all I know was the next day I woke up with a black eye um he was snoring his head off, sleeping off a drunken night. So I went off to my midwife appointment on my*

*own and obviously that's the first thing they noticed and they ask me how I got it and then I said it was D... So obviously they sent off a form, or whatever it was to social services. (Tracey: interview 2)*

The midwife shared the information with Social Services, who undertook an assessment of the family. The initial assessment conducted by social services highlighted her partner's abusive history from a previous relationship. This involved serious concerns involving child abuse, which Tracey knew nothing about:

*Um so that was the end of that and then social services got involved obviously because of the allegations around child abuse and everything else and um they did a core assessment and everything else on us and that was that until my son was born. He was so angry that I had told the midwife. Then when I was then about 8 months pregnant and um he was paralytic and he said I don't want this baby, he said I am going to give you a caesarean right now and flush the bloody baby down the toilet. I was really scared, so I walked out and went and stayed with my brother for a few days. (Tracey: interview 1)*

Fear of reprisals from partners seemed to inhibit disclosure to the midwife. Kirsty verbalised that she did want to open up to her midwife and tell her about the abuse but was too frightened to do so. The midwife tried to offer her some support when she realised how depressed Kirsty was during her pregnancy. However, Kirsty was unable to open up to the midwife due to the fear of retaliation:

*My midwife was absolutely lovely she was as good as gold. Um she always knew what he was really like. Because when he came he came more often than not because obviously he was pretending to be the caring father devoted and loving, like you know and he doesn't want me talking about my business. Um he was always the same. I knew not to tell the midwife, I knew the consequences, I would get a beating. (Kirsty: interview 1)*

*I was very depressed, very, very depressed and although she had never seen me with bruises because I had to go to the midwife and things like that, there would be a phase where he wouldn't hit me. But anyway this one day he was in a hurry to get out as usual and my midwife pulled me aside she went oh Kirsty one last thing I need to talk to you about and I said ok and like he rushed off, she said is everything ok at home and I said yeah I'm fine she went no its not and I said everything is fine, I'm fine and she said um you can tell me anything it can be private and confidential. She said I can tell that something's wrong and I said no, no everything is fine, everything is fine and she said well if you need to talk to me about anything she said I'm here you can ring me if you need to and I'll phone you back but I never did. (Kirsty: interview 2)*

Seven of the women elected not to tell their midwives about the abuse in their relationship. They all offered a *raison d'être* for electing to make this decision, with the underlying explanation being one of fear and reprisals from the partner, if they found out about the disclosure and fear of a referral to Social Services. The lack of opportunity to disclose to the midwife about the violence for some of the participants was also due to either the partner being present during the consultations, or the midwives' failure to routinely question the woman about the existence of violence in their relationship.

Whilst some of the women were able to suggest occasions where they had been provided with positive support, overall, their experiences tended to focus on the failure of health professionals to recognise and offer support. The majority of participants in the study indicated that they were cautious about bringing up or admitting to the midwives about their personal experiences of violence. The women also acknowledged that there were some physical as well as emotional barriers, which prevented them from seeking help and support from the health professionals. Some of the barriers will now be explored.



### 13.5 Barriers that prevent women from seeking help and support

This section seeks to provide a glimpse into some of the reasons identified by women which may go some way towards explaining why women did not seek help. I would suggest that for some of the women in the study, they felt a need to remain silent about the abuse they were experiencing. Many of the women explained this reluctance, as due to shame and their belief that it was their responsibility to make their relationship a success, especially when children were part of the relationship:

*No, because in Hong Kong, there was nowhere to go and stay it's not like here, where women and children have a place they can go and stay and be safe. Then, once we have the baby, I felt that I had to stay and make my marriage work. (Jane: interview 1)*

This feeling of shame is supported by Hague and Malos (2005) who suggest that in the main, women believe it is their role to make their relationship a success.

Wendy revealed that had the opportunity arisen, she would have told the midwife about her partner's abuse. However, despite her willingness to declare the abuse, Wendy would not have wanted the midwife to take any action at that particular time, as she was still hopeful that she could make her marriage a success:

*I think if I got chance to talk to her I think it's just kind of like tried to you know to have a talk with someone I didn't expect her to have you know take action or me to go further of that I think I just need somebody to talk to really because I didn't want you know anything to go further then you know because at that time I was still to keep my marriage for my baby really so yeah. (Wendy: interview 2)*

However, Wendy like some of the other women in the study was never given the opportunity to disclose the abuse to a midwife, as they were always accompanied to antenatal appointments by their partners. One of the important themes that emerged from a number of the interviews was the fear of the involvement of Children's Services. There was a reluctance to be honest with health professionals because of the fear that disclosure to a healthcare professional would result in an immediate referral to children's service. This issue will be addressed in more depth in the discussion chapter. Trepidation concerning a referral to Social Services was expressed by Tamara:

*Women, don't want to open up to you because they don't want you to go to Social Services, they don't want to risk their kids being taken away or anything. So anyone will only tell you as much as they want to tell you because they are scared of that happening. I think if there was someone confidential you can go to who can advise you of what to do and not point the finger and say right I am going to have to phone Social Services I am going to have to do this, it puts people off. (Tamara: interview 1)*

Lisa was also unsure whether she would have been completely honest about the violence in her relationship, even if the midwife had asked her. Although she did feel it was right that midwives ask women about abuse:

*It's probably a good thing that midwives ask, but I personally don't reckon that many people would say unless they were ready to leave because like it took me ages to pluck the courage to leave, I only left when I thought my baby was in danger. Even if the midwife had asked I just don't think I would have been ready to tell anyone. I just didn't think I was ready. (Lisa: interview 1)*

Sarah also chose not to disclose about the abuse to her midwife because she, like some of the other participants, believed her partner's behaviour towards her would change once the baby was born:

*I kind of convinced myself that he would change and everybody was saying to me oh once the baby is born he will be different but it didn't it got worse so um you know so where people on one side telling me that he would change and it would get better. I was also worried and too scared to go to the local authority, in case they took her off me so I just kept it all in. I just kept it to myself. (Sarah: interview 1)*

The women presented a multiplicity of explanations for not disclosing about their history of violence to the midwife. For some, there was an element of not only shame about being part of an abusive relationship, but also the belief and hope that their partners would change their behaviour, once the baby was born. Some of the women talked about being brainwashed into believing that the violence was their fault, by their abusive partner. As a consequence, they were reluctant to open up about the ongoing abuse to a health professional, because of the fear of being judged and blamed for the violence by the midwife and GP. However, it is important to acknowledge that the genuine fear of reprisals by the partner helped maintain their silence. Whilst some of the women were clearly hesitant and wary about opening up to the midwife about the abuse, they also acknowledged that they perceived midwives to be caring and would have welcomed the opportunity to discuss the violence with them. They believed a sufficiently caring response would have been, to be believed and not judged. Overall, the findings from interviews with the women would appear to only partially support the assumption that when women are routinely asked about domestic violence by health professionals, they will always disclose.

## Summary

The findings from this chapter were not intended to provide a complete overview of the present NHS provision being offered to women in relation to domestic violence and abuse. This will be explored in more depth in the discussion chapter. Instead, they have been offered to provide a brief synopsis of some of the women's encounters with an array of health professionals.

Within the context of the UK, some progress has been made in the past decade in attempting to readdress the long legacy that the NHS and healthcare professionals have for the main part been ignoring domestic violence (Hague and Malos, 2005, Department of Health 2010a). Despite the fact they are often the first group of professionals to see abused women and their children and help deal with the consequences. However, notwithstanding the attempts of the health services to improve the range of services they offer, women still talked about feeling 'let down' by some of the services. Professional guidance and care pathways have been developed with training for health professionals, with the aim of empowering health professionals to ask women about domestic violence. This is underpinned by numerous policy recommendations (Department of Health, 2005; 2009; 2010a; 2010b, World Health Organisation, 2005; 2010). It is hoped that for other victims of domestic violence, unlike some of the women in this particular study, their encounter with a health professional will be more caring and proactive.

## Chapter Fourteen

### Findings: Coping and Survival Strategies

#### Introduction

Every study participant had their own unique journey in relation to the abuse they experienced and similarly they all had their own methods of coping with their personal circumstances. This chapter explores how the women managed to devise complex coping and survival tactics which allowed them to stay in the relationship, whilst not revealing the true extent of their situation to those around them.

#### 14.1. Coping with and surviving domestic violence and abuse

The women's narratives established that they had developed a range of coping strategies helping them to survive the abuse. The reasons the women gave for maintaining the silence were multifaceted and complex, ranging from shame, fear, and self blame to hope and desire that their partner's violent behaviour would stop.

Only one of the women left the violent relationship whilst pregnant: the others elected to remain in the relationship. Two of the women stayed in the relationship because they were concerned about their immigration status, as they had entered the UK on their husbands' visa. Their husbands frequently taunted and threatened them by telling them they would be deported and sent back to their own country if they left them. This was regardless of the fact that both women were employed and had obtained the right to live in the UK:

*if I answered him back he would often threaten me, saying' I have no use of you now, just remember, if it were not me you would not in England and I can send you back to your poor country, where you wouldn't have any access to money' (Jane: interview 1).*

*When on holiday in Indonesia, he was being aggressive and I answered him back so he pushed me into a corner and threatened me telling me, that he was going to leave me in Indonesia. I will book a flight tomorrow and go back to England by myself and you will not be allowed to follow me, you will have to stay in Indonesia as passport control will not allow you back into the country without me. I was so... you know I was shocked and scared when he said that because N..... needed to go to school in September at that time and I didn't want to ruin his school and stuff even though we all now had British Citizenship, I was still scared, I thought he could stop me coming back to the UK. So I gave in to his demands and forgave his behaviour, so all of us could come home (Wendy: interview 2).*

In the case of Jane and Wendy, both male partners frequently ridiculed and threatened them, by suggesting that they had the power to prevent them from staying in the UK. These threats were used to maintain the women's silence preventing them from telling anyone about the abuse or seeking help from any outside agencies.

The women also talked about learning the importance of quickly identifying their partner's moods. By adapting their own behaviour, they hoped, they would be able to avoid a violent outburst. Some of the women blamed themselves for the abuse, believing they were responsible for the abusive behaviour of their partner. Many of the participants managed to conceal the violence and abuse from people close to them for many years, feeling too ashamed to tell anyone, especially family and friends. The men consistently told the women that they were to blame for the abuse perpetrated against them and eventually the women started to believe them.

Several of the women attempted to reduce the violence, by developing coping strategies which could be considered passive or submissive. These included hiding the abuse from family and friends, pretending everything was all right in the relationship, using prescribed medication, agreeing to social isolation, agreeing to sexual intercourse whenever the partner demanded it, handing over the household income and modifying their own behaviour, trying at all times to be compatible with their

partner's demands. In essence by modifying their conduct they hoped to prevent irritating their partner:

*To keep him happy I used to shave him, cut his toenails for him, I had to wash him, he already had that much control over me. I would do anything to stop him losing his temper (Sarah: interview 1).*

*It's really hard because when you are living with an abusive partner you have got to be so careful about what you say and do. Sometimes you just have to agree with them even though you don't think they are right, you know you don't believe him and you don't really want to listen to him, but you have to. You have to be attentive all the time or else he will whack you one or beat you up. When I was pregnant, I had to listen to him tell me how we were going to bring up our baby, even though half of it was complete rubbish, I never disagreed with him, I knew better (Nicola: interview 1).*

*He always knew me as a confident and well presented person I have always been a big girl and everyone loves my personality and I have always been extremely confident. However, bit by bit he started stripping that away from me until I had no confidence left, he would tell me after a beating it was all my fault and I knew it wasn't but then I found myself questioning myself, perhaps it is my fault. He completely took away my confidence. (Susan: interview 1)*

As previously discussed in an earlier chapter, some of the participants in this study frequently endured sexual abuse and rape during the relationship. The women often submitted to unreasonable sexual demands of their partner as a means of avoiding an eruption of anger and a physical assault. These women used sex as a means of pacifying the partners. According to Stanko (1990), using sex as a coping strategy as a means to avoid further violence is not unusual. When the threat of sexual violence within a relationship is normalised, women will routinely adapt their behaviour, according to the potential for sexual violence. At an individual level, they will explore

the decision making process in terms of whether to resist or not, by using a trade off between the probable costs and benefits of their actions (Dobash and Dobash, 1998).

Living with repeated violence and abuse from a partner can lead to learned helplessness and low self esteem amongst women (Barnett *et al.* 2005; Williamson, 2010) especially if they feel there is no escape from the perpetrator. The low self esteem and self blaming of some women interviewed in this particular study can perhaps be attributed to the years of living in an abusive and controlling relationship. Some of the women interviewed had endured years of abuse, of denigration and criticism. They had been repeatedly told they were to blame for the violence and abuse, until they themselves believed this to be true. As a result, they felt they did not have the power or strength to escape the abusive relationship. Such viewpoints are not thought to be uncommon amongst survivors of abuse, indicating that intelligence does not necessarily equate to power (Baker, 2008). Often women have the intelligence to know that they should not stay in the relationship, but they often lack the power or the material resource to escape.

## **Summary**

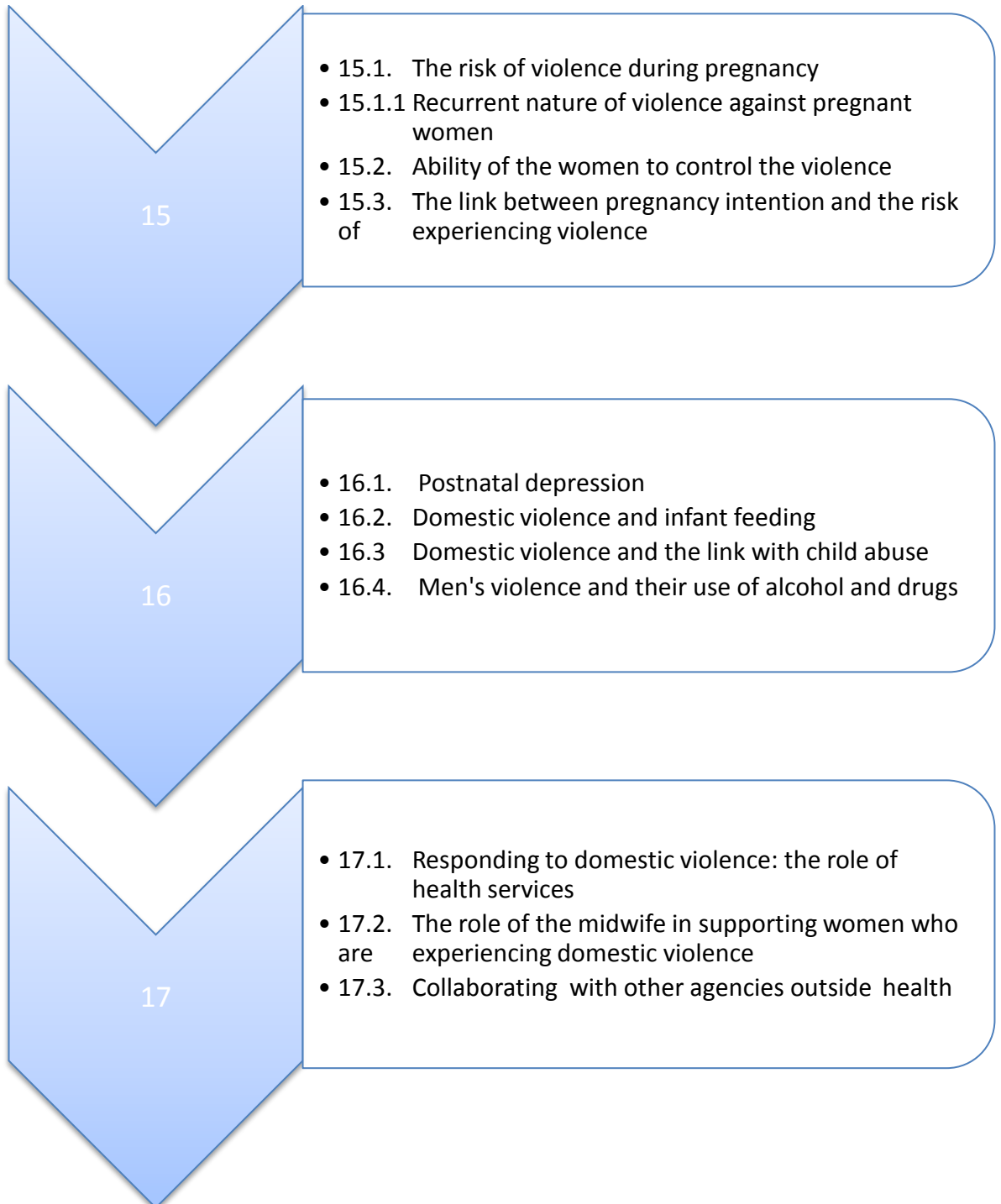
The findings chapters have presented the findings from the experiential study reported in this thesis, situating them in the experiences of the 11 women who took part in the study, allowing their voices to be heard. The findings have described the women's experiences of domestic violence before and during their pregnancy and following the birth of their baby. The women placed their feelings, emotions and bodily experiences at the heart of their accounts, authenticating that living with violence has a destructive effect on the women's perceptions of self, their emotional wellbeing and their abilities to mother.



# PART FOUR

## Discussion of Themes

### Structure of Part Four



## **Chapter Fifteen**

### **Discussion**

#### **Introduction**

The previous nine chapters in part three have presented an overview of the women who participated in the study. The findings intentionally focused on the 'voices' and 'experiences' of the women who took part in the study. This discussion chapter will support the study's findings by including pertinent and contemporary literature regarding domestic violence and especially within the context of pregnancy. In accordance with my epistemological position, the women's experiences will continue to be situated within the patriarchal structures in which these experiences took place.

Part four is divided into three chapters. Chapter 15 considers the women's general experiences of violence during pregnancy and their ability to control the violence. Chapter 16 explores the relationship between domestic violence and postnatal depression, infant feeding, the link between domestic violence and child abuse and the men's indifference to pregnancy. This chapter also considers the relationship between some perceived risk factors and domestic abuse, (e.g. poverty, ethnicity, educational attainment, unintended pregnancy) and the incidence. Chapter 17 considers the role of health services in responding to domestic abuse, and the challenges and intrinsic worth of multi-agency collaboration. What women want and expect from health clinicians and other services is also acknowledged and discussed in this chapter.

#### **15.1. The risk of violence during pregnancy**

The findings in this study highlighted the range and complexity of the subjective beliefs the women had about themselves, as a result of experiencing violence and abuse before, during and after pregnancy. This discussion chapter will therefore focus on a critical engagement with the subjective meanings the women attached to their individual experiences.

There is an ongoing discourse as to whether pregnancy itself can trigger an increase in physical violence. A literature review by Gazmararian *et al.* (1996) examining the prevalence of violence against pregnant women found that reported rates in developed countries varied considerably ranging from 0.9% to 20.6%, with a large number of studies suggesting prevalence rates of between 3.9% and 8.3%. More recently, a review of studies conducted post 1996 with data from both developed and developing nations indicated prevalence rates of physical violence during pregnancy ranging from 0.9% to 30% (Muhajarine and D'Arcy, 1999; Covington *et al.* 2001; Janseen, *et al.* 2003; Johnson. *et al.* 2003; Saltzman *et al.* 2003; Bacchus *et al.* 2004b; Heaman, 2005; Charles and Perreira, 2007; Perales, *et al.* 2009). A number of the studies have explored emotional and verbal abuse during pregnancy, determining prevalence rates ranging from 1.5% to 36% (Shumway *et al.* 1999; Janssen *et al.* 2003; Charles and Perreira, 2007). Unfortunately, most studies failed to assess sexual violence during pregnancy. Of the limited studies that did report on sexual violence, reported prevalence rates of 1% to 3.9% (Bacchus *et al.* 2004a; Perales *et al.* 2009), which is much lower than the reported rates of physical violence. Taillieu and Brownridge (2010) suggest that cultural differences and the degree of gender equality may explain the varied range of prevalence rates found throughout the developing world. The degree of gender inequality, privileging the male sex and patriarchy has been shown to impact on the rates of violence against women (World Health Organisation, 2004; Archer, 2006). The World Health Organisation (2010) infers that violence against women transcends all societies and therefore must be measured as a component of 'gender inequality and inequity' (p 52). Martin *et al.* (2006b) explored the incidence of rape in US cities and their findings indicated that women having a higher absolute status, together with rhetoric of gender equality were associated with a lower incidence of rape within particular cities. Using similar methods, Vieraitis *et al.* (2008) also considered homicide rates in relation to women's economic status and established that:

Women's absolute status index is in the expected negative direction in both models, it is only statistically significant for [homicides] by intimates. Thus our findings are consistent with feminist arguments that in cities where women are more economically advantaged; rates of female homicide victimization by male partners are lower. (Vieraitis *et al.* 2008, p. 170)

Such findings would seem to suggest that economic and educational resources, although not necessarily preventing a woman from entering into an abusive relationship, can help provide an escape route from the violence. Poverty and limited economic opportunities are a risk factor for women becoming trapped in an abusive relationship. A wide range of studies has demonstrated that whilst domestic violence affects all socio-economic groups, women living in poverty are disproportionately affected. Heaman (2005) revealed that women in the low-income bracket were more likely to be abused during pregnancy; 61.1% compared to 31.5% of non - abused women. Fanslow *et al.* (2008) found similar findings, determining that an increased household income decreased the risk of experiencing violence during pregnancy, supporting the earlier work of Martin *et al.* (2006b) and Vieraitis *et al.* (2008) that economic resources may decrease a woman's risk of violence. Evidence would seem to suggest that some women may find themselves socially and economically trapped in a situation they cannot control or escape from, as their opportunities for educational achievement and economic independence are extremely limited (Kaya and Cook, 2010). This leaves them feeling trapped in a situation that they feel they have no control over.

Faludi (1991) previously suggested that the subsequent backlash of male superiority was essentially in response to the feminist movement's demands and modest gains for equality for women. The resulting discourse that followed attributed the breakdown of the family, infertility and disputes between couples to demands for equality (Faludi, 1991). Stark (2007) supports Faludi's supposition, although he also claims that sexual equality is more complex than merely achieving female equality. Stark (*op cit*) maintains that it is still not clear whether improvements in women's status have

protected them or instead made them even more vulnerable. Stark (*op cit*) believes that greater female equality threatens male privilege, thereby causing oppressive behaviours and violence to escalate.

Culture also shapes discourses about equality; in many societies law and/or religion dictate that women, regardless of their personal income, continue to be subordinate to men. Some men will always strive to find a way to preserve their privileges and control women by devising or increasing coercive control. A 'backlash' as suggested by Stark (2007), will be victorious in suppressing women's new found independence because it is continued inequalities that preserve women's vulnerability to male domination in their personal lives. Despite the fact that equality may have reduced male partner violence by making it easier for women to leave violent men, it has not completely removed the probability that a woman will continue to be abused or killed by her partner. Stark (2007) believes this is because men have shrewdly expanded their 'repressive and dictatorial repertoire' towards their female partners, by exerting more control in their personal life.

It is also important to acknowledge that women who leave a violent relationship continue to be at risk of violence and death even after leaving (Humphreys and Thiara, 2003; Walby and Mayhill, 2004; Smith *et al*, 2011). At least a third of all women will continue to experience post separation violence (Harne and Radford, 2008). The 2009/10 British crime self completion survey demonstrated that women who separate or divorce, actually have an increased risk of being a victim of domestic abuse, compared to all other marital groups. However, these findings should be treated with caution as it may be that the abuse was already occurring prior to the separation (Hall, 2011).

Eight of the women who were residing in the refuge at the time of interview had moved there because they were seeking a place of safety from their violent partners.

Some of the partners had threatened to kill the women if they ever left them, telling them they would never be free from them. Although the women welcomed the opportunity to be finally free from the men, they were also worried about their own and their children's future. It is not uncommon for women who are living in refuges to experience depression and develop concerns over ensuing poverty and their own and their children's safety (Taft, 2003; Abrahams, 2007). Abrahams' (2007) work has explored the difficult journey survivors undertake to recover from a violent relationship, highlighting that despite the support services provided by refuges and other women's advocacy agencies, women continue to experience psychological trauma. This shows that although a refuge can provide a safe place, resident women's emotional and mental wellbeing remains very tentative.

## **15.2. Recurrent nature of violence against pregnant women**

One theme uniting all the women in this study was that pregnancy did not guarantee safety from male violence. Six of the eleven participants experienced their first incidence of physical violence during their pregnancy, and for the women who were already experiencing physical violence, the violence continued throughout their pregnancy. Only three of the participants did not experience physical violence during the pregnancy; however, all three experienced physical violence early in the postnatal period. All the women reported an increase in other forms of abusive behaviour, including controlling behaviour, intimidation, verbal, financial and sexual abuse during pregnancy. The women's narratives revealed that they frequently experienced repeated physical assaults during their pregnancy.

Research evidence indicates that violence during pregnancy is a reoccurring experience. McFarlane *et al.* (1995) established that 60% of participants in their study experienced two or more incidents of physical violence during their pregnancy. These findings were corroborated by Martin *et al.* (2004) who confirmed that abused pregnant women reported on average one violent injury per month. Valladares and

colleagues (2002) highlighted that 15% of mothers in their study who gave birth to low birth weight infants had experienced three or more incidents of physical violence, demonstrating an association between violence and low birth weight babies. Other studies have found that women who are abused during pregnancy, experience an increase in the frequency and severity of abuse (Campbell *et al.* 1992; Mc Farlane *et al.* 1995), demonstrating the association between pregnancy and the increase in physical violence in comparison with the incidence of violence before becoming pregnant.

Stewart and Cecutti (1993) established that 63.9% of their sample reported an increase in the frequency and severity of abuse during their pregnancy, with 30.6% reporting that it remained the same, and only 5.6% reporting a decrease in violence during their pregnancy. Overall, research evidence shows that between 13% – 71% of women who are abused before and during pregnancy will encounter an increase in the frequency and severity of violence during their pregnancy (Stewart and Cecutti, 1993; Valladares *et al.* 2002; Saltzman *et al.* 2003; Fanslow *et al.* 2008). None of the women in this study reported a decrease in physical violence during their pregnancy. Two participants who were experiencing physical violence prior to pregnancy reported an increase in the amount and severity of attacks whilst pregnant. These findings support the hypothesis that if violence is occurring in a relationship prior to a pregnancy, it will increase during pregnancy. Six of the participants experienced physical violence for the first time during their pregnancy, thereby supporting the evidence that pregnancy is not a protector against violence.

The women in this study also reported an escalation of some of the men's other abusive behaviours during pregnancy, including an increase in verbal and sexual abuse and an increase in control and domination. Such behaviour would seem to suggest that the men perceived pregnancy as increasing a woman's vulnerability and dependence. Paternal behavioural traits such as nurturing and protection did not appear to be present during the women's pregnancy. The women frequently verbalised feelings of vulnerability and defencelessness during pregnancy, which could

be attributed to the sense of responsibility they felt towards their unborn babies. This extra sense of responsibility is also illustrated by the women's reports of how they adapted and modified their own behaviour, in an attempt to defuse any volatile situations that could trigger a physical attack.

Bowen *et al.* (2005) conducted a prospective longitudinal survey of pregnant women in the South West of England, exploring the prevalence of emotional and physical abuse by a partner at eighteen weeks gestation, and at eight weeks, eight months, twenty one months, and thirty three months postpartum. Results demonstrated that fewer women reported less violence and abuse during pregnancy than during the post pregnancy period (5.1% v 11%). Bowen *et al.*'s. (2005) work also established that the women's risk of experiencing violence depended upon the number of social hardships the family had to endure, including large family size, low education attainment, being single, living in poverty, depression, history of anti social behaviour and a lack of social networks. Pregnant women with just one of these hardships were 2.7 times more likely to experience violence than women with no social adversities. However, women who reported five social adversities during pregnancy were 14.7 times more likely to experience domestic violence during the postpartum period. Bowen *et al.*'s. (2005) findings demonstrate that violence against women is experienced within a context of adverse factors that families often confront on a daily basis. Therefore whilst it is important to acknowledge and realise that domestic abuse can and does affect any woman, regardless of age, ethnicity, social grouping and sexual orientation, it is also imperative to acknowledge that '*one size does not fit all*' (Lochart and Danis 2010, p xxv,). Academics, researchers and clinicians cannot expect the same intervention to be effective for every woman, as evidently there is no such thing as a '*universal victim*' (Lochart and Danis pxxv, 2010).

Utilising an intersectionality framework in this work allowed for an appreciation of some of the distinctive and diverse cultural backgrounds of the woman involved in the study. For example, six of the women and their children could be considered as living



in poverty. For some of these women, poverty was the result of the partner's reluctance to find paid employment, yet at the same time control the limited household finances. The men frequently commandeered nearly all of the household income to buy alcohol and/or drugs. It has been suggested that women who are abused and stay in an abusive relationship feel trapped and forced to remain because they are economically and socially dependent on their male partners for material support (Bacchus *et al.* 2006) However, Pallitto *et al.* (2005) claim that restricting women's access to finances is just another means of maintaining absolute control in an intimate relationship.

Whilst many women are able to survive domestic violence, unfortunately some women will not. Current UK homicide statistics show that on average over 100 women are murdered by male partners each year (Department of Health, 2005). This figure does not include deaths that result from suicide (Harne and Radford, 2008). Women experiencing violence are at high risk for attempting and successfully achieving suicide (McFarlane *et al.* 2002; Campbell *et al.* 2004). Suicide may be attempted when women find themselves with no means of escape from the violence (Stark and Flitcraft, 1995; Humphreys and Thiara, 2003; Barnett *et al.* 2005). The suicide rate for women who experience violence during pregnancy is three times greater than average (McFarlane *et al.* 2002). Although none of the women in this study admitted to attempting suicide, several alluded to having considered it as a means of escape from their partners and the violence.

Women in this study frequently spoke about the psychological abuse that occurred in their relationships. This included unrelenting intimidation and verbal abuse, sometimes on a daily basis. The verbal abuse was frequently accompanied by bullying and coercion to obey the rules as set down by the men, with threats of physical abuse, including murder, if the women did not conform to their wishes. Weapons such as knives, and other household items were frequently used as a means to enforce the threat. However, the men most often used their fists and feet to threaten and assault

the women. Williamson (2010) suggests that women have persistently talked about the types of abuses that are not always visible, yet have the power to completely erode a woman's self esteem, self confidence, and self respect. Indeed, Williamson (2010) stresses that the current definitions of what domestic violence actually encompasses can often fall short of embodying the real effect and consequence of living daily with violence. Living daily with psychological and emotional abuse, including constant insults and threats to kill can eventually completely erode a woman's confidence and self belief.

In this study, men successfully used the tactic of belittling and destabilising the women's confidence in the postnatal period, thereby undermining the women's mothering skills. Emotional abuse is very common and very destructive, with survivors claiming it is more traumatic than physical violence, due to its long lasting effects (Barnett, *et al.* 2005). Martin *et al.* (2004, 2006a) revealed that compared to non pregnant women, pregnant women experience higher rates of psychological aggression before, during and after pregnancy. Martin *et al.* (2004, 2006a) also demonstrated that psychological abuse during pregnancy is correlated with an increased risk of postnatal depression. Women who experience psychological abuse in pregnancy report significantly poorer mental health outcomes, when compared to women without a history of psychological abuse (Tiwari *et al.* 2008).

The data in this study offer an indication of the range and complex tactics used by men to damage the women's self confidence. All of the women described how the men's constant vilification and criticism led to a loss of self confidence and low self esteem. Denzin (1984) considers that an emotional outburst can do as much damage as an act of physical violence, as it diminishes a person's personal worth and transforms them into an object. Denzin (1984) states emotionally abusive behaviour results in the subjectivity of women being denied, "she is interacted- at, not with" (p 500), where the bodies of the women become instruments, tools or weapons.

Rape was also a frequent occurrence for some of the women in this study and this continued throughout their pregnancy. The women's descriptions of their sexual lives in this study were mostly negative. Four of the participants recounted the horrendous and distressing consequences of being raped by their partner. Most of the women voiced feelings of disgust, shame and helplessness when discussing their sexual relationships; with the four women being frequently raped before, during and after their pregnancy. Two of the women mentioned noticing a decrease in physical attacks during their pregnancy, however they experienced an increase in both sexual and psychological abuse. Several other participants, although not actively raped during pregnancy, talked about agreeing to sexual intercourse, just to avoid further torment and abuse.

The women in this study frequently acquiesced to the men's demands for sexual intercourse. Women perceived this acquiescence as a means of pacifying their partner; for some of the women, it appeared that sexual intercourse with their partner was not an act they enjoyed or found personally fulfilling. Some of the women referred to their sexual relationships with their partners as 'disgusting' or 'dirty'. None of the participants referred to this element of their relationship as tender, caring or loving. Lempert (1996) describes the women's behaviour as 'passive resistance'. The women were aware resisting their partner's sexual advances was futile, and would result in an outburst of anger and violence. Therefore it was safer not to resist the men's sexual advances. Yllö (1988) describes this form of male behaviour as "force only rape" (p 32) which frequently takes place in partnerships where there is no actual physical violence, just the threat of physical violence. Force only rape is strongly associated with power and control. The men's desire is to control the relationship by means of sexual coercion (Yllö and Bograd 1988). The male will shrewdly only use a sufficient amount of coercion to force the woman to comply with his wishes.

One participant in the study was raped by her partner on the day she arrived home from hospital after giving birth. Denzin (1984) describes sexual abuse as a form of "In

active emotional embodiment” (p 500) where the bodies of women become instruments, tools or weapons, with the body being viewed as a complementary extension of the subjects’ verbal and emotional forms of action. This in turn leads to the use and expression of the lived body of others in a hostile and destructive manner. Denzin (1984) suggests that just as a person can use their voice to demonstrate emotional anger, the actions of their body alone can be used to speak loudly. Young (1990b) recognises that women’s space is frequently invaded by inappropriate touching and argues that:

Women in sexist society are physically handicapped. Insofar as we learn to live out our existence in accordance with the definition that patriarchal culture assigns to us, we are physically inhibited, confined, positioned and objectified. As lived bodies we are not open and unambiguous transcendences that move out to master a world that belongs to us, a world constituted by our intentions and projections. (Young 1990b, p. 153)

Wiehe (1998) suggests that within a patriarchal family structure, women are frequently dominated by men, with some males subscribing to the ideology of machismo, defined as a worldview that advocates male dominance. de Beauvoir (1953) alleged that women were destined to fit into the role of immanence, and were expected to be confined to the home and comply with their reproductive role and never to be afforded the same dignity as men. The woman’s role was to provide society with children, satisfy a man’s sexual needs and take care of his household. These views may seem an extreme example of passivity and outdated and irrelevant as women have achieved greater equality since Simone de Beauvoir’s writings. However, it was evident from the women’s stories that the behaviour and attitudes of some of the men embodied de Beauvoir’s and Young’s suppositions regarding the position and immanence of women.

The participants’ stories, although shocking, were not unexpected as other studies have clearly identified sexual violence as a large element of abusive control and

domination, substantiating the idea that women in violent relationships have limited control over their sexuality (Dobash and Dobash, 1998; Heise, *et al.* 2002; Pallitto and O'Campo, 2004; Pallitto *et al.* 2005; Bacchus *et al.* 2006; Brownridge *et al.* 2011). In this study, the women's experiences of intimate partner rape varied greatly in terms of physical pain, injury and humiliation. All the women including those who were bullied into consensual sex reported being greatly traumatised. According to Denzin (1984), some men regard their partners as their sexual property and in such a situation:

The culture of violence and the cultural values that define females as the sexual properties of males contributes to the stabilisation of violence and partner abuse within the family domain. (Denzin 1984, p. 493)

Given the closeness of the aggressor, women who are raped within an intimate relationship are likely to experience rape repeatedly. Russell (1990) reports an average 13.2 rapes per year for women raped by their partners. Campbell *et al.* (1999) also intimates that women who are physically assaulted and raped by their partners are at a much higher risk of experiencing severe and lethal assaults. Denzin (1984) proposes that sexual violence within a family unit occurs because the male has been socialised into violence, whereas in contrast the female has been socialised into passivity, consequently, the more aggressive the male partner, the more passive the female becomes. In this study, women talked about feelings of hopelessness, realising that any sign of resistance would only result in more violence. Their passivity arose out of the need for survival. Many of the participants lived with frequent threats from their partners to murder them, if they attempted to end the relationship.

Sexual violence is closely associated with physical violence, a conjecture supported by Campbell and Soeken, (1999a). Campbell and Soeken confirmed 40 to 45% of physically abused women also reported sexual assault by a partner or ex partner. Bennice *et al.* (2003) proposed that intimate partner rape is a rare event, and that

compared to stranger rape, it is relatively harmless. However, the evidence does not bear out this claim. In fact, the opposite is true, with partner rape being the most prevalent form of rape, with serious consequences for the woman (Russell, 1990; Campbell and Soeken, 1999a; Baker, 2008). Findings from the latest UK British Crime Survey (BCS) contest Bernice *et al.*'s claims, by establishing that 54% of UK rapes are in fact committed by a woman's current or former partner (Hall, 2011). Such findings would seem to suggest that rape may be committed by men as another means of exerting control over women (Baker 2008). There are physical and psychological consequences of experiencing forced sex. Psychological consequences of experiencing ongoing partner rape include depression, self harm, low self esteem, anxiety, fear, shame and self blame (Finkelhor and Yllö, 1985; Campbell and Soeken, 1999a; Campbell *et al.* 2002). Physical consequences include increased risks of gynaecological and reproductive health problems such as urinary problems, abdominal pain, and genital injuries (Campbell *et al.*, 2000).

Forced sex within an intimate liaison, also has consequences for reproductive health, including control over contraception and sexually transmitted diseases. Population studies have previously established links between domestic violence, lack of contraception, sexually transmitted diseases and unintended pregnancies (Gazmararian *et al.* 1995; Campbell *et al.* 2000; Goodwin *et al.* 2000; Saltzman *et al.* 2003; Dunn and Oths, 2004; Pallitto *et al.* 2005). Foucault's (1979) micro-physics of disciplinary power provides a useful framework for thinking about the role of men's and women's bodies in relation to power and control dynamics which are central to domestic violence. Foucault (1979) proposes that perpetrators use their own bodies to gain power over the bodies of their victims, through the calculated dispensing of emotional and physical pain, which turns their victims into docile bodies. According to Foucault perpetrators use violence or threats to ensure victims do as they are told. The combination of verbal abuse and violence together is a powerful means of constraining a victims' behaviour (Foucault, 1979; McNay, 1992). Marilyn Frye (1983) a feminist philosopher uses the oppression and control of non-humans as a metaphor

for human oppression, suggesting that women are kept captive by invisible barriers that prevent escape:

The experience of oppressed people is that the living of one's life is confined and shaped by forces and barriers which are not accidental or occasional and hence avoidable, but are systematically related to each other in such a way as to catch one between and among them and restrict or penalize motion in any direction. It is the experience of being caged in: all avenues, in every direction, are blocked or booby trapped. Consider a bird cage(...) It is perfectly "obvious" that the bird is surrounded by a network of systematically related barriers, no one of which would be the least hindrance to its flight, but which, by their relations to each other, are as confining as the solid walls of a dungeon. (Frye 1983, p. 4-5)

Frye's metaphor could be ascribed to all the women in this study, who voiced feelings of despair because they felt they could not escape from their oppressive and controlling partners.

For women experiencing domestic violence, their intersectional constraints are not mere metaphors, they are everyday realities and barriers which make it almost impossible to escape from the cage they find themselves living in. Frye (1983) suggests that by others attempting to understand the women's realities may provide a way of thinking, which may help overcome the oppression.

Stark (2007) proposes that the spatial and temporal facets of coercive control are wider than in comparable instances of power and control, suggesting that the majority of suffering for victims comes from their existential loss of freedom. Stark suggests that men can deploy coercive control to prevent escape and exposure through spatial patterns of rules, phones, stalking and more recently cyber- stalking. The men frequently used the women's mobile phone as a means of control even when they themselves were not present. For instance, they used the phone to check on the women's whereabouts, phoning repeatedly to check that they were at home, whether

household chores had been performed, what they were wearing, dictating their bed time. Using mobile phones meant the men did not have to be in the same room or even in the home to control the women's movements. Dobash and Dobash (1998) claim, some controlling men will be particularly concerned about household chores being carried out to their exact orders, especially if those chores address their own needs. This was especially true for one woman in this study. Julia had to endure relentless controlling behaviour from her partner every day. Julia's husband would call her from his workplace several times each day using the home phone to check she had not left the house. He would also check that she had completed the list of household tasks he had left for her. Any chores not performed to his high standards resulted in a deduction from the family household budget. Stark (2007) believes this is not unusual behaviour for controlling partners, who frequently devise methods to penetrate safe zones, commandeering any free safe space or time the women may have. Stark (2007) describes this as diffuse regulation, which leaves an impression "there is no outside, outside" (p. 209). Young (1990a) suggests that societal restrictions placed on the female body contribute to a restricted spatiality, and the sense that the body is positioned within invisible as well as visible barriers.

Violence during pregnancy endangers the well being of both the woman and her unborn child (Campbell *et al.* 1998). Women who experience domestic violence during pregnancy are four times more likely to experience a miscarriage than women who are not abused (Mc Williams and Mc Kiernan, 1993; Schornstein, 1997). Violence during pregnancy may result in the death of the mother and her unborn baby (Lewis, 2007; 2011). In this study, three women experienced a fetal death following violent assaults from their partners. Indeed, six of the women in this study reported being kicked or punched in the abdomen during an assault, fortunately three did not experience a miscarriage as a result of the attacks. Two of the three women who reported experiencing a late miscarriage as result of a violent attack when they were repeatedly punched and kicked in the abdomen; such findings demonstrate a male indifference for the safety of both the women and the unborn baby. Existing literature suggests that the abdomen, breasts, genitalia and head are the most common sites for violent



injury during pregnancy (Hedin *et al.* 2000). Stewart and Cecutti's (1993) study concluded that 63.9% of women, who had been physically abused, had been struck in the abdomen during pregnancy. Intentionally placing punches so that any resulting bruising remains hidden from public gaze, suggests some awareness of guilt and possible social disapproval (Hunt and Martin, 2001). Abuse directed at the abdomen can cause antepartum haemorrhage, premature rupture of the membranes and premature labour. At its worst, physical blows can cause fetal death due to placental abruption and uterine rupture (Saltzman, 1990; McWilliams and Mc Kiernan, 1993; Connelly *et al.* 1997; Valladares *et al.*, 2002; Janseen *et al.* 2003; Boy and Salihu, 2004). During the interviews, it was evident from their anguish and sadness that none of the women had come to terms with what they considered to be an unnecessary loss of their unborn baby, as a result of the violence. All of the women who had experienced a fetal loss became very emotional and tearful when recalling the incident.

The next section of the discussion considers the women's experiences of violence during their pregnancy, comparing their experiences with pertinent literature. In the following section, the women's belief about their ability to control the violence will be discussed.

### **15.3. Women's ability to control the violence**

Control appeared to be the mainstay of the men's ability to dominate the women and as a theme, it haemorrhaged through every one of the participant's relationships and their experiences. All of the participants discussed their partner's attempts to control and manipulate them. This study has at all times striven to recognise that women who experience violence are not all the same. Their individual perceptions of their experiences were all influenced by their individual circumstances and as such, they all had different stories to tell. However, one theme that was constant throughout the women's narrative was that pregnancy seemed to sanction the men's authority over them and heighten the level of male control in the relationship.

Power and control are often considered implicit as a cause of domestic violence within an intimate relationship (Dobash and Dobash, 1998; Eisikovits and Buchbinder 2000; Pallitto *et al.* 2005; Barnett *et al.* 2005; Bacchus *et al.* 2006). Currently, there exists a restricted amount of research exploring the impact of patriarchal control and its link to the increased risk of violence during pregnancy (Pallitto *et al.* 2005; Bacchus *et al.*, 2006; Brownridge *et al.* 2011). Nonetheless, many academics and experts have situated partner violence within the context of power and control. This suggests that male violence is positioned within the context of social, historical and economic structures, in which gender roles and opportunities differ. Indeed, Eisikovits and Buchbinder (2000) suggest from a constructivist point of view, that intimate partner violence should be viewed as a socially constructed manifestation where gender inequality is an essential component where:

Personal experiences should always be located, understood, and interpreted in the light of socio-historical facts such as unequal power distribution, differential rights, and cultural norms based on resources. (Eisikovits and Buchbinder 2000, p. 10)

The women's narratives demonstrated that they had very little control over the violence and that their status was that of the 'other', whilst the men had set themselves up as the Self or as the One, as de Beauvoir (1953) suggests "He is the Subject, he is the Absolute – She is the other" (p.xxii). However, de Beauvoir suggests that, whilst woman's otherness is forced upon her, she may also collude in her submission. Therefore, suggesting that whilst no one volunteers to become inessential, there is a tendency for women to accept their status, by failing to assert their transcendence. Therefore the woman is also to blame for her condition, believing "when an individual is kept in a situation of inferiority, the fact is that he is inferior" (de Beauvoir, 1953 p. xxx) However, when considering the inimitable situation of women who are controlled by an abusive partner, I find myself in opposition with this proposition by de Beauvoir. Women living in a violent and controlling setting do not

volunteer to become the inessential; they become the inessential, because they are forced into submission by an aggressive partner.

Stark (2007) intimates that coercive control is built on practices determined by gender norms within intimate relationships, such as relinquishing financial decisions to men or women leaving work to stay at home and being assigned devalued activities such as cooking, cleaning and child care. When men start to scrutinise such activities within an abusive regime, there is the potential for ambiguity about where appropriate expectations end and risk begins. Stark (2007) suggest that not all women in a violent and controlling relationship will experience the same spatial restrictions. Some women continue to go to work and are even able to visit their families. However, despite these domains of freedom, the level of control that a partner retains within the relationship means that some women may behave like a “corpse on a furlough” (p.263).

Whilst there is a wealth of literature demonstrating a relationship between patriarchal dominance and domestic violence, there remains a lack of research which focuses on the relationship between patriarchal power and control and the overall risk of violence during pregnancy (Taillieu and Brownridge, 2010). Violent and controlling behaviour can develop from the need to enforce power and control within a relationship (Pallitto *et al.* 2005; Bacchus *et al.* 2006; Stark, 2007). According to Stark (2007), addressing control is far more difficult than stopping violence and this will continue as long as masculinity is identified with being in control including the use of force if necessary.

Bacchus *et al.* (2006) suggests that pregnancy may represent a time when the woman takes more control over her own body, representing a degree of independence from her partner. This may lead to the partner resorting to violence in order to regain control of the relationship. Such an explanation may explain why six of the participants experienced their first experience of physical violence whilst they were

pregnant. Other potential explanations include financial pressures, the woman's preoccupation with the pregnancy or the pregnancy preventing the woman from performing her customary chores (Jasinski, 2001; Pallitto *et al.* 2005; Bacchus *et al.* 2006). Lempert (1996) suggests women have processes which they call on to halt, change or cope with the violence, with the main strategy chosen being 'passive resistance becoming an invisible presence' (p. 281). As stated previously, all the women in this study developed strategies including passive behaviours for coping with or trying to avoid their partner. All the women strove not to provoke or frustrate their partner, in that they attempted not to provide them with a motive for a violent outburst. To avoid confrontation the women ensured the house was kept tidy, the children were kept quiet, and any money they had for housekeeping was handed over. The women went without essential items including food, rather than cause an argument by asking for money. They stopped seeing family and friends, and agreed to sexual intercourse whenever the partner requested or demanded it, regardless of their own feelings, all examples of their passivity. Denzin (1984) supports Lempert's theory of passive resistance, asserting that the husband's aggression is mirrored by the woman's passivity.

Denzin (1984) proposes that domestic violence must be understood as occurring within the context of negative symbolic interaction, which destroys the status quo within the family unit. When violence occurs within a family, normal reciprocal interaction becomes impossible. The progressive intensification of negativity eventually leads to a breakdown in the cycle of interaction which binds the family together (Denzin, 1984). Should the woman meet the violence with violence, this will result in an escalation of violence being produced. Whatever her response, the man is able to achieve his goal, he gains control over the 'other' (de Beauvoir, 1953). Many of the women related to this conjecture, alleging that they never knew how to behave around the men. They reported that the men would get angry if they answered them back but would also get angry if the women were silent. However, in most instances the women responded to the abuse with passive resistance, aware that if they argued back, the men's abusive behaviour would escalate.

Men frequently exert financial control through restricting women's access to money (Pallitto *et al.* 2005), and this was true for the women in this study. The women's lack of access to finances curtailed their ability to go out, visit family or friends or go shopping, resulting in further isolation. This isolation seemed more significant after the birth of their baby and may have contributed to the development of postnatal depression. Seven of the women in this study experienced postnatal depression following the birth of their baby. Following the birth of a baby a woman needs a lot of support and guidance from her partner, family and friends. For most of the women support was very restricted. This lack of informal support could have been a contributing factor to the women's depression. Most pregnant women are usually encouraged to build close networks with other pregnant women. Such systems will usually provide informal emotional support throughout pregnancy and into motherhood. However, if this support is limited or prohibited social isolation can be the result. The theme of isolation is not unique to this study. Many women who were abused during pregnancy reported that their partners isolated them from family and friends (Campbell, 1992; Pulido and Gupta, 2002; Bacchus *et al.* 2006). One of the ways in which men were successful in controlling their partners' movements during pregnancy was by denying them access to money.

The women in this study frequently recited incidents when financial tensions had been the precursor to an argument which resulted in physical violence. Pregnancy is often associated with financial tensions, since there is a reduction in family income, due to women leaving employment. The birth of a baby can result in further demands on limited family resources (Bacchus *et al.* 2006). For instance, one participant experienced her first incidence of physical violence during the postnatal period, when her husband lost his temper and punched her because they could not pay a household bill. Another participant's partner refused to give her money to buy nappies and she had to resort to cutting up towels as a substitute. Some of the participants were very dependent upon family and friends to buy items for the baby. Several of the women frequently went without food or essential items themselves, rather than incite a violent response by asking for money.

There is a consensus among academics, researchers and organisations who work with both survivors and perpetrators of violence that violence cannot be dissociated from the power relations of gender. Unquestionably, feminists writers have persistently emphasised the connection between patriarchy and unequal power in society between males and females (de Beauvoir, 1953; Bartky, 1990; Young, 1990a; Dobash and Dobash, 1979, 1984, 1998; Dobash *et al.* 1992; Yllö and Straus, 1990; Yllö, 1993; Bartky, 1990; Eisikovits and Buchbinder, 2000; Stark, 2007; Barnett *et al.* 2005; Harne and Radford, 2008). Bownridge *et al.* (2011) suggest that although there is a strong intuition that there is a close correlation between patriarchal dominance and the increased risk of violence during pregnancy, most of the current data has been collected without a comparison group who have not experienced violence during pregnancy. This suggests that the relationship between patriarchal domination and the increased risk for violence during pregnancy is yet to be established, signifying that more research is required in this specific area.

Bartky (1990) considers the psychological effects of sexist oppression resemble those of racism and colonialism suggesting that to be “psychologically oppressed is to be weighed down in your mind and have harsh domination weighed over your self-esteem” (Bartky, p.22). Psychological oppression breaks the spirit of those who are oppressed, enabling them to be dominated. Bartky (1990) believes psychological oppression arises from belonging to a society which affirms the human status, yet simultaneously strives to prevent that person from taking part, leading to feelings of isolation and alienation. Even though Bartky’s theory is not directly referring to women being subjected to violence, her theory of alienation resonates with the women’s narratives. Many of the women were denied the freedom to go out, or to participate in the social world of new mothers.

## **15.4. The link between pregnancy intention and the risk of experiencing violence**

This section will explore the association between pregnancy intention and the risk of experiencing violence during pregnancy.

A pregnancy that is unplanned and unwanted by the male partner may generate abuse in a relationship (Goodwin *et al.* 2000; Campbell *et al.* 2004; Bacchus *et al.* 2006). Evidence suggested that abused women are less likely to have planned their pregnancy. Women with unwanted or mistimed pregnancies reported higher rates of physical violence during pregnancy than during the year before conception (Taft, 2002). Stewart and Cecutti (1993) also established that women with an unplanned pregnancy were three times more likely to experience violence during their pregnancy, than women with a planned pregnancy. Bacchus *et al.* (2006) suggests a pregnancy which is unwanted by the male partner, may initiate abuse within that relationship.

In this study, eight of the eleven participants did not plan their pregnancies and two women only agreed to become pregnant after relentless bullying from their partner. Only one participant, Wendy and her partner jointly planned her pregnancy. Seven of the eight women with unplanned pregnancies experienced physical violence during their pregnancy. Research has found a significant association between partner violence and unintended pregnancy, even after allowing for confounding factors. The adjusted odds of a woman having an unintended pregnancy were 41% higher if she had been physically or sexually abused by her partner (Pallitto's *et al.*, 2004; 2005). The available evidence suggests an association between pregnancy intendedness and physical violence, although further research is required to explore this matter in more depth.

Such findings have consequences for the maternity services. Late entry into antenatal care may be correlated with an unintended pregnancy, as women may enter a period of denial before they engage with the maternity services. It is of course, also important to consider that women, especially those who are socially advantaged with professional occupations and their own incomes, and planned their pregnancies may under report violence. According to Gazmararian *et al.* (1995), another explanation is that the prevalence of violence amongst women from socially deprived groups is already so high, that an unintended pregnancy cannot significantly increase its frequency.

Research from the United States (US) has explored the possible association between pregnancy intention and the risk of experiencing violence during pregnancy. (Stewart and Cecutti, 1993; Campell *et al.* 1995; Gazmararian *et al.* 1995; Goodwin *et al.* 2000; Saltzman, 2003; Pallitto *et al.* 2005; Silva *et al.* 2008). Goodwin *et al.*'s. (2000) study focused on a large cohort of 39,348 women who had delivered a live infant within the previous two – six months. Amongst the women who reported abuse at the time of conception, during the pregnancy or during the 12 months prior to the conception, only 33.7% reported that their pregnancy was planned. Of the 66.3% experiencing an unintended pregnancy, which resulted in a live birth, 46.0% were 'inopportune' and 20.3% unwanted. Violent abuse by a partner during the pregnancy was significantly higher amongst the group of women whose pregnancies were unintended - 15.3% - as opposed to 5.3% in the group with intended pregnancies.

Goodwin *et al.* (2000) also found a link between abuse and maternal demographics. Levels of abuse were significantly more prevalent among younger women, those with less educational attainment and unmarried women. Population studies from America using the PRAMS (Pregnancy Risk Assessment Monitoring System) data have revealed that women reporting unintended pregnancies were approximately 2.5 times more likely to experience violence during pregnancy compared to women with an intended pregnancy (Goodwin *et al.* 2000; Saltzman *et al.* 2003).



Undoubtedly, experiencing domestic violence during pregnancy will also impact upon a woman's individual experiences of being pregnant. This was articulated by one of the participants who felt she had been cheated of the opportunity to enjoy her pregnancy. Eisikovitis and Buchbinder (2000) note that living with violence impacts on the quality of life in all areas:

living with violence creates an existential situation that becomes all encompassing and affects identities, relationships and roles, as well as the perception of time, places and other people. (Eisikovitis and Buchbinder, 2000 p. 145)

Whilst there is an extensive literature establishing the correlation between abuse and reproductive consequences (Campbell *et al*, 2002; Heise, 1995; Heise *et al*, 1999; Pallitto *et al* 2005), very few studies focused on the possible causal relationship between violence and pregnancy, or examined the temporal relationship between these two phenomena (i.e. what precedes the other). A common finding amongst several of the studies is that less socially advantaged women reported higher rates of physical violence (Gamararian *et al*. 1995; Goodwin *et al*. 2000; Saltzman, 2003). In this study, two of the eleven women had continued with their education to degree level, with the remainder of the women completing their secondary school education. Two of the participants had been attending college, studying for vocational qualifications when they had met their partners; however, they both left college before completing their studies. Both of the women who had obtained degrees were non-English by birth and over thirty years of age. One had a planned pregnancy and the other an unplanned pregnancy. The woman who experienced physical violence during her pregnancy had not planned her pregnancy. The woman who had planned her pregnancy experienced behaviours such as verbal abuse and intimidation but no physical violence during her actual first pregnancy.

Pallitto *et al.*, (2004; 2005), discovered a significant association between partner violence and unintended pregnancy even after controlling for confounding factors. The adjusted odds of a woman having an unintended pregnancy in the past five years were 41% higher if she had been physically or sexually abused by her partner. A national woman's study conducted in the US in the mid nineties, involving 3000 women over eighteen years of age investigated rape – related pregnancy. The results concluded that 13.6% of women reported a lifetime prevalence of rape and 5% of women conceived a rape related pregnancy. For 59% of women, the pregnancy was the result of a single rape whilst 41% of the women experienced repeated rape. Distressingly, 29.9% of the perpetrators were boyfriends, and 17.6% were husbands, with family and friends being the third most common group. Almost half of the rape related pregnancies occurred when the women were less than 18 years old. 50% of the women opted to have a termination of pregnancy (Holmes *et al.* 1996). Findings such as these demonstrate the vulnerability of young women and the clear association between violence, rape and unintended pregnancies, resulting in requests for abortions. The findings also identify the need for more research exploring the link between pregnancy violence and pregnancy termination.

## **Summary**

This chapter has discussed some of the main findings to evolve from the women's stories related to pregnancy, within the context of existing pertinent literature and research. The following chapter will consider the women's experiences of violence during the postnatal period. This will include an exploration into post pregnancy violence and the impact that such violence can have on the woman's adjustment into motherhood.

## Chapter Sixteen

### Discussion

#### 16.1. Postnatal depression

From the interviews with the women who had experienced domestic violence it became apparent that, whilst physical injuries were of great consequence, it was the psychological and emotional effects of the ongoing abuse which had the most impact. This is not an extraordinary finding, as it has been established that women who are in a violent relationship, will report much higher rates of poor psychological health than women who are not experiencing violence (Coker, *et al.* 2000; Woolhouse *et al.* 2012). In fact, all ten women in Williamson's (2000a) research had had some form of contact with the psychiatric services, with seven women having attempted suicide, four on several occasions. Therefore, it should not be unreasonable that there may be a relationship between pregnancy violence and postpartum depression. Depression at any time during a woman's life is distressing (Donaldson–Myles, 2011) but it is of special concern during pregnancy and in the postnatal period. This is because maternal infant attachment may be affected, resulting in women's negative feelings towards their newborn infants, and in turn this may impact on the infants' development (Hall, 2006; Martin *et al.* 2006a; Beck 2008).

Abuse during pregnancy has been linked to depression both during pregnancy and in the postnatal period (Dunn and Oths, 2004; Martin *et al.* 2006a; Pallitto *et al.* 2005; Woolhouse *et al.* 2012). Martin *et al.* (2006a) established that any degree of abusive behaviour experienced during pregnancy is associated with increased levels of depression. The women's accounts in this study suggested that the men habitually undermined their mothering abilities and treated them as objects of ridicule. The men developed strategies deliberately aimed at eroding the women's confidence, when caring for their newborn babies. Several of the women believed these tactics contributed to their depression and lack of self belief in their own mothering abilities. The findings of this study suggest that abusive men use the mothering role as a focus

for psychological abuse and a means to exert further control over the women, thereby increasing the women's feelings of worthlessness and low self esteem.

Richie (1995) provides a useful framework, which she calls gender entrapment, for exploring domestic violence and its relationship to mothering. Gender entrapment refers to a process whereby African - American women are set up to fail in their relationships and life ambitions. Failure results from being marginalised by the intersectional disadvantages of experiencing violence, racism, sexism and poverty. Richie (1995) highlights how an individual woman's experience varies according to their individual circumstances and the multifaceted interplay between racism, sexism and poverty. Richie's (*op cit*) theory of gender entrapment can be applied to all the women in this study. All of the participants had an element or elements of susceptibility, which intersected with their pregnancies, thereby increasing their vulnerability. I consider pregnancy and motherhood can contribute to a woman's vulnerability, allowing male partners to exert even more control over the women. Radford and Hester (2006) propose that gender entrapment is a useful concept for exploring mothering and domestic violence, because it not only allows one to look at how violence affects woman's health, but also acknowledges how violent men use the mothering role to their advantage:

overcoming gender entrapment is a complex process in which women deal with domestic violence on a daily basis and try to protect and shield their children from abuse. (Radford and Hester, 2006, p. 47)

Many of the women described feelings of depression, exhaustion and disillusionment during the postnatal period. Depression can be considered a common response amongst women, whose partners have left them feeling powerless and with little control over their own life. It has been suggested that little attention has been paid to the effects of psychological abuse during pregnancy (Stampfel *et al.* 2010; Zlotnick *et*

*al.* 2011), yet depression and post-traumatic stress disorder (PTSD) are considered to be the most prevalent mental health outcome of living with abuse (Campbell *et al.* 1997; Campbell and Soeken, 1999b; Coker *et al.* 2000; Campbell, 2002; Tiwra *et al.* 2008; Woodhouse *et al.* 2011). Depression during pregnancy has also been linked to other harmful health related behaviours including poor maternal nutrition, alcohol dependence and prescribed and non prescribed drug taking and even suicide (Martin *et al.* 2006a). Smoking, alcohol and drug dependence despite being harmful behaviours to the unborn baby and the woman are used as coping strategies to help women cope with their partners' violent behaviour (Martin *et al.* 2006a): although, in this study, none of the women reported alcohol or illegal drug dependency to help them cope with their partner's abuse. However, five of the seven women who were diagnosed with postnatal depression, were prescribed medication by their general practitioner to help them cope with their depressive feelings during the postnatal period.

Abuse during pregnancy has been linked to depression, both during pregnancy and in the postnatal period (Pallitto *et al.* 2005; Martin *et al.* 2006a; Charles and Perreira, 2007; Tiwari *et al.* 2008; Ludemir *et al.* 2010). All the women who participated in this study expressed feelings of misery and despondency about their situation, and believed such feelings were caused by living with the tension and trauma of a violent relationship. There is evidence that depression can be generated by violence (Campbell, 2002), and some longitudinal evidence reports that depressive symptoms gradually decrease with the reduction of partner violence (Silvia *et al.* 1997; Campbell and Soeken, 1999b).

Women often blame themselves for their partners' violence, believing they have provoked the violence, or that they should have been able to prevent it happening by modifying their own behaviour (Hydèn, 1999; Barnett *et al.* 2005). Such thoughts can lead to low self esteem; self reported low self esteem was present in all of the women who participated in this study. The women talked about losing their self confidence and ability to make decisions: they told how they tried to modify their behaviour. This

included changing the way they dressed and behaved, in an attempt to meet their partners' demands. Researchers have frequently reported on low self esteem and feelings of powerlessness amongst assaulted women (Angilar and Nightingale, 1994; Orava *et al.* 1996; Barnett *et al.* 2005; Baker, 2008). Earlier research suggested that women with low self esteem may even be attracted to abusive partners (Shainess, 1997). However, a meta analysis of causal factors linked to women's abuse provided no evidence that low self esteem increased the risk of abuse (Walker 1984; Hotaling and Sugarman, 1986). According to Giles-Sims (2008), research suggests that low self esteem among abused women actually stems from living in a violent relationship, with women who had experienced emotional abuse including controlling behaviour, reporting the greatest impact on their self esteem (Aguilar and Nightingale, 1994).

In this study, ten of the eleven men refused to help the women at home or take any responsibility for parenting. The women were expected to provide all the childcare and do all the housework. In most instances the men were reported to have a general lack of interest in the baby's welfare. A longitudinal UK study conducted by the Avon Longitudinal Study Parents And Children's (ALSPAC) by Roberts *et al.* & ALSPAC study team, (2004), reported that a lack of partner support significantly increases the risk of postpartum depression amongst new mothers. The women in my study all experienced a lack of partner support following the birth, and due to forced isolation from family and friends the majority had no one to call upon for support or help.

A recent study by Woolhouse *et al.* (2012) found that around 40% of the women who reported depressive symptoms were also experiencing domestic abuse. In addition, Woolhouse *et al's* (*op cit*) reported that women subjected to violence prior to pregnancy were significantly more likely to suffer depression during early pregnancy. Woolhouse *et al* (*op cit*) study corroborated existing evidence that more women experience emotional abuse than physical abuse. Such findings substantiate and strengthen the existing theory that emotional and psychological abuse are as strongly associated with poor health outcomes as physical abuse and that in many cultures,

psychological abuse may be the principal form of abuse perpetrated against women during pregnancy (Martin *et al.* 2004, 2006b; Hegarty *et al.* 2005; Bacchus *et al.*, 2006; Tiwari *et al.* 2008).

Overall, the findings from the existing body of research and this study have important lessons for practice. The findings not only validate the importance of routine enquiry by healthcare professionals about abusive behaviours during pregnancy, but also for associated maternal depression during the antenatal and postnatal periods. Healthcare professionals should ensure that all female clients who disclose about violent relationships should also be assessed for depression. Conversely women seeking help for depression should also be assessed for partner violence and referred to the most appropriate support services.

## **16.2 Domestic violence and infant feeding**

The limited literature available suggests that a strong relationship exists between a mother's abusive relationship and the choices she will make regarding infant feeding (Benedict *et al.*, 1994; Prentice *et al.*, 2002; Bair-Merritt *et al.*, 2006). Breastfeeding is something that all new mothers are encouraged to consider in view of its health benefits for the baby and mother. However, pregnant women living in an abusive relationship will have other factors to consider, which may dictate their choices regarding infant feeding. Midwives, health visitors and other healthcare professionals need to develop an awareness that some women living in a violent relationship may have very little or no choice, when considering feeding methods for their newborn babies.

In this study, only four of the eleven women decided to breastfeed their baby. Some of the women had not considered breastfeeding and their intention was always to formula feed their baby. Of the four women who decided to breastfeed three women

decided to stop shortly after the birth, two in the first two weeks and one after four weeks. Only one continued to breastfeed for six months. Explanations offered by the women for their decision to stop breastfeeding, included their partner's jealousy and to stop the baby from crying too much. Several of the women associated breastfeeding with an unsettled baby. Several women also perceived their partners to be jealous of the time they spent breastfeeding and reported that the men became irritated and showed their displeasure, if they thought the women were spending too much time breastfeeding. Likewise, the same men would become stressed and agitated if their newborn babies cried too much. The women soon realised that their baby would sleep for longer periods between feeds and therefore cry less, if they gave them formula milk. (A newborn baby who is being breastfed will often feed frequently until breastfeeding is fully established; once this is achieved, a breast fed baby will appear as settled as a formula feed baby).

Kendall –Tackett (2007) suggests that women living in an abusive relationship are much more likely to encounter obstacles to breastfeeding such as smoking, short stays in hospital following birth, premature birth and lack of partner support. It is known that women who choose to breastfeed have a different demographic and socio-economic profile to women who chose formula feeding. The UK Infant Feeding Survey of 2000 (Hamlyn *et al.* 2002) found that women from higher economic groups, older women and those with a higher educational attainment are most likely to breastfeed. Of the three women in this study who choose to breastfeed, two were older mothers with a degree level education supporting the findings from the Infant Feeding Survey. A recent review has concluded that there is a significant link between feeding methods and maternal mood. There is a lower incidence of postnatal depression amongst breastfeeding women, whilst women suffering from depression were much more likely to be formula feeding. This relationship exists independently of other known economic and environmental differences (Donaldson-Myles, 2011).



Women who smoke are more likely to give up breastfeeding early in the postpartum period (Heck *et al.* 2003), and smoking is frequently cited as a coping mechanism and a means to relieve stresses (Kendall – Tackett, 2003). Women who are being abused may be more likely to smoke as a means of relieving the daily stress of living in a violent relationship. Short postpartum hospital stays have been also linked with the cessation of breastfeeding. Women with a violent partner may only be permitted a very short hospital stay, following the birth. Male partners may demand that a woman return home as soon as possible, following the birth, reducing the opportunity for a midwife or other healthcare professional who may suspect abuse, to question the woman without a partner being present. Heck *et al.* (2003) reported that women, who gave birth prematurely or to low weight infants which resulted in an admission to the Special Care Baby Unit (SCBU), were also much more likely to stop breastfeeding. Premature labour and low birth weight have already been clearly associated with abuse during pregnancy (Bohn, 1990; Webster *et al.* 1996; Valladares *et al.* 2002; Janssen *et al.* 2003).

The findings from this study, suggest that male jealousy does feature in a woman's decision, whether to initiate or stop breastfeeding. Such jealousy may include breast ownership, but also the amount of time the woman may spend breastfeeding and caring for her baby on a one to one basis may also be a factor in the jealousy. Several of the women in this study believed their partners were resentful of the time they spent breastfeeding. Presently, there are substantial gaps in knowledge and research exploring the links between breastfeeding and a woman's experiences of violence and sexual abuse. However, it does appear that there is a relationship between male violence and lower rates of breastfeeding. In view of the immense health benefits of breastfeeding to both mother and baby, it is important that further research is conducted in this area.

Healthcare professionals, especially midwives should as part of their health promotion role continue to encourage pregnant women to breastfeed. At the same time,

sensitivity and support must also be shown to the women who make the decision not to breastfeed. As some of the women who decide not to breastfeed may be a victim or survivor of violence and sexual abuse and therefore may not have a 'choice' in their newborn's feeding method.

The remaining section of this chapter intends to explore the links between domestic violence and child abuse, the association between violence and male substance abuse and the women's perceptions of their partners' indifference towards the pregnancy.

### **16.3. Domestic violence and the link with child abuse**

During the interviews, none of the women suggested that their partners were purposely physically violent towards their children. However, some of the men regularly threatened to harm the children if the women did not obey their rules or give in to their demands. Stark (2007) identifies this behaviour by the men as "child abuse as tangential spouse abuse" (p. 251), where the partner threatens to hurt the children as an extension of the mother, adding to his ability to control or hurt her. Stark suggests this tactic is usually used when the woman has stopped reacting to direct threats or violence, or when she has left the perpetrator and he has less access to her (Stark, 2007). In this study, older children often witnessed violence and abusive behaviours first hand or found themselves caught up in the violence. Julia's partner frequently encouraged their teenage children to be disrespectful towards Julia; by encouraging the children to call her hurtful names Julia believed this behaviour was an attempt to undermine her relationship with the children. Susan's thirteen year old daughter M..... was frequently forced to watch her mother being beaten and threatened by Susan's partner. Radford *et al.* (1999) claims violent fathers often attempt to involve children in the verbal and physical abuse of their mother. Such undermining tactics by men may cause some children to lose confidence in and respect for their mother and may even destroy the mother and child relationship (McGee, 2000; Mullender *et al.* 2002; Radford and Hester, 2006). However, Stark (2007)

suggests such incidents can bring a sharp sense of reality to a mother as it brings into focus the terrible circumstances that a woman finds herself living in. In Julia's case this forced her to make the decision to leave her partner.

In the UK, one in seven children and young people under the age of eighteen will have lived with domestic violence (Radford, 2011). Research has consistently shown that a high percentage of children who live in homes where domestic abuse occurs, are also being physically or/and sexually abused (Barron, 2005; Hague and Malos, 2005). It is known that nearly three-quarters of children on the 'at risk' register live in households where domestic violence is occurring (Department of Health, 2002), signifying the unmistakable association between child abuse and domestic violence. Clearly, such findings should be of a great concern to society as a whole. Indeed, recent research by Brandon *et al.* (2010) concluded that domestic violence was present in the family of two-thirds of the serious case reviews where a child died.

Although none of the women's children in this study were directly physically harmed by their fathers, babies and children in the home were still at risk of being indirectly physically injured. Three of the eleven women described episodes when their partners indiscriminately lashed out at them, when they were feeding or holding their baby. For two of the three women, these violent episodes were the catalyst which gave them the courage to seek help and leave the relationship. This demonstrates that some women will develop an increased sense of responsibility, if their children become caught up in the violence.

There is now growing recognition that children do not have to be directly physically or sexually abused, to suffer harm when there is violence within the family home. Growing up, witnessing domestic violence can have a detrimental effect on children, which affects their emotional and behavioural development (Barnett *et al.* 2005; Radford and Hester, 2006; Harne and Radford, 2008). Research conducted by Jaffe *et*

*al.* (1990) established that children could recount violent events, even when their mothers believed they had not been aware of the incidents. This suggests parents frequently misjudge the extent of their own children's knowledge of any domestic violence within the home. Another study by Suderman and Jaffe (1999) found that babies as young as six weeks could be affected by witnessing and hearing domestic abuse. Accordingly, a child witnessing domestic violence is now recognised as an indirect form of abuse in itself. Children's organisations such as the National Society for the Prevention of Cruelty to Children (NSPCC), Barnado's, Action for Children and Women's Aid have developed strong awareness and publicity campaigns to highlight the immediate and long term harm that children experience when living in a home where there is domestic violence. Professional bodies have also published safe guarding children guidelines and introduced training for staff, all with the purpose of safe guarding children. Such developments have also led to an increased awareness of the close association between domestic and child abuse. However, Hague and Malos (2005), whilst welcoming such developments, advise caution when involving state agencies who have extensive power and authority, but lack the knowledge and appreciation of gender matters. They consider such misunderstandings have led to bureaucratic safe guarding responses towards the mother. Radford and Hester (2006) suggest healthcare practitioners need to develop an awareness of the complex and tyrannical approaches perpetrators apply, including the indiscriminate use of children in attempt to keep control and power over women and children.

#### **16.4. Men's violence and their use of alcohol and drugs**

Several studies have demonstrated a correlation between the consumption of alcohol and partner violence against women and children (Hotaling and Sugarman, 1986; Shepherd *et al.* 1988; Leonard, 1993; Field *et al.* 2004; Graham *et al.* 2011; Smith *et al.* 2011). Domestic violence literature recognises that substance abuse, including alcohol and illegal drugs, appears to be one of the most common risk factors for domestic violence within a relationship. Research has consistently reported higher rates of violence by partners who are heavy drinkers (McFarlane *et al.* 1995; Parker and

Auerhahn, 1998; Muhajarine and D'Arcy, 1999; White and Chen, 2002; Phillips *et al.* 2007, Foran and O'Leary, 2008). Garcia – Moreno *et al.* (2006) suggest the link between alcohol and violence against women varies considerably among cultures. It may be partly related to societal factors such as poverty and social inequalities (Krug *et al.* 2002). However, much less is known about the link between alcohol and partner violence during pregnancy. Few studies have explored whether heavy drinking or illegal drug use by the male partner can exacerbate the risk of violence against a pregnant woman (Taillieu and Brownridge, 2010).

My study found that alcohol and drug abuse did contribute to an increase in the men's violent behaviour towards their partners during pregnancy. Alcohol and drug abuse occurred in ten of the eleven relationships. Illicit drug use included the use of cannabis, crack cocaine and heroin. Excessive drug abuse was present in seven of the relationships, with some of the men abusing both alcohol and drugs. In most of the relationships affected by alcohol and drug use the men controlled the family finances. The women believed the men's need for money to buy alcohol and drugs increased financial tensions within the family. Women were often deprived of money to buy basic necessities, such as food and to meet the payment of household bills. Two of the women were forced to relocate frequently, due to the non payment of rent.

Many studies have explored the link between alcohol and drug abuse and domestic violence (Amaro *et al.* 1990; Leonard and Quigley, 1999; Muhajarine and D'Arcy, 1999; Cunradi, *et al.* 2000; Gilchrist *et al.* 2003; Charles and Perreria, 2007; Graham *et al.* 2011). Muhajarine and D'Arcy (1999) found that women whose partners consumed excess amounts of alcohol were three times more likely to be abused, than women whose partners did not have a drinking problem. However, it is important to realise that whilst substance abuse can make the situation worse, the use of alcohol and drugs does not in itself lead to violence. Many men are violent towards their partner with or without alcohol (Women's Aid, 2006).

Graham *et al's* (2011) study explored the link between alcohol and domestic violence in thirteen countries and found more severe acts of aggression were associated with alcohol over-usage. Regardless of the cultural differences regarding the acceptability of alcohol consumption, a similar pattern emerged from all the countries. The British Crime Survey data for the years 2008/9 confirmed that 38% of domestic violence incidents were alcohol related (Walker *et al.* 2009b), demonstrating an association between alcohol and violence.

In my study, three women suffered a miscarriage following a physical assault by their male partners, who were under the influence of alcohol (three men) and crack cocaine (two men). The two men who had taken both drugs and alcohol were extremely aggressive, kicking and punching their partners; both these violent assaults resulted in a late miscarriage. The third man pushed his partner off her bicycle in a drunken rage, resulting in the woman miscarrying the following day. Many women in this study believed that their partners' violence and aggression increased when under the influence of alcohol and/or drugs. However, these men were also violent towards their partners when they were sober. Bacchus *et al.* (2006) reports similar findings with pregnant women reporting being assaulted by their drunken partners.

During the interviews, the women portrayed their partners as being unconcerned or uninterested in the pregnancy. The behaviour of some of the men took a turn for the worse; they were described by the women as being difficult, uncaring and dominating. It appears the men did not offer any extra emotional or psychological support to their partners during their pregnancies. For several of the women, who had been coerced into motherhood by their partners, the men's lack of interest in the pregnancy and indifference towards them was unanticipated. The women's stories offered an insight into their partners' irritation towards them, the pregnancy and birth. The men thought life should carry on as normal, viewing the pregnancy as nothing more than an inconvenience. The women's hopes that their partners would change, or at least modify their abusive behaviour during their pregnancy, were in vain. The men did not

become thoughtful and nurturing, most men carried on with their emotional and controlling behaviour as usual, showing a total disregard for the women's feelings.

It is important to remember that six of the women in this study experienced physical violence for the first time during their pregnancy. Some of the women believed the men were jealous of the pregnancy and the unborn baby, and of the extra attention that the pregnancies brought the women. Research by Campbell *et al.* (1993) with pregnant women highlighted four main themes that their respondents used to explain men's violent behaviour. These were: jealousy of the unborn baby, anger towards the unborn baby, pregnancy-specific violence and business as usual. In my study, some of the male partners used the unborn baby to threaten the women. The women's stories offered some insights into why pregnancy may be a trigger for the initiation or the intensification of violence and abuse.

Male jealousy and indifference is frequently cited as a cause of violent behaviour (Dobash and Dobash, 1984; Yllö and Bograd, 1988; Campbell *et al.* 1993; Dobash and Dobash, 1998; Bacchus *et al.*, 2006; Stark, 2007). Violent men are often portrayed as emotionally insecure and driven by jealousy and possessiveness (Dobash and Dobash, 1984). According to Peterson del Mar's study (1996) men's violent responses are due in part to the fact that the men view the women's pregnancies as a personal threat. During pregnancy, a woman may become more introverted and preoccupied with bodily changes. She may be focussed on preparation for the impending birth and therefore be less emotionally engaged with or available to her partner. This may reinforce the man's view of pregnancy being a personal threat (Mezey, 1997). Such conjectures are supported by Dobash and Dobash (1998) who suggest jealousy can be galvanised when the male thinks his place in the relationship might be usurped by a third party e.g. a newborn baby. Jealousy may unleash contingent responses including violence, aimed at countering and reducing the threat. Bacchus *et al.* (2006) also proposes that abusive men may find it difficult to respond in a supportive manner to the increased emotional and physical demands of their pregnant partners. Many of the

male partners in this study appeared to be jealous of their partner's family and friends. It therefore seems likely that these feelings of jealousy could extend to anything or anyone, including an unborn baby who may have distracted the women's attention away from them.

The results from my study and others, suggest that partner indifference, jealousy, alcohol and illegal drug taking can be risk factors for partner violence, and can lead to an intensification of violence. The existing evidence is compelling enough for the World Health Organisation (2009) to acknowledge alcohol consumption as a major risk factor for domestic violence. Acknowledging the relationship between alcohol and violence is the first step that will perhaps allow for the development of effective prevention and treatment programmes.



## Chapter Seventeen

### Discussion

This chapter will consider and explore some of the interactions that occurred between the study participants and a range of healthcare professionals.

#### **17.1. Responding to domestic violence: the role of health professionals**

In the last decade, recognising the need for a better response to domestic violence by health care staff and services (Ramsay *et al.* 2006), regulatory bodies including the UK government, the Department of Health and a wide range of professional bodies have introduced awareness raising campaigns, crime reduction programmes, policy guidelines, and guidance and training for practitioners (British Medical Association, 1998; Royal College of Nursing, 2000; Department of Health, 2000; 2005; 2010a, 2010b; Royal College of Midwives, 2006; Lewis, 2007, 2011). This has led to greater clarity, regarding the role of the health professionals in responding to domestic violence.

Asking women about their experiences of domestic violence is now accepted as best practice and is recommended professional practice. However, health professionals remain reluctant to engage with, or effectively respond to, domestic violence (Ramsay *et al.* 2006). Such ambivalence may be attributed to several different factors, including personal attitudes and values; a perceived lack of time, fear of offending clients, or lack of knowledge, training and support about how best to intervene (Hague and Malos, 2005; Salmon *et al.* 2004; Tower, 2007; Bacchus *et al.* 2010; Department of Health, 2010a). Warshaw *et al.* (2005) state that addressing partner violence may present challenges for clinicians, as developing the relevant skills requires them to confront their own position, social beliefs and personal and home relationships, which might include violence in their own context.

Currently, the debate continues between policy makers, researchers, health professionals and third sector agencies about the overall potential of health service interventions. The debate concerning the best way to identify and support women including the intrinsic worth of routine enquiry by health professionals, continues to dominate the research and policy agenda. Many health professionals are still attempting to define their own effective strategies to address domestic violence. It has been claimed that many NHS staff are unaware of appropriate interventions or referral pathways because they have not received effective, or indeed, any training about the issue (Richardson *et al*, 2001; Salmon *et al* 2004, 2006; Department of Health, 2009; 2010b).

There is an ongoing debate as to whether interventions by healthcare staff are effective or not. There is currently no evidence that such interventions cause more harm than good (Ramsay *et al*. 2006) or that negative impacts are an acceptable trade-off for whatever benefits might accrue. I would suggest that if healthcare staff are to take the issue of domestic abuse seriously then continuing to collect important prevalence data via some form of questioning is vital. For the NHS to be able to respond effectively, appropriately and responsibly to this issue the following issues have to be addressed: ongoing supportive training and staff awareness, the development of an environment in which women feel safe to disclose, supportive protocols to be developed with appropriate multi-agency referral pathways and a fostering of multi-agency working. The importance of multi-agency working will be considered in more depth later in this chapter.

UK research has focused on the role that healthcare professionals can play in addressing domestic abuse. UK based studies have found that when health professionals receive up to date evidence-based and evaluated training, with continued support and clearly flagged referral pathways to specialist advocacy services, routine enquiry is successful at identifying women who are experiencing

domestic violence (Salmon *et al.* 2004; Bacchus *et al.* 2007; Baird *et al.* 2011; Feder *et al.* 2011).

Many healthcare professionals may struggle to understand why women remain in an abusive relationship. Such judgements demonstrate a lack of understanding of the context of the problem. Suggesting that women who experience domestic violence should always leave the relationship, conflicts with the social discourse that women have a responsibility to keep families together. Such attitudes place women in a no-win situation, where they end up feeling stigmatised, regardless of the choices they make (Williamson, 2000a). Leaving a violent relationship does not guarantee safety for women. In fact, the opposite is true; leaving a relationship is the most dangerous time. Most women who are murdered by their partner are killed during the process of leaving or just after leaving a relationship (Kelly, 1988; Walby and Allen, 2004; Hague and Malos, 2005; Walker 2009a; Walker 2009b). Therefore advising a woman to leave a violent relationship before an adequate safety plan is in place, is the most perilous piece of advice a health professional can offer.

Stark and Flitcraft (1995) suggest women's continued silence can be attributed to the medical profession's stigmatisation of women who have experienced domestic abuse. This may also be used to explain the professional's shortcomings in not responding effectively to domestic violence. Williamson (2000a) supports Stark and Flitcraft's (1996) conjecture, by suggesting such stigmatisation of abused women may complement the way society individualises domestic violence. It is constructed as a problem in which no one has the right to intervene. Such responses by health staff may not only result in a woman feeling blamed for her own situation, but may also lead her to reject health and other public services such as the police when she is most vulnerable and requires help and support (Taft, 2003).

Health professionals must try to appreciate how women perceive their own ability to manage their own situation. Haggerty *et al.* (2001) suggest women's perceptions of control, like beliefs about danger, are usually related to several factors: perceptions of her partner's mood changes; their own intuition; the degree of their social isolation; the available level of interpersonal and community support. This suggests that a woman's indecision about her current situation and relationship may be connected to her ability to control the abuse. It is known that abusive behaviours perceived to be most dangerous by women do not match agency workers' perceptions (Stuart and Campbell, 1989; Haggerty *et al.* 2001). A survey by Stuart and Campbell (1989) found that women's perceptions of danger were based on subjective signs such as their partner's moods, their own intuition and stress levels within the relationship. Agency workers by contrast based their evaluation of danger on the incidence of abusive acts ranging from slapping to the use of a weapon. Haggerty *et al.* (2001) findings were consistent with those of Stuart and Campbell (1989), in that women's assessments of danger did not correlate with those of agency workers. Haggerty *et al.*'s (2001) confirmed earlier findings that women's perceptions of abuse extend beyond abusive acts by partners. The social context and other experiential features, influence a woman's beliefs and perceptions about abuse and her own situation. These findings indicate that women themselves are best placed to make decisions about when it is safe to divulge about the existence of abuse in her relationship and, most importantly when it is safe for them to leave the relationship.

## **17.2. The role of the midwife in supporting women who are experiencing domestic violence**

In the following section I will discuss some of the challenges and dilemmas for maternity staff when identifying and supporting women who have experienced domestic violence. Midwives have frequent contact with women during pregnancy and therefore maternity services are ideally placed as a universal point of contact for all childbearing women. Maternity services should be a valuable setting to communicate with women who are being abused by their partner (Bewley *et al.* 1997).

Much of the literature during the last decade supports Bewley *et al's* (1997) proposal. This belief has led to improvements in how the maternity services address domestic abuse. Several studies have reported that the more frequently health professionals are encouraged to make routine enquiry and hear disclosure, the greater their understanding and confidence. This leads to better practice, as not only are health professionals more likely to ask women about domestic violence; they are also much more likely to recognise the signs of ongoing domestic abuse (Mezey *et al.* 2003; Taket *et al.* 2004; Salmon *et al.* 2004; Bacchus *et al.* 2007; Baird *et al.* 2011; Feder *et al.* 2011).

The findings from my study concur with findings from international and UK studies that women generally approve of routine enquiry into domestic abuse during the antenatal period (Friedman *et al.* 1992; Stenson *et al.* 2001; Webster *et al.* 2001; Bacchus, *et al.* 2002; Bradley *et al.* 2002; Richardson *et al.* 2002; Sethi *et al.* 2004; Lutz, 2005; Mc Donnell, 2006; Bacchus *et al.* 2007; Baird *et al.* 2011). Data from UK surveys demonstrates that 35% - 99% of women find screening for domestic violence acceptable (Bacchus *et al.* 2002, 2006; Sethi *et al.* 2004; McDonnell, 2006; Baird *et al.*, 2011). A survey of 200 antenatal and postnatal women receiving maternity care at a London hospital in 2002 reported that 87% of women agreed that midwives should ask all pregnant women about domestic violence (Bacchus *et al.*, 2002). More recently, Baird *et al.* (2011) conducted a survey of 236 antenatal women in an area of the South West of England and found that 96.6 % of the participants believed it is appropriate for a midwife to enquire about domestic violence. 94.4% of the women also reported that they felt comfortable about their midwife asking them about domestic violence. This suggests that women have a positive view of screening in healthcare settings by professionals.

Studies from other countries support these findings (Gielen *et al.* 2000; Webster, *et al.* 2001; Stenson *et al.* 2001; McCord-Duncan, *et al.* 2006). Gielen *et al.* (2000) conducted a case control study exploring women's responses to routine enquiry for violence and the subsequent compulsory reporting of positive disclosures. Women experiencing violence from a partner were more likely to support routine screening than women who were not (54% vs. 44%). Another study involving 1300 pregnant women found that 96% felt it was acceptable to be asked about domestic violence during pregnancy (McCord-Duncan *et al.* 2006). In their sample of 879 women, Stenson *et al.* (2001) found that a large majority (80%) of pregnant women found questioning acceptable; 12% of women were neutral, 5% of their population found questioning both acceptable and unacceptable, and only 3% found it unacceptable.

Feder *et al.* (2009) corroborated such findings, when conducting their systematic review, concluding that women find routine enquiry in certain health settings acceptable, providing that the health professional was caring, sensitive and non judgemental and most importantly that any information they disclosed was not used to suggest that they were not caring for their children correctly. However, Phelan (2007) intimates that compulsory or conditional reporting can also be a dilemma for healthcare workers; for example, the duty to report can cause a conflict with their own ethical unease about maintaining patient confidentiality and the increased risk that a disclosure may cause for the women and her family. Nevertheless, if the consequences of domestic violence are to be abated, it is imperative that healthcare professionals continue to routinely enquire about domestic violence in all health settings.

Bacchus *et al.* (2007) suggest women can find routine enquiry beneficial even if they chose not to disclose about the violence in the relationship, as it removes any shame that a woman may feel. It also provides women with a mechanism for disclosure at a later date, should the violence intensify during pregnancy. However, Taft (2003) suggests that the introduction of screening brings with it the:

baggage of surveillance and state and professional control over families and individuals, which have been radically and effectively critiqued by Foucault amongst others. (Taft, 2003, p. 11)

Nevertheless, from a practical sense, routinely asking all women about a history of domestic violence is the only conceivable way of increasing the proportion of women who will disclose and as a result, may benefit from safe and measured interventions. Such findings from this study and others, lead one to consider whether there is a better way to enquire about family violence in health populations rather than the blanket policy of mandatory reporting of all domestic abuse disclosures to other organisations such as Children's Services, which can have the potential to dis-empower a woman, perhaps leaving her reluctant to disclose about a history of violence (Phelan, 2007).

Even though there is literature available that demonstrates women's acceptance of being asked about violence, the findings from this study suggest it is much more complex than someone merely asking a question and expecting to receive an honest response. The women's narratives confirmed that they spent a long time deliberating about whether they felt it was safe or not to tell the midwife about the abuse. In general, there appeared to be a reluctance of the women to talk with their midwife or any other healthcare professional that they came into contact with during their pregnancy. Their main anxieties appeared to be concerned with the potential risk of involvement of Children's Services. The women's concerns included: being viewed as a 'bad mother' and being held responsible for exposing their children to domestic violence and automatic referral to Children's Services. This raises a number of issues in relation to health and Children's Services and how they respond to disclosures of abuse from women. Lavis *et al.* (2005) suggest that to change such a practice would constitute a challenge to current and long standing healthcare customs where the health professional is viewed as powerful and 'the expert'. In effect health professionals would be working outside the medical model of care, adopting a non

directive approach (Sasseti, 1993), surrendering their power and demonstrating a commitment to work in partnership with the women.

Tower (2007) suggests that midwives, nurses, social workers and other health professionals are to a certain extent 'controlled' by their organisational guidelines, policies and procedures that support controlling models of care. This, in turn, creates a tension for the health professional between the organisational interests and what is in the best interests of the woman. Perley (1992) believes the continued investment in the medical model of health to deal with what is a social problem, only leads to further objectifying of women. Warshaw (1993, 1997) agrees, suggesting that the discursive practice of the utilising a medical model of care only serves to relocate women as passive patients in their own lives rather than active agents. Such unthinking practices only serve to perpetuate the women's experience of domination, with the health professional undermining or ignoring the woman's perceptions of her own experience, an enactment of her abusive relationship (Lavis, 2005).

The women in this study described having a good relationship with their midwife. They described their midwife as caring and friendly, with some of them stating that they had considered opening up to their midwife about the abuse but for a variety of reasons decided to remain silent. Their reasons for maintaining the silence about the violence included: embarrassment, fear of the partner finding out, economic dependence on their partner or concern that the disclosure would result in a referral to children's services. Nearly all the women were not presented with the opportunity to disclose about the abuse to the midwife, as they were accompanied to all their antenatal appointments by their partners. The continued presence of a partner during consultations has been identified as a barrier to asking about domestic violence (Bacchus *et al*, 2001; Salmon *et al*. 2004; Baird *et al*. 2011). In response to such findings, it is recommended that every woman during her antenatal period should be offered at least one appointment alone with the midwife as part of her maternity care (Lewis, 2007, 2011). This change in practice would allow the midwife to ask the



woman about a history of domestic violence. However, currently in the UK, a national policy advocating such practice does not exist and, as a result, it can be difficult for a midwife to negotiate time alone with a woman. However, it must also be acknowledged that even should such a cultural change in midwifery practice take place, most controlling partners would continue to insist on accompanying their partner to all their appointments.

### **17.3. Collaborating with agencies outside health**

Most healthcare providers tend not to be aware of community based services that can offer expert advice and support to women and children who are experiencing domestic abuse. In spite of this, there is an expectation that health professionals and healthcare organisations should be working collaboratively with voluntary sector agencies, to provide optimum care and support for women and families who are experiencing domestic violence (Department of Health 2010a).

Child protection activity, in relation to children living with domestic violence, has increased in recent years. Following the introduction of section 120 of the Adoption and Children Act (HM Government, 2002) and the Domestic Violence and Crime Bill (House of Commons, 2003) there has been a significant change in health professionals' attitudes towards their role in addressing domestic abuse. This change has subsequently led to an increased responsive approach towards domestic violence, with more emphasis on early intervention and referral to appropriate agencies. Consequently, this has resulted in an increased number of referrals to children and young people's services, leading to tensions between agencies working in the field in relation to safeguarding. Such tensions were largely connected to perceived organisational differences in thresholds for services (Baird *et al.* 2011; Radford *et al.* 2011).

There was an indisputable belief by some of the women in this study that they felt they had little to gain by the involvement of Children's Services. On the other hand, they considered they had a lot to lose, should their partner find out they had disclosed the abuse to either a healthcare professional, or to another member of staff from the Children's Services team. Other studies exploring women's reservations and reluctance about disclosure to a health professional have found similar findings, highlighting that the women's main trepidation about disclosure is focused on being judged by professionals, the unwanted involvement of Children's Services and breaches of confidentiality (Bacchus *et al.* 2002; Bradley *et al.* 2002; Richardson *et al.* 2002; Chang *et al.* 2005; Bacchus *et al.*, 2006; McDonnell, 2006; Radford and Hester, 2006; Phelan, 2007). According to Radford and Hester (2006), women fear the involvement of Children's Services which may bring unwanted judgements of them as incapable mothers. Perhaps such apprehension and suspicion by women can be attributed to the suggestion that women themselves are to blame for the violence and the failure to protect their own children.

Several studies have attempted to answer the question why women remain in violent relationships or why they return to their abused partners. In actuality, some women may not want the relationship to end; what they do want is for the violence to stop (Landenburger, 1998). Indeed, as Landenburger (1989) highlights, abuse is such a multifaceted phenomenon that women rarely perceive it as merely leaving or staying in the relationship. This leaves women and professionals in a stand-off situation, with women feeling unable to subscribe to a recovery pathway as stipulated by health professionals (Williamson, 2000a). Lavis *et al* (2005) suggest healthcare professionals must attempt to foster a mutually agreed joint plan of care, one which women find agreeable. Leaving a relationship is not always an easy route for a woman to follow; especially as leaving the relationship does not guarantee that she will be physically safe. For some women, it is not about the decision whether to stay or go, but whether she wants to live or die (Hydèn, 1999). The fear and stress involved in leaving a relationship requires courage and a lot of outside support (Barnett *et al.* 2005), which health professionals are often ill equipped to provide.

For some of the women in this study the decision to leave their partner did not appear to have been made lightly. Many stayed and endured violence for many years, as they were afraid to leave the relationship. It was also evident that even though some of the participants were now living in safety within the refuge, they were still frightened of their partners. Moving out of the family home and leaving all their possessions, had been a difficult decision for them. The women realised that by making the decision to leave their partner and move into a refuge, they were making themselves and their children temporarily homeless. This was a genuine concern for them, especially as the majority of the women had no access to funds. Setting up a new family home resulted in major financial implications for them; the women were reliant upon benefits and financial help from family and friends.

Some of the male partners used the threat of a referral to Social Services to blackmail the women into maintaining the silence around the violence they were experiencing. This was particularly true for the two women who were born outside the UK, despite entering the country legally and having obtained UK residency. Their partners managed to convince them they had an insecure immigration status and that they were vulnerable to extradition and the removal of their children, if they decided to leave their British born husband. Literature pertaining to intersectionality has verified how ethnic identities can result in domination and oppression. Certainly, Crenshaw (1997) specifically refers to immigration status as an example of how race affects violent victimisation. Radford and Hester (2006) hypothesise that the fear of a mother losing her children will keep a woman coupled to a violent man, especially if the partner has successfully managed to erode a woman's self esteem and confidence in her ability to mother. The emotional burden women feel as mothers, to maintain a family unit regardless of how dysfunctional that unit may be, means that some women may decide to stay in a violent relationship for many years (Radford and Hester, 2006).

In recent years, multi-agency initiatives regarding domestic violence have become more established (Hague and Malos, 2005). It is now accepted as best practice that the

National Health Service (NHS) can and should respond to domestic violence by working collaboratively with other statutory and third sector agencies (Bacchus *et al.* 2007). This expectation is also supported by the UK Government, whose message is unmistakable. The way forward for addressing the challenge of violence against women and children can only be met by means of multi-agency working, with a locally-driven co-ordinated approach to domestic violence services in every local authority area (Department of Health, 2009, 2010a, 2010b). Multi-agency partnerships can help increase public awareness about domestic violence and widen the choice of options available to women, establish new domestic violence services and endorse a wide reaching message that domestic violence is no longer acceptable (Hague and Malos, 2005). However, the challenge is to develop an appropriate educational tool and validated training to make this happen. Although collaborative partnerships have a popular appeal a lack of understanding of professional roles, poor information sharing and boundary infringement have all been identified as major factors which limit the potential for collaboration (Department of Health 2005, 2009, 2010a, 2010b, 2011; Lewis, 2007, 2011).

Collaborative work necessitates a united commitment across agencies, which can sometimes be hampered by potential conflicts over organisational boundaries, lack of consensus, differences in principles and values between professional groups, inadequate resources and professional mistrust (Sloper 2004; O'Connor, 2007; Banks *et al.* 2008). The case has been made for interprofessional responses to be based upon interactive approaches. Such approaches enable those involved to engage with one another in a manner that facilitates knowledge, skills, attitudes and confidence, all of which are required for collaborative competence (Barr, 2002; Barr *et al.* 2005; Freeth *et al.* 2005). Bacchus *et al.* (2007) suggest there is an inclination for statutory organisations to take the lead in partnership working, yet for partnership working to be successful within the forum of domestic violence and abuse requires all organisations and participants to be aware of and avoid, power disparity and contradictory organisational philosophies. Previously, a lack of awareness of such behaviours has led to the marginalisation of national and local women's agencies, who

have tirelessly provided services to women and children. Such agencies, despite being recognised and respected for providing a unique and effective service to women and children experiencing violence and abuse, find themselves continually struggling for national funding, and having to rely on charity donations and fund raising.

A recent report compiled by Professor Walby suggested the possible outcomes of recent cuts on budgets and services, are leading to a reduction in the vital services which support women and children experiencing domestic violence (Towers and Walby, 2012). The cuts include a 31% funding cut from local authorities to domestic violence and sexual abuse sectors in 2011/12. Such funding cuts are alarming, as currently 230 women a day seeking refuge are already turned away by Women's Aid due to a lack of space (Barron, 2011). IMKAAN (2012) an organisation providing vital support for Black, Asian and Minority Ethnic groups have had to close two of their six refuges due to funding cuts (IMKAAN, 2012). Statutory provision, including police and court services, has also been reduced following funding cuts. As a result of such funding cuts, Women's Aid estimate that nationally the number of clients they will be able to support is likely to decrease substantially. They estimate that around 70,000 women and children will not be able to have access to their services (Barron, 2011). The full effect of such funding cuts will not be appreciated right away. It is therefore important that information and statistics are collected which demonstrate the full consequences of these funding cuts (Tower and Walby, 2012). Alarmingly, these budgetary cuts are in opposition to the recommendations of the domestic violence taskforce health sub group, who have advocated for a "national guidance on commissioning for both the NHS and the third sector a specialist domestic violence service for women and children" (Department of Health, 2010b, p. 44). They hope this will allow for women and healthcare professionals to access services to specialist domestic violence services, from any health setting. They suggest services should be commissioned in partnership with the local authority and the Crime and Disorder Reduction Partnership (Department of Health, 2010b). The formalisation and development of such partnerships would greatly improve the affiliation and rapport

between health and women's specialised organisations. Doing so, can only be to the benefit of women and children experiencing domestic violence.

## **Summary**

This chapter has provided a snapshot of the women's engagement with health care professionals before, during and after pregnancy. Women who experience domestic violence face a number of interrelated and intricate factors and barriers that complicate their pursuit to be free of violence. In many circumstances leaving a violent partner is not always the safest option at the precise time of a disclosure.

Women can experience difficulties communicating with some healthcare professionals and certainly current healthcare practices are not always conducive to an open and honest dialogue between a woman and a health professional. The social aspects of care can become very nonessential when they have to compete with the physical aspects of care. Women themselves are often resistant to share their experiences with professionals due to fear of a partner, embarrassment and shame and the fear of a referral to Children's Services. These findings emphasise the significant disparities in the best way to approach the important subject of child protection, whilst at the same time identifying a way to engage and work with the women themselves.

Some of the women in this study were never asked about the existence of domestic violence in their relationship by any of the health professionals they encountered. I believe this inadequacy may be attributed to a lack of awareness, education, training and guidance policies that continue to persist in some clinical areas, together with the continued attendance of a male partner during consultations. Consequently, training health professionals to respond effectively and appropriately must become a priority, with ambivalent attitudes of staff being challenged.

## Structure of Conclusion Chapter

### Chapter Eighteen



18

- 18.1. Conclusion
- 18.2. Policy and Practice Recommendations
- 18.3. Recommendations for future research

## Chapter Eighteen

### Conclusion

#### 18.1. Conclusion

The findings in this thesis make evident the profound impact that domestic violence and abuse can have on a woman's mental and physical wellbeing. Whilst recognising that the sample size in this study is small, I would advocate that the depth of stories reported here will resonate with other women and workers' experiences. In this study, women described their experiences of domestic violence and abuse before, during and following the birth of their baby. During pregnancy the women were physically attacked including blows and kicks to the pregnant abdomen, they were punched, slapped, kicked, bitten, pushed around, held by the throat, and attempts at strangulation occurred for two of the women. The women were sexually abused, experienced enforced isolation and financial hardship. They suffered extreme psychological distress, including depression before, during and after pregnancy.

For the majority of the women in this study, their relationship started as a love story. Sadly, however, their love story progressively turned into the reality of abuse. For all the women in this study, the abuse continued in the postnatal period, where the men showed an indifference to fatherhood and the abuse continued whilst the women were attempting to adjust to motherhood. The continuing abuse and the men's indifference to parenthood seemed to be a contributing risk factor for the women developing postnatal depression. The continued abuse in the relationship also appeared to have an effect on some of the women's infant feeding choices, especially for those mothers who chose to breastfeed.

This study has shown that despite negative health consequences for both women and their unborn child, some women will refrain from spontaneous disclosure of domestic violence to healthcare providers, including midwives. Reasons cited for remaining



silent about the violence included, fear of their partner; personal shame; feelings of guilt; concern over confidentiality and a fear of referral to Children's Services, all of which contributed to the women's reluctance to disclose to a health professional. It was apparent from the women's narratives that the midwifery mandatory practice of reporting a history of family violence to Children's Services was an obstacle to facilitating disclosure, for this particular group of women. The women were not seeking an immediate solution from professionals, but someone who was willing to listen, believe their experiences, and advise them of available support services such as the women's advocacy services. Unfortunately, some of the women were not provided with the opportunity to disclose about the ongoing violence, either due to the disinclination of professionals to enquire or due to the continued presence of a male partner. Such findings suggest that a maternity service which acknowledges itself to be women-focused must strive to include time alone with a woman during her pregnancy.

Health professionals, including midwives can play an important role in assisting women who are experiencing partner violence. However, much more research is required before evidence based interventions can be designed and promoted. Given the magnitude of the problem and its far reaching health and social consequences there is an urgent need for further research, which includes strong partnership working with policy makers, researchers, service providers and most importantly women themselves.

My motivations for considering this work were two-fold. Firstly and most importantly to make audible the voices of women who are survivors of domestic violence. The voices of women are often ignored, neglected and marginalised in studies when considering violence during pregnancy. I hope I have managed to achieve this first aim. Secondly, by talking to the women themselves, I wanted to gain some understanding of the complex dynamics of why women are abused by their partners during pregnancy. However, I now realise that for the majority of the women the violence during pregnancy was a continuation of a normative pattern of abuse. However, the

pregnancy served to afford the men further opportunities to control and dominate them. Only two of the eleven women experienced physical violence before pregnancy, six women experienced their first physical violence assault during their pregnancy and three were physically assaulted following childbirth. However, all the women had facets of abusive behaviours in their relationships in the form of controlling, sexual and psychological abuse, before the physical violence began.

Domestic violence is very complex on both the individual and society level. It is linked with power structures regarding gender and the status of women; therefore, there can be no simple or straightforward solution to partner violence. The findings that have been presented in this doctoral thesis attempt to explore and highlight the feelings, emotions and viewpoints of the women who have experienced violence within the context of their pregnancies. This is in accordance with feminist philosophy, which has been concerned with developing an understanding of women's experiences and oppression in terms of struggling with male domination. It is hoped that this research will contribute to that understanding in some way. As a consequence of this study, the following recommendations are suggested.

## **Study Recommendations**

### **18.2. Policy and practice recommendations**

Midwives and other healthcare professionals must listen to women and not be judgmental of their personal circumstances. They need to be patient and empathetic, whilst acknowledging that for women in a violent and abusive relationship, leaving is a process and not a one off event. Women must feel empowered to make the best decision for themselves and their children and not be coerced by a professional into making a decision they are not ready to make.

Midwives and other health professionals must strive to develop an open trusting relationship and create opportunities for women to talk about their experiences of domestic violence before and during pregnancy and after childbirth. They need to strive to provide a safe space for disclosure.

All maternity and other healthcare premises should have up to date and relevant information about domestic violence services for women to take away. Posters and helpline numbers should be clearly visible in waiting rooms, toilets and consulting rooms, thereby promoting awareness of domestic violence to women and staff.

A sustained commitment to universal routine enquiry within the maternity services is required. Although the question may be asked routinely, midwives should be skilled in their communication so that women do not experience routine enquiry as nothing more than a tick box exercise.

Midwives and other healthcare professionals should ensure all female clients who disclose about violent relationships are also assessed for depression. Equally, women

seeking help for depression should also be assessed for partner violence and referred on to the most appropriate support services.

There should be a continued commitment to the continuation of education and training for routine enquiry, for all qualified healthcare professionals. Links should be made to other aspects of safeguarding, including child protection. Training programmes should be knowledge and skills based, and evaluated for efficacy.

Presently routine enquiry is often conducted at the antenatal booking appointment. This appears very early in the midwife – woman relationship. Therefore a second opportunity should be created to ask about domestic violence at a later stage in the woman’s pregnancy.

All women should be seen alone at least once during their pregnancy. Introducing this change will hopefully lead to an increased opportunity for midwives to ask women about a history of domestic violence.

The integration of education about all aspects of domestic violence training should be implemented in all relevant undergraduate curricula. The delivery of this education should take the form of a multi-agency approach.

Professional bodies such as the Nursing and Midwifery Council and the British Medical Council should develop practice competencies for all undergraduate students.

The development of services between the NHS and local organisations, both statutory and non–statutory should be promoted, facilitating local partnerships working. This partnership should include the voices of survivors of domestic violence.

### **18.3. Recommendations for future research**

There is a need for further quantitative and qualitative research exploring the dynamics of a trusting relationship between a midwife and a woman. Such research is necessary in order to enhance positive disclosure from a woman when routine enquiry occurs.

Further research is required into enquiry based interventions, so they can be tailored to suit the women's needs. They should consider how to detect and measure women-centred outcomes. Presently, qualitative research with women remains an underused source of evidence for valuing and understanding experience.

As advocated by Taillieu and Brownbridge (2010) further research is necessary to develop a deeper understanding of violence against pregnant women. To be able to fully understand the phenomenon of pregnancy violence, future research must be directed at understanding how the patterns and nature of violence change throughout a woman's pregnancy. The research should also include the types and sites of injuries women sustain during pregnancy and the consequences of such injuries.

Presently, the majority of research exploring domestic violence is focused on the prevalence, detection and the negative health consequences of domestic violence. There continues to be a gap in the evidence in respect of effective interventions, their long term effects and women's subjective accounts of the effectiveness of referral pathways. Further research is required to explore such outcomes.

To conclude, the findings from this study suggest further research is also required to explore the association between domestic violence and antenatal and postnatal depression. In addition, further research is also necessary to ascertain to what degree experiencing domestic violence can influence a woman's infant feeding choices.

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## Appendix 2



### INFORMATION ABOUT THE RESEARCH

#### **Exploration of women's perceptions and lived experiences of domestic violence during pregnancy**

##### **Part 1**

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen if you take part. Part 2 gives you more detailed information about the conduct of the study). Please ask me if there is anything that is not clear or if you would like more information. Take time your time to decide whether or not you wish to take part.

##### **What is the purpose of the study?**

The aim of the study is to find out about women's experiences of domestic violence especially during pregnancy, birth and in the postnatal period.

##### **Why have I been invited?**

As part of my work, I am asking women who have experienced domestic violence to help with my study. This includes asking women who are currently pregnant or have been ideally in the last 2 years. There will be no trick questions, right or wrong answers, I am interested in listening to your honest experiences, what you think and what you feel.

##### **Do I have to take part?**

No, it is entirely up to you to decide. I will describe the study and go through the information sheet, which I will then give to you to keep. I will also give you a consent form ask you to sign the consent form is to show that you have agreed to take part. Even after you sign the consent form you are still free to withdraw from the study at any time, without giving a reason. You will be given 7 days to complete the consent form, allowing you ample time to consider whether you wish to take part.

**What will happen to me if I take part?**

I would like to meet with you to discuss the study in more detail. If you agree to take part, you will be asked to complete a consent form. If you consent to take part I would like to meet with you to talk about your experiences of domestic violence during your pregnancy, birth and postnatal period. Ideally, I would like to talk to you 2 – 3 times. I anticipate the interviews may last 30 – 45 minutes or for as long as you wish to talk to me. This will be a one to one private discussion. All meetings will take place where you are currently living (safe house) or at the offices of Next Link if you are still living with your partner. You do not have to take part in the second discussion, even if you agreed and have taken part in the first discussion. With your permission I would like to tape record our conversation, this will help with the transcribing of our meetings at a later date. It is up to you whether our discussions are tape-recorded. All meetings will take occur in a place of safety and at a date and a time that is convenient to you. Whether you decide to take part or not your care will not be compromised. If you wish you will be able to check all typed transcripts from our interviews for accuracy.

**Will my part in the study be kept confidential?**

Any information collected about you will be kept confidential. This means I will not tell anyone what you have said during our conversations. If I use any information from our meetings, I will change any details that might identify you – you will remain anonymous. But there are some things that I can't keep confidential; an exception to this would be a disclosure in the case of child protection for example if any information shared leads me to believe a child is at serious risk of harm then I am bound by the Nursing and Midwifery Council Code of Professional Conduct to inform the relevant authorities to prevent you or someone else being harmed.

**Will I be paid for taking part?**

No, however, after the completion of all our meetings I would like to offer you a £10.00 voucher as a small 'thank you' for your participation in the study.

**How will you keep my information secure?**

To keep your information completely secure all of the tapes and relevant study information will be kept in a locked cabinet. Information, which is collected, about you during the research will be kept strictly confidential, only the researcher (myself) will have access to them. My PhD supervisory team will review my written work but only after all identifying features have been removed. You will remain anonymous at all times.

**What will happen to the results of the research study?**

The results of the study will be written up into my PhD research thesis. I anticipate that my study will be used raise awareness and improve outcomes for women who are experiencing domestic violence. Some of my work may be published in professional journals and presented at conferences. However, none of the work arising from my study will identify you or anyone taking part. I am hopeful that the results of the study will be available for you to access via Next Link/Survive Website

## **Part 2**

### **What will happen if I don't want to carry on with the study?**

You are free to withdraw from the study at any time. However, any information already obtained may still be used.

### **What if there is a problem or you wish to make a complaint?**

If you have a concern about any aspect of the study, you should speak to me and I will do my best to answer your questions, you can contact me on telephone 0117 3388776. If you remain unhappy and wish to complain formally, you can do this by contacting my supervisor: Dr Theresa Mitchell at the University of the West of England, telephone number 01452 702168

### **Who is organising the research?**

The University of the West of England are the sponsors of the research.

### **Who has reviewed the study?**

Nearly all research carried out is looked at by independent group of people, called a Research Ethics Committee this is to protect your safety, rights, well being and dignity. This study has been reviewed and given favourable opinion by Southmead Research Ethics Committee.

### **What happens next?**

If you are interested in taking part in the study, please inform your support worker who will contact me. I will come to the safe house and see you in person to discuss the study in more depth. If you decide you still want to take part, I will arrange a suitable date and time to come back to the safe house to conduct the first interview. If you change your mind and decide you do not want to take part, you can let me know at anytime before our first interview.

Thank you for taking the time to read this information sheet.

### **Contact details or more information**

Kathleen Baird  
PhD student  
School of Health and Social Care  
Faculty of Life Sciences  
Glenside Campus  
University of The West of England  
Bristol BS16 1DD  
Telephone 0117 3288776  
E mail Kathleen2.Baird@uwe.ac.uk

## Appendix 3



**Centre Number: 08/H0102/70**

**Study Number: 2512/7037/1/245**

### CONSENT FORM

**Title of Project:** Exploration of women's perceptions and lived experiences of domestic violence during pregnancy

Name of Researcher: Kathleen Baird, PhD Student, University of the West of England.

Please Initial box

I confirm that I have read and understood the information sheet dated 29/09/08 (version 2), for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

I understand that the researcher's supervisory team may read my anonymous data.

I agree to my anonymous data being used for teaching purposes, conference and publications.

I agree to the use of audio tape recording.

I agree to take part in the above study

Name of participant

Date

Signature



## Appendix 4



### Indicative content for semi-structured interview: **interview one**

(First interview is a preamble to develop a relationship between researcher and participant)

#### **Introductions**

Explanation of the study

Written consent (if not already obtained) and consent for use of tape recorder

Right to withdraw

Expectations (to include a discussion about motivations to participate in the study)

Confidentiality

Right to stop interview at any time

Contact Information

#### **Family Biography and background questions**

How long they have been living in the safe house and details of any previous visits

Children

Close family and friends network

Discussion of activities, friends

How they met their partner

How long they had been with their partner

When did they first experience violence in their relationship?

What was that experience of violence?

General description of friendships and support

Developing the family story

## **Staying in the refuge**

Circumstances of leaving

What made them decide to leave and come to the refuge?

Were there any support mechanisms to help them leave or stay with their partner?

Had they previously left their partner and then returned?

What made them return to their partner?

Would they have returned if more support had been available?

Did they try and access any support for anyone?

Had they previously disclosed their abuse to anyone family or friends

## **Role of health professionals including midwifery**

Had they discussed the abuse with any health professional?

Or had any health professional asked them about domestic violence?

If so who was that person e.g. family, friends, GP, practice nurse, health visitor, midwife A & E staff, and women's service groups such as Refuge, Woman's Aid or local support agencies.

If a health professional had asked them about domestic violence would they have told that person?

Was your abuse occurring when you were pregnant?

When you were pregnant did the midwife ask you about domestic violence?

Did you mind the midwife asking you about domestic violence? And were you or would have been willing to disclose about the abuse?

Do you think midwives should be asking about domestic violence?

Were you asked about domestic violence in a sensitive manner?

What support did the midwife offer you?

What prevented you from telling the midwife about the domestic violence?

## **Ensure ongoing support is available for participants following interview**

### **Appendix 5**

Indicative Content for semi-structured interview: **interview two**

(This interview will focus on the women's experiences of abuse during pregnancy)

**General re-cap**

Reminder of research

Confidentiality matters

Right to withdraw

Anything else you would like to add about since our previous conversation

**Domestic violence during pregnancy**

Would you like to tell me about your pregnancy?

-Sickness, tiredness, mental health issues caring for other children,  
managing to work outside the home

Was your pregnancy planned? And were you and your partner pleased about the pregnancy?

Was the abuse occurring before you became pregnant?

When in your pregnancy did the abuse start?

How did your partner hurt you?

Did the abuse include physical, psychological, emotional or all types of abuse?

Where did you sustain the injuries? And how often would your partner hurt you?

How did that make you feel? And did it affect your feelings towards your pregnancy?

Did your partner abuse you during your previous pregnancies (if any previous pregnancies) and do you feel that the violence has increased with each pregnancy?

Did your partner threaten to harm your baby? And if so how?

## **Seeking help during the pregnancy**

Did you want to tell people about the violence/ did anyone know what you were going through?

Did you work during your pregnancy? If yes did anyone at work notice your injuries or behaviour?

Did you seek help for your injuries from any health professional e.g. GP midwife, or were you admitted for any care during your pregnancy?

Did you seek admission to the maternity ward as a means of safety or escaping your partner?

## **Effects on your pregnancy and unborn baby**

Did you develop any medical problems during your pregnancy?

Did any of the injuries result in you seeking medical assistance?

Did your pregnancy progress normally?

How many admissions did you have during your pregnancy?

Did your baby grow at a normal rate?

Did your pregnancy go to term or did you experience a pre-term labour?

Do you feel you bonded with your baby during your pregnancy?

## **Experiences in Labour and Birth**

Can you tell me about your labour and how you felt during labour?

Did your labour progress normally?

Did your partner accompany in labour?

How long did your labour last?

What weight was your baby?

How did you feel when you gave birth to your baby/babies?

## **Ensure ongoing support is available for participants following interview**

## Appendix 6



### Indicative Content for semi-structured interview: **interview three**

(This interview will focus on the women's experiences in the postnatal period and where they are now)

#### **General re-cap**

Reminder of research

Confidentiality

Right to withdraw

Anything else you would like to add about since our previous conversation

#### **Postnatal Period**

Tell me about the violence during your postnatal period

Did the violence increase or decrease at home with your newborn baby?

Do you feel you bonded with your baby?

Did you breastfeed your baby, if not why not?

How did your partner behaviour towards your baby?

Did you attempt to seek help from your GP, Midwife, and Health visitor? Or did any health professional ask you about domestic violence in the postnatal period?

Did you ever feel concerned or worried about your baby, did you feel they were in danger from your violent partner?

#### **Leaving your partner**

What made you decide to leave your partner and how did you leave?

How did you find out about the safe house?

Do you feel safe now?

Has your partner tried to contact you?

What about child contact? Does your partner see your children?

How has the violence made you feel towards your baby?

## **Future**

How do you feel about your partner now?

How do you feel about your future? Have you made any plans for your future?

Where are you gaining your support?

Where do you see yourself in the future? (1 – 2 years time)

Is there anything we have not discussed which you would like to include?

## **Discussion about end of research**

How has the research involvement been for you?

Reinforce their anonymity and contribution

The doctorate, future publications and feedback to participants

Thank participants

## **Ensure ongoing support is available for participants following interview**



## National Research Ethics Service

Southmead Research Ethics Committee

c/o Clinical Governance Directorate

Beaufort House

Southmead Hospital

Westbury-on-Trym

Bristol

14 October 2008

Mrs Kathleen M Baird  
Senior Midwifery Lecturer and part-time PhD student  
Room 2A07, Glenside Campus,  
University of West of England  
Blackberry Hill  
Stapleton  
Bristol BS16 1DD

Dear Mrs Baird

**Full title of study:** Exploration of Women's Perceptions and Lived Experiences  
of Domestic Violence During Pregnancy (version 1)  
**REC reference number:** 08/H0102/70

Thank you for your letter of 08 October 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

I have considered the further information on behalf of the Committee.

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

### Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Research Ethics Committees to be informed or SSA to be carried out at each site.

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements.

This Research Ethics Committee is an advisory committee to South West Strategic Health Authority  
*The National Research Ethics Service (NRES) represents the NRES Directorate within  
the National Patient Safety Agency and Research Ethics Committees in England*

Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Various letters of support		
Interview Schedules/Topic Guides For Interviews 2 and 3	1	04 August 2008
Compensation Arrangements		01 August 2008
Peer Review		17 March 2008
Letter from Sponsor		05 August 2008
Investigator CV		22 August 2008
Agreement to publish on NextLink website		02 October 2008
Response to Request for Further Information		08 October 2008
Participant Information Sheet	2	28 September 2008
Advertisement	1	29 August 2008
Interview Schedules/Topic Guides - Interview 1	2	25 September 2008
Application	2	27 August 2008
Participant Consent Form	2	28 September 2008

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review.

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email

[referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).



**08/HO102/70**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

A handwritten signature in cursive script that reads "Sue".

**Dr David Evans Chair**

Email: Sue.Bowman@nbt.nhs.uk

*Enclosures:* "After ethical review — guidance for researchers"

*Copy to:* *Professor Kath Ross*  
*R&D office for North Bristol NHS Trust*

## Glossary of Terms

**Antenatal booking appointment:** An antenatal booking visit usually occurs around 10 – 12 weeks of the woman's pregnancy. During this appointment the midwife discusses a woman's medical, obstetric and social history.

**Antenatal appointment:** antenatal appointments are carried out at regular intervals during a woman's pregnancy. The midwife will use this appointment to assess maternal emotional, social, physical and fetal wellbeing. It should also be an opportunity for the pregnant woman to discuss any concerns she may have.

**Antepartum haemorrhage:** Bleeding from the genital tract after the 24<sup>th</sup> week of gestation and prior to the onset of labour.

**Abruptio placentae:** also known as **placental abruption**, occurs when the placenta becomes separated from its uterine attachment. It refers to the abnormal separation after 20 weeks of gestation and prior to birth.

**Caesarean section:** is the delivery of the fetus through the uterine and abdominal wall. It can be performed as an elective procedure by to the onset of labour or as an emergency at any time.

**Fetus:** is the term for an unborn baby whilst in utero.

**Gestation:** is the period from fertilisation until the birth of the baby

**Gestational diabetes:** It is a condition in which women without previously diagnosed diabetes displays high blood glucose levels during pregnancy. Usually resolves after birth.

**Intrauterine growth restriction:** refers to the delayed growth of a baby whilst in utero.

**Low birth weight:** is a baby who weighs 2500 g or less at birth.

**Maternal death:** is defined as the death of a woman while pregnant or within 42 days of the termination of pregnancy, from any cause related to or aggravated by the pregnancy, or its management but not from accidental or incidental causes.

**Maternal mortality:** In the UK this is the number of deaths per 100 000 maternities.

**Miscarriage:** is an unscientific term for an abortion. It refers to the natural end of a pregnancy at a stage where the embryo or fetus prior to 20 weeks of gestation.

**Neonate:** A newborn child born up to 4 weeks old.

**Perineum:** is an area of the body, including the perineal body and surrounding structures. It is found in the region between the pubic symphysis and the coccyx. It is a diamond shaped area on the interior surface of the trunk which includes the anus and in the female the vagina. Perineal tears and trauma can occur during childbirth, which may require suturing (definition of suturing below) by a midwife or obstetrician.

**Perinatal morality rate:** This is the number of stillbirths and early neonatal deaths per 1000 births.

**Placenta:** Originates from the trophoblastic layer of the fertilised ovum. The placenta is an organ which connects the developing fetus to the uterine wall to allow nutrient uptake, waste elimination, and gas exchange via the mother's blood supply.

**Postnatal depression:** refers to a maternal depression that usually occurs following the birth. It varies in severity and has been linked with both psychological and physical factors.

**Premature birth:** refers to the birth of a baby before the expected date of birth, before 37 weeks gestation. Premature infants are at greater risk for short and long term complications, including disabilities and impediments in growth and mental development.

**Uterus:** The uterus is female organ of reproduction in which the fertilised ovum is implanted and the fetus develops. The female uterus shelters and protects the fetus as it grows.

**Uterine rupture:** is a life-threatening event for mother and baby. It occurs where the integrity of the myometrial (muscle) wall is breached.

**Small for gestational age:** is a baby whose weight falls below the 10<sup>th</sup> percentile for its gestational age, but is not necessarily growth restricted.

**Special Care Baby Unit (SCBU):** is an intensive care unit which specialises in the care of premature or newborn infants.

**Suturing:** involves the repair of perineum (area between anus and vulva) following a perineal tear or episiotomy (surgical procedure used for the widening of the outlet of the birth canal) sustained during the second stage of labour.

**Termination of pregnancy:** (Abortion) is the planned termination of a pregnancy by the removal or expulsion of a fetus or embryo from the uterus. An abortion can occur spontaneously due to complications of and during pregnancy, or it can be induced.