PROFESSIONAL DOCTORATES

An investigation into domestic violence, violence in pregnancy and implications for mother-child relationships.

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WALES BANGOR

An Investigation Into

Domestic Violence, Violence In Pregnancy And

Implications

For Mother-Child Relationships.

Rachel L. McCormick

Lancashire Doctorate in Clinical Psychology Course

July 2001

An Investigation Into Domestic Violence,

Violence In Pregnancy And Implications

For Mother-Child Relationships.

Submitted in partial fulfilment of the Degree of Doctor in Clinical Psychology, Lancashire Doctorate in Clinical Psychology Course, affiliated to the University of Wales, Bangor

Rachel L. McCormick

July 2001

Acknowledgements

My greatest thanks go to my family who have supported me over a number of years to achieve this goal. I am very grateful to Chris Hatton for his keen help and advice, to fellow trainees who have been mutually supportive, and to Anna Daiches for our discussions. Thankyou also to the contacts who helped with access to research participants and finally, many thanks to all the women who agreed to take part in the study.

Abstract

This study investigated the experiences of women subjected to domestic violence with a particular focus on violence during pregnancy and implications for the mother-child relationship. This is an area of increasing attention in health settings as the potential impact on women and children has been well established. Specific aims of the study were to investigate the impact of violence during pregnancy on women and their children and to assess whether the risk of child abuse is increased. In addition, the impact of violence on the mother-child relationship and the role of maternal mental health were investigated. Fifty-two women took part in the study, 28 of whom had experienced domestic violence; over half of these experienced violence during pregnancy. In addition to the questionnaire-based study, four women who had experienced domestic violence during pregnancy also took part in a semi-structured interview.

The main findings highlighted an increased risk of child abuse in domestic violence cases but the risk was not increased in relation to violence in pregnancy. In addition, women who experienced domestic violence were more likely to perceive their child to be at risk from abuse. An increased prevalence of physical and mental health problems during pregnancy was found in women who experienced violence during the pregnancy. Domestic violence was associated with higher levels of maternal distress and child agency involvement. A mediation analysis of the mother-child relationship revealed that maternal distress was the stronger predictor of the quality of the relationship, although the experience of violence was also an important factor. Implications of the findings, limitations of the study and future research directions are discussed.

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Section 1

Research Ethics Proposal

Research Ethics Proposal

Domestic Violence and Pregnancy

This proposal has been prepared in accordance with and submitted to the University of Wales School of Psychology Ethics Committee.

(See Appendix 1)

This proposal conforms to The British Psychological Society Style Guide

3, 752 words (excluding tables, figures, reference lists and appendices)

8, 622 words (including tables, figures, reference lists and appendices)

UNIVERSITY OF WALES, BANGOR

RESEARCH ETHICS COMMITTEE PROPOSAL

1 **DOMESTIC VIOLENCE IN PREGNANCY**

An investigation of the association between violence during pregnancy and the mother-child relationship.

2 **RACHEL L. McCORMICK,** Trainee Clinical Psychologist, Lancashire Doctorate in Clinical Psychology Course, The Health Centre, 156, Whitegate Drive, Blackpool, FY3 9HG.

Research Supervisors: Dr. Anna Daiches, Clinical Psychologist, Blackpool, Wyre & Fylde NHS Trust

Dr. Chris Hatton, Research Director, Lancashire Doctorate in Clinical Psychology Course

3 The intention of this study is to explore the subject of domestic violence in pregnancy, in particular, examining the association with the mother-child relationship and child abuse. It is hoped that the findings will contribute to and clarify some of the issues concerning domestic violence during pregnancy and its association with subsequent child abuse.

Whilst there have been a number of studies examining domestic violence during pregnancy, the focus of these has been primarily upon the physical impact on the mother and child. There is a dearth of literature about the psychological experience of such women, in particular in relation to their thoughts and feelings concerning the safety of the child. This would seem a

useful area to examine whilst trying to build on the links between domestic violence and child abuse, particularly as some of the injuries inflicted on pregnant women by their partners may indicate negative feelings towards the unborn child.

These are pertinent issues for clinical psychology. For example, the potential risk of the child also becoming abused and the impact the woman's experience may have on her relationship with the child can all be contributory factors for the eventual referral of such families to, in particular, child and adolescent services. It would seem appropriate that clinical psychologists alongside the statutory agencies and other health professionals, have a role to play in contributing to the knowledge and understanding of family violence.

Such knowledge would be useful to all health professionals not just clinical psychology in stimulating thought on how services can help women, not only to protect themselves but also their children.

4 Background to the study

There are numerous definitions of what constitutes domestic violence, however, for the purpose of this current study, the following definition is applied, 'the physical and sexual abuse of an adult woman by a male with whom she has or has had an intimate relationship' (McKay & MacGregor, 1994).

In the UK, as in other countries, domestic violence is widespread (Harwin, 1997). It is now recognized that the problem is not confined to particular social classes (Hedin, 2000), ethnic groups or geographical areas (Lloyd, 1997). Despite clear evidence that women have experienced domestic violence for centuries, it is only in the last decade that it has been viewed as a serious problem at a national level. Home Office studies and changes in institutional responses (e.g. the police) to domestic violence have contributed to a growing awareness of the scale of the problem (Langley, 1997). The most recent British Crime Survey

reported that one in four women between the ages of 16 - 59 had experienced physical assault by a current or former partner (Mirrlees-Black, 1999).

Domestic violence has considerable implications for the National Health Service (NHS) particularly in accident and emergency departments, primary care and in specialist settings such as maternity services and child and adolescent mental health services. Health care costs incurred are thought to be substantial, personal costs even more so (Department of Health, 1997).

In 1981, total healthcare costs of domestic violence, in the US, were estimated at 44.4 million dollars (Langley, 1997). Research into the extent and cost to the health service is still in the early stages in the UK, presently restricted to local surveys. For example, a London based study of GP surgeries, found that 40 percent of women attending for appointments had experienced domestic violence in the last year (Stanko, Crisp, Hale, & Lucraft, 1998).

The impact of domestic violence on a person's health is considerable, not only from the physical injuries that may be inflicted, but also from the psychological effect. It has been established that abused people make greater use of inpatient and outpatient psychiatric services than average (Stevens, 1997). Jacobsen and Richardson (1987) reported that, 64 percent of a female, psychiatric in-patient population in America had experienced domestic violence. Similarly, it is estimated in Britain, that, 45 percent of female alcoholics have a history of domestic violence, as do 25 percent of all female suicide attempts (Langley, 1997).

It is well established that women subjected to domestic violence experience greater levels of depression, anxiety, and post-traumatic stress disorder compared to women who have not (British Medical Association, 1998). Women abused by their partners are more likely to be in contact with mental health professionals often attending for ill-defined illnesses such as sleeping difficulties, eating disorders and irritable bowel syndrome (Stevens, 1997).

It is recognized that child maltreatment, which includes exposure to domestic violence, can have an impact on child development. Jaffe, Wolfe, Wilson & Zak (1986) report that children who witness domestic violence are more likely to experience health problems, behavioural difficulties and impairment of cognitive and emotional development. Clinicians working within child mental health services have speculated that the prevalence of children attending services, who live within violent families, is likely to be higher than children in the general population. However, studies have yet to be carried out to confirm this.

The links between domestic violence and child abuse have been well established through research, 'children whose mothers are battered are more than twice as likely to be physically abused than children whose mothers are not battered' (Stark & Flitcraft 1985, p.147).

Similarly, Mullender (2000) reports the overlap of domestic violence and child abuse to occur in between 30-60 percent of cases. Child abuse is one of the most common reasons for fatality in children under the age of five (NSPCC, 1985). Enquiries into non-accidental deaths of children show that violence towards the child's mother was frequently a feature in the family (O'Hara, 1994). The effects of child abuse are well documented, including cognitive, behavioural and social consequences for the child (Browne & Saqi, 1987).

Men's violence towards their partners and their children is arguably difficult to separate into discrete categories of 'child abuse' or 'domestic violence'. For example, in some instances the intention of the perpetrator is that the abuse of a child will have an abusive impact on the woman and vice versa. There is undoubtedly an interconnectedness between the two areas (Bowen, 2000). However, the child protection and domestic violence communities have, until recently, developed in relative separation to each other (Berliner, 1998).

The interconnectedness of domestic violence and child abuse is an important consideration concerning the conflicts and problems women face as mothers. One area of interest where

domestic violence and child abuse may overlap is when pregnant women are abused by their partners.

Research has shown that pregnancy can be a trigger for domestic violence to begin or intensify (Department of Health, 2000). Pahl (1982) reported, in a study of women abused by their partners, that one third of the women had disclosed that the abuse began during pregnancy.

Where women are subjected to domestic violence during pregnancy, there are likely to be increased levels of smoking and alcohol consumption during the pregnancy (Hedin, 2000) and an unhealthy diet with poor weight gain (Campbell, Torres, Ryan, King, Campbell, Stallings & Fuchs, 1999). Such factors have been shown in obstetric and gynaecological research to contribute to low birth weight. In addition, Campbell et al. (1999) argue that the abuse adversely affects maternal physical and mental health which, in turn, has been identified as a risk factor for low birth weight.

Injuries inflicted on pregnant women are often focused around the breasts, abdomen, and genitals (Dobash & Dobash, 1979). Some studies have suggested that such violence may be directed at the developing foetus as well as the woman (Bullock & McFarlane, 1989). Both the woman and the unborn child are at risk from such violence. The incidence of premature labour, miscarriage and stillbirth is greatly increased in populations of women subjected to domestic violence (Bewley & Gibbs, 1994). McWilliams & McKiernan (1993) interviewed 127 women resident in refuges in Northern Ireland. They found that 60 percent of these women had experienced violence during pregnancy and 13 percent had lost their unborn children because of the violence. Robinson (1996) refers to a case cited in *The Lancet* where a child was delivered prematurely following the mother having been struck in the abdomen by her partner. On delivery, it was noted that the newborn was bruised on the left arm,

shoulder and neck and the left eye was swollen. The child later died following a haemorrhage because of internal injuries.

Hillard (1985) argues that a 'battered foetus' is less likely to be planned or wanted and the mother is more likely to have considered abortion. Where pregnancies are unwanted and in the context of violence, there may be an adverse effect on maternal foetal attachment. A number of factors are known to affect the quality of early attachments, including pre birth and birth traumas (which may include violent assaults) and parental difficulties. Condon & Corkindale (1997) suggest that poor maternal foetal attachment may predict difficulties in future mother child attachments (Condon, 1993). In addition, some studies have highlighted an association between marital violence/conflict and a disorganized attachment of the child (Owen & Cox, 1997).

In a study by Campbell, Oliver & Bullock (1998), of women subjected to domestic violence, four categories were identified, based on anecdotal evidence, of assaults during pregnancy:

- Violence as a result of the partner being jealous of the unborn child
- Violence from partners who expressed anger towards the unborn child
- Violence that was pregnancy specific but did not appear to be directed at the unborn child
- Violence that was 'business as usual' in that it occurred before, during and after pregnancy.

Campbell et al. (1998) suggest that subsequent abuse of the child may be more likely to occur in cases where the partner was jealous of or angry with the child.

It is not clear to what extent such women are able to identify that their child may be at risk in the womb or at risk following birth. For example, Bowen (2000) highlights that levels of domestic violence are higher in women who experienced physical abuse in childhood. Bowen, therefore, suggests that for some women, not having dealt with their own history of

abuse may prevent them from recognising that their child may be at risk or from helping that child.

Aims and Objectives of the current study

- To determine the prevalence of abuse during pregnancy, the impact of the abuse on the pregnancy and whether subsequent abuse of the child occurred.
- To examine whether women had any fears for the safety of the child either before or after birth.
- To assess the feelings of the women towards the children born in the context of domestic violence.
- To explore the experiences of women subjected to violence during pregnancy, including thoughts concerning whom they perceived the violence to be directed at.

Research Questions

1. What, if any is the prevalence of complications in pregnancy in women who experienced violence during pregnancy and those who did not?
2. What, if any, is the prevalence of abuse by the partner of the children of women who experienced violence during pregnancy compared to those who did not?
3. To what extent could women identify that their child may be at risk from violence either before birth or afterwards?
4. Does the experience of violence during pregnancy have an impact on the mother-child relationship?

5 The Hypotheses

1. Women who experienced violence during pregnancy will also have experienced a greater prevalence of pregnancy related problems compared to women who did not experience violence whilst pregnant.

2. Children whose mothers have experienced violence during pregnancy will be more likely to have been abused compared to those children whose mothers experienced violence but not during pregnancy.
3. Children whose mothers have experienced violence during pregnancy will be more likely to have had difficulties in their childhood than children whose mothers experienced violence but not during pregnancy.
4. Women who have experienced domestic violence are more likely to experience greater levels of psychological distress.

6 Recruitment of participants

Participants will be derived from:

- Women with children under the age of 16 in the general population.
- Women with children under the age of 16 from domestic violence populations, this will include, Refuge populations (inc. ethnic minority populations), women accessing voluntary agencies (e.g. Womenspace), and women accessed via police sources and Victim Support.

It was not possible to calculate statistical power for this study due to the exploratory nature of the topic and the lack of suitable measures previously administered to this population. The aim is to have 100 participants each from the general and domestic violence populations in the initial stage of the study, and to include no more than six participants from the domestic violence population for the second stage of the study.

Preliminary agreement and support for the study has been obtained from individuals who can access the domestic violence populations. Discussions have taken place, and based on previous studies carried out in the target area it is felt that a sufficient number of participants can be obtained and would be willing to participate in the study.

Participants from the general population will be sought after the questionnaires have been returned from the domestic violence population, to ensure similar demographic details. It is hoped to enlist participants for the study through 'snowball' sampling. Based on the definition described by Robson (1993), individuals will be identified in the general population who fulfil the inclusion criteria for the general population. These participants will then be used to access other members of that population who have similar demographic characteristics to the participants in the domestic violence sample.

7 Research design

The research is a survey design with between-participant comparisons.

It incorporates a combined strategy using questionnaires in the first stage of the study and semi-structured interviews in the second stage.

8 Procedures employed

Information will be provided for the relevant contacts for the domestic violence agencies. The contacts will seek agreement of participation from service users and distribute the questionnaires. An information sheet (Appendix 2) and consent form (Appendix 3) will be provided for each participant.

Questionnaires will be administered to an opportunistic sample of women in the general population; as far as possible, a diverse sample will be obtained. Information sheets and consent forms will be attached to the questionnaires.

At the end of the questionnaires, individuals will be asked if they wish to participate further in the study and will be asked to supply a name and contact address/number. Otherwise, all questionnaires will be anonymous to protect identity and maximize participation.

It is hoped, through liaison with ethnic minority agencies, that help will be provided for translation difficulties. Similarly, steps will be taken to provide help, if needed, for women with literacy problems. Although this may compromise anonymity, it is hoped that accessing these women through the voluntary agencies with whom they already have contact will minimize this.

All questionnaires will be returnable to a freepost address.

Participants for the interview stage of the study will be selected dependent on those volunteering to do so (see Appendix 4). The sample will be solely women who have experienced domestic violence; however, it is hoped to include women where the violence occurred during pregnancy and women where it did not.

The women will be approached by the researcher, supplied with further information about the study and asked to sign a consent form. Interviews will be carried out at a place of each woman's choice and will be audiotaped.

9 Measures employed

Stage 1 *Demographic questionnaire* (Appendix 5)-devised by researcher

Reproductive health questionnaire (Appendix 6) -adapted by researcher from standard ante-natal questions

Abuse questionnaire (Appendix 7)- devised by researcher adapted from the Abuse Assessment Screen (AAS, Parker & MacFarlane, 1991 in Soeken, McFarlane, Parker & Lominack, 1998) (Appendix 8).

GHQ 12 – (Goldberg, 1992) (Appendix 9).

Child Questionnaire (Appendix 10) – devised by researcher.

Child Grid - extracted from The Family Grid (Davis, 1997) (Appendix 11).

Stage 2 Semi-structured interview schedule to be devised on basis of questionnaire responses. This will be forwarded to the ethics committee following completion of the first stage of the study.

10 All measures in the questionnaire stage are self-report questionnaires. The researcher who is a trainee clinical psychologist in the final year of training will conduct all the interviews.

11 The only venues necessary are in the interview stage of the study and these will be the preferred choice of the participants, for example their own home or a suitable location provided by the agencies involved.

12 The intention is to carry out a pilot study immediately after gaining ethical approval. Following this and any subsequent amendments, it is hoped that all questionnaires will have been distributed by the end of December 2000. Interviews will be carried out in January/ February 2001. Analysis will be carried out during March with anticipated completion of the study at the end of May 2001.

13 Data analysis

Stage 1 Quantitative analysis - descriptive between-group comparisons (e.g. t-tests) and correlations.

Stage 2 Qualitative analysis - content analysis. A second rater will be sought for this stage of the analysis.

14 and 15 Ethical considerations

- *Anonymity and confidentiality*- all questionnaires will be anonymous unless the participant volunteers to take part in the second stage of the study. In these cases, only the researcher will know the identity of the participant and code numbers will be used to further protect identity. The interviews again will be confidential and protected with the use of code numbers. The only instances in which confidentiality will be breached are detailed below. All raw data such as questionnaires contact details and tapes from the interviews will be kept in a locked filing cabinet in a storeroom at the researcher's home. This location is used only by the researcher, therefore preventing access to raw data by others.
- *Distress of the women which may be triggered as a result of taking part in the study* – the domestic violence populations will all be accessed via agency contacts, their co-operation will be obtained to be sources of support for any women affected by the study. This will be made clear to the participants in the information sheet.

  For those women who may be affected in the general population, contact numbers of support agencies will be provided in the information sheet. A contact number will also be provided for the researcher in the event that further information or clarification is required.
- *Disclosure of abuse of a child* – As the questionnaires will be anonymous; it will not be possible to ascertain whether disclosures of abuse of children have also been made to the appropriate child protection agencies. However, before the interview stage of the study, participants will be informed that any disclosures made, where it is possible that individuals are still at risk of abuse, information will be forwarded to the appropriate statutory agencies.

16 and 17 Written consent for inclusion in the study will be required from each participant. Combined information sheets and consent forms will be attached to the front of the questionnaires (Appendices 2 &3).

18 Discussions have taken place with key individuals who hold positions related to the topic area. These include the local area lead council officer on domestic violence, the co-ordinator of the local area domestic violence forum, a senior police officer in child protection and various persons working within midwifery, social work and clinical psychology. Support for the study has been obtained from these people, many of whom will be providing access to potential participants.

19 No payment involved

20 Audio- taping equipment required only, this has been acquired

21 Participants are provided with a contact number for the research to answer queries and provide feedback. Following the interviews, participants will be asked about their thoughts regarding participation in the study and feedback will be provided following analysis.

22 The proposal has been checked in relation to BPS Guidelines on Ethical Standards and does adhere to these.

Signed R. L. McCormick

See Appendix 12 for reply from Ethics Committee

Lancashire Doctorate in Clinical Psychology
The Institute for Health Research
Alexandra Square
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Lancaster
LA1 4YT

Coordinator-Research Ethics Committee
School of Psychology
University of Wales Bangor
Bangor
Gwynedd
LL57 2DG

23rd March 2001

Dear

Research Proposal – Domestic Violence in Pregnancy

Further to my original proposal, which was reviewed in November 2000, I am writing to provide you with additional information concerning the second stage of the study.

Please find enclosed the following details:

- Interview Procedure
- Letter to interview participants
- Information sheet and consent form
- Interview schedule

I hope this additional information is found satisfactory and I look forward to hearing from you.

Yours sincerely

R. L. McCormick

Rachel McCormick

Research Study into Domestic Violence - Interview Procedure

1. Participants for the interview are to be obtained from volunteers who submitted their names for the second stage of the study at the back of the questionnaire (see previous correspondence for details).
2. All volunteers will be sent a letter (Appendix 13) and information sheet/consent form (Appendix 14) returnable in a prepaid envelope.
3. When consent has been obtained, participants will be contacted by telephone by the researcher to arrange a convenient time and location for the interview. Location will be agreed in relation to guidelines for domiciliary visits.
4. On meeting, the nature of the study will be outlined again to participants. Confidentiality will be assured but participants will be informed that confidentiality will be broken if information is supplied to suggest that children may be currently at risk from violence.
5. Interviews will be audiotaped, the structure is given in Appendix 15. On completion of the interview, participants will be thanked for their co-operation and offered the opportunity of feedback when analysis has been completed.
6. Tapes of the interviews are to be stored in a locked cabinet at the home of the researcher. The researcher only will have access to the tapes. Transcripts of the interviews are to be coded with identifying information kept separately. The research supervisor and an additional rater during analysis of the interviews may see transcripts. On completion of the study, all tapes will be destroyed.

See Appendix 16 for reply from Ethics Committee.

References

Berliner, L. (1998). Battered women and abused children: the question of responsibility. Journal of Interpersonal Violence, 13, 287-288.

Bewley, C. & Gibbs, A. (1994). Coping with domestic violence in pregnancy. Nursing Standard, 8, 25-28.

Bowen, K. (2000). Child abuse and domestic violence in families of children seen for suspected sexual abuse. Clinical Paediatrics, 39, 33-40.

British Medical Association (1998). Domestic Violence: A Health Care Issue? London: BMA.

Browne, K. & Saqi, S. (1987). Parent – child interaction in abusing families: it's possible causes and consequences. In P. Maher (Ed.) Child Abuse: The Educational Perspective, pp.55-85. Oxford: Basil Blackwell Ltd.

Bullock, L. & McFarlane, J. (1989). The birth-weight / battering connection. American Journal of Nursing, 89, 1153-1155.

Campbell, J., Oliver, C., Bullock, L. (1998). Why battering during pregnancy? Clinical Issues in Perinatal and Women's Health Nursing, 4, 343-349.

Campbell, J., Torres, S., Ryan, J., King, C., Campbell, D., Stallings, R. & Fuchs, S. (1999). Physical and non-physical partner abuse and other risk factors for low birth weight among full term and premature babies. American Journal of Epidemiology, 150, 714-726.

Condon, J. (1993). The assessment of antenatal emotional attachment: development of a questionnaire instrument. British Journal of Medical Psychology, 66, 167-183.

Condon, J. & Corkindale, C. (1997). The correlates of antenatal attachment in pregnant women. British Journal of Medical Psychology, 70, 359-372.

Davis, H. (1997). The Family Grid. In: I. Sclare (Ed.) Child Psychology Portfolio. Windsor: NFER-Nelson Publishing Co..

Department of Health (1997) Annual Report of the Chief Medical Officer for 1996: The State of the Public health. London: HMSO

Department of Health (2000). Domestic Violence: A Resource Manual for Health Care Professionals. London: HMSO.

Dobash, R. & Dobash, R.E. (1979). Violence Against Wives. New York: Free Press.

Harwin, N. (1997). Domestic violence: understanding women's experiences of abuse. In S. Bewley, J. Friend & G. Mezey (Eds.), Violence against Women, pp. 59-72. Sussex: RCOG Press.

Goldberg, D. (1992). General Health Questionnaire (GHQ-12). Windsor: NFER-Nelson Publishing Co.

Hedin, L. (2000). Postpartum: Also a risk period for domestic violence. European Journal of Obstetrics and Gynaecology and Reproductive Biology, 89, 41-45

Hillard, P. (1985). Physical abuse in pregnancy. Obstetric Gynaecology, 66, 185-190.

Jacobsen, A. & Richardson, B. (1987). Assault experiences of 100 inpatients: evidence of the need for routine enquiry. American Journal of Psychiatry, 144, 908-913.

Jaffe, P., Wolfe, D., Wilson, S. & Zak, L. (1986). Emotional and physical health problems of battered women. Canadian Journal of Psychiatry, 31, 625-629.

Langley, H. (1997). The health professionals: an overview. In S. Bewley, J. Friend & G. Mezey (Eds.), Violence against Women, pp. 147-156. Sussex: RCOG Press.

Lloyd, S. (1997). Defining Violence against women. In S. Bewley, J. Friend & G. Mezey (Eds.), Violence against Women, pp. 3-12. Sussex: RCOG Press.

McKay, A. & MacGregor, L. (1994). Hit or Miss. Dundee: Tayside Regional Council.

McWilliams, M. & McKiernan, J. (1993). Bringing it out in the Open: Women and domestic violence in Northern Ireland. Belfast: HMSO.

Mirrlees-Black, C. (1999). Domestic Violence: Findings from a new British crime survey self-completion questionnaire. London: Home Office Publications.

Mullender, A. (2000). Reducing Domestic Violence – what works? Meeting the needs of children- Briefing Note, January. London: Policing and Reducing Crime Unit.

National Society for the Prevention of Cruelty to Children (1985) Child Abuse Deaths. Information Briefing No. 5. London: NSPCC.

O' Hara, M. (1994). Child deaths in the context of domestic violence: implications for professional practice. In A. Mullender & R. Morley (Eds.), Children Living with Domestic Violence, pp. 21-39. London: Whiting & Birch.

Owen, M. & Cox, M. (1997). Marital conflict and the development of infant-parent attachment relationships. Journal of Family Psychology, 11, 152-164.

Pahl, J. (1982). Men who assault their wives: what can health visitors do to help? Health Visitor, 55, 528-530.

Robinson, J. (1996). The battered foetus. British Journal of Midwifery, September, 49.

Robson, C. (1993). Real World Research: A Resource Manual For Social Scientists And Practitioner –Researchers. Oxford: Blackwell Publishers.

Soeken, K., McFarlane, J., Parker, B. & Lominack, M. (1998). The Abuse Assessment Screen: a clinical instrument to measure frequency, severity, and perpetrator of abuse against women. In: J. Campbell (Ed.) Empowering Survivors of Abuse: Healthcare For Battered Women And Their Children, pp. 195-203. California: Sage Publications.

Stanko, E., Crisp, D., Hale, C. & Lucraft, H. (1998). Counting the Costs: estimating the impact of domestic violence in the London borough of Hackney. Swindon: Crime Concern.

Stark, E. & Flitcraft, A. (1985). Women battering, child abuse, and social heredity: what is the relationship? In N. Johnson (Ed.), Marital Violence. London: Routledge & Kegan Paul.

Stevens, K. (1997). The role of the accident and emergency department. In S. Bewley, J. Friend & G. Mezey (Eds.), Violence Against Women, pp. 168-178. Sussex: RCOG Press.

Appendix 1

Project information required by University of Wales School of Psychology Ethics Committee

Please give information on the following:

1 Title of Project.

2. Name of Investigator(s)

3. The potential value of addressing this issue

4. Brief background to the study

5. The hypotheses

6. Recruitment of participants

7. Research design

8. Procedures employed

9. Measures employed

10. Qualifications of the investigators to use the measures

11. Venue for investigation

12. The duration of the study

13. Data analysis

14. Potential hazards to participants / investigators

15. Potential offence / distress to participants

16. *How consent is to obtained (see BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The College has its own Welsh translation facilities on extension 2036).

17. *Information for participants

18. Approval of relevant professionals (e.g. G.P.'s, Consultants, Teachers, parents etc.)

19. Payment to: participants
investigators
departments / institutions

20. Equipment required and its availability

21. What arrangements you are making to give feedback to participants. The responsibility is yours to provide it, not participants' to request it.

22 Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.

* Provide actual consent forms and information sheets.

(Revised 11.3.97.)

Appendix 2

Information sheet for participants

My name is Rachel McCormick; I am a Trainee Clinical Psychologist employed in the NHS. I am conducting a study exploring domestic violence during pregnancy and the possible future difficulties for children. The purpose of the study is to help inform professionals working with children and their families where a history of domestic violence in the family may contribute to current difficulties.

To carry out the study, I need a variety of participants including women who have experienced violence during pregnancy, women who may have experienced violence but not whilst pregnant and women who have not experienced domestic violence at all.

Attached is a set of questions covering a variety of areas. Although there are a number of pages, the questions are straightforward and take approximately half an hour to complete. The questionnaires are confidential and will not be seen by anyone else but the researcher. Your decision on whether to take part in the study will not affect any help or services that you receive now or in the future.

If you wish to participate, on the next page is a consent form which you need to read carefully and tick the relevant box. The consent form stays attached to the questionnaire but you can remove this information sheet if you wish and keep it for future reference.

If any questions are unclear or you wish to discuss an aspect of the study either before completing the questionnaire or after, I can be contacted on . Please leave a message and I will contact you as soon as possible.

I am aware that answering some of the questions may well be difficult and upsetting. If this should be the case and you wish to speak to someone, there are a number of contacts on the last page of the questionnaire who would be happy for you to get in touch and who are aware of this study.

I would like to express my sincere thanks in anticipation of your taking part in this important study.

Rachel McCormick

Lancashire Doctorate in Clinical Psychology Course.

Appendix 3

Consent form for questionnaire participants

- I have carefully read the information on the previous page and am aware of what the study is about and that I need to complete the attached questionnaire.

- I know that I can contact the Researcher to ask questions about the study before completing the questionnaire and after I have filled it in.

- I know that should I need to talk to someone after completing the questionnaire, there are a number of places that I can contact.

- I know that I do not have to complete the questionnaire if I do not want to and am aware that this will not affect any help that I receive.

- I know that if I change my mind, I can withdraw from the study at any time and that this will not affect any help that I receive.

- I know that any information I give in this questionnaire will remain confidential.

Any complaints about the study should be addressed to: Head of School, School of Psychology, University of Wales, Bangor, Gwynedd, LL57 2DG.

Consent:

I agree to participate in this study by completing the attached questionnaire

☐ Please put tick in box if you have read the above and are willing to take part in the study

Appendix 4

Information on volunteering for interview stage

Thank you for taking the time to complete this questionnaire, I would be grateful if you could take a few minutes more to check that you have answered all the questions.
At the bottom of this page are numbers that you can contact should you feel the need to discuss any of the issues covered in this study.

The second stage of the study involves an interview carried out by me, taking no longer than an hour; this can take place at a venue of your choice. I am particularly keen to interview women who have experienced violence during pregnancy and women who did not but experienced violence at other times from a partner.
If you may be willing to take part in the interview stage, there are a number of ways that you can volunteer. You can include your name; address and/or telephone number on this sheet and either return it with the questionnaire or return it separately. Any contact details you give will remain confidential. Alternatively, you can contact me on the number given on the front sheet of this questionnaire.

If you are interested in participating in the second stage of the study, I will contact you to provide more information about the interview and ask if you definitely wish to take part.
Please complete any of these details if you would like me to contact you about the next stage of the study:
Name:
Address:

Telephone Number:

Email address:

CONTACT DETAILS (please contact any of the following should you feel the need)

Appendix 5

Demographic Questions

1) How old are you? (please state in box) ☐

2) What is your ethnic origin? (please tick appropriate box)

White UK ☐ White other ☐ please specify----------

Black African ☐ Black Caribbean ☐ Black other ☐ please specify----------

Indian ☐ Pakistani ☐ Asian other ☐ please specify----------

Any other ethnic group ☐ please specify----------

3) What is your marital status? (please tick appropriate box)

Married ☐ Living as married ☐ Separated ☐ Divorced ☐

Widowed ☐ Single ☐

4) If currently living with a partner, approximately how long have you been living together? (please state in box) ☐

5) What is you current employment status?

Employed full-time ☐ Employed part-time ☐ In educational training ☐

Not in paid employment or training ☐

If employed, please state your occupation ----------

-

6) Is your partner (or ex-partner) in paid employment? Yes ☐ No ☐

If yes, please state their occupation ----------

7) Approximately, what is your current annual family income? (please tick appropriate box)

less than £10,000 ☐ £10,000- £15,000 ☐ £15,001- £25,000 ☐ £25,001 or over ☐

Appendix 6

Reproductive Questions

1) How many children do you have? (please state) ----------

2) How many pregnancies have you had? (please state)----------

3) Have you ever experienced a miscarriage before 12 weeks? (please tick appropriate box)

Yes ☐ No ☐

If yes, please state how many if you have experienced more than one----------

4) Have you ever experienced a miscarriage after 12 weeks? (please tick appropriate box)

Yes ☐ No ☐

If yes, please state how many if you have experienced more than one----------

5) Have you ever experienced a stillbirth? (please tick appropriate box)

Yes ☐ No ☐

If yes, please state how many if you have experienced more than one ----------

Appendix 7

Abuse Questions

1) Have you ever been hit, slapped or otherwise physically hurt, at any time by a partner?

(please tick appropriate box)

Yes ☐ No ☐

If yes, was this your: current partner? ☐ ex-partner? ☐ or both? ☐

2) Has a partner ever forced you, at any time, to have sexual activities?

(please tick appropriate box)

Yes ☐ No ☐

If yes, was this your: current partner? ☐ ex-partner? ☐ or both? ☐

3) If applicable, please state, approximately, how long ago it was when a partner last physically hurt you ----------.

4) When you were pregnant, were you ever hit, slapped or otherwise physically hurt by a partner? (please tick appropriate box)

Yes ☐ No ☐

Appendix 8

Abuse Assessment Screen

(Parker & McFarlane, 1991)

(Circle Yes or No for each question)

1. Have you *ever* been emotionally or physically abused by your partner or someone important to you?

   Yes No

2. *Within the last year*, have you been hit, slapped, kicked or otherwise physically hurt by someone?

   Yes No

   If Yes, by whom (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple

   Total number of times ----------

3. *Since you have been pregnant*, have you been hit, slapped, kicked or otherwise physically hurt by someone? Yes No

   If Yes, by whom (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple

   Total number of times ----------

Mark the area of injury on the body map (Refer to diagram of body map)

Score each incident according to the following scale: (If any descriptions for the higher numbers apply, use the higher number)

1= Threats of abuse including use of a weapon Score-------

2= Slapping, pushing; no injuries and/or lasting pain Score-------

3= Punching, kicking, bruises, cuts and/or continuing pain Score-------

4= Beating up, severe contusions, burns, broken bones Score-------

5= Head injury, internal injury, permanent injury Score-------

6= Use of a weapon; wound from weapon Score------

4. *Within the last year*, has anyone forced you to have sexual activities?

   Yes No

   If Yes, by whom (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple

   Total number of times ----------

5. Are you afraid of your partner or anyone listed above? Yes No

Appendix 9

General Health Questionnaire (GHQ-12)

(Goldberg, 1992)

PLEASE READ THIS CAREFULLY.

I would like to know if you have had any medical complaints and how your health has been in general, *over the last few weeks.* Please answer ALL the questions simply by circling the answer which you think most nearly applies to you. Remember that I want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

HAVE YOU RECENTLY:

1.	**been able to concentrate on whatever you are doing?**	Better than usual	Same as usual	Less than usual	Much less than usual
2.	**lost much sleep over worry?**	Not at all	No more than usual	Rather more than usual	Much more than usual
3.	**felt that you are playing a useful part in things?**	More so than usual	Same as usual	Less useful than usual	Much less useful
4.	**felt capable of making decisions about things?**	More so than usual	Same as usual	Less so than usual	Much less capable
5.	**felt constantly under strain?**	Not at all	No more than usual	Rather more than usual	Much more than usual
6.	**felt you couldn't overcome your difficulties?**	Not at all	No more than usual	Rather more than usual	Much more than usual
7.	**been able to enjoy your normal day-to-day activities?**	More so than usual	Same as usual	Less so than usual	Much less than usual
8.	**been able to face up to your problems?**	More so than usual	Same as usual	Less able than usual	Much less able
9.	**been feeling unhappy and depressed?**	Not at all	No more than usual	Rather more than usual	Much more than usual
10.	**been losing confidence in yourself?**	Not at all	No more than usual	Rather more than usual	Much more than usual
11.	**been thinking of yourself as a worthless person?**	Not at all	No more than usual	Rather more than usual	Much more than usual
12.	**been feeling reasonably happy, all things considered?**	More so than usual	About same as usual	Less so than usual	Much less than usual

Appendix 10

Child Questions

The following pages require you to think about just one child under the age of 16, answer the questions thinking about the same one child throughout. Please read the following instructions carefully:

- If you have **not** experienced physical or sexual violence from a partner, please think of any one of your children under 16.

- If you have experienced violence from a partner, but **not** during pregnancy, think about any child of yours, under 16, who was born after the first violent incident.

- If you have experienced violence whilst pregnant, think of any child, under 16, who you were pregnant with and experienced violence during that pregnancy.

1) What is the sex of your child? (please tick appropriate box) male ☐ female ☐

2) How old is your child now? (please state) ----------

3) Did you experience domestic violence whilst pregnant with this child?

Yes ☐ No ☐ If yes, please describe briefly ----------

---

4) Did you experience any physical and/or mental health problems whilst pregnant with this child?

Yes ☐ No ☐ If yes, please describe briefly ----------

---

5) Did you experience any problems during labour or birth with this child?

Yes ☐ No ☐ If yes, please state ----------

---

6) Did you experience any physical and/or mental health problems following the birth of this child?

Yes ☐ No ☐ If yes, please describe briefly ----------

-

7) Approximately, what was your child's weight at birth? (please state) ----------

8) When was your child born? before 37 weeks ☐ at 37 weeks or after ☐

9) Whilst you were pregnant, was your partner at that time the father of your unborn child? (please tick appropriate box)

Yes ☐ No ☐

10) Was this child planned? (please tick appropriate box)

Yes ☐ No ☐

11) Was the discovery of the pregnancy:

a happy event? ☐ an unhappy event? ☐ Neither? ☐

12) Whilst you were pregnant with this child, did your partner (or ex-partner) show any feelings of:

anger towards your unborn child? (please tick appropriate box) Yes ☐ No ☐

jealousy of your unborn child? (please tick appropriate box) Yes ☐ No ☐

If yes to any of the above, please provide brief examples of what was said or done to make you think your partner was angry/ jealous of your unborn child----------

---

---

13) Whilst pregnant, did you have any concerns for the safety of your child? (please tick appropriate box)

Yes ☐ No ☐

If you had concerns, please describe briefly what these concerns were----------

---

14) Has your child had contact with any of the following services? If yes to any of these, please state reason for contact and whether he/she is still involved. Please use space provided;

Paediatrician Yes ☐ No ☐ ----------

Social Worker Yes ☐ No ☐ ----------

Educational Psychologist Yes ☐ No ☐ ----------

Clinical Psychologist Yes ☐ No ☐ ----------

Speech and Language Therapist Yes ☐ No ☐ ----------

Child Psychiatrist Yes ☐ No ☐ ----------

Education Welfare Officer Yes ☐ No ☐ ----------

15) Have you ever been concerned that your child may be at risk from abuse?

Yes ☐ No ☐

If yes, briefly explain ----------

16) To your knowledge, has your child ever been physically or sexually abused?

Yes, physically abused ☐ Yes, sexually abused ☐

Yes, both ☐ No, neither ☐

17) If yes to the previous question, was your child abused by:

(please tick box, if appropriate, more than one box can be ticked)

Yourself? ☐ Their father? ☐ A step-father? ☐

Another family member? ☐ A significant other? ☐ A stranger? ☐

Appendix 11

Child Grid

Instructions for the following questions

This is the final part of the study. In this next set of questions, you are asked to consider what your child is like.

On the following page entitled 'My child' there are 25 scales on which to rate your child. The first scale is 'happy' to 'miserable' and is to be completed in the following way:

If you think your child is extremely miserable please put a cross in square 1.

If you think your child is generally miserable put a cross in square 2.

If you think your child is quite happy put a cross in square 5 and so on.

On the other hand, if your child is an extremely happy child, please put a cross in square 7.
Put a cross in one square for each line and complete all the scales, working quickly to give your very first impression.

The page entitled 'My child as I would like her/him to be ideally' is completed in the same way. You work down each scale rating your child, as you would like them to be.

My Child

	Extremely		Generally		Quite			Quite		Generally		Extremely	
Happy	7		6		5		4	3		2		1	Miserable
Has a temper	7		6		5		4	3		2		1	Does not have a temper
Anxious	7		6		5		4	3		2		1	Not anxious
Concentrates well	7		6		5		4	3		2		1	Concentrates poorly
Learns quickly	7		6		5		4	3		2		1	Learns slowly
Naughty	7		6		5		4	3		2		1	Good
Healthy	7		6		5		4	3		2		1	Unhealthy
Needs everything done	7		6		5		4	3		2		1	Manages on own
Likes people	7		6		5		4	3		2		1	Does not like people
Communicates well	7		6		5		4	3		2		1	Communicates poorly
Has problems	7		6		5		4	3		2		1	Does not have problems
Over-active	7		6		5		4	3		2		1	Under-active
Lazy	7		6		5		4	3		2		1	Not lazy
Noisy	7		6		5		4	3		2		1	Quiet
Interested in surroundings	7		6		5		4	3		2		1	Disinterested in surroundings
Affectionate	7		6		5		4	3		2		1	Not affectionate
Determined	7		6		5		4	3		2		1	Not determined
Disobedient	7		6		5		4	3		2		1	Obedient
Difficult to control	7		6		5		4	3		2		1	Easy to control
Has a strong personality	7		6		5		4	3		2		1	Not a strong personality
Clinging	7		6		5		4	3		2		1	Independent
Sociable	7		6		5		4	3		2		1	Shy
Not loveable	7		6		5		4	3		2		1	Loveable
Predictable	7		6		5		4	3		2		1	Unpredictable
Spiteful	7		6		5		4	3		2		1	Not spiteful

My Child as I would like Her/Him to be Ideally

	Extremely	Generally	Quite		Quite	Generally	Extremely	
Happy	7	6	5	4	3	2	1	Miserable
Has a temper	7	6	5	4	3	2	1	Does not have a temper
Anxious	7	6	5	4	3	2	1	Not anxious
Concentrates well	7	6	5	4	3	2	1	Concentrates poorly
Learns quickly	7	6	5	4	3	2	1	Learns slowly
Naughty	7	6	5	4	3	2	1	Good
Healthy	7	6	5	4	3	2	1	Unhealthy
Needs everything done	7	6	5	4	3	2	1	Manages on own
Likes people	7	6	5	4	3	2	1	Does not like people
Communicates well	7	6	5	4	3	2	1	Communicates poorly
Has problems	7	6	5	4	3	2	1	Does not have problems
Over-active	7	6	5	4	3	2	1	Under-active
Lazy	7	6	5	4	3	2	1	Not lazy
Noisy	7	6	5	4	3	2	1	Quiet
Interested in surroundings	7	6	5	4	3	2	1	Disinterested in surroundings
Affectionate	7	6	5	4	3	2	1	Not affectionate
Determined	7	6	5	4	3	2	1	Not determined
Disobedient	7	6	5	4	3	2	1	Obedient
Difficult to control	7	6	5	4	3	2	1	Easy to control
Has a strong personality	7	6	5	4	3	2	1	Not a strong personality
Clinging	7	6	5	4	3	2	1	Independent
Sociable	7	6	5	4	3	2	1	Shy
Not loveable	7	6	5	4	3	2	1	Loveable
Predictable	7	6	5	4	3	2	1	Unpredictable
Spiteful	7	6	5	4	3	2	1	Not spiteful

Appendix 12

Reply from Ethics Committee 1

Prifysgol Cymru · University of Wales
BANGOR

YSGOL SEICOLEG
Prifysgol Cymru, Bangor
Adeilad Brigantia
Ffordd Penrallt
Gwynedd LL57 2AS

SCHOOL OF PSYCHOLOGY
University of Wales, Bangor
Adeilad Brigantia
Penrallt Road
Gwynedd LL57 2AS

November 29, 2000

Rachel McCormick
Lancashire Doctorate in Clinical Psychology
The Health Centre
156 Whitegate Drive
Blackpool
FY3 8HG

Dear Colleage

Domestic Violence in Pregnancy

Your research proposal (referred to above and on the attached sheet) has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines.

If you wish to make any substantial modifications to the research project, please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Good luck with your research.

Coordinator -School of Psychology Research Ethics Committee

Athro a Phennaeth yr Ysgol
Professor and Head of School

Appendix 13

Letter to interview participants

The Lancaster University Doctorate in
Clinical Psychology
Alexandra Square
Lancaster University
Lancaster
LA1 4YT

Date:

Dear

RE: Domestic Violence Study

Thankyou for completing the questionnaire related to the above research and volunteering to participate in the second stage of the study.

Please find enclosed further information about the interviews and a consent form please read this carefully. If you consent to take part in an interview, I will telephone you to arrange a convenient time. If you would prefer that I wrote to you rather than telephoning, please indicate this on the consent form.

Your participation is much appreciated.

Yours sincerely

R. L. McCormick.

Rachel McCormick

Trainee Clinical Psychologist

Appendix 14

Information sheet and consent form for interview participants

Thank you for expressing an interest in participating in the second stage of the study involving an interview. To remind you, the aim of the study is to explore domestic violence during pregnancy and future difficulties for children. The purpose of this work is to help inform professionals who work with children and their families where a history of domestic violence may be have an impact on current difficulties.

The interview will cover some of the questions in the questionnaire, although this will be in more detail. It is intended that the interview will take approximately one hour and can take place at a venue of your choice. The interviews will be audiotaped but the researcher will be the only individual who will listen to these. On completion of the study, all tapes will be destroyed. Transcripts of the interviews will be coded so that individuals cannot be identified from the information given. If you wish, the researcher will return after the interview has taken place to feedback on the information obtained in the interview.

If you require more information or have any questions, you can contact me on ..... If I am not available when you ring, please leave a message and I will contact you as soon as possible. If you are still willing to participate, please read the following carefully, sign the consent form and return the sheet in the prepaid envelope.

- I have carefully read the above information, am aware of what the study is about and I am willing to take part in an interview.
- I understand that the interview will be audio taped.
- I know that if I change my mind, I can withdraw from the study at any time and that this will not affect any help that I receive now or in the future.

Consent:

I agree to participate in the interview stage of the study

Signed----------

Date ----------

Appendix 15

Interview Schedule

The interview is to be semi-structured, below are the headings that will be covered with the questions that will be used as guidelines to ensure that all necessary aspects are covered.

Experience of abuse in general

When did the abuse begin? (first incident, how often)

What form of abuse did you experience? (physical, sexual, emotional, examples)

How long did this go on for? (when did it stop, if at all, how was it stopped, contact now)

Did the abuse occur in the context of: e.g. stress, arguments, alcohol use?

Experience of abuse in pregnancy

How many children do you have? Did you experience violence whilst pregnant with all of them?

What type of abuse-did you experience whilst pregnant? (physical, sexual, emotional, examples)

Can you remember the first incident? What happened?

How often did abuse occur in pregnancy? (e.g. frequently, isolated incidents)

Did the abuse occur in the context of: e.g. stress, arguments, alcohol use?

What was said by partner during the abuse (e.g. examples of anger, jealousy)?

What physical injuries did you receive?

Were there any pregnancy related problems following incidences of abuse (e.g. bleeding, miscarriage)

Did the violence continue after the birth of the child? How soon?

Were there any differences at all between the abuse you experienced whilst pregnant and the abuse that occurred before you were pregnant or after pregnancy? (e.g.more/less severe, directed at self/child)

Reactions to the abuse

How did you respond to the abuse generally? (e.g. fought back, did nothing, phoned for help)

How did you respond whilst pregnant?

Did you tell anyone about the abuse? Who?

What thought did you have about the abuse at the time it was occurring/now (e.g. why he did it, did you think it would stop)

How did you feel about yourself then/now?

What were your feeling s about your partner then/now?

Whilst pregnant what were your feelings about the child you were carrying? (e.g. safety of unborn child, relationship)

How aware were your children of the violence? (e.g. witnessed it, overheard, drawn into it, abused also, from what age).

Do you think that the violence had an effect on the children in any way? (directly- fear, anger, withdrawn, on mother-child relationship, on father-child relationship)

Relationship with children born following DV in pregnancy

What were your feelings about the child/children at birth? How did your partner react?

Was his reaction as you expected?

Describe your early relationship with your child/children (any problems, milestones)

Describe your partner's relationship with his child/children

Were you ever concerned that your child/children may be at risk from harm? Please explain in what ways.

Do you experience any difficulties with your child/children? (e.g. behaviour, emotional, withdrawn)

Describe you relationship with your child/children now?

Support

What support did you receive, if any, and from whom, then/now?

How did family and friends react to the abuse?

Were any agencies involved then/now?

What would have been helpful at the time and since?

Overall Reflections

What do you think the impact of violence on the family has been, if an impact at all?

Do you think what you have experienced has affected your relationship with your child/children? If so, how?

Appendix 16

Reply from Ethics Committee 2

sgol Cymru · University of Wales
BANGOR

YSGOL SEICOLEG
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Adeilad Brigantia
Ffordd Penrallt
Gwynedd LL57 2AS

SCHOOL OF PSYCHOLOGY
University of Wales, Bangor
Adeilad Brigantia
Penrallt Road
Gwynedd LL57 2AS

April 20, 2001

Rachel McCormick
Lancashire Doctorate in Clinical Psychology
The Health Centre
156 Whitegate Drive
Blackpool
FY3 9HG

Dear Colleague

Domestic Violence in Pregnancy - Second Stage

Your research proposal (referred to above) has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines.

If you wish to make any substantial modifications to the research project, please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Good luck with your research.

Coordinator -School of Psychology Research Ethics Committee

Athro a Phennaeth yr Ysgol
Professor and Head of School

Section 2

Literature Review

Domestic violence, pregnancy and implications for the mother-child relationship: a review of the literature

R. McCormick, Trainee Clinical Psychologist

Lancashire Doctorate in Clinical Psychology Course

This literature review has been prepared in accordance with the instructions for contributors to the

Journal of Family Therapy

(See Appendix 1)

4,789 words (excluding figures, references and appendices)

7,382 words (including figures, references and appendices)

Running Head: Domestic violence in pregnancy

Address for Correspondence:

Rachel McCormick

Lancaster University Doctorate in Clinical Psychology

Institute for Health Research

Alexandra Square

Lancaster University

LA1 4YT

01524 592970

Domestic violence, pregnancy and implications for the mother-child relationship:

a review of the literature

This review focuses on domestic violence, an area of increasing interest both in terms of developing a comprehensive theoretical understanding and in prevention. The main objective of the paper is to review studies detailing findings relating to the impact of domestic violence on women and their children. In addition, the review considers what is known about the extent and impact of domestic violence during pregnancy and discusses what impact this may have on the developing mother-child relationship.

Several theoretical models are discussed which provide possible explanations for the reactions of women and their children to domestic violence, in particular, the potential impact on relationships. Attachment theory is highlighted as one useful model to explain how the mother-child relationship may be affected by domestic violence.

The implications of findings are discussed, as are the limitations of previous studies, highlighting possible areas for future research.

Introduction

Domestic violence in the UK, as in other countries, is widespread (Harwin, 1997). The problem is not confined to particular social classes (Hedin, 2000), ethnic groups (Mills, 1998) or geographical areas (Lloyd, 1997). It has considerable implications for health services, particularly in accident and emergency departments, primary care and specialist settings such as maternity services and child and adolescent mental health services. Health care costs incurred are thought to be substantial, personal costs even more so (Department of Health, 1997).

Definitions of domestic violence vary, making the estimation of the extent of the problem difficult. A 1993 Home Affairs Select Committee report concluded that domestic violence describes any form of physical, sexual or emotional abuse which takes place within the context of a close relationship (Department of Health, 1997). Whilst domestic violence can take place within any intimate relationship, the vast majority and more severe assaults are perpetrated by men against their female partners (Kurz, 1993). The focus of this review is primarily on the physical and sexual abuse of women by a male partner.

The review will firstly provide an overview of what is currently known about the extent and impact of domestic violence on female victims and, secondly, the impact on their children. The review will then focus upon the specific area of domestic violence during pregnancy. This will be followed by a review of the literature concerning parent-child relationships, in particular the mother-child relationship, to highlight the

indirect impact of domestic violence on family relations. Finally, the limitations of current knowledge will be discussed, highlighting possible future directions.

The extent and impact of domestic violence on female victims

Despite clear evidence that women have experienced domestic violence for centuries (Dobash & Dobash, 1979), it is only in the last decade in the UK that it has been viewed as a serious problem. As a result of local surveys, Home Office studies and changes in institutional practice (e.g. the police), the 1990s have seen domestic violence discussed at a national level. Despite subsequent developments in the growth of inter-agency forums and multi-agency co-operation, problems remain in understanding the core issues of domestic violence and the long-term impact on families (Langley, 1997).

Domestic violence is a complex area in which to undertake research. Studies are generally limited to survey designs and interviews with the difficulties of experimental methodologies in this area being widely acknowledged (Gordon *et al.*, 1999). Local surveys suggest that between one in three and one in four women have experienced physical violence from a partner (McGibbon *et al.*, 1988; Radford *et al.*, 1998). More extensively, the British Crime Survey confirmed that one in four women between the ages of 16 - 59 had experienced physical assault by a current or former partner (Mirrlees-Black, 1999).

Research into the extent and cost to the health service is in the early stages in the UK, presently restricted to local surveys. For example, a 1996 study in North London estimated that the cost of providing crisis services in one district to women experiencing domestic violence was in excess of £7.5 million (Stanko *et al.*, 1998).

The impact of domestic violence on women can result in both direct and indirect effects. The direct impact of the abuse can be a variety of physical injuries such as bruises, cuts, fractured bones and internal injuries (Dobash & Dobash, 1980). In a study of 129 women attending GP surgeries, 40 percent were found to have experienced domestic violence severe enough to warrant physical medical attention in the last year (Stanko *et al*, 1998).

In terms of indirect effects, it is well established that women subjected to domestic violence experience greater levels of depression and anxiety (British Medical Association, 1998) and post-traumatic stress disorder (Finkelhor & Yllo, 1985) compared to women in the general population.

Clearly, domestic violence is an important issue for mental health services; women abused by their partners are more likely to be in contact with mental health professionals (Johnson, 1995). However, such women often attend for ill-defined illnesses such as sleeping difficulties, eating disorders and irritable bowel syndrome, and the context of domestic violence is not, therefore, always identified (Stevens, 1997). It is known that individuals with a history of abuse make greater use of inpatient and outpatient psychiatric services (Stevens, 1997). In relation to domestic violence, it is estimated that 45 percent of female alcoholics have a history of domestic violence (Stark *et al.*, 1979), and it has been highlighted as a factor in 25 percent of all female suicide attempts (Langley, 1997; Stark *et al.*, 1979). In one study, 64 percent of a female, psychiatric in-patient population were found to have been abused by their male partners (Jacobsen & Richardson, 1987).

The extent and impact of domestic violence on children

Children living in maritally violent homes have received little attention in comparison to those who have been physically or sexually abused (Holden, 1998). Discussions with clinicians working within child and family mental health services suggest that the prevalence of children attending services who live within violent families may be high.

It is well established that child maltreatment can have a negative impact on child development (Stevenson, 1999), but equally, exposure to domestic violence may have adverse consequences for children (Henning *et al.*, 1996).

The literature reviewed in this section focuses both on the direct and indirect effects on children, and highlights the links between domestic violence and child abuse. However, it is acknowledged that direct and indirect effects of witnessing domestic violence are difficult to separate into discrete categories.

Nevertheless, children of 'battered' women are estimated to be two to four times more likely than children from non-violent homes to exhibit clinically significant behaviour problems (Grych *et al.*, 2000). In a study of 198 children aged four to 16, those from violent homes exhibited significantly higher levels of behaviour problems and lower social competence skills (Wolfe *et al.*, 1985). A variety of adjustment problems have been associated with exposure to domestic violence including anxiety, depression, aggression and low self-esteem (Grych *et al.*, 2000; Jaffe *et al.*, 1990).

However, studies have also found a greater degree of child behaviour problems in families where there is general marital discord, suggesting that marital difficulties may be the stronger predictor of child problems rather than the child witnessing domestic violence specifically (Hershom & Rosenbaum, 1985; Rosenbaum & O'Leary, 1989).

Indeed, family disharmony in general is identified as a significant factor in later problems for children (Browne & Hamilton, 1999). However, when methodological limitations of these studies were addressed, for example, using ratings of child adjustment from partners and teachers alongside maternal reports and controlling for general marital discord, parental physical violence remained a significant factor in child behaviour problems (Jouriles *et al.*, 1989).

Early explanations for adjustment problems in children from maritally violent homes focused primarily on social learning theory (Jouriles & Norwood, 1995). Based on the principles of vicarious observational learning and modeling (Bandura, 1973), it was argued that children learn to manipulate, coerce, or avoid based on the behaviour of their parents (Jouriles *et al.*, 1989). To support this, Jaffe *et al.* (1990) noted that exposure of children to violence in general has been found to lead to elevated levels of aggression immediately after a violent incident.

However, it remains unclear as to the specific mechanisms through which domestic violence interferes with normative child development (Graham-Bermann, 1998). It is suggested that the emotional well being of the mother may have a greater impact on child development rather than witnessing violence itself (Hughes, 1992; Wolfe *et al.*, 1985). As previously highlighted, women who are abused are more likely to suffer physical and emotional problems which in turn may have an impact on their maternal effectiveness (Holden *et al.*, 1998). In a study of the adjustment of children from violent homes, it was found that the severity of the violence and the level of maternal stress equally predicted child behaviour problems (Wolfe *et al.*, 1985).

Similarly, trauma theories (Graham-Bermann, 1998) highlight an association between the presentation of post traumatic stress disorder (PTSD) in women subjected to domestic violence and the development of PTSD in their children. As discussed, an increased prevalence of PTSD has been highlighted in women subjected to domestic violence. Whilst PTSD studies have not been carried out focusing specifically on children exposed to domestic violence, Famularo *et al.* (1994) found high levels of PTSD symptomatology in maltreated children. In addition, a significant association was found between maternal levels of PTSD and child symptomatology. Hence, it could be argued that child adjustment may be influenced somewhat by maternal reactions to domestic violence (Wolfe *et al*; 1986). Such theories suggest a model of adjustment whereby domestic violence can have an impact on both the woman and her children and that maternal reactions can influence child behaviour (see Figure 1).

INSERT FIGURE 1 HERE (Appendix 2)

However, it is necessary to highlight that not all children experience negative effects in relation to domestic violence (Jouriles *et al.*, 1989). Twenty-six percent of children in one sample remained well adjusted despite living with domestic violence (Wolfe *et al.*, 1985). The consequences for children have been found to vary greatly depending on the age and gender of the child, the quality of their relationship with each parent, and the severity of the violence witnessed (Saunders, 1995). It is suggested that mother-child and father-child relations may account for the variation in child adjustment (Osborne & Fincham, 1996). Certainly, quality of relationships can provide some

insight into why there may be variations in adjustment (Graham-Bermann, 1998). Positive child-parent relationships have been shown to protect children from adverse consequences of negative life experiences (Moore & Pepler, 1998). It has also been found that a good relationship with at least one significant adult can mitigate some of the effects of severe marital conflict on children (Humphreys, 1998; Milner *et al.*, 1990). Similarly, a study of mothers who witnessed violence as children found that they were less likely to repeat the cycle of abuse if they had the support of at least one significant adult during childhood (Egeland *et al.*, 1988).

The impact of domestic violence on children is not necessarily limited to witnessing the conflicts. The links between domestic violence and child abuse have been well established:

> 'Children whose mothers are battered are more than twice as likely to be physically abused than children whose mothers are not battered.'
>
> Stark & Flitcraft (1985, p.147).

Mullender (2000) reports that an overlap of domestic violence and child abuse occurs in 30-60 percent of cases. In a study of 481 children referred to a sexual abuse assessment clinic, 54 percent were found to have witnessed domestic violence (Bowen, 2000). Clearly, domestic violence provides a context in which child abuse may readily develop (Mills, 1998). The effects of child abuse are well documented, including cognitive, behavioural and social consequences for the child (Browne & Saqi, 1987; Kolko, 1996). Studies have shown that abused children display lower IQ levels (Aber & Allen, 1987), delays in language development (Cicchetti & Beeghly, 1987), and

exhibit a variety of emotional, behavioural and social problems both at home and at school (Gaensbauer & Sands, 1979).

Men's violence towards their partners and their children is arguably difficult to separate into discrete categories of 'child abuse' or 'domestic violence'. For example, in some cases the intention of the perpetrator may be that the abuse of a child will have an abusive impact on the woman and vice versa (Bowen, 2000). Whether physical child abuse is identified or not, it could be argued that growing up in a violent family constitutes a form of emotional abuse. However, until recently, the child protection and domestic violence communities have developed in relative separation to each other (Berliner, 1998).

The overlap of domestic violence and child abuse is an important factor in understanding the conflicts and problems women may face as mothers and as victims of domestic violence. For example, in cases where both the woman and her children are abused, the issue of maternal responsibility in child protection is potentially in conflict to her own experience as a victim of abuse (Wilson, 1998). Clearly, ignoring this experience does little to further the knowledge and understanding of the impact of domestic violence (Berliner, 1998). One particular area of interest where such issues may begin to overlap is when pregnant women are abused by their partners.

The extent and impact of domestic violence during pregnancy

Research has shown that pregnancy can be a trigger for domestic violence to begin or intensify (Department of Health, 2000). In one study, one third of women abused by their partners disclosed that the abuse began during pregnancy (Pahl, 1982). Abuse in

pregnancy has been found to be associated with a greater frequency and severity of violence, suggesting that a man who assaults his pregnant partner is likely to be an extremely violent individual (Campbell *et al.*, 1998; Helton *et al.*, 1987).

Reasons why a man would abuse his pregnant partner are complex and varied. Possible theories include jealousy of the attention given by the woman to the unborn child, anger concerning the additional responsibilities a child brings, anger at the physical changes pregnancy brings for the woman or frustration at the woman's inability to attend to his needs as before pregnancy (Campbell *et al.*, 1998; O'Shea, 1996).

The assault of pregnant partners occurs with sufficient frequency to pose a significant threat to the health and safety of those women and their unborn children (Curry & Harvey, 1998). The direct impact of violence can include physical injuries, which are often inflicted around the breasts, abdomen, and genitals (Dobash & Dobash, 1979). The incidence of premature labour, miscarriage and stillbirth is greatly increased in populations of women subjected to domestic violence (Bewley & Gibbs, 1994; Helton *et al.*, 1987). Interviews carried out with 127 women in refuges in Northern Ireland highlighted that 60 percent had experienced violence during pregnancy and 13 percent had miscarried following an incidence of violence (McWilliams & McKiernan 1993).

There are a number of indirect effects of violence during pregnancy on women and their unborn children. In the US, it has been found that abused pregnant women are more likely to abuse drugs and alcohol, three times more likely to be diagnosed as depressed and five times more likely to attempt suicide (Helton *et al.*, 1987). Evidence from the UK shows increased levels of smoking and alcohol consumption during

pregnancy amongst abused women (Hedin, 2000) and an unhealthy diet with poor weight gain (Campbell *et al.*, 1998).

As previously highlighted, domestic violence can have an impact on maternal physical and mental health. These factors have been identified as risk factors for low birth weight infants (Campbell *et al.*, 1998). Abused pregnant women are four times more likely to have low birth weight babies (Bullock & McFarlane, 1989; Helton *et al.*, 1987). In turn, birthweight has been found to be the most significant predictor of infant wellness and positive future development (Campbell *et al.*, 1998). Considering these issues, it would be reasonable to suggest that children of women who experienced violence whilst they were pregnant are at increased risk of future difficulties. In addition the existing evidence of the impact of family violence and maternal mental health on children would suggest that the experience of violence whilst pregnant is likely to have an impact on the mother's reaction to, and relationship with, the child.

The impact of marital difficulties on the mother-child relationship

A number of factors are known to affect the quality of early parent-child relationships, including pre birth and birth traumas (which may include violent assaults), ill health, parental difficulties and environmental factors such as poverty and stress (Levy & Orlans, 2000). Findings suggest that there is an association between marital quality and parent-child relationships (Harrist & Ainslie, 1998; Shek, 1998).

In turn, it has been argued that major disruptions to the parent-child relationship are precursors to later psychopathology (Erikson, 1963; Freud, 1965). It is argued that marital conflict adversely affects the emotional availability of parents, thereby having

a negative impact on parent-child relationships (Davies & Cummings 1994). A study of couples before and after the birth of their first child found that chronic marital difficulties were a strong predictor of poor parent-child relationships (Owen & Cox, 1997).

A useful framework for exploring the issues of parent-child relationships is that of attachment theory (Bowlby, 1969; 1982). Empirical findings have shown that successful attachment to the primary caregiver in the first two years of life is related to greater sociability and effective emotional regulation (Ainsworth, *et al*; 1978; Richters & Waters, 1991). Poor attachment experiences before the age of two are associated with poor peer relations and poor behavioural self-control (Carlson & Sroufe, 1995).

The primary role of the attachment figure is to reduce anxiety in stressful situations and provide the child with a secure base from which to explore new situations (Browne, 1998). The quality of infant-caregiver attachment is typically assessed using the 'Strange Situation' paradigm (Ainsworth, *et al.*, 1978). During this process, the infant is exposed to a series of stressful events culminating in separation from the caregiver. The child's reaction to separation and more importantly reunion is assessed to measure the quality of the attachment relationship (Cicchetti, 1987). In brief, securely attached infants are characterized by distress at separation followed by a positive response to caregivers on reunion. Insecure attachment relationships are manifested by angry, resistant, or avoidance behaviours (Ainsworth *et al.*, 1978).

Recent refinements in the attachment coding system identified a further attachment pattern characterized by dazed expressions, confusion and disorientation (Main *et al.*, 1985). Referred to as 'disorganized attachment', a number of studies have highlighted

an association between marital violence and disorganized attachment behaviours in children (e.g. Owen & Cox, 1997). Longitudinal studies have shown that disorganized attachment in infancy is a strong predictor of externalizing problems and cognitive delay in childhood (Lyons-Ruth, 1996) and psychopathology and dissociative symptoms in adolescence (Carlson, 1998).

One theory put forward to explain this pattern of attachment behaviour is that, within the context of a violent relationship, an infant may experience confusion and unpredictability when trying to seek comfort from a frightening or frightened caregiver. It is possible that the person to whom they look to meet their needs will also be the person who creates for them the greatest anxiety (Main & Hesse, 1990; Owen & Cox, 1997). A mother living in fear of her partner may be unable to handle the stressful demands of an infant. Evidence has shown that infants who live within environments of domestic violence exhibit greater degrees of poor health, sleep problems and excessive screaming (Jaffe *et al.*, 1990). It is suggested that infants may suffer such consequences when their basic needs are not met (James, 1994). Clearly, any rejection due to lack of availability of their principal caretaker, which is likely to continue for the duration of the violence, would be felt by the child and could have long-term effects in the form of emotional deprivation (Hart & Brassard, 1987).

Whilst there is clearly an association between marital violence and poor child-parent relationships, the exact nature of the relationship is undoubtedly complex. Returning to a similar argument concerning maternal adjustment and the impact of violence on children discussed earlier, it is suggested that parental psychological functioning has an impact on the quality of the parent-child relationship (Lauch *et al.*, 1994).

Unfortunately, there is limited research concerning the impact of paternal functioning on child adjustment. This is disappointing as in some cases fathers may be the primary caregiver. Interestingly, paternal psychiatric problems have been found to be strongly associated with chronic marital difficulties (Lauch *et al.*, 1994). A study of violent husbands found greater levels of insecurity and disorganized adult attachment behaviours when compared to non-violent husbands (Holtzworth-Munroe *et al.*, 1997). This would suggest that attachment patterns may play a role in marital functioning and possibly be a factor in marital violence. Similarly, these adult attachment patterns are likely to impact on parent-child relationships.

Literature pertaining to maternal functioning and child adjustment is much more extensive. Whilst the majority of this paper focuses upon the mother-child relationship, it is acknowledged that the quality of the father-child relationship is also likely to have an impact on child development. Neither is it assumed that, even in the context of marital violence, father-child relationships are inevitably poor. Indeed, it may be possible that a positive relationship with a father, despite his violence towards the mother, may be a protective factor for the child (Osborne & Fincham, 1996).

Maternal psychological difficulties, in particular depression, have been found to be strong predictors of negative mother-child interactions (Martins & Gaffan, 2000). Similarly, marital discord has been found to have a disruptive effect on maternal parenting skills (Belsky *et al.*, 1991). A study of 74 women found that those who experienced domestic violence attended less to their child's needs and experienced more conflicts with the child than women in a control group (Holden & Ritchie, 1991).

There is some evidence to suggest that the attachment of a woman to her unborn child can begin in pregnancy (Condon, 1993; Cranley, 1981) and that poor attachment of the mother to the foetus may predict difficulties in future mother-child relationships (Condon, 1993). Behaviours of expectant mothers such as talking to the foetus, calling it by a name and trying to engage others in conversation with it, have been identified as early signs of mother to foetus attachment (Leifer, 1977). In one study, a positive correlation was found between mother to foetus attachment and the quality of the marital relationship (Weaver & Cranley, 1983). In addition, factors such as alcohol abuse, depression and domestic violence have also been found to have an impact on the quality of the mother's attachment to the foetus (Condon & Cortindale, 1997). There is evidence to suggest that in cases of domestic violence, forced sexual contact is commonplace which may result in a number of unplanned pregnancies (Finkelhor & Yllo, 1983; Painter & Farrington, 1998). Where pregnancies are unwanted and in the context of violence, this may also have an adverse effect on the mother's feelings towards her unborn child (Hillard, 1985; Kelly, 1994).

In summary, a review of the literature has highlighted that domestic violence can result in extensive direct and indirect consequences for women and their children. However, the specific processes by which exposure to domestic violence influences child development remain unclear (Grych *et al.*, 2000). A number of developmental theories have been suggested to explain variations in adjustment including social learning, trauma and other parental mental health theories. Each of these suggest a model of adjustment whereby domestic violence can have an impact on both the woman and her

children, and that maternal reactions can further influence child adjustment. More recently, relationship theories have been used to explain some of the variation in child adjustment. These suggest that domestic violence may interfere with effective parenting which, in turn, impacts on the parent-child relationship with the potential to adversely affect child development (see Figure 2).

INSERT FIGURE 2 HERE (Appendix 3)

The focus of this review has been the mother-child relationship and has highlighted violence during pregnancy as one area where these issues may be particularly pertinent. As discussed, evidence suggests that where a woman has been abused in pregnancy, the risk factors for poor mother-child relationships, adjustment problems, and eventual abuse of the child are even greater.

Limitations of current knowledge and future directions

There has been a vast amount of literature published in the area of domestic violence, the majority of which has focused on defining the problem and providing theoretical explanations for why it may occur. Whilst some studies have been more specific and focused on issues such as why women stay in the relationship and the impact on both women and children, there are clearly limitations in current knowledge.

There have been a number of methodological limitations to previous studies. For example, there has been an over reliance on sample groups from domestic violence refuges (Holden, 1998). By their very nature, refuges provide accommodation for women escaping a crisis. This questions how representative such samples are of

women experiencing domestic violence in general. In addition, there has been a notable lack of comparison groups in a number of studies. Although this has been addressed in more recent years there remains in domestic violence research, an over reliance on case studies and survey designs without adequate control groups (Graham-Bermann, 1998; Holden, 1998).

A deficit in much of the research to date has been the failure to link findings with implications for intervention (Graham-Bermann, 1998). As highlighted in the introduction, domestic violence is a pertinent issue for a number of services. The focus of this review has primarily been the implications for child and family mental health services. The potential risk of child abuse, behaviour problems and difficulties in parent-child relationships can all be contributory factors for eventual referral to services.

It is argued that early identification of domestic violence and immediate intervention for children in terms of therapy can prevent serious detrimental effects (Humphreys, 1998). At present, there are few attempts in tertiary services to routinely screen referred children for experience of domestic violence. Further, where domestic violence has been identified, there is little opportunity for children to receive interventions directly related to their experiences (Mullender, 2000). This is in contrast to services in other countries, for example Canada, where numerous groups have been developed for children focusing directly on the experience of domestic violence. Outcome studies have shown that 92 percent of the children partaking in the groups reported a positive impact whilst 87 percent of the mothers reported a positive impact on the child (Mullender, 2000).

Literature focusing on the treatment of abused women and their children has predominantly been concerned with behavioural and emotional consequences, and little attention has been paid to the impact of the violence on relationships. Intervention focusing on improving disrupted mother-child relationships is limited. This is in spite of evidence which suggests that difficulties related to the disruption in early parent-child relationships may be modified by focused intervention and subsequent experiences. For example, in a single case study of a disrupted mother-child relationship which persisted after the violence had ended, part of the focus of direct intervention was the mother's feelings about her child and her ability to attend to his needs. At one year follow-up, the mother had managed to create a secure and affectionate environment for her child and demonstrated effectiveness at containing her own emotional distress and that of her child (Puckering *et al.*, 1996).

Clearly there are a number of different avenues for further research in the area of domestic violence. Specific areas to explore include the multi faceted nature of domestic violence, as marital, parent-child and sibling violence may all co-exist (Graham-Bermann, 1998). In addition, examining children's perceptions of domestic violence would be useful, in particular their explanations for its occurrence, whether it is discussed with the mother and the perception of continued threat. Trauma theories (e.g. Pynoos *et al.*, 1993) would suggest that such factors are important in adjustment.

This review has highlighted that parent-child relationships, in the context of domestic violence, is an area of limited attention. There is little knowledge concerning the quality of parenting in this context (Holden *et al.*, 1998). Studies that have examined parenting have focused on parenting style, in particular, parent-child aggression (e.g.

Jaffe *et al.*, 1990), rather than exploring the actual relationship (Osborne & Fincham, 1996).

As highlighted by this review, women's experiences of violence whilst pregnant and the impact on child development and the mother-child relationship are important areas to progress. There have been a number of studies examining domestic violence during pregnancy but the focus of these has been primarily upon the physical impact on the mother and child (e.g. Helton *et al.*, 1987). There is a dearth of literature pertaining to the psychological experience of women, particularly focusing on their thoughts and feelings concerning the impact of the violence on themselves and their child whilst pregnant and afterwards.

In general, the processes and mechanisms by which children are affected by domestic violence need further exploration to build on existing theoretical foundations, enhance understanding and guide effective intervention. In order to provide effective intervention, it is necessary to be aware of the potential impact of domestic violence on women and their children and, in particular, on their relationships. It would seem appropriate, therefore, that all professionals working in child and family mental health services alongside other health professionals, have a role to play in developing the knowledge and understanding of domestic violence and the various mechanisms involved.

References

Aber, J. & Allen, J. (1987) The effects of maltreatment on young children's' socio-emotional development: an attachment theory perspective. *Developmental Psychology*, **23:** 406-414.

Ainsworth, M., Blehar, M., Waters, E. & Wall, S. (1978) *Patterns of Attachment: A Psychological Study of the Strange Situation.* Hillsdale, New Jersey: Erlabum.

Bandura, A. (1973) *Social Learning Theory.* Englewood Cliffs, New Jersey: Prentice-Hall.

Belsky, J., Youngblade, L., Rovine, M. & Volling, B. (1991) Patterns of marital change and parent-child interactions. *Journal of Marriage and the Family*, **53:** 487-498.

Berliner, L. (1998) Battered women and abused children: the question of responsibility. *Journal of Interpersonal Violence*, **13:** 2, 287-288.

Bewley, C. & Gibbs, A. (1994) Coping with domestic violence in pregnancy. *Nursing Standard,* **8:50:** 25-28.

Bowen, K. (2000) Child abuse and domestic violence in families of children seen for suspected sexual abuse. *Clinical Paediatrics*, **Jan, 39:** 33-40.

Bowlby, J. (1969; 1982) *Attachment and Loss: Volume 1. Attachment.* New York: Basic Books

British Medical Association (1998) *Domestic Violence: A Health Care Issue?* London: BMA.

Browne, K. & Hamilton, C. (1999) Police recognition of the links between spouse abuse and child abuse. *Child Maltreatment*, **4:** 2, 136-147.

Browne, K. & Saqi, S. (1987) Parent – child interaction in abusing families: its possible causes and consequences. In: P. Maher (Ed.) *Child Abuse: The Educational Perspective*. Oxford: Basil Blackwell Ltd.

Bullock, L. & McFarlane, J. (1989) The birth-weight / battering connection. *American Journal of Nursing*, **89:** 1153-1155.

Campbell, J., Oliver, C., Bullock, L. (1998) Why battering during pregnancy? *Clinical Issues in Perinatal and Women's Health Nursing*, **4:** 343-349.

Carlson, E. (1998) A prospective longitudinal study of attachment. *Child Development*, **69:** 1107-1128.

Carlson, E. & Sroufe, L. (1995) Contributions of attachment theory to developmental psychopathology. In: D. Cicchetti & D. Cohen (Eds.) *Developmental Psychopathology*. New York: Wiley.

Cicchetti, D. (1987) Developmental psychopathology in infancy: illustration from the study of maltreated youngsters. *Journal of Consulting and Clinical Psychology*, **55:** 6, 837-845.

Cicchetti, D. & Beeghy, M. (1987) Symbolic development in maltreated youngsters: an organisational perspective. In: D. Cicchetti & M. Beeghy (Eds.) *Atypical Symbolic Development*. California: Jossey-Bassey.

Condon, J. (1993) The assessment of antenatal emotional attachment: development of a questionnaire instrument. *British Journal of Medical Psychology*, **66:** 167-183.

Condon, J. & Cortindale, C. (1997) The correlates of antenatal attachment in pregnant women. *British Journal of Medical Psychology*, **70:** 359-372.

Cranley, M. (1981) Development of a tool for the measurement of maternal attachment during pregnancy. *Nursing Research*, **30:** 5, 281-284.

Curry, M. & Harvey, S. (1998) Stress related to domestic violence in pregnancy and infant birthweight. In: J. Campbell (Ed.) *Empowering Survivors of Abuse: Healthcare For Battered Women and Their Children.* California: Sage Publications.

Davies, P. & Cummings, E. (1994) Marital conflict and child adjustment: an emotional security hypothesis. *Psychological Bulletin*, **116:** 387-411.

Department of Health (1997) *Annual Report of the Chief Medical Officer for 1996: The State of the Public health.* London: HMSO

Department of Health (2000) *Domestic Violence: A Resource Manual for Health Care Professionals.* London: HMSO.

Dobash, R. & Dobash, R.E. (1980) *Women, violence and Social Change.* London: Routledge.

Dobash, R. & Dobash, R.E. (1979) *Violence Against Wives.* New York: Free Press.

Egeland, B., Jacobvitz, D. & Srouge, L. (1988) Breaking the cycle of abuse. *Child Development,* **59:** 1080-1085.

Erikson, E. (1963) *Childhood and Society.* New York: Norten.

Famularo, R., Fenton, T., Kinscherff, R., Ayoub, c. & Barnum, R. (1994) Maternal and child post traumatic stress disorder in cases of child maltreatment. *Child Abuse and Neglect*, **18:** 27-36.

Finkelhor, D. & Yllo, K. (1985) *Licence to Rape: Sexual Abuse of Wives.* New York: Free Press.

Finkelhor, D. & Yllo, K. (1983) Rape in marriage: a sociological view. In: D. Finkelhor, R. Gelles, G. Hotaling & M. Straus (Eds.) *The Dark Side of families: Current Family Violence Research.* California: Sage.

Freud, A. (1965) *The Writings of Anna Freud: Volume 6. Normality and Pathology in Childhood: Assessments of Development.* New York International Universities Press.

Gaensbauer, T. & Sands, K. (1979) Distorted affect communication in abused and/or neglected infants. *Journal of American Psychiatry*, **18:** 531-540.

Gordon, R., Holmes, M. & Maly, C. (1999) Research productivity in the areas of child abuse and domestic violence. *Psychological Reports*, **84:** 887-898.

Graham-Bermann, S. (1998) The impact of woman abuse on children's' social development: research and theoretical perspectives. In: G. Holden, R. Geffner & E. Jouriles (Eds.) *Children Exposed to Marital Violence: Theory, Research and Applied Issues.* Washington D.C.: American Psychological Association.

Grych, J., Jouriles, E., Swank, P., McDonald, R. & Norwood, W. (2000) Patterns of adjustment among children of battered women. *Journal of Consulting and Clinical Psychology,* **68:** 1, 84-94.

Harrist, A. & Ainslie, R. (1998) Marital discord and child behaviour problems: parent-child relationship quality and child interpersonal awareness as mediators. *Journal of Family Issues,* **19:** 2, 140-163.

Hart, S. & Brassard, N. (1987) A major threat to children's mental health: psychological maltreatment. *American Psychologist*, **42:** 1, 160-165.

Harwin, N. (1997) Domestic violence: understanding women's experiences of abuse. In: S. Bewley, J. Friend & G. Mezey (Eds.) *Violence against Women.* Sussex: RCOG Press.

Hedin, L. (2000) Postpartum: Also a risk period for domestic violence. *European Journal of Obstetrics and Gynaecology and Reproductive Biology*, **89:** 41-45

Helton, A., McFarlane, J. & Anderson, E. (1987) Battered and pregnant: a prevalence study with intervention measures. *American Journal of Public Health,* **77:** 1337-1339.

Henning, K., Leitenberg, H., Coffey, P. & Turner, T. (1996) Long-term psychological and social impact of witnessing physical conflict between parents. *Journal of Interpersonal Violence,* **11:** 1, 35-51.

Hershom, M. & Rosenbaum, A. (1985) Children of marital violence: a closer look at the unintended victims. *American Journal of Orthopsychiatry*, **55:** 260-266.

Hillard, P. (1985) Physical abuse in pregnancy. *Obstetric Gynaecology*, **81:** 1-3.

Holden, G. (1998) The development of research into another consequence of domestic violence. In: G. Holden, R. Geffner & E. Jouriles (Eds.) *Children Exposed to Marital Violence: Theory, Research and Applied Issues.* Washington D.C.: American Psychological Association.

Holden, G. & Ritchie, K. (1991) Linking extreme marital discord, child rearing and child behaviour problems: evidence from battered women. *Child Development*, **62:** 311-327.

Holden, G., Stein, J., Ritchie, K., Harris, S. & Jouriles, E. (1998) Parenting behaviours and beliefs of battered women. In: G. Holden, R. Geffner & E. Jouriles (Eds.) *Children*

Exposed to Marital Violence: Theory, Research and Applied Issues. Washington D.C.: American Psychological Association.

Holtzworth-Munroe, A., Stuart, G. & Hutchinson, G. (1997) Violent versus non-violent husbands: differences in attachment patterns, dependency and jealousy. *Journal of Family Psychology*, **11:** 3, 314-331.

Hughes, L. (1992) Impact of spouse abuse on children of battered women. *Violence Update*, **2:** 12, 7-11.

Humphreys, J. (1998) Helping battered women take care of their children. In: J. Campbell (Ed.) *Empowering Survivors of Abuse: Healthcare For Battered Women and Their Children.* California: Sage Publications.

Jacobsen, A. & Richardson, B. (1987) Assault experiences of 100 inpatients: evidence of the need for routine enquiry. *American Journal of Psychiatry*, **144:** 908-913.

Jaffe, P., Wolfe, P. & Wilson, S. (1990) *Children of Battered Women.* California: Sage.

James, M. (1994) *Domestic Violence as a form of Child Abuse: identification and prevention. Domestic Violence Information Manual.* Australia: National Child Protection Clearing House.

Johnson, N. (1995) Domestic violence: an overview. In: P. Kingston & B. Pennale (Eds.) *Violence and the Caring Professions.* London: Macmillan.

Jouriles, E. & Norwood, W. (1995) Physical aggression towards boys and girls in families characterised by the battering of women. *Journal of Family Psychology*, **9:** 69-78.

Jouriles, E., Murphy, C. & O'Leary, K. (1989) Interspousal aggression, marital discord and child problems. *Journal of Consulting and Clinical Psychology*, **57:** 3, 453-455.

Kelly, L. (1994) The interconnectedness of domestic violence and child abuse: challenges of research, policy and practice. In: A. Mullender & R. Morley (Eds.) *Children Living with Domestic Violence.* London: Whiting & Birch.

Kolko, D. (1996) Child physical abuse. In: J. Briere, L. Berliner, J. Buckley, C. Jenny & T. Reid (Eds.) *APSAC Handbook on Child Maltreatment.* California: Sage Publications.

Kurz, D. (1993) Physical assaults by husbands: a major social problem. In: R. Gelles & D. Loseke (Eds.) *Current Controversies on Family Violence.* Newbury Park, California: Sage.

Langley, H. (1997) The health professionals: an overview. In: S. Bewley, J. Friend & G. Mezey (Eds.) *Violence against Women.* Sussex: RCOG Press.

Laucht, M., Esser, G. & Schmidt, M. (1994) Parental mental disorder and early child development. *European Child and Adolescent Psychiatry*, **3:** 3, 125-137.

Leifer, M. (1977) Psychological changes accompanying pregnancy and motherhood. *Genetic Psychology Monographs*, **95:** 55-96.

Levy, T. & Orlans, M. (2000) Attachment disorder as an antecedent to violence and antisocial patterns in children. In: T. Levy (Ed.) *Handbook of Attachment Intervention.* New York: Academic press.

Lloyd, S. (1997) Defining Violence against women. In: S. Bewley, J. Friend & G. Mezey (Eds.) *Violence against Women.* Sussex: RCOG Press.

Lyons-Ruth, K. (1996) Attachment relationships among children with aggressive behaviour problems: the role of disorganised early attachment patterns. *Journal of Consulting and Clinical Psychology*, **64:** 64-73.

McGibbon, A., Cooper, A. & Kelly, L. (1988) *What Support?* London: Hammersmith and Fulham Council/Polytechnic of London.

McWilliams, M. & McKiernan, J. (1993) *Bringing it out in the Open: Women and domestic violence in Northern Ireland.* Belfast: HMSO.

Main, M. & Hesse, E. (1990) Parents' unresolved traumatic experiences are related to infant disorganised attachment status. In: M.Greenberg, D. Cicchetti & E. Cummings (Eds.) *Attachment in the Pre-school Years:Theory, Research and Intervention.* Chicago: University of Chicago Press.

Main, M., Kaplan, N. & Cassidy, J. (1985) Security in infancy, childhood and adulthood: a move to the level of representation. In: I. Bretherton & E. Waters (Eds.) *Growing Points of Attachment Theory and Research.* Monographs of the Society for Research in Child Development.

Martins, C. & Gaffan, E. (2000) Effect of early maternal deprivation on patterns of infant-mother attachment: a meta-analytic investigation. *Journal of Child Psychology and Psychiatry*, **41:** 6, 737-746.

Mills, L. (1998) Integrating domestic violence assessment into child protection services. In: A. Roberts (Ed.) *Battered Women and Their Families.* New York: Springer.

Milner, J., Robertson, K. & Rogers, D. (1990) Childhood history of abuse and adult child abuse potential. *Journal of Family Violence*, **5:** 15-43.

Mirrlees-Black, C. (1999) *Domestic Violence: Findings from a new British crime survey self-completion questionnaire*. London: Home Office Publications.

Moore, T. & Pepler, D. (1998) Correlates of adjustment in children at risk. In: G. Holden, R. Geffner & E. Jouriles (Eds.) *Children Exposed to Marital Violence: Theory, Research and Applied Issues.* Washington D.C.: American Psychological Association.

Mullender, A. (2000) *Reducing Domestic Violence – what works? Meeting the needs of children- Briefing Note*, January. London: Policing and Reducing Crime Unit.

O'Shea, L. (1996) Domestic violence in pregnancy. *Modern Midwife*, **199:** 10-12.

Osborne, L. & Fincham, F. (1996) Marital conflict, parent-child relationships and child adjustment: does gender matter? *Merrill-Palmer Quarterly*, **42:** 48-75.

Owen, M. & Cox, M. (1997) Marital conflict and the development of infant-parent attachment relationships. *Journal of Family Psychology*, **11:** 2, 152-164.

Pahl, J. (1982) Men who assault their wives: what can health visitors do to help? *Health Visitor*, **55:** 528-530.

Painter, K. & Farrington, D. (1998) Marital Violence in Great Britain and it's relationship to marital and non-marital rape. *International Review of Victomology*, **5:** 3-4, 257-276.

Puckering, C., Evans, J., Maddox, H., Mills, M. & Cox, A. (1996) Taking control: a single case study of mellow parenting. *Clinical Child Psychology and Psychiatry*, **1:** 4, 539-550.

Pynoos, R., Sorenson, S. & Steinberg, A. (1993) Interpersonal violence and traumatic stress reactions. In: L. Goldberger & S. Breznitz (Eds.) *Handbook of Stress: Theoretical and Clinical Perspectives*. New York: Free Press.

Radford, L., Hester, M. & Pearson, C. (1998) *Domestic Violence: Fact Sheet*. London: School for Policy Studies.

Richters, J. & Waters, E. (1991) Attachment and socialization. In: M. Lewis & S. Feinman (Eds.) *Social Influences and Socialization in Infancy*. New York: Plenum Press.

Rosenbaum, A. & O'Leary, K. (1989) Children: the unintended victims of marital violence. *American Journal of Orthopsychiatry*, **51:** 692-699.

Saunders, A. (1995) *It Hurts Me Too – Fact Sheet*. London: Childline/ Women's Aid Federation/ National Institute for Social Work.

Shek, D. (1998) Linkage between marital quality and parent-child relationship. *Journal of Family Issues*, **19:** 6, 687-704.

Stanko, E., Crisp, D., Hale, C. & Lucraft, H. (1998) *Counting the Costs: estimating the impact of domestic violence in the London borough of Hackney*. Swindon: Crime Concern.

Stark, E. & Flitcraft, A. (1985) Women battering, child abuse, and social heredity: what is the relationship? In: N. Johnson (Ed) *Marital Violence*. London: Routledge & Kegan Paul.

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

Stevens, K. (1997) The role of the accident and emergency department. In: S. Bewley, J. Friend & G. Mezey (Eds.) *Violence Against Women*. Sussex: RCOG Press.

Stevenson, J. (1999) The treatment of the long-term sequelae of child abuse. *Journal of Child Psychology and Psychiatry*, **40:** 1, 89-111.

Weaver, R. & Cranley, M. (1983) An exploration of paternal-foetal attachment behaviour. *Nursing Research*, **36:** 68-72.

Wilson, C. (1998) Battered women and abused children: the question of responsibility. *Journal of Interpersonal Violence*, **13:** 2, 287-288.

Wolfe, D., Jaffe, P., Wilson, S. & Zak, L. (1985) Children of battered women: the relationship of child behaviour to family violence and maternal stress. *Journal of Consulting and Clinical Psychology*, **53:** 651-665.

Wolfe, D., Zak, L., Wilson, S. &. Jaffe, P (1986) Child witnesses to violence between parents: critical issues in behavioural and social adjustment. *Journal of Abnormal Child Psychology*, **14:** 1, 95-104.

Appendix 1

Journal instructions for authors

Blackwell Publishers

Journal of Family Therapy

How to Submit Your Article

NOTES FOR AUTHORS

Papers submitted for publication should be original work not previously published in English and not currently submitted elsewhere for consideration. If accepted for publication. a paper cannot be published elsewhere in any language without the consent of Editor and publisher. It is a condition of acceptance that the Association for Family Therapy and Systemic Practice automatically acquires the copyright throughout the world.

Submission of Manuscripts

Four copies of each manuscript should be submitted to the Editorial Office.

Format for Manuscripts

1. Manuscripts should allow for 'blind' refereeing and be prepared accordingly. Failure to conform to this requirement will result the manuscript not being reviewed.
2. Manuscripts should be presented on one side of white bond A4 paper with wide margins (31cm) and *must* be typed in double spacing throughout. *including quotation, notes and references* in the following order:

i) Title Page: to contain the title of the paper. the full name of each author. their current professional position and work context and an indication of which author will be responsible for correspondence, proofs and reprints. Correspondence address and telephone numbers should be included. A word count *must* be included on the title page together with a suggested running head.

ii) Abstract: On a separate sheet. the title to be repeated followed by not more that 150 words summary of the paper The suggested running head should also be present.

iii) Organisation of the text: See copy of Journal for the format currently in use.

iv) References: a.) In the text these should be indicated by the name and date e.g. ' Carr (1995).'. If more than two authors are listed. cite the reference as 'McGroary *et al.* (1997).'. Quotations should include page numbers.

b) References used should be listed at the end of the paper in alphabetical order according to the first author and be complete in all details. again following the Journal's existing format.

Articles: -Carr. A. (1995) Family therapy and clinical psychology. *Journal of Family Therapy*. **17:** 435-444.

Chapters: -Carpenter. J. And Treacher. A. (1993) Introduction: the changing contexts of family therapy. In: J. Carpenter and A. Treacher (eds) *Using Family Therapy in the 90s*. Oxford: Blackwell. If there are queries A.P.A. reference style is appropriate.

v) Figures, tables, etc.: All figures and tables should be numbered with

consecutive arabic numerals, have descriptive captions and be mentioned in the text. They should be kept separate from the text but an approximate position for them should be indicated.
vi) Styie: Whilst the style of the Journals is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

Evaluation of Manuscripts

The Editorial office will acknowledge receipt of manuscripts. The Editor will arrange for evaluation by at least two assessors. Following receipt of the assessors comments the Editor will advise the authors about the decision concerning the manuscript. This will be done as rapidly as possible with the aim being 12 weeks.

On Acceptance

When the article is formally accepted for publication the author(s) will be required to provide two hard copies of the final manuscript and the same version of the article on a computer disc. Advice on preparation of the latter will be provided at that time.

Copy Editing

Following acceptance for publication an article is copy edited for conformity to the style of publication, clarity of presentation, punctuation, standard usage of terms, etc. After an article has been typeset authors will be charged for any changes they wish to make.

Proofs

First-named authors will receive proofs for correction which must be returned within **48 hours** of receipt.

Reprints

The senior author only will be sent 25 reprints free of charge. Additional copies may be purchased when returning proofs.

PREPARING THESIS MATERIAL FOR PUBLICATION

Beginning From the outset, it needs to be appreciated that the audience for a thesis is very different to the readership of a Journal. A thesis is prepared to demonstrate candidates' knowledge of an area. their understranding of how theoretical matters link and their ability to use a wide range of sources to develop arguments. In presenting research material, the thesis will provide explanations about the process of deciding on a methodology, the utilisation of that methodology and a critique of its application. A Journal article by contrast seeks to make one or two points clearly and to link these with the current understandings and conceptions in such a way that there is the development of ideas. The Journal reader assumes that the author has a wide range of knowledge of the area and is looking for the author to make a few points well by building on what is already known. Essentially therefore a thesis and a Journal article are very different pieces of writing and the process of preparing one for the other is more than just re-wording of the title page!

The key to overcoming the difficulties of moving from a thesis to a Journal article is to be aware that one uses the **thesis as a source**

rather than using it as an earlier version of the article. In preparing a Journal article you begin with a blank sheet of paper, a lot of knowledge and previous written material. What is available has the potential of being an article but further work will be necessary.

Common Problems For the reasonably experienced Journal reviewer it is easy to identify thesis based material by the common problems that appear.

- *The introduction is over long and covers too broad an area.* Histories of where family therapy came from and descriptions of core elements of systemic practice are not necessary in Journal articles. Only the theoretical point germane to the article's principle aims need to be outlined.
- *Long explanations as to why particular methodologies are used.* For a Journal article there is no need to enter into discussions of this nature or to compare different methodologies. The decision was made to undertake the research on one particular methodology and this is what should be present.
- *Too many quotes from other authors.* There is a need in thesis to seek validation from a wide range of sources, but in a Journal article the author's own arguments should be enough with a few selected quotes to emphasise points.
- *The attempt to write the journal article by following the same structure of the thesis.* In many cases this is not necessary as the article will demand a different type of structure.
- *Over long self critique of the work.* Although self criticism is a necessary part of any public presentation of one's work, it needs to be pertinent to the material presented. There is no need for a full descriptive account of the self reflective process.
- *De-emphasising the main findings of any research study in an attempt to fit it in with the fuller perspective of the thesis.* In an article the main findings of the research study need to be emphasised and examined and then linked to broader themes relevant to the issues discussed.

In short, writers of the journal articles prepared from thesis often attempt to include as much of their thinking that went into the thesis in the article. There is a need to overcome the reluctance to cut out elements of the thesis in the preparation of an article to keep the writing solely relevant to the ideas being present.

Types of Papers There are three types of papers that can be prepared from theses (and two of these types could emerge from extended essays):

- 1. *The Literature Review* Unfortunately there are too few of this variety presented for publication even though they are much sought after by the readership. Such a paper would have:

  a. A brief general introduction.
  b. A description of the way in which the themes in the literature are organised by the author for review. This may include conceptual and definition problems.
  c. The review.
  d. An overview of the review process including gaps in existing knowledge.
  e. Future directions.

Such a review would be in the order of 3,000-6,000 words.

- 2. *A Theoretical Discussion or Argument* Again there are few articles of this nature offered for possible publication. A paper of this type would include:

    a. A brief general introduction.
    b. Review of previous statements of the issues.
    c. Definition of problems and solutions.
    d. Development of an argument (Research based work which was undertaken for a thesis may be referrenced).
    e. Relation of theory to practice.
    f. Issues to be resolved.

    An article of this nature would be in the order of 4,000-6,000 words.

- 3. *Research Presentation* This is the usual type of article that is presented. This article should include:
    a. An introduction to the principal concepts and theoretical issues relevant to the study.
    b. Previous work.
    c. Brief description of methodology including participants.
    d. Results.
    e. Discussion of results in terms of (a) and (b), including implications for future research and practice.

    Research presentation should typically be of the order of 3,000-4,000 words for M. Sc. thesis and possible 4,000-6,000 for Ph. D. thesis.

Good Marks and Articles

- Because the consumers of theses and articles are different, the potential author needs to be aware that if a thesis is praised it does not necessarily mean it is readily translatable into an article. It simply means a good mark towards the degree. Similarly. even if a thesis or extended essay just scrapes past the pass mark. it may contain some very useful material that can be worked with for future submissions as an article to a Journal.

The Question of Authorship

- In many academic departments there is a tradition that material which is offered for publication which is based on a thesis should be seen as a joint endeavour between the student and the supervisor. The student is seen as being the senior author with the supervisor in a supporting role. Courses and supervisors are quite likely to have different views on this. There are no set rules. However in some situations it may be that by using the thesis material as a source a good quality article could be developed by the student and supervisor working on it jointly. This is a point that should be borne in mind by both students and staff.of family therapy courses.

A Final Point

- Writing is a very enjoyable and satisfying way of being involved in the world of family therapy. The exchange of ideas and experience is important for the development of our chosen field and is important for the deveolpment of the individual practitioner. We intellectually sustain ourselves by creating a

heathy and vibrant literature. Family therapy needs to develop authors.

The Journal of Family Therapy wants to hear from you. Get writing.

- GOOD LUCK!!!!

- For further information on publishing in the *Journal of Family Therapy* please contact:

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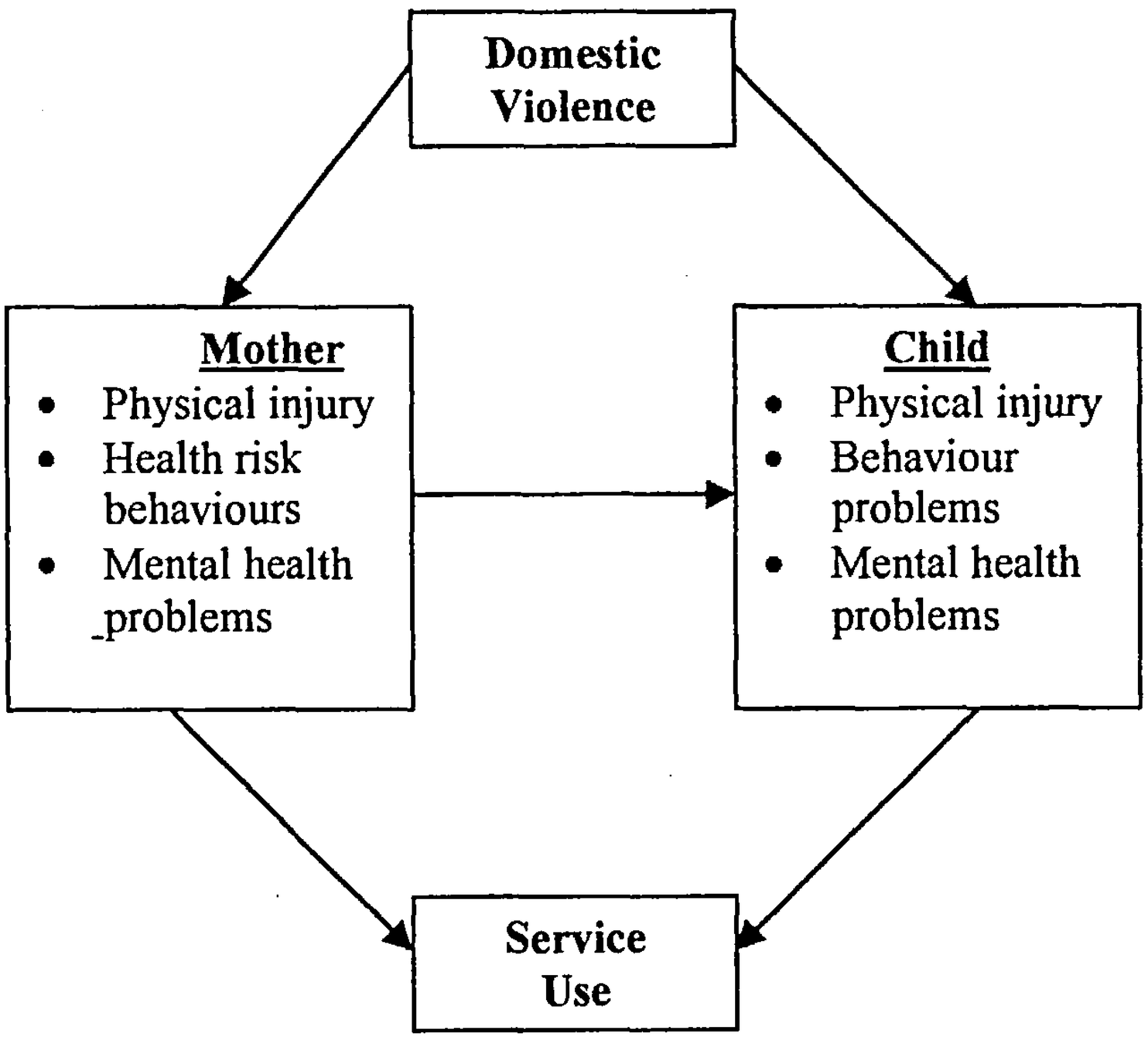
Appendix 2

Figure 1

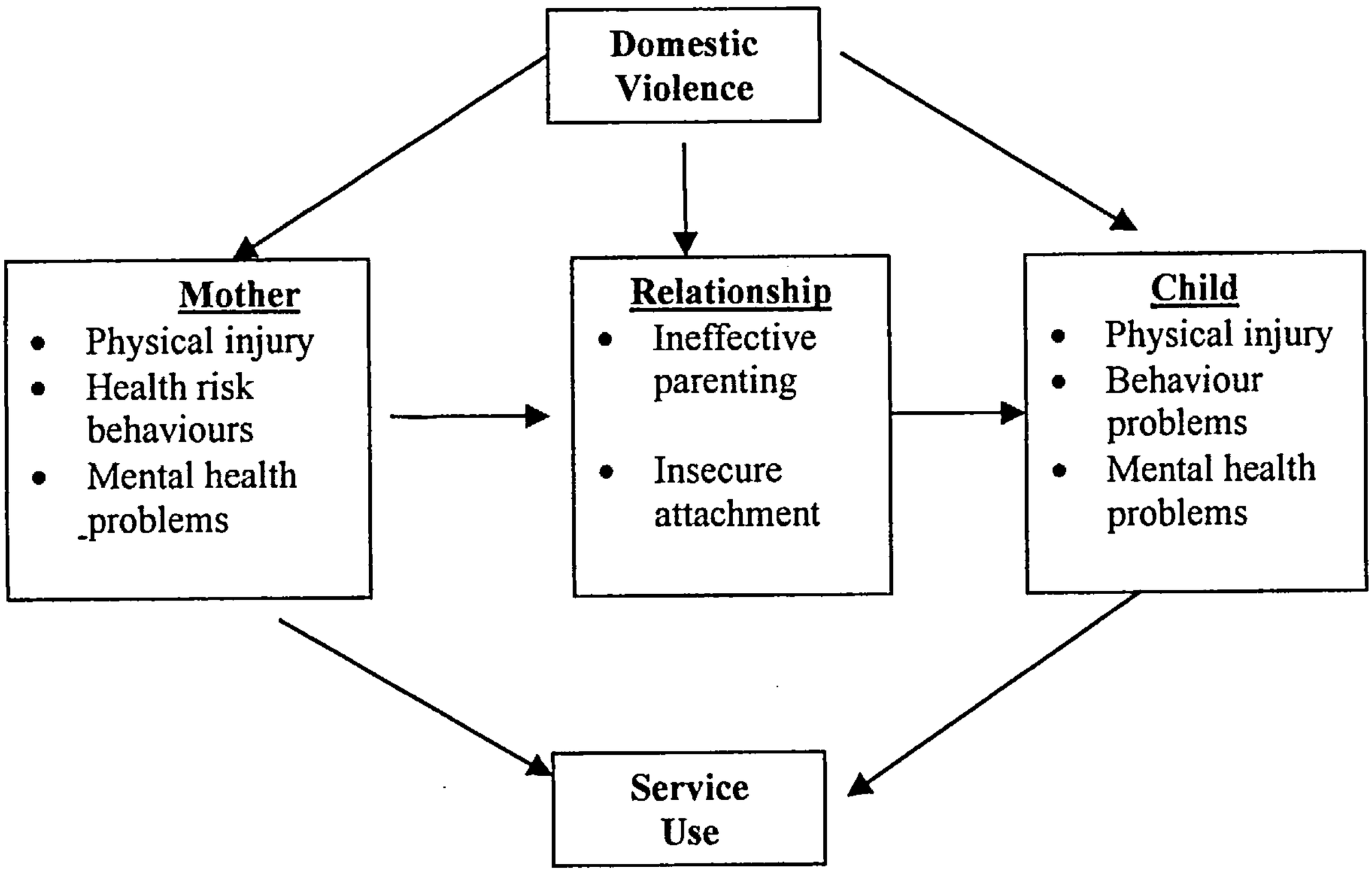
Figure 1 Model of the impact of domestic violence



Appendix 3

Figure 2

Figure 2 Alternative model of the impact of domestic violence



Section 3

Research Paper

An investigation into domestic violence, violence in pregnancy and implications for mother-child relationships.

R. McCormick, Trainee Clinical Psychologist

Lancashire Doctorate in Clinical Psychology Course

This paper has been prepared in accordance with the instructions for contributors

to the International Journal of

Child Abuse and Neglect

(See Appendix 1)

4,892 words (excluding reference list and appendices)

7,292 words (including reference list and appendices)

Running title: Domestic violence in pregnancy

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ABSTRACT:

Objective: The study aims to; investigate the impact of violence on maternal mental health and child difficulties, examine the link between domestic violence and child abuse in relation to violence in pregnancy; explore the impact of violence on the mother-child relationship and to assess the role of maternal mental health.

Method: A questionnaire design was used, the sample consisted of 28 women who had experienced domestic violence and 24 women who had not. Fifteen participants in the domestic violence sample had experienced violence during pregnancy, four of whom took part in a semi-structured interview.

Results: There was an increased prevalence of child abuse in the domestic violence sample but increased risk was not related to violence in pregnancy. An increased prevalence of physical and mental health problems during pregnancy was found in women who experienced violence in pregnancy. Domestic violence, in general, was associated with higher levels of maternal distress and child agency involvement. A mediation analysis of the mother-child relationship revealed that maternal distress was the stronger predictor of the quality of the relationship, although the experience of violence was also an important factor.

Conclusions: The findings indicate that maternal mental health and exposure to domestic violence are both important factors in the development of difficulties in mother-child relationships. The findings highlight the need for routine screening for domestic violence in child mental health services, not only to plan effective intervention, but also to address child protection issues.

Key Words: Domestic Violence, Pregnancy, Relationships

Introduction

Domestic Violence has considerable implications for health services particularly in accident and emergency departments, primary care and specialist settings such as maternity services and child and adolescent mental health services (Langley, 1997).

Whilst domestic violence can take place within any intimate relationship, the vast majority and more severe assaults are perpetrated by men against their female partners (Kurz, 1993). The impact of domestic violence on women is well documented, ranging from physical injuries (Stanko, Crisp, Hale & Lucraft, 1998) to psychological difficulties such as depression and anxiety (British Medical Association, 1998). Women abused by their partners are more likely to be in contact with mental health professionals (Johnson, 1995) and make greater use of inpatient and outpatient psychiatric services (Jacobsen & Richardson, 1987).

Domestic violence can also have a negative impact on children within the family (Henning, Leitenberg, Coffey & Turner, 1996). Children exposed to domestic violence have been found to exhibit greater degrees of health problems, behavioural difficulties and impairment of cognitive and emotional development compared to children from non-violent homes (Jaffe, Wolfe & Wilson, 1990).

The experience of domestic violence for children is not necessarily limited to witnessing the conflict; links between spouse abuse and child abuse are well established (Mullender, 2000; Stark & Flitcraft, 1985). The effects of child abuse are extensively documented, including cognitive, behavioural and social difficulties for the child (Browne & Saqi, 1987; Kolko, 1996).

Violence towards partners and children is arguably difficult to separate into discrete categories of 'child abuse' or 'domestic violence' (Bowen, 2000). Yet until recently the child protection and domestic violence communities developed in relative isolation (Berliner, 1998). The

overlap of domestic violence and child abuse is an important factor in understanding the conflicts and problems women may face as mothers and as victims of domestic violence (Berliner, 1998, Wilson, 1998). Focusing on child protection issues alone may do little to further the knowledge and understanding of the impact of domestic violence.

Pregnant women who are abused by their partners is an area where such issues begin to overlap. Research has shown that pregnancy can be a trigger for domestic violence to begin or intensify (Department of Health, 2000). Abuse in pregnancy has been found to be associated with a greater frequency and severity of violence, suggesting that a man who assaults his pregnant partner is likely to be an extremely violent individual (Campbell, Oliver & Bullock, 1998; Helton, McFarlane & Anderson, 1987).

Reasons why a man would abuse his pregnant partner are complex and varied, including jealousy of the unborn child or anger at the additional responsibilities a child brings (O'Shea, 1996). The incidence of premature labour, miscarriage and stillbirth is greatly increased in populations of women subjected to violence in pregnancy (Bewley & Gibbs, 1994; Helton et al., 1987). Studies have found that such women are more likely to smoke and abuse alcohol (Hedin, 2000), be diagnosed as depressed and are at increased risk of suicide (Helton et al., 1987). Abused pregnant women are also four times more likely to have low birth weight babies (Bullock & McFarlane, 1989; Helton et al., 1987). Based on these facts, it would be reasonable to suggest that the children of women abused in pregnancy are at increased risk of future difficulties. Existing findings of the impact of domestic violence on maternal mental health would also suggest that the experience of violence whilst pregnant may have an impact on the mother's adjustment to the pregnancy and her subsequent relationship with the child.

A number of factors are known to affect the quality of early relationships, including pre birth and birth traumas (which may include violent assaults), ill health, parental difficulties and environmental factors such as poverty and stress (Levy & Orlans, 2000). Findings suggest that there is an association between marital quality and parent-child relationship quality (Harrist & Ainslie, 1998; Owen & Cox, 1997; Shek, 1998).

Studies have also highlighted an association between marital violence and disorganized attachment behaviours exhibited by the child (e.g. Owen & Cox, 1997). Within the context of a violent relationship, an infant may experience confusion and unpredictability when trying to seek comfort from a frightening or frightened caregiver (Main & Hesse, 1990).

Parental psychological functioning has also been found to have a significant impact on the quality of the parent-child relationship (Laucht, Esser & Schmidt, 1994). Focusing on the mother-child relationship, marital discord has been found to have a disruptive effect on maternal parenting skills (Belsky, Youngblade, Rovine & Volling, 1991; Holden & Ritchie, 1991). Maternal psychological difficulties, in particular depression, have also been found to be strong predictors of negative mother-child interactions (Martins & Gaffan, 2000).

While several studies have examined domestic violence during pregnancy, the focus of these has been primarily upon the physical impact on the mother and the unborn child (e.g. Helton et al., 1987). There is a dearth of literature regarding the psychological experience of these women, for example their thoughts and feelings concerning the impact of the violence on themselves and their children and the impact the violence has had on the mother-child relationship. This study aims to address this issue by exploring a number of research questions generated by previous research and discussion with professionals working in the area of

domestic violence concerning domestic violence in general and the experience of violence during pregnancy.

The first question is whether the experience of violence during pregnancy increases the likelihood that the child will be abused. The overlap of domestic violence and child abuse has been found to occur in 30-60 percent of cases (Bowen, 2000; Mullender, 2000). However, there is no data pertaining to violence during pregnancy and subsequent child abuse. In addition, given the clear link between spouse abuse and child abuse, it would be interesting to examine to what extent abused women acknowledge that their children may be at risk. Secondly, this study aims to explore the impact of violence in general and violence during pregnancy specifically, on the mother-child relationship. This will include assessing to what extent maternal psychological health is a factor in the mother-child relationship as opposed to the experience of domestic violence.

Based on previous research, four specific hypotheses will be tested. First, have women who were abused during pregnancy experienced more pregnancy–related difficulties than women who were abused outside of pregnancy? Second, have children whose mothers were abused during pregnancy experienced more difficulties during their childhood than children whose mothers were abused outside of pregnancy? Third, are children whose mothers were abused during pregnancy more likely to have been abused themselves than the children whose mothers were abused outside of pregnancy? Finally, do women who have been abused by a partner experience greater levels of psychological distress than women who have not and does the experience of violence during pregnancy have a greater impact?

Method

Participants

Fifty-two women took part in the study, 21 of whom were recruited through domestic violence agencies (e.g. police, Women's Aid). The comparison group (n=31) was recruited through social workers and parent-child groups. The inclusion criterion for both groups was that participants had children under the age of 16. The exclusion criterion was if women were currently experiencing a crisis. Seven women (22.6%) recruited through the parent-child groups were found to have experienced domestic violence and were therefore included in the domestic violence group.

Demographic characteristics of the sample are reported in Table 1.

(INSERT TABLE 1 ABOUT HERE) (Appendix 2)

Analysis of the demographic data was carried out using Fisher's exact tests and Mann-Whitney U tests (Appendix 3). Significant differences were not found between the Domestic Violence group (DV) and the comparison group (non-DV) on age of participant, number of children, employment status, or gender and age of the focus child. A significant difference was found, however, in marital status, with a higher prevalence of lone parents in the DV group.

Just over 53 percent of the DV sample reported having experienced domestic violence during pregnancy. Analysis of the data showed the only significant difference between the DV (pregnancy) and DV (non-pregnancy) groups was the gender of the focus child. A higher proportion of focus children in the DV (pregnancy) group were female (p= Fishers' Exact test p=. 01) (see Appendix 3).

.

Measures

Maternal psychological health. This was assessed using The General Health Questionnaire–12 (GHQ-12; Goldberg, 1992). A self-administered screening measure, it is used to detect psychological distress in community settings. Respondents are required to rate 12 items on a four-point scale indicating to what extent they have experienced a particular symptom/ behaviour in the past week. The items are scored using a binary method (0,0,1,1) which yields an overall score ranging from 0-12. A threshold score of 3/4 is recommended to identify probable cases of minor psychiatric disorder (Hardy, Shapiro, Haynes & Rick, 1999). For simplicity, four was used as the threshold for this study. Good psychometric properties are reported for the GHQ-12 in a number of studies (e.g. Hardy et al., 1999).

Experience of domestic violence. This was assessed using questions adapted from the Abuse Assessment Screen (AAS; Parker & McFarlane, 1991 in Soeken, McFarlane, Parker & Lominack, 1998). The AAS is a questionnaire used to assess the frequency, severity, and perpetrator of abuse against women, it has been adapted for screening purposes in settings such as Accident and Emergency departments (Department of Health, 2000). In a study comparing the AAS with established abuse assessment measures, the reliability and validity of the AAS were found to be satisfactory (Soeken et al., 1998). Three of the five questions from the AAS were adapted for the purpose of this study, focusing on the experience of physical and/or sexual violence from a partner to which participants were required to respond 'yes or no'. Participants were asked to identify whether the perpetrator was a current or former partner (or both) and a further question was used to assess whether participants had experienced violence during pregnancy.

Reproductive health. A number of questions were used to assess general reproductive health and included questions about number of pregnancies and experiences of miscarriage or still-birth.

Focus child questions. A variety of questions were devised by the researcher, through discussion with relevant professionals, concerning the birth and development of the focus child; for example whether the pregnancy was planned and whether the participant experienced physical and/or mental health problems during the pregnancy or afterwards. Participants were asked if their partner displayed feelings of anger or jealousy towards the unborn child and if they themselves had concerns regarding the safety of the unborn child. A checklist was used to assess history of agency involvement with the focus child on which participants were required to indicate 'yes or no' to involvement. Finally, participants were asked whether they believed their child to be at risk from abuse, whether the child had been abused and, if so, who the perpetrator was.

Mother-child relationship. The Child Grid section of the Family Grid (Davis, 1997) was used to examine this. Based on repertory grid technique (Fransella & Bannister, 1977), it is a self-administered measure designed to assess an individual's self-esteem and relationships with a partner and child. On the Child Grid, participants are required to rate their child and their imagined, ideal child on 25 supplied construct dimensions using a seven-point scale. The mean difference between the child and ideal child on the constructs is calculated and the discrepancy is used as a measure of the quality of the parent-child relationship. A mean discrepancy score of 1.5 or less is used as an indication of a satisfactory relationship between respondent and child whereas a threshold score of 2.0 and above indicates significant relationship problems

(Davis, 1997). Adequate psychometric properties have been reported for the Family Grid (Davis & Hester, 1996)

Interview. A semi-structured interview schedule was devised to provide additional information regarding participants' experiences. Questions were generated based on the responses from the questionnaire and discussion with professionals working in the area of domestic violence. There were six areas of focus, the experience of abuse in general; the experience of abuse in pregnancy; reactions to abuse; relationships with children; support; and overall reflections. Specific questions were used as guidelines to provide some structure during the interviews.

Procedure

The quantitative measures were collated into an anonymous questionnaire which was returnable in an attached freepost envelope. An information sheet and consent form were attached to the questionnaire in addition to local contact numbers for support agencies.

Key figures in domestic violence agencies were contacted and informed of the study and an agreed number of questionnaires were forwarded to them. In turn, the agencies explained the nature and the procedure of the study to women they had contact with and, based on the inclusion/exclusion criteria, distributed the questionnaires to women who agreed to participate in the study. Social workers and parent-child groups were approached in the same manner and agreed to distribute questionnaires based on the inclusion/exclusion criteria. Participants were informed that help was available in completing the questionnaire if required.

Participants were able to volunteer for the interview stage of the study if they had experienced domestic violence during pregnancy. A sheet attached to the back of the questionnaire was used for this purpose; the information supplied remaining confidential. If appropriate, participants were sent further information about the interview stage of the study and a consent

form. Once consent was obtained, participants were contacted by either letter or telephone. All interviews took place in interviewees' homes and were carried out by the researcher. The interviews were audio taped and transcribed verbatim. Feedback was offered to interviewees on completion of the study.

Results

Analysis of the four hypotheses will be presented initially, followed by the analysis of the research questions. Qualitative data obtained from the interviews will be at the end of this section.

Due to the small sample size of the study, differences between categorical variables were tested using Fisher's Exact tests. Differences between groups on remaining variables were compared using Mann-Whitney U tests. Correlations were investigated using Spearman's rank coefficient correlations and multiple regression was used to explore predictive factors. Following examination of the descriptive statistics and calculations of skewness and kurtosis, the following variables were eliminated from the analyses, ethnicity, number of miscarriages, timing of birth, feelings about pregnancy and concern for the child.

Hypothesis 1- Domestic violence during pregnancy and pregnancy-related difficulties. (Appendix 4)

Table 2 illustrates the results from the analysis of reported difficulties during pregnancy, labour and post-natally.

(INSERT TABLE 2 ABOUT HERE) (Appendix 2)

A significantly higher proportion of the DV (pregnancy) group reported physical and/or mental health difficulties during the pregnancy compared to the DV (non-pregnancy) group. In

addition, there was a trend for the DV (pregnancy) group to report more physical and/or mental health difficulties post-natally (p=. 07). A significantly higher proportion of the DV group, as a whole, reported physical and/or mental health difficulties during labour compared to the control group. There was a trend for the DV group, as a whole, to have lower birthweight babies (p=. 06) but this was not specifically related to violence during pregnancy.

Hypothesis 2- Domestic violence during pregnancy and child agency involvement.

(Appendix 5)

A significantly higher proportion of the DV (pregnancy) group (46.7%) reported involvement with two or more child agencies than the DV (non-pregnancy) group (7.7%), (Fishers' Exact test p=. 04). Similarly, analysis of violence in general revealed that a significant proportion of the DV group (28.6%) reported involvement with two or more child agencies compared to the control group (0%), (Fishers' Exact test p=. 005).

Hypothesis 3- Domestic violence during pregnancy and child abuse. (Appendix 6)

Although a higher proportion of the DV (pregnancy) group (33.3%) reported that their child had been abused compared to the DV (non-pregnancy) group (15.4%), this was not a significant result (p=. 40). However, there was a significant difference between the DV and non-DV groups on the incidence of child abuse (25% vs. 0%), (Fishers' Exact test p=. 01).

Hypothesis 4- Domestic violence and maternal psychological distress. (Appendix 7)

There was a significant difference between the DV and non-DV group in numbers scoring above the threshold score on the GHQ-12 (42.9% vs.12.5%), (Fishers' Exact test p=. 03). Whilst a significant result was not obtained in the analysis of violence during pregnancy, there was a trend for the DV (pregnancy) group to score above the threshold compared to the DV

(non-pregnancy) group (p=. 07). Table 3 shows the analysis of the mean scores of psychological distress between the DV and non-DV groups.

(INSERT TABLE 3 ABOUT HERE) (Appendix 2)

As highlighted, the DV group had a significantly higher mean score on the GHQ-12. Analysis of violence during pregnancy revealed a trend for the DV (pregnancy) group to have a higher mean score (p=. 07).

Research Questions

To what extent can women who have experienced domestic violence identify that their children may also be at risk? (Appendix 8)

A significant proportion of the DV group as a whole (21%) reported that their partner displayed feelings of anger towards their unborn child compared to the control group (0%), (Fishers' Exact test p=. 02). A similar result was found in the analysis of jealousy (Fishers' Exact test p=. 02). A higher proportion of the DV group (28.6%) believed their child to be at risk from abuse compared to the control group (0%), a highly significant result (Fishers' Exact test p= .005).

Analysis of violence during pregnancy found that a significant proportion of the DV (pregnancy) group (40%) reported that their partner displayed feelings of anger towards the unborn child compared to the control group (0%) (Fishers' Exact test p=. 02). A significant difference between the groups was not found on partners' feelings of jealousy. A significant difference was not found between the DV (pregnancy) and DV (non-pregnancy) groups related to whether participants believed their child to be at risk from abuse.

Does the experience of domestic violence whilst pregnant have an impact on the mother's relationship with that child? (Appendix 9)

Analysis of the scores on the Child Grid revealed a significant difference between the DV group and non-DV group (M=1.6, SD=. 80, vs. M=. 90, SD=. 60), (z=-3.2, p=. 001). Analysis of violence during pregnancy did not yield a significant result.

Analysis of the Child Grid threshold score revealed that 16.6 percent of the DV group scored at or over the threshold compared to 4.5 percent of the non-DV group, however the difference was not found to be significant.

To what extent are maternal psychological health and the experience of domestic violence significant factors in the quality of the mother-child relationship?

Correlation analysis revealed a significant positive relationship between GHQ-12 score and the discrepancy score on the Child Grid (rho=. 40, n=46, p=. 01) (Appendix 10). As, both GHQ score and the experience of violence in general were found to be associated with the discrepancy score, a multiple linear regression analysis was performed to determine which variable was most strongly associated with the discrepancy score (Appendix 11). Table 4 shows the results from the regression analysis.

(INSERT TABLE 4 ABOUT HERE) (Appendix 2)

As shown, participant GHQ score was most strongly associated with the Child Grid discrepancy score. However, the experience of domestic violence was also significantly associated. Combined, the two variables accounted for 27.9 percent of the variance in discrepancy scores (p<. 01).

Analysis of Interviews

Full transcripts of the interviews can be made available on request.

Four interviews were carried out with women who had experienced domestic violence during pregnancy. All interviewees were separated from their violent partners (see Table 5 for demographic data).

(INSERT TABLE 5 ABOUT HERE) (Appendix 2)

Content analysis was used to explore the data obtained from the interviews. Major themes are presented in relation to the focus areas covered in the interviews. Inter-rater reliability, based on the mean percentage of agreement of themes across all interviews, was 75.5 percent.

The experience of abuse in general

In three cases, the first violent incident occurred early in the relationship and in all four, the abuse escalated over time. The predominant explanation given for the violence was difficulties in their partners' past, for example, child abuse (three out of four). In all four cases physical violence ended when the interviewee terminated the relationship but verbal and emotional intimidation continued.

'*He did not have any excuses, he had no addictions, he wasn't drunk, his dad was very violent towards him and I think that is where a lot of it comes from but that is still no excuse.*'

The experience of abuse in pregnancy

In all four cases, violence during pregnancy was the same as at any other time. Two women reported medical difficulties during pregnancy although only one of these linked the

difficulties directly to the violence. Three interviewees referred to a '*honeymoon*' period following the birth of a child; however, the violence then began again within a few weeks.

'There were problems through the pregnancies, I bled all through all of them, when C was born, the back of his head was bruised and it wasn't a birth bruise.'

Reactions to domestic violence

In all four cases, interviewees referred to a detrimental effect on their own mental health; two of the four were hospitalised following *'breakdowns'*. Verbal insults were cited as the worst aspects of the abuse in all cases. Violence was avoided by all interviewees by *'keeping out of the way'*, three made reference to *'trying to do things right'*. In all cases, the children witnessed the abuse and all interviewees were adamant that the violence had an impact on their children.

'My son was violent at school, every time there was a violent incident at home, he seemed to act it out the next day on other kids.'

Maternal relationship with children

Three of the four cases referred to relationship problems which were all linked to the violence experienced. Difficulties included child aggression (four cases) and the woman's inability to care for the children (three cases). Two interviewees associated their own emotional state with difficulties in addressing the needs of their children.

'It just got to where I was rock bottom and my only way out was to end it, it even got to where the children didn't matter.'

Support

Three of the four interviewees reported that very few people were aware of the abuse and support from family members was either limited or non existent. Poor support from services

was a common theme, particularly in relation to the police and general practitioners. In three cases a significant event was cited as the *'turning point'* which enabled them to end the violent relationship; in two cases, this event was a mental breakdown.

'I had a nervous breakdown and came out of it a stronger person, it actually gave me the courage to contact ... ..., that was my turning point.'

Overall reflections

All four interviewees felt the violence had affected relationships, three referred to the '*devastating*' impact on the family. Three interviewees referred to *'overprotecting'* their children and their children's lack of trust of other people. In all cases, interviewees reported some improvements over time in their own emotional state, the behaviour of the children and the mother-child relationship. However, in all cases, at least one child in the family was reported to be still experiencing significant difficulties.

'It's totally ruined our lives, I've lost years of my life and years with the kids which you can't get back. I hate him for ruining our lives.'

Discussion

As hypothesised, the findings of this study highlighted that women subjected to domestic violence whilst pregnant were more likely to report having experienced physical and/or mental health difficulties during the pregnancy. However, in contrast to previous research (e.g. Helton et al., 1987; Bullock & McFarlane, 1989), violence during pregnancy was not associated with low child birth weight.

Focusing on domestic violence in general, women were more likely to perceive their child to be at risk from abuse if they themselves had been subjected to domestic violence. However,

whilst 40 percent of women abused during pregnancy indicated that their partner had displayed feelings of anger towards the unborn child, the experience of violence whilst pregnant did not increase the likelihood that a woman would perceive her child to be at risk of abuse.

Interestingly, children whose mothers experienced violence during pregnancy were not any more likely to be abused than children from violent homes where mothers were not assaulted during pregnancy. However, when compared to children from non-violent homes, children whose mothers had been subjected to domestic violence were more likely to have been abused. Whilst 25 percent of children in the domestic violence sample had been abused, this rate is slightly lower than previous reports ranging from 30 to 60 percent (Bowen, 2000; Mullender, 2000).

Focusing on maternal mental health, over 40 percent of the domestic violence sample reported levels of psychological distress above the threshold as measured by the GHQ-12. There was a trend for women who had experienced violence in pregnancy to report higher levels, with over 60 percent of them scoring above the threshold. These figures support the well established literature regarding the negative impact of domestic violence on the psychological well-being of women (e.g. Langley, 1997; Stark, Flitcraft & Frazier, 1979).

The current findings also highlighted a positive association between maternal psychological distress and mother-child relationship difficulties, as measured by the Child Grid. This provides some support for previous research suggesting a link between maternal mental health and negative interactions with the child (Martins & Gaffan, 2000).

Further indication of child problems was provided in the analysis of agency involvement. Results showed that children whose mothers had experienced domestic violence were more

likely to have a history of multi agency involvement. This likelihood increased if the child's mother had also experienced violence during pregnancy.

Analysis of a mediation model revealed that maternal psychological distress was the most significant predictor of the quality of the mother-child relationship. This supports previous studies which argued that maternal adjustment was a key factor in the adjustment of children (e.g. Holden & Ritchie, 1991; Wolfe, Jaffe, Wilson & Zak, 1985). However, the analysis also showed that the experience of violence itself was also a strong predictor of the quality of the mother-child relationship. This would suggest that focusing exclusively on maternal reactions to the violence does not adequately explain difficulties in the mother-child relationship. Similarly, experience of violence and maternal mental health accounted for 24-30 percent of child adjustment in a previous study (Jaffe et al., 1990).

Analysis of the data provided by the interviews highlighted both similarities and differences in experiences. For example, it was clear that all interviewees felt that the violence had an effect on all of their children. However, there was considerable diversity in the ways in which mothers perceived their children to have been affected. In addition, there were differences amongst children in the same family and differences in their long-term adjustment after the violence had stopped. Anecdotal evidence gained from the interviews suggested that factors involved in child adjustment may be associated with gender, relationship with the perpetrator and the support provided since. This would support previous studies citing such factors as possibly accounting for variation in child behaviour (Osborne & Fincham, 1996; Saunders, 1995). All interviewees felt that the violence had an enormous impact on family life as a whole, with three acknowledging difficulties in the mother-child relationship. It was clear that, despite the acknowledgment and attempts by mothers to address the issue of relationships,

significant difficulties remained. Access to therapeutic intervention was either limited or not felt to be what the family was looking for. Examples of therapy ranged from counselling services to family support units and clinical psychology, with intervention primarily focused at an individual level.

There were a number of limitations to this research, not least the size of the study which inhibits the generalizability of the results. Unfortunately, small sample sizes are a common problem within domestic violence research (Holden, 1998). It is questionable to what extent participants who volunteer to take part are representative of domestic violence victims as a whole. Whilst it is acknowledged to be problematic undertaking research in this area, studies still need to address the difficulties.

A further limitation was the lack of attention to cultural issues. Attempts were made to obtain multi-cultural representation in the study. However, this proved difficult with only five participants from ethnic minority populations forming part of the sample. Finally, it is debatable as to the validity of the Child Grid as a measure of relationship quality. Whilst it was a useful measure as an indication of difficulties, it did not yield information regarding particular difficulties. Clearly, any future research would need to incorporate a more extensive assessment of relationship quality.

Despite these limitations, there are several implications generated by the study both in developing awareness of the potential impact of domestic violence and the services provided. The results of this study suggest that exploring the impact of domestic violence on relationships is an important area in furthering understanding of child adjustment. Although this study did not highlight that violence during pregnancy was an increased risk factor for

difficulties in the mother-child relationship, the small sample of this study means that this is still an area needing further examination.

It is clear from the results of this study that the impact can be devastating and that affected children are more likely to have multi-agency involvement. However, whilst parental discord may be routinely screened for in clinic-referred children in child and family services, this is not the case for domestic violence (McDonald, Jouriles, Norwood, Shinn–Ware & Ezell, 2000). Clearly, this is necessary not only in order to plan appropriate interventions but also from a child protection perspective, as children exposed to domestic violence are at increased risk of physical abuse themselves.

The difficulties identified in mother-child relationships would suggest that interventions planned around relationships may be useful. Some success has been achieved in family work (Furniss & Bingley-Miller, 1995) and group work (Bannister & Gallagher, 1995) in child abuse cases. Such interventions for families who have experienced domestic violence may be useful.

It is evident that there remains a long way to go in domestic violence research to obtain a comprehensive understanding of its impact and numerous future directions can be suggested. However, specifically related to the outcome of this study, further research is warranted into the nature of relationships in the context of domestic violence. Much of the research in this area, including this present study, relies on maternal reports. The views and experiences of other family members is necessary to gain a fuller understanding. Research focusing on perpetrators of domestic violence or directly involving children is very limited for obvious reasons. However, a perpetrator's role as a parent would be an interesting area to explore as little is known about the nature of fathering in violent homes (Holden & Ritchie, 1991).

Conclusions

As a result of numerous studies into domestic violence a good understanding has been developed into the effects such violence can have on women and their children. There is now no doubt as to its potential harm. However, inconsistencies remain and the various processes by which the violence affects children needs further exploration. This study has highlighted that examining parent-child relationships is one area worthy of further study.

References

Bannister, A. & Gallagher, E. (1995) Group work and child protection agencies. In K. Wilson & A. James (Eds.) *The Child Protection Handbook.* London: Bailliere-Tindall.

Belsky, J., Youngblade, L., Rovine, M. & Volling, B. (1991) Patterns of marital change and parent-child interactions. *Journal of Marriage and the Family*, 53, 487-498.

Berliner, L. (1998) Battered women and abused children: the question of responsibility. *Journal of Interpersonal Violence*, 13, 2, 287-288.

Bewley, C. & Gibbs, A. (1994) Coping with domestic violence in pregnancy. *Nursing Standard,* 8:50, 25-28.

Bowen, K. (2000) Child abuse and domestic violence in families of children seen for suspected sexual abuse. *Clinical Paediatrics*, Jan, 39, 33-40.

British Medical Association (1998) *Domestic Violence: A Health Care Issue?* London: BMA.

Browne, K. & Saqi, S. (1987) Parent – child interaction in abusing families: its possible causes and consequences. In: P. Maher (Ed.) *Child Abuse: The Educational Perspective.* Oxford: Basil Blackwell Ltd.

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

Campbell, J., Oliver, C., Bullock, L. (1998) Why battering during pregnancy? *Clinical Issues in Perinatal and Women's Health Nursing*, 4,343-349.

Davis, H. (1997) The Family Grid. In: I. Sclare (Ed.) *Child Psychology Portfolio.* Windsor: NFER-Nelson Publishing Co.

Davis, H. & Hester, P. (1996) *An Independent Evaluation of Parent-Link: a parenting education programme*. London: Parent Network.

Department of Health (2000) *Domestic Violence: A Resource Manual for Health Care Professionals*. London: HMSO.

Fransella, F. & Bannister, D. (1977) *A Manual for Repertory Grid Technique.* London: Academic Press.

Furniss, T. & Bingley-Miller, L. (1995) Working with abusing families. In K. Wilson & A. James (Eds.) *The Child Protection Handbook.* London: Bailliere-Tindall.

Goldberg, D. (1992) *The General Health Questionnaire (GHQ-12).* Windsor: NFER-Nelson Publishing Co.

Hardy, G., Shapiro, D., Haynes, C. & Rick, J. (1999) Validation of the General Health Questionnaire-12 using a sample of employees from England's health care services. *Psychological Assessment*, 11, 2, 159-165.

Harrist, A. & Ainslie, R. (1998) Marital discord and child behaviour problems: parent-child relationship quality and child interpersonal awareness as mediators. *Journal of Family Issues,* 19, 2, 140-163.

Hedin, L. (2000) Postpartum: Also a risk period for domestic violence. *European Journal of Obstetrics and Gynaecology and Reproductive Biology*, 89, 41-45

Helton, A., McFarlane, J. & Anderson, E. (1987) Battered and pregnant: a prevalence study with intervention measures. *American Journal of Public Health*, 77, 1337-1339.

Henning, K., Leitenberg, H., Coffey, P. & Turner, T. (1996) Long-term psychological and social impact of witnessing physical conflict between parents. *Journal of Interpersonal Violence*, 11, 1, 35-51.

Holden, G. (1998) The development of research into another consequence of domestic violence. In: G. Holden, R. Geffner & E. Jouriles (Eds.) *Children Exposed to Marital Violence: theory, research and applied issues*. Washington D.C.: American Psychological association.

Holden, G. & Ritchie, K. (1991) Linking extreme marital discord, child rearing and child behaviour problems: evidence from battered women. *Child Development*, 62,311-327.

Jacobsen, A. & Richardson, B. (1987) Assault experiences of 100 inpatients: evidence of the need for routine enquiry. *American Journal of Psychiatry*, 144,908-913.

Jaffe, P., Wolfe, P. & Wilson, S. (1990) *Children of Battered Women*. California: Sage.

Johnson, N. (1995) Domestic violence: an overview. In: P. Kingston & B. Pennale (Eds.) *Violence and the Caring Professions*. London: Macmillan.

Kolko, D. (1996) Child physical abuse. In: J. Briere, L. Berliner, J. Buckley, C. Jenny & T. Reid (Eds.) *APSAC Handbook on Child Maltreatment*. California: Sage Publications.

Kurz, D. (1993) Physical assaults by husbands: a major social problem. In: R. Gelles & D. Loseke (Eds.) *Current Controversies on Family Violence*. Newbury Park, California: Sage.

Langley, H. (1997) The health professionals: an overview. In: S. Bewley, J. Friend & G. Mezey (Eds.) *Violence against Women.* Sussex: RCOG Press.

Laucht, M., Esser, G. & Schmidt, M. (1994) Parental mental disorder and early child development. *European Child and Adolescent Psychiatry*, 3, 3, 125-137.

Levy, T. & Orlans, M. (2000) Attachment disorder as an antecedent to violence and antisocial patterns in children. In: T. Levy (Ed.) *Handbook of Attachment Intervention.* New York: Academic press.

McDonald, R., Jouriles, E., Norwood, W., Shinn-Ware, H. & Ezell, E. (2000) Husbands' marital violence and the adjustment problems of clinic referred children. *Behaviour Therapy*, 31, 649-665.

Main, M. & Hesse, E. (1990) Parents' unresolved traumatic experiences are related to infant disorganised attachment status. In: M.Greenberg, D. Cicchetti & E. Cummings (Eds.) *Attachment in the Pre-school Years: theory, research and intervention.* Chicago: University of Chicago Press.

Martins, C. & Gaffan, E. (2000) Effect of early maternal deprivation on patterns of infant-mother attachment: a meta-analytic investigation. *Journal of Child Psychology and Psychiatry*, 41, 6, 737-746.

Mullender, A. (2000) *Reducing Domestic Violence – what works? Meeting the needs of children- Briefing Note,* January. London: Policing and Reducing Crime Unit.

O'Shea, L. (1996) Domestic violence in pregnancy. *Modern Midwife*, 199, 10-12.

Osborne, L. & Fincham, F. (1996) Marital conflict, parent-child relationships and child adjustment: does gender matter? *Merrill-Palmer Quarterly*, 42, 48-75.

Owen, M. & Cox, M. (1997) Marital conflict and the development of infant-parent attachment relationships. *Journal of Family Psychology*, 11, 2, 152-164.

Saunders, A. (1995) *It Hurts Me Too – Fact Sheet.* London: Childline/ Women's Aid Federation/ National Institute for Social Work.

Shek, D. (1998) Linkage between marital quality and parent-child relationship. *Journal of Family Issues*, 19, 6, 687-704.

Soeken, K., McFarlane, J., Parker, B. & Lominack, M. (1998) The Abuse Assessment Screen: a clinical instrument to measure frequency, severity, and perpetrator of abuse against women. In J. Campbell (Ed.) Empowering Survivors of Abuse: healthcare for battered women and their children. California: Sage Publications.

Stanko, E., Crisp, D., Hale, C. & Lucraft, H. (1998) *Counting the Costs: estimating the impact of domestic violence in the London borough of Hackney.* Swindon: Crime Concern.

Stark, E. & Flitcraft, A. (1985) Women battering, child abuse, and social heredity: what is the relationship? In: N. Johnson (Ed) *Marital Violence*. London: Routledge & Kegan Paul.

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

Stevenson, J. (1999) The treatment of the long-term sequelae of child abuse. *Journal of Child Psychology and Psychiatry*, 40, 1, 89-111.

Wilson, C. (1998) Battered women and abused children: the question of responsibility. *Journal of Interpersonal Violence*, 13, 2, 287-288.

Wolfe, D., Jaffe, P., Wilson, S. & Zak, L. (1985) Children of battered women: the relationship of child behaviour to family violence and maternal stress. *Journal of Consulting and Clinical Psychology*, 53, 651-665.

Appendix 1

Journal instructions for authors

Child Abuse & Neglect
The International Journal
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Guide for Authors

TYPES OF CONTRIBUTIONS: (1) Original, theoretical, and empirical contributions. The main text of the manuscript should be 16-20 pages, typed double-spaced; should include a clear introductory statement of purpose, a historical review when desirable, a description of method and scope of observations, a full presentation of the results and a brief comment or discussion on the significance of the findings and any correlation with those of others in the literature, a section on speculation and relevance or implications, and a summary in brief which may include conclusions. (2) Brief Communications, shorter articles of 5 to 7 pages (abstracts and/or references are optional). (3) Articles on clinical practice: Case studies, commentaries, process and program descriptions, clinical audit and outcome studies, original clinical practice ideas for debate and argument. (4) Invited reviews: Plans for proposed reviews are invited to be submitted to the editor in draft outline in the first instance. The editors will commission reviews on specific topics. (5) Letters to the Editor. Letters pertaining to articles published in Child Abuse & Neglect or on issues relevant to the field, brief and to the point, should be prepared in the same style as other manuscripts. (6) Announcements or notices regarding events of national or international multidisciplinary interests are subject to editorial approval and must be submitted at least 8 months before you wish the notice to appear.

SUBMISSION REQUIREMENTS: Manuscripts and all correspondence should be submitted to the Editor-in-Chief, Richard D. Krugman, M.D., Editorial Office, Child Abuse & Neglect The International Journal, 1825 Marion St., #320, Denver, CO 80218, USA. Tel: 1-303-864-5316, E-mail: mary.roth@uchsc.edu. Submit four (4) copies of the complete manuscript in English, French, or Spanish on clear, readable, high-quality white bond. Allow ample margins on all sides and type double-spaced throughout. A letter to the Editor must be enclosed requesting review and possible publication; the letter must also state that the manuscript has not been previously published and is not under simultaneous consideration by another publication The corresponding author's address, telephone, and fax (as well as any forthcoming changes) should also be noted. Manuscripts submitted will receive a blind review by at least two editorial consultants, therefore only the cover page should contain any information relevant to the authorship of the manuscript. Authors should insure that the paper itself contains no statements which allow the reviewer to identify the author. Upon acceptance for publication, the author(s) must complete a Transfer of Copyright Agreement form. Brief Communications receive the same blind review as other manuscripts.

Title Page: The title page should list (1) title of article; (2) the authors' names and affiliations at the time the work was conducted; (3) corresponding author's address, telephone, and fax number; (4) a concise running title; (5) at least three and no more than five key words for indexing purposes; and (6) an unnumbered footnote giving address for reprint requests and any acknowledgements. Abstract: All articles (except Brief Communications; see Types of Contributions section) must have a structured abstract not to exceed 250 words in length covering the main factual points and statement of the problem, method, results, and conclusions. Example: (from Welch, S. L., Fairburn, C. G. (1996). Childhood sexual and physical abuse as risk factors for the development of bulimia nervosa: A community-based case control study. Child Abuse & Neglect, 20, 663-642)

ABSTRACT:
Objective: There were two aims: First, to determine whether sexual or physical abuse in childhood or adolescence increases the risk of developing bulimia nervosa, and second, to see whether any increase in risk is specific to bulimia nervosa rather than being common to psychiatric disorders in general.
Method: A case control design with individual matching was used. There were two related case control comparisons based on community samples. One hundred and two young adult women with bulimia nervosa were compared with 204 control subjects without an eating disorder, and with 102 control subjects with

other psychiatric disorders, all recruited from the same community source. An investigator-based interview was used to assess sexual and physical abuse.

Results: Sexual abuse involving physical contact was reported by 35% of the cases of bulimia nervosa. It was more common among this group than among the normal controls. Physical abuse was also reported by a minority of the cases of bulimia nervosa, and was more common among this group than among the normal controls. However, there were no significant differences between the cases of bulimia nervosa and the controls with general psychiatric disorder, except in the category of repeated severe sexual abuse: This was more common among the cases of bulimia nervosa altho ugh present only in small numbers within these two groups.
Conclusions: The findings indicate that sexual and physical abuse are both risk factors for the development of bulimia nervosa. However, they are not present in the majority of cases. This indicates that other risk factors must operate in these cases. Sexual and physical abuse do not appear to be risk factors specific to bulimia nervosa; rather, they appear to be risk factors for psychiatric disorder in general in young adult women.

Style and References: Manuscripts should be carefully prepared using the Publication Manual of the American Psychological Association (4th ed.), 1994, for style. The Journal does not use footnotes in the text of the manuscript - these should be incorporated into the text itself. The reference section must be double-spaced and all works cited in the paper must be listed. Avoid abbreviations of journal titles.

Reference style for works cited in the text, and listed in the reference section must adhere to APA style - do not use a numerical style for references.

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Appendix 2

Report Tables

Table 1 Demographic characteristics of the domestic violence and comparison group

	Mean (SD)		**Significance**
	Domestic Violence Group (DV) (n=28)	General Group (non-DV) (n=24)	
Age of respondent	34..2 (5.7)	37.1 (5.9)	z=-1.35, p=.18
Number of children	2..5 (1.1)	2.0 (2.0)	z=-1.35, p=.18
Age of focus child	8.5 (3.9)	9.3 (4.7)	z= -.67, p=.50
	Proportion of the sample		
	DV (%)	non-DV (%)	
Marital status			
Living with a partner	50.0	79.2	
Lone parent	50.0	20.8	p=.04
Employment status			
Employed	53.6	62.5	
Not employed	6.4	37.5	p=.58
Gender of focus child			
Male	57.1	62.5	
Female	42.9	37.5	p=.78

Table 2 Analysis of pregnancy-related difficulties

	Proportion of the sample		
Difficulties	**DV (%)**	**non-DV (%)**	**significance**
Pregnancy	32.1	16.7	p=.34
Labour	46.4	16.7	p=.04
Post-natally	42.9	33.3	p=.57
	DV (pregnancy)	**DV (non-pregnancy)**	
Pregnancy	53.3	7.8	p=.02
Labour	40.0	53.8	p=.71
Post-natally	60.0	23.1	p=.07

Table 3 Analysis of mean scores on the GHQ-12

	Mean (SD)	Range	Significance
DV Group	4.1 (4.2)	0-12	
			Z=-2.6, p=.009
Non-DV Group	1.3 (1.7)	0-5	

Table 4 Multiple Regression Analysis: Variables associated with Child Grid score

Variable	**Adjusted R Squared**	**Std. Error of the Estimate**	**Beta**	**t**	**Sig.**
Constant				4.522	.000
GHQ score	.279	.6547	.365	2.599	.013
Violence			.291	2.070	.045

Table 5 Demographic data of interviewees

Interviewee	**Age**	**Marital status**	**Employment status**	**No. of children**	**Length of time since last violent incident**
1	36	Living as married	Employed full-time	3	3 years
2	45	Separated	Not employed	2	18 months
3	35	Separated	Not employed	4	7 years
4	36	Married	Not employed	3	4 years

Appendix 3

DV vs Non-DV Analysis of Demographic Data

Marital status

		experience of physical abuse		Total
		yes	no	
MARITAL2	Living with partner	14	19	33
	Living without partner	14	5	19
Total		28	24	52

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.741[b]	1	.029		
Continuity Correction[a]	3.567	1	.059		
Likelihood Ratio	4.891	1	.027		
Fisher's Exact Test				.044	.028
Linear-by-Linear Association	4.650	1	.031		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.77.

Employment status

		experience of physical abuse		Total
		yes	no	
EMPLOY2	Full/part-time employment	15	15	30
	Training/unemployed	13	9	22
Total		28	24	52

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.422[b]	1	.516		
Continuity Correction[a]	.136	1	.713		
Likelihood Ratio	.423	1	.515		
Fisher's Exact Test				.581	.357
Linear-by-Linear Association	.414	1	.520		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.15.

Gender of child

		gender of focus child		Total
		male	female	
experience of physical abuse	yes	16	12	28
	no	15	9	24
Total		31	21	52

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.154[b]	1	.695		
Continuity Correction[a]	.012	1	.913		
Likelihood Ratio	.154	1	.694		
Fisher's Exact Test				.781	.457
Linear-by-Linear Association	.151	1	.697		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.69.

Age of participant, number of children and age of child

	experience of	N	Mean Rank	Sum of Ranks
age of participant	yes	27	23.35	630.50
	no	24	28.98	695.50
	Total	51		
number of children of participant	yes	28	29.00	812.00
	no	24	23.58	566.00
	Total	52		
age of focus child	yes	28	25.20	705.50
	no	24	28.02	672.50
	Total	52		

Test Statistics[a]

	age of participant	number of children of participant	age of focus child
Mann-Whitney U	252.500	266.000	299.500
Wilcoxon W	630.500	566.000	705.500
Z	-1.353	-1.351	-.673
Asymp. Sig. (2-tailed)	.176	.177	.501

a. Grouping Variable: experience of physical abuse

DV (pregnancy) vs DV (non-pregnancy)

Marital status

		experience of domestic violence with child		Total
		yes	no	
MARITAL2	Living with partner	5	9	14
	Living without partner	10	4	14
Total		15	13	28

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.590[b]	1	.058		
Continuity Correction[a]	2.297	1	.130		
Likelihood Ratio	3.673	1	.055		
Fisher's Exact Test				.128	.064
Linear-by-Linear Association	3.462	1	.063		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.50.

Employment status

		experience of domestic violence with child		Total
		yes	no	
EMPLOY2	Full/part-time employment	7	8	15
	Training/unemployed	8	5	13
Total		15	13	28

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.619[b]	1	.431		
Continuity Correction[a]	.166	1	.684		
Likelihood Ratio	.622	1	.430		
Fisher's Exact Test				.476	.343
Linear-by-Linear Association	.597	1	.440		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.04.

Gender of child

		gender of focus child		Total
		male	female	
experience of domestic violence with child	yes	5	10	15
	no	11	2	13
Total		16	12	28

Chi-Square Tests

physical=1 (FILTER)		Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Selected	Pearson Chi-Square	7.479[b]	1	.006		
	Continuity Correction[a]	5.531	1	.019		
	Likelihood Ratio	7.985	1	.005		
	Fisher's Exact Test				.009	.008
	Linear-by-Linear Association	7.212	1	.007		
	N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.57.

Age of participant, number of children and age of child

	experience of domestic	N	Mean Rank	Sum of Ranks
age of participant	yes	14	14.86	208.00
	no	13	13.08	170.00
	Total	27		
number of children of participant	yes	15	14.23	213.50
	no	13	14.81	192.50
	Total	28		
age of focus child	yes	15	15.77	236.50
	no	13	13.04	169.50
	Total	28		

Test Statistics[b]

	age of participant	number of children of participant	age of focus child
Mann-Whitney U	79.000	93.500	78.500
Wilcoxon W	170.000	213.500	169.500
Z	-.584	-.195	-.880
Asymp. Sig. (2-tailed)	.559	.846	.379
Exact Sig. [2*(1-tailed Sig.)]	.583[a]	.856[a]	.387[a]

a. Not corrected for ties.

b. Grouping Variable: experience of domestic violence with child

Appendix 4

Analysis of Pregnancy Related Data

DV vs Non-DV

Problems during pregnancy

		experience of physical abuse		Total
		yes	no	
problems during pregnancy	yes	9	4	13
	no	19	20	39
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.651[b]	1	.199		
Continuity Correction[a]	.929	1	.335		
Likelihood Ratio	1.691	1	.193		
Fisher's Exact Test				.336	.168
Linear-by-Linear Association	1.619	1	.203		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.00.

Problems during labour

		experience of physical abuse		Total
		yes	no	
problems during labour	yes	13	4	17
	no	15	20	35
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.202[b]	1	.023		
Continuity Correction[a]	3.937	1	.047		
Likelihood Ratio	5.426	1	.020		
Fisher's Exact Test				.037	.022
Linear-by-Linear Association	5.102	1	.024		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.85.

Problems post-natally

		experience of physical abuse		Total
		yes	no	
problems post-natally	yes	12	8	20
	no	16	16	32
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.495[b]	1	.482		
Continuity Correction[a]	.175	1	.676		
Likelihood Ratio	.497	1	.481		
Fisher's Exact Test				.573	.339
Linear-by-Linear Association	.486	1	.486		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.23.

Child Birthweight

	experience of	N	Mean Rank	Sum of Ranks
birthweight of focus child	yes	28	22.84	639.50
	no	24	30.77	738.50
	Total	52		

Test Statistics

	birthweight of focus child
Mann-Whitney U	233.500
Wilcoxon W	639.500
Z	-1.883
Asymp. Sig. (2-tailed)	.060

DV (pregnancy) vs DV (non-pregnancy)

Problems during pregnancy

		experience of domestic violence with child		Total
		yes	no	
problems during pregnancy	yes	8	1	9
	no	7	12	19
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.651[b]	1	.010		
Continuity Correction[a]	4.723	1	.030		
Likelihood Ratio	7.386	1	.007		
Fisher's Exact Test				.016	.013
Linear-by-Linear Association	6.414	1	.011		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 4.18.

Problems during labour

		experience of domestic violence with child		Total
		yes	no	
problems during labour	yes	6	7	13
	no	9	6	15
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.537[b]	1	.464		
Continuity Correction[a]	.124	1	.724		
Likelihood Ratio	.538	1	.463		
Fisher's Exact Test				.705	.362
Linear-by-Linear Association	.518	1	.472		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.04.

Problems post-natally

		experience of domestic violence with child		Total
		yes	no	
problems post-natally	yes	9	3	12
	no	6	10	16
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.877[b]	1	.049		
Continuity Correction[a]	2.516	1	.113		
Likelihood Ratio	4.007	1	.045		
Fisher's Exact Test				.067	.055
Linear-by-Linear Association	3.738	1	.053		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.57.

Child Birthweight

	experience of domestic	N	Mean Rank	Sum of Ranks
birthweight of focus child	yes	15	13.67	205.00
	no	13	15.46	201.00
	Total	28		

Test Statistics

	birthweight of focus child
Mann-Whitney U	85.000
Wilcoxon W	205.000
Z	-.577
Asymp. Sig. (2-tailed)	.564
Exact Sig. [2*(1-tailed Sig.)]	.586

Appendix 5

DV vs Non-DV Analysis of Child Agency Data

		experience of physical abuse		Total
		yes	no	
AGENCY3	None/one agency	20	24	44
	Two or more agencies	8		8
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.104[b]	1	.004		
Continuity Correction[a]	6.058	1	.014		
Likelihood Ratio	11.146	1	.001		
Fisher's Exact Test				.005	.004
Linear-by-Linear Association	7.948	1	.005		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.69.

DV (pregnancy) vs DV (non-pregnancy)

		experience of domestic violence with child		Total
		yes	no	
AGENCY3	None/one agency	8	12	20
	Two or more agencies	7	1	8
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.184[b]	1	.023		
Continuity Correction[a]	3.450	1	.063		
Likelihood Ratio	5.724	1	.017		
Fisher's Exact Test				.038	.029
Linear-by-Linear Association	4.998	1	.025		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.71.

Appendix 6

Analysis of Child Abuse Data

DV vs Non-DV

		experience of physical abuse		Total
		yes	no	
CHABUSE2	Actual abuse	7		7
	No actual abuse	21	24	45
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.933[b]	1	.008		
Continuity Correction[a]	4.953	1	.026		
Likelihood Ratio	9.596	1	.002		
Fisher's Exact Test				.011	.009
Linear-by-Linear Association	6.800	1	.009		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.23.

DV (pregnancy) vs DV (non-pregnancy)

		experience of domestic violence with child		Total
		yes	no	
CHABUSE2	Actual abuse	5	2	7
	No actual abuse	10	11	21
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.197[b]	1	.274		
Continuity Correction[a]	.431	1	.512		
Likelihood Ratio	1.233	1	.267		
Fisher's Exact Test				.396	.258
Linear-by-Linear Association	1 154	1	.283		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.25.

Appendix 7

Analysis of GHQ Scores

DV vs Non-DV

Threshold scores

		experience of physical abuse		Total
		yes	no	
GHQTHRES	Below threshold (3 or less)	16	21	37
	Above threshold (4 or more)	12	3	15
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.802[b]	1	.016		
Continuity Correction[a]	4.418	1	.036		
Likelihood Ratio	6.152	1	.013		
Fisher's Exact Test				.030	.016
Linear-by-Linear Association	5.691	1	.017		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.92.

DV (pregnancy) vs DV (non-pregnancy)

Threshold scores

		experience of domestic violence with child		Total
		yes	no	
GHQTHRES	Below threshold (3 or less)	6	10	16
	Above threshold (4 or more)	9	3	12
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.877[b]	1	.049		
Continuity Correction[a]	2.516	1	.113		
Likelihood Ratio	4.007	1	.045		
Fisher's Exact Test				.067	.055
Linear-by-Linear Association	3.738	1	.053		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.57.

DV vs Non-DV

Mean score differences

	experience of	N	Mean Rank	Sum of Ranks
ghq-12 score of participant	yes	28	31.45	880.50
	no	24	20.73	497.50
	Total	52		

Test Statistics[a]

	ghq-12 score of participant
Mann-Whitney U	197.500
Wilcoxon W	497.500
Z	-2.624
Asymp. Sig. (2-tailed)	.009

a. Grouping Variable: experience of physical abuse

DV (pregnancy) vs DV (non-pregnancy)

Mean score differences

	experience of	N	Mean Rank	Sum of Ranks
ghq-12 score of participant	yes	15	17.10	256.50
	no	13	11.50	149.50
	Total	28		

Test Statistics[a]

	ghq-12 score of participant
Mann-Whitney U	58.500
Wilcoxon W	149.500
Z	-1.816
Asymp. Sig. (2-tailed)	.069
Exact Sig. [2*(1-tailed Sig.)]	.072[b]

a. Not corrected for ties.

b. Grouping Variable: experience of domestic violence with child

Appendix 8

Analysis of Identifying Risk Data

DV vs Non-DV

Anger about pregnancy

		experience of physical abuse		Total
		yes	no	
partner anger about pregnancy	yes	6		6
	no	22	24	46
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.814[b]	1	.016		
Continuity Correction[a]	3.904	1	.048		
Likelihood Ratio	8.097	1	.004		
Fisher's Exact Test				.025	.019
Linear-by-Linear Association	5.702	1	.017		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.77.

Jealousy about pregnancy

		experience of physical abuse		Total
		yes	no	
partner jealousy of pregnancy	yes	6		6
	no	22	24	46
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.814[b]	1	.016		
Continuity Correction[a]	3.904	1	.048		
Likelihood Ratio	8.097	1	.004		
Fisher's Exact Test				.025	.019
Linear-by-Linear Association	5.702	1	.017		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.77.

DV (pregnancy) vs DV (non-pregnancy)

Anger about pregnancy

		experience of domestic violence with child		Total
		yes	no	
partner anger about pregnancy	yes	6		6
	no	9	13	22
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.618[b]	1	.010		
Continuity Correction[a]	4.456	1	.035		
Likelihood Ratio	8.906	1	.003		
Fisher's Exact Test				.018	.013
Linear-by-Linear Association	6.382	1	.012		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.79.

Jealousy about pregnancy

		experience of domestic violence with child		Total
		yes	no	
partner jealousy of pregnancy	yes	5	1	6
	no	10	12	22
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.720[b]	1	.099		
Continuity Correction[a]	1.410	1	.235		
Likelihood Ratio	2.950	1	.086		
Fisher's Exact Test				.173	.117
Linear-by-Linear Association	2.622	1	.105		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.79.

DV vs Non-DV

Risk of abuse

		experience of physical abuse		Total
		yes	no	
risk of abuse of child	yes	8		8
	no	20	24	44
Total		28	24	52

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.104[b]	1	.004		
Continuity Correction[a]	6.058	1	.014		
Likelihood Ratio	11.146	1	.001		
Fisher's Exact Test				.005	.004
Linear-by-Linear Association	7.948	1	.005		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.69.

DV (pregnancy) vs DV (non-pregnancy)

Risk of abuse

		experience of domestic violence with child		Total
		yes	no	
risk of abuse of child	yes	6	2	8
	no	9	11	20
Total		15	13	28

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.068[b]	1	.150		
Continuity Correction[a]	1.037	1	.308		
Likelihood Ratio	2.150	1	.143		
Fisher's Exact Test				.221	.155
Linear-by-Linear Association	1.994	1	.158		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.71.

Appendix 9

Analysis of Child Grid Data

DV vs Non-DV

Mean score differences

	experience of	N	Mean Rank	Sum of Ranks
score of positiveness	yes	24	29.60	710.50
	no	22	16.84	370.50
	Total	46		

Test Statistics[a]

	score of positiveness
Mann-Whitney U	117.500
Wilcoxon W	370.500
Z	-3.224
Asymp. Sig. (2-tailed)	.001

a. Grouping Variable: experience of physical abuse

DV (pregnancy) vs DV (non-pregnancy)

Mean score differences

	experience of	N	Mean Rank	Sum of Ranks
score of positiveness	yes	14	14.04	196.50
	no	10	10.35	103.50
	Total	24		

Test Statistics[a]

	score of positiveness
Mann-Whitney U	48.500
Wilcoxon W	103.500
Z	-1.260
Asymp. Sig. (2-tailed)	.208
Exact Sig. [2*(1-tailed Sig.)]	.212[a]

a. Grouping Variable: experience of domestic violence with child

DV vs Non-DV

Threshold scores

		child threshold score		Total
		satisfactory	not	
experience of physical abuse	yes	20	4	24
	no	21	1	22
Total		41	5	46

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.741[b]	1	.187		
Continuity Correction[a]	.714	1	.398		
Likelihood Ratio	1.865	1	.172		
Fisher's Exact Test				.349	.202
Linear-by-Linear Association	1.703	1	.192		
N of Valid Cases	46				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.39.

Appendix 10

Correlation Analysis of GHQ Score and Child Grid Score

Nonparametric Correlations

Correlations

			ghq-12 score of participant	score of positiveness
Spearman's rho	ghq-12 score of participant	Correlation Coefficient	1.000	.401**
		Sig. (2-tailed)	.	.006
		N	52	46
	score of positiveness	Correlation Coefficient	.401**	1.000
		Sig. (2-tailed)	.006	.
		N	46	46

**. Correlation is significant at the .01 level (2-tailed).

Appendix 11

Regression Analysis

Regression

Descriptive Statistics

	Mean	Std. Deviation	N
score of positiveness	1.2567	.7709	46
experience of physical abuse	1.4783	.5050	46
ghq-12 score of participant	2.8043	3.6063	46

Correlations

		score of positiveness	experience of physical abuse	ghq-12 score of participant
Pearson Correlation	score of positiveness	1.000	-.450	.492
	experience of physical abuse	-.450	1.000	- 436
	ghq-12 score of participant	.492	-.436	1.000
Sig. (1-tailed)	score of positiveness	.	.001	.000
	experience of physical abuse	.001	.	.001
	ghq-12 score of participant	.000	.001	.
N	score of positiveness	46	46	46
	experience of physical abuse	46	46	46
	ghq-12 score of participant	46	46	46

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	ghq-12 score of participant, experience of physical abuse[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: score of positiveness

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.558[a]	.311	.279	.6547	1.751

a. Predictors: (Constant), ghq-12 score of participant, experience of physical abuse

b. Dependent Variable: score of positiveness

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	8.316	2	4.158	9.701	.000[a]
	Residual	18.429	43	.429		
	Total	26.745	45			

a. Predictors: (Constant), ghq-12 score of participant, experience of physical abuse

b. Dependent Variable: score of positiveness

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.694	.375		4.522	.000
	experience of physical abuse	-.444	.215	-.291	-2.070	.045
	ghq-12 score of participant	7.813E-02	.030	.365	2.599	.013

Coefficients[a]

Model		Correlations		
		Zero-order	Partial	Part
1	(Constant)			
	experience of physical abuse	-.450	-.301	-.262
	ghq-12 score of participant	.492	.368	.329

a. Dependent Variable: score of positiveness

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	.8059	2.1876	1.2567	.4299	46
Residual	-1.1626	. 1.9324	-2.82E-16	.6400	46
Std. Predicted Value	-1.049	2.166	.000	1.000	46
Std. Residual	-1.776	2.952	.000	.978	46

a. Dependent Variable: score of positiveness

Section 4

Critical Review

An investigation into

domestic violence, violence in pregnancy and implications for mother-child relationships:

a critical review

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Lancashire Doctorate in Clinical Psychology Course

This review has been prepared in accordance with the instructions for contributors to the International Journal of

Child Abuse and Neglect

2,609 words excluding reference list and appendices

3,589 words including reference list and appendices

An investigation into domestic violence, violence in pregnancy and implications for mother-child relationships: a critical review.

The preceding study focused on violence experienced during pregnancy and the impact domestic violence as a whole has on the mother-child relationship. Implications of the findings, limitations of the study and directions for future research were highlighted in the discussion. This review will present additional analyses that were not included in the research paper, highlight some of the problems encountered in carrying out this research, expand upon some of the issues highlighted in the original discussion, and finally reflect upon the research process as a whole.

Additional Analysis

It was not possible to highlight all the results in the research paper therefore key findings only which related directly to the hypotheses and research questions were presented. However, there were a number of additional analyses carried out that relate to the experiences of women in the context of domestic violence.

For example, in the questionnaire participants were asked whether the pregnancy was planned, this is an interesting area to explore in relation to the prevalence of forced sexual contact in domestic violence cases (Finkelhor & Yllo, 1983; Painter & Farrington, 1998). It has been suggested that, in the context of domestic violence, unwanted pregnancies may be common and this may affect the mother's feelings about the pregnancy (Hillard, 1985). Analysis of the questionnaire data did not support these suggestions. Although the pregnancies of women who had experienced domestic violence were more likely to be unplanned than the comparison group (46.4% vs. 25%), the difference was not a significant

one (Appendix 1). Interestingly, 60 percent of the women who had experienced violence during pregnancy reported that the pregnancy was unplanned compared to just over 30 percent of the group of women who had experienced violence but not whilst pregnant. Again, this was not found to be a significant difference (Appendix 1). However, analysis of the interview data revealed that, in two cases, pregnancies had been planned by the interviewee against the wishes of the violent partner and in one case, all the pregnancies (5) were reported to be as a result of marital rape.

Irrespective of the experience of violence, it is acknowledged that socio-economic factors such as marital status and poverty possibly have a role to play in maternal mental health and child problems (Holden, Stein, Ritchie, Harris & Jouriles, 1998). Analysis of demographic information provided in the report highlighted a significant difference between women who had experienced domestic violence and those that had not in terms of marital status, with the former having a higher prevalence of lone parenting.

Additional analysis of marital status and maternal psychological distress revealed that a significantly higher proportion of lone parents scored at or above the GHQ-12 threshold of four compared to those women living with partners (52.6% vs. 15.1%), (Fishers' Exact test, p=. 009) (Appendix 2). Similarly, children of lone parents were more likely to have multi-agency involvement compared to those children from two-parent families (31.6% vs. 6.1%), (Fishers' Exact test, p=. 04) (Appendix 2).

Further analysis of marital status and Child Grid scores also yielded significant results. There was a significant difference between lone parent families and two-parent families on the Child Grid discrepancy score with the former more likely to yield higher scores (z=-3.7, p<. 01). In addition, a significant proportion of lone parent families scored at or above the Child Grid

threshold score, an indication of significant relationship problems (29.4% vs. 0%) (Fishers' Exact test, p=. 005) (Appendix 2). Clearly this has implications for the results in that marital status is an important factor in maternal and child adjustment. However, by the very nature of the research area, unless the focus was exclusively on women still within violent relationships, domestic violence samples will undoubtedly have a higher prevalence of lone parenting.

Further analysis of child demographics did not yield any significant results; gender and age were not found to be associated with scores on the Child Grid or child agency involvement (Appendix 3). It is suggested that gender differences in child adjustment begin to emerge by school age with boys more likely to be described as 'disruptive' and 'aggressive' and girls presenting with somatic complaints or becoming 'withdrawn' (Black & Newman, 1998). Clearly, it would be useful in future studies to examine the nature of any child difficulties reported rather than just focusing on agency involvement.

It was established in this study that the children of women who had experienced domestic violence were themselves at increased risk of abuse. Examination of the perpetrator data in the questionnaire revealed that, of the seven children (25%) who had been abused, in four cases the violent partner had abused the child, in two cases the child had been abused by both the mother and her violent partner and in one instance the perpetrator had been a stranger (Appendix 4). It is acknowledged in previous studies that abuse of the child in domestic violence cases is not necessarily confined to the male abuser (Mills, 1998). In some cases, it has been found that mothers may respond to their own experience of violence with violence towards the children as part of a process referred to as 'maternal reciprocity' (Straus, 1983). One study highlighted that women who experienced domestic violence were up to eight times

more likely to abuse their children (Walker, 1984). Whilst the number of cases was small in this study, it is possible that the actual prevalence is underestimated due to an unwillingness on the part of participants to disclose such information.

Problems Encountered

The greatest difficulty in this study was obtaining a large representative sample, to ensure this contact was made with numerous individuals working within agencies supporting victims of domestic violence. Contacts included police domestic violence liaison officers, social workers, victim support, women's aid refuges and domestic violence forum members. Enthusiasm for the study was good during discussion and help with obtaining participants was assured, although it was difficult to estimate what numbers could be obtained or what response there would be from potential participants.

Contacts were approached within ethnic minority groups, for example, Asian and Afro-Caribbean refuges and ethnic minority support services. However, little progress was made with regard to obtaining help in distributing questionnaires. The services approached were characteristically under resourced and no one was available to support the study. This difficulty needs to be addressed in future studies. Women from ethnic minority populations are known to experience greater difficulties in seeking protection and help following domestic violence for a variety of reasons including the experience of racism, language difficulties and the cultural assumptions of others (Department of Health, 2000).

Numerous problems were encountered when questionnaires were needed to be distributed. Difficulties ranged from contacts leaving post and crises within individual agencies to individuals simply not replying to further enquiries despite numerous attempts. Having secured contacts who agreed to distribute questionnaires, obstacles lay in ensuring that the

questionnaires were distributed. The anonymity of the questionnaire and voluntary nature of the study meant relying on contacts to secure participants. In all 178 questionnaires were sent to domestic violence contacts of which 21 were returned, a response rate of 11.8% which was very poor. Distribution to non-domestic violence participants was far less problematic, with a 31% response rate.

The domestic violence agencies were later contacted to gain information regarding the number of questionnaires they had been able to distribute, two replies were received out of 15 original contacts. Feedback from the two indicated that they had distributed 65% and 75% of their questionnaires. Given that these numbers combined would have doubled the eventual sample, it is clear that response rates were low due to participants not returning questionnaires and contact difficulties in distribution.

Strengths and Limitations

Clearly, a limitation of this study was the small sample; it is difficult to see how problems with small sample sizes in domestic violence research can be overcome. Larger samples can be obtained by focusing on, for example, refuge populations. Unfortunately this inevitably questions how representative such populations are of domestic violence victims as a whole (Holden, 1998).

This study did attempt to address the issue of representation by focusing more than on refuge populations. However, women who access any form of service may be characteristically different form those women who have no contact with agencies. It would be interesting to explore the experiences of women who, for whatever reason, do not access services; however access could well be problematic particularly with the possibility that they are still within a violent relationship.

This leads to a further limitation of the study in that it was a retrospective analysis of women's experiences and the majority of participants were no longer in a violent relationship. Analysis of the questionnaires revealed that the length of time since the last violent incident ranged from one week to 15 years. Clearly there will have been substantial variation in length of time exposed to violence, chronicity of violence, and types of abuse experienced. These differences were not examined in this study and it will be necessary to address these issues in future work. Domestic violence research is renowned for over reliance on survey data (Gordon, Holmes, Maly, 1999), and although this study did make some attempts to address this, more experimental methodologies may be needed in the future to explore further causal factors.

Wider Issues and Implications

The implications for services in terms of developing awareness and interventions were highlighted in the report discussion, particularly in relation to the need to identify cases and the implementation of appropriate interventions. Family work, in particular, was identified as a possible area of effective intervention (Mullender, 2000). Interventions which focus on family structure, communication, belief systems and how different family members give meaning to their shared experience would seem applicable in domestic violence cases.

In addition, therapy directly focusing on repairing the mother-child relationship would be a further area of intervention to develop. It is argued that the identification of parent-child attachment difficulties is vital for effective intervention (Jones, 1998). Analysis of the questionnaires and the interview data highlighted potential difficulties in relationships in the context of domestic violence. As discussed, literature focusing on the treatment of abused women and their children has predominantly been concerned with the behavioural and

emotional consequences and little attention has been paid to the impact of violence on relationships.

Analysis of the interviews identified key themes of maternal guilt concerning inability to attend to the needs of the children whilst experiencing domestic violence and child mistrust of others. Similarly maternal guilt and child mistrust have been identified as significant factors in difficult mother-child relationships in child abuse cases (Furniss & Bingley-Miller, 1995). Intervention with the mother-child relationship which focuses on, for example, enabling the parent to become more emotionally stable and allowing the child to make sense of their experiences, may be useful. An example of this is highlighted in a single case study of a disrupted mother-child relationship which persisted after the violence had ended. Part of the focus of direct intervention was the mother's feelings about her child and her ability to attend to his needs. At one year follow-up, the mother had managed to create a secure and affectionate environment for her child and demonstrated effectiveness at containing her own emotional distress and that of her child's (Puckering, Evans, Maddox, Mills & Cox, 1996).

Having expanded on the implications for intervention, it is necessary to highlight some of the wider issues relevant to this study. For example, the attention paid to the problem of domestic violence within the health arena is limited despite the potential cost of domestic violence to health services. Health care costs incurred are thought to be substantial (Department of Health, 1997). A 1996 study in North London estimated that the cost of providing crisis services in one district to women experiencing domestic violence was in excess of £7.5 million (Stanko, Crisp, Hale & Lucraft, 1998). With the lack of routine screening for domestic violence in adult and child mental health settings, it is not possible to estimate the cost of the problem to those services alone. However, the results of this study and previous research

would suggest that costs might be high. There is a need for routine screening of the problem in these services not only to guide appropriate intervention as discussed, but also to assess the prevalence of domestic violence in those attending mental health services. In addition, it could be argued that failure to screen adequately for domestic violence not only ignores a significant part of an individual's experience but also fails to identify a clear risk of abuse of any children in the family.

From a societal perspective, it is clear that the wider issues of family abuse as a whole and the intergenerational transmission of violence needs to be addressed. Egeland (1988) argues that it is difficult to break cycles of abuse without intervention which directly addresses the abuse. To what extent are such issues addressed with all children or to what extent does work take place with domestic violence cases aimed at preventing future violence either in repeat victimization or as a perpetrator?

Clearly longitudinal research is necessary to examine some of the wider issues. For example, a useful area to explore with children who have been exposed to domestic violence would be their perceptions of male and female roles and what impact this has on future relationships. Undoubtedly, domestic violence research has inevitable ethical issues that need to be considered when undertaking studies. For example, using child reports in studies is difficult in terms of consent and the potential for further harm that any study may have. Also, as previously discussed, there is a need to progress from relying on retrospective data, although the ethics of research with participants who are currently being abused is questionable.

Reflections on the Research Process

This was a very difficult area in which to undertake research with numerous obstacles to overcome. The decision to research in this area was based on a desire to explore an 'exciting'

new area for clinical psychology as opposed to a study that was 'safe' and well researched in comparison. In hindsight, safe and straightforward may have been less fraught. However, the enthusiasm for the topic has been maintained and with the limited knowledge of this area in clinical psychology, there is a sense that the study has highlighted some important implications, in particular the need for routine screening and effective intervention.

A further difficulty in researching a relatively new area for clinical psychology is the lack of a relevantly knowledgeable supervisor. Extensive discussion with various clinical psychologists at the start of the research process highlighted that this was an important area to develop and had relevance in both adult and child settings. However, knowledge of domestic violence was limited, and whilst cases could be identified, generally, this was not the reason for referral or the focus of intervention.

In conclusion, the review has expanded on some of the issues raised in the preceding report. In particular, further directions for future research and planning of intervention have been highlighted. The Department of Health has demonstrated commitment to raising awareness of domestic violence in all health professions (Department of Health, 2000). However, whilst examples of screening and awareness raising can be found in Accident and Emergency departments and antenatal settings, this is not the case in mental health services. As discussed, domestic violence can have a devastating impact on, maternal health, child development and family life. This is justification enough for why everyone working with women and children should be alert to the prevalence, nature and impact of domestic violence and services should implement protocols for screening and disclosure of and intervention for domestic violence.

References

Black, D. & Newman, M. (1998) Children and domestic violence: a review. *Clinical Child Psychology and Psychiatry, 1*, 1, 79-88.

Bowen, K. (2000) Child abuse and domestic violence in families of children seen for suspected sexual abuse. *Clinical Paediatrics*, Jan, 39,33-40.

Department of Health (2000) *Domestic Violence: A Resource Manual for Health Professionals*. London: HMSO.

Department of Health (1997) *Annual Report of the Chief Medical Officer for 1996: The State of the Public health*. London: HMSO.

Egeland, B. (1988) Breaking the cycle of abuse: implications for prediction and intervention. In K. Bowen, C. Davies & P. Stratton (Eds.) *Early Prediction and Prevention of Child Abuse*. Avon: John Wiley & Sons Ltd.

Finkelhor, D. & Yllo, K. (1983) Rape in marriage: a sociological view. In: D. Finkelhor, R. Gelles, G. Hotaling & M. Straus (Eds.) *The Dark Side of families:Current Family Violence Research*. California: Sage.

Furniss, T. & Bingley-Miller, L. (1995) Working with abusing families. In: K. Wilson & A. James (Eds.) *The Child Protection Handbook*. London: Bailliere-Tindall.

Gordon, R., Holmes, M. & Maly, C. (1999) Research productivity in the areas of child abuse and domestic violence. *Psychological Reports*, 84, 887-898.

Hillard, P. (1985) Physical abuse in pregnancy. *Obstetric Gynaecology*, 81, 1-3.

Holden, G. (1998) The development of research into another consequence of domestic violence. In: G. Holden, R. Geffner & E. Jouriles (Eds.) *Children Exposed to Marital*

Violence: theory, research and applied issues. Washington D.C.: American Psychological Association.

Holden, G., Stein, J., Ritchie, K., Harris, S. & Jouriles, E. (1998) Parenting behaviours and beliefs of battered women. In: G. Holden, R. Geffner & E. Jouriles (Eds.) *Children Exposed to Marital Violence: theory, research and applied issues.* Washington D.C.: American Psychological Association.

Jones, D. (1998) The effectiveness of intervention. In: M. Adock & R. Whiles (Eds.) *Significant Harm: It's Management and Outcome.* Croydon: Significant Publications.

Mills, L. (1998) Integrating domestic violence assessment into child protection services. In: A. Roberts (Ed.) *Battered Women and their Families.* New York: Springer.

Mullender, A. (2000) *Reducing Domestic Violence – what works? Meeting the needs of children- Briefing Note,* January. London: Policing and Reducing Crime Unit.

Painter, K. & Farrington, D. (1998) Marital Violence in Great Britain and it's relationship to marital and non-marital rape. *International Review of Victomology*, 5,3-4, 257-276.

Puckering, C., Evans, J., Maddox, H., Mills, M. & Cox, A. (1996) Taking control: a single case study of mellow parenting. *Clinical Child Psychology and Psychiatry*, 1, 4, 539-550.

Stanko, E., Crisp, D., Hale, C. & Lucraft, H. (1998) *Counting the Costs: estimating the impact of domestic violence in the London borough of Hackney.* Swindon: Crime Concern.

Straus, M. (1983) Ordinary violence, child abuse and wife beating: what do they have in common. In: D. Finkelhor, R. Gelles, G. Hotaling & M. Straus (Eds.) *The Dark Side of families: Current Family Violence Research.* California: Sage.

Walker, L. (1984) *The Battered Woman Syndrome.* New York: Springer.

Appendix 1

Analysis of planning pregnancy

DV vs. non-DV

		experience of physical abuse		Total
		yes	no	
was the pregnancy planned	yes	15	18	33
	no	13	6	19
Total		28	24	52

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.559[b]	1	.110		
Continuity Correction[a]	1.718	1	.190		
Likelihood Ratio	2.606	1	.106		
Fisher's Exact Test				.152	.094
Linear-by-Linear Association	2.510	1	.113		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.77.

DV (pregnancy) vs. DV(non-pregnancy)

		experience of domestic violence with child		Total
		yes	no	
was the pregnancy planned	yes	6	9	15
	no	9	4	13
Total		15	13	28

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.392[b]	1	.122		
Continuity Correction[a]	1.362	1	.243		
Likelihood Ratio	2.435	1	.119		
Fisher's Exact Test				.151	.122
Linear-by-Linear Association	2.307	1	.129		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.04.

Appendix 2

Analysis of marital status

Marital status and GHQ threshold

		GHQTHRES		
		Below threshold (3 or less)	Above threshold (4 or more)	Total
MARITAL2	Living with partner	28	5	33
	Living without partner	9	10	19
Total		37	15	52

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.252[b]	1	.004		
Continuity Correction[a]	6.527	1	.011		
Likelihood Ratio	8.121	1	.004		
Fisher's Exact Test				.009	.006
Linear-by-Linear Association	8.094	1	.004		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.48.

Marital status and child agencies

		AGENCY3		
		None/one agency	Two or more agencies	Total
MARITAL2	Living with partner	31	2	33
	Living without partner	13	6	19
Total		44	8	52

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.032[b]	1	.014		
Continuity Correction[a]	4.231	1	.040		
Likelihood Ratio	5.861	1	.015		
Fisher's Exact Test				.040	.021
Linear-by-Linear Association	5.916	1	.015		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.92.

lann-Whitney Test

Marital status and Child Grid scores

	MARITAL2	N	Mean Rank	Sum of Ranks
score of positiveness	Living with partner	29	17.90	519.00
	Living without partner	17	33.06	562.00
	Total	46		

Test Statistics[a]

	score of positiveness
Mann-Whitney U	84.000
Wilcoxon W	519.000
Z	-3.701
Asymp. Sig. (2-tailed)	.000

a. Grouping Variable: MARITAL2

Marital status and Child Grid threshold

		MARITAL2		Total
		Living with partner	Living without partner	
child threshold score	satisfactory	29	12	41
	not		5	5
Total		29	17	46

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	9.570[b]	1	.002		
Continuity Correction[a]	6.774	1	.009		
Likelihood Ratio	11.031	1	.001		
Fisher's Exact Test				.005	.005
Linear-by-Linear Association	9.362	1	.002		
N of Valid Cases	46				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.85.

Appendix 3

Analysis of age . and gender of child

Age and Child Grid score

			age of focus child	score of positiveness
Spearman's rho	age of focus child	Correlation Coefficient	1.000	.222
		Sig. (2-tailed)	.	.138
		N	52	46
	score of positiveness	Correlation Coefficient	.222	1.000
		Sig. (2-tailed)	.138	.
		N	46	46

Mann-Whitney Test

Gender and Child Grid score

	gender of focus child	N	Mean Rank	Sum of Ranks
score of positiveness	male	28	22.20	621.50
	female	18	25.53	459.50
	Total	46		

Test Statistics[a]

	score of positiveness
Mann-Whitney U	215.500
Wilcoxon W	621.500
Z	-.822
Asymp. Sig. (2-tailed)	.411

a. Grouping Variable: gender of focus child

Gender and child agency involvement

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
gender of focus child * AGENCY3	52	100.0%	0	.0%	52	100.0%

gender of focus child * AGENCY3 Crosstabulation

Count

		AGENCY3		Total
		None/one agency	Two or more agencies	
gender of focus child	male	27	4	31
	female	17	4	21
Total		44	8	52

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.363[b]	1	.547		
Continuity Correction[a]	.044	1	.833		
Likelihood Ratio	.358	1	.550		
Fisher's Exact Test				.700	.410
Linear-by-Linear Association	.356	1	.551		
N of Valid Cases	52				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.23.

Appendix 4

Examination of perpetrator data

perpetrator of abuse of focus child[a]

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	their father	4	14.3	14.3	14.3
	stranger	1	3.6	3.6	17.9
	not applicabel	21	75.0	75.0	92.9
	more than one person	2	7.1	7.1	100.0
	Total	28	100.0	100.0	

a. experience of physical abuse = yes

Section 5

Additional Appendices

Appendix 1

Examples of Letters to Contacts

Lancashire Doctorate in Clinical Psychology Course
Whitegate Drive Health Centre
156, Whitegate Drive
Blackpool

Dear
..... gave your name to me, as I understand that you may be able to help in obtaining participants for a research project that I am carrying out in the area of domestic violence.
To explain further, I am in my final year of training as a clinical psychologist, the research is the final stage of my training. The project has been devised following consultation with a number professionals working within the area of domestic violence. The study has received ethical clearance from University of Wales, Bangor.
The specific aim of the study is to examine violence experienced during pregnancy, whether women feared for the safety of their child either whilst pregnant or after birth and to explore the mother- child relationship. Participation in the study involves completing a questionnaire (approx. 30 minutes long) which covers a variety of questions. A small pilot study has already been carried out with women who have experienced domestic violence.
I wondered if you knew of any women who may be willing to take part in this study. I am looking for women who have experienced violence from a partner at any time, not necessarily during pregnancy. In addition, participants should have at least one child under the age of 16.
Completion of the questionnaire is anonymous and an information sheet is provided for participants along with contact numbers if needed.
If you know of any women who you think may be willing to complete the questionnaire, the questionnaires can be sent either directly to them (names and addresses naturally remaining confidential) or questionnaires could be sent to yourself to pass on.
I would be extremely grateful if you could help in this matter and look forward to hearing from you.

Yours sincerely

Rachel McCormick
Trainee Clinical Psychologist
Lancashire Doctorate in Clinical Psychology Course
(Affiliated to University of Wales, Bangor)

Lancashire Doctorate in Clinical Psychology Course
Whitegate Drive Health Centre
156, Whitegate Drive
Blackpool

8th March 2001

Dear……..,

Re: Research study in Domestic Violence

Following our telephone conversation last week, please find enclosed six copies of the questionnaire.
The aim of the study is to explore domestic violence experienced by women with children. In particular, whether women feared for the safety of their child either whilst pregnant or after birth and to explore the mother- child relationship. I have already distributed a number of questionnaires through various agencies.
For participation, I am looking for women who have experienced violence from a partner at any time, not necessarily during pregnancy. In addition, participants should have at least one child under the age of 16. Participation in the study involves completing a questionnaire (approx. 30 minutes long) which covers a variety of questions.
A small pilot study has already been carried out. The project has been devised following consultation with a number professionals working within the area of domestic violence and has received ethical clearance from University of Wales, Bangor.
Completion of the questionnaire is anonymous and an information sheet is provided for participants along with contact numbers if needed. I do not need to have direct contact with participants but I am willing to do so if they wish or need help in completing the answers.
I hope this provides you with all the information that you need. I am not distributing any more questionnaires after April so would be grateful if you could return any unused questionnaires at the end of the month. If you have any further queries, please contact me.

Yours sincerely

Rachel McCormick
Trainee Clinical Psychologist
Lancashire Doctorate in Clinical Psychology Course
(Affiliated to University of Wales, Bangor)

Appendix 2

Additional Information on Standard Measures used in the study

General Health Questionnaire-12 (GHQ-12)

The GHQ-12 (Goldberg, 1992) is a shortened version of a well validated measure (GHQ-60, Goldberg, 1978). The rationale for using this scale in the study was to obtain a brief assessment of participant psychological well being with a measure that was user-friendly, quick and simple to complete. The reliability and validity of the GHQ-12 have been examined in a number of studies, following is a brief summary.

Reliability- The internal consistency of the scale, as assessed by Cronbach's alpha, has ranged between 0.82 to 0.90 in a variety of studies (e.g. Banks et al., 1980; Hardy et al., 1999). The reliability of the measure has been examined using the test-retest method, following a 2-week interval, the correlation was found to be .73 (Hardy et al., 1999), and using the split-half method where the correlation was .83 (Banks et al., 1980).

Validity – Validity has been examined by evaluating the scale's sensitivity in detecting psychiatric disorder. Sensitivity, using a threshold score of 2/3, was found to be 93.5% and specificity 75.8% (Goldberg, 1992). In a more recent study, using a threshold score of 3/4 sensitivity was found to be 73% and specificity was 88% (Hardy et al., 1999). Convergent validity has been assessed by comparing the GHQ-12 with the Clinical Interview Schedule-Revised (CIS-R, Lewis et al., 1992); a correlation of .70 was obtained.

The Abuse Assessment Screen (AAS)

Designed by the American Nursing Research Consortium on Violence and Abuse (Parker & McFarlane, 1991 in Soeken et al., 1998), the AAS assesses the frequency, severity and

perpetrator of abuse against women. The rationale for using this measure in the study was that other measures used to assess presence of domestic violence such as the. Conflict Tactics Scale (CTS; Straus, 1979) and the Index of Spouse Abuse (ISA; Hudson & McIntosh, 1981) are lengthy and are used to obtain detailed information about the type of assaults. The AAS in comparison is a short measure that is self-administered, straightforward, quick and was easily adaptable for this study. However, as the AAS is a relatively new measure, information regarding psychometric properties is limited:

Reliability- The test-retest method was used on a sample of 1,203 women, following a 2-month retest period, the correlation was found to be .83 (Soeken et al., 1998).

Validity-As the AAS does not produce a total score, criterion validity was assessed by comparing the responses to individual items form other abuse scales. The CTS and the ISA have demonstrated reliability and validity and have been used widely in research about violence. The AAS was significantly associated with the standard abuse measures across items (CTS .28; ISA .35 p<. 01), (Soeken et al., 1998).

The Child Grid

The Family Grid (Davis, 1997) was designed as a clinical instrument to help give a focus to professionals working in a counselling relationship with parents and has been used in a number of studies (e.g. Davis & Spurr, 1998). It aims to assess family functioning and measure therapeutic change, The Family Grid is described in full in The Child Psychology Portfolio (Sclare, 1997).

The rationale for using The Child Grid section was that it was self administered, relatively simple to complete and aimed to assess the quality of the parent-child

relationship rather than parenting stress or explicit child behaviour. Normative data are still being collected for the scale, however the mean discrepancy score on samples of clinic referred children range from 1.94 (SD= .86) to 2.1 (SD= 1.04). In samples of non-index children from clinic referred families, mean discrepancy scores range from 1.36 (SD= 1.02) to 1.43 (SD= .75) (Davis, 1997). The author of the scale also reports internal consistency and test-retest reliability to be satisfactory (Davis, 1997).

In addition to its purpose for this study, the internal consistency of the scale was examined using Cronbach's alpha. For the actual child scale, alpha was found to be .73, however, for the ideal child scale, alpha was .61 which is reasonable. Correspondence with the author of the scale revealed that The Family Grid has since been revised based on the original normative data and analysis of psychometric properties . The new revised version has yet to be published.

References

Banks, M., Clegg, C., Jackson, P., Kemp, N., Stafford, E. & Wall, T. (1980) The use of the General Health Questionnaire as an indicator of mental health in occupational studies. *Journal of Occupational Psychology*, 53, 187-194.

Davis, H. (1997) The Family Grid In: I. Sclare (Ed.) Child Psychology Portfolio. Windsor: NFER-Nelson.

Davis, H. & Spurr, P. (1998) Parent Counselling: an evaluation of a community child mental health service. *Journal of Child Psychology and Psychiatry*, 39, 3, 365-376.

Goldberg, D. (1992) *General Health Questionnaire (GHQ-12).* Windsor: NFER-Nelson.

Goldberg, D. (1978) *General Health Questionnaire (GHQ).* Windsor: NFER-Nelson.

Hardy, G., Shapiro, D., Haynes, C. & Rick, J. (1999) Validation of the General Health Questionnaire-12 Using a Sample of Employees for England's Health Care Services. *Psychological Assessment*, 11, 2, 159-165.

Hudson, W. & McIntosh, S. (1981) The assessment of spouse abuse: two quantifiable dimensions. *Journal of Marriage and the Family*, November, 873-888.

Lewis, G., Pelos, A. & Dunn, G. (1992) Measuring psychiatric disorder in the community: a standardised assessment for use by lay interviewers. *Psychological Medicine*, 22, 465-486.

Soeken, K., McFarlane, J., Parker, B. & Lominack, M. (1998) The Abuse Assessment Screen. In: J. Campbell (Ed.) *Empowering Survivors of Abuse: healthcare for battered women and their children.* California: Sage Publications.

Straus, M. (1979) Measuring Intrafamily conflict and violence: The Conflict Tactic Scale. *Journal of Marriage and the Family*, February, 75-88.

Reliability Analysis of the Child Grid

Reliability

Child Scale

****** Method 2 (covariance matrix) will be used for this analysis

RELIABILITY ANALYSIS - SCALE (ALPHA)

		Mean	Std Dev	Cases
1.	CHILD1	5.5111	1.3250	45.0
2.	CHILD2	4.4889	1.8169	45.0
3.	CHILD3	3.7333	1.7633	45.0
4.	CHILD4	5.0667	1.6706	45.0
5.	CHILD5	5.5111	1.6043	45.0
6.	CHILD6	3.4889	1.8043	45.0
7.	CHILD7	5.7333	1.6153	45.0
8.	CHILD8	3.1333	1.8414	45.0
9.	CHILD9	5.8667	1.1201	45.0
10.	CHILD10	5.9333	.9630	45.0
11.	CHILD11	2.8222	1.8001	45.0
12.	CHILD12	4.4667	1.0574	45.0
13.	CHILD13	3.5111	1.7139	45.0
14.	CHILD14	4.6000	1.4678	45.0
15.	CHILD15	5.7111	1.2902	45.0
16.	CHILD16	6.0667	1.3551	45.0
17.	CHILD17	5.5111	1.7139	45.0
18.	CHILD18	3.2889	1.6043	45.0
19.	CHILD19	3.2000	1.8166	45.0
20.	CHILD20	5.5333	1.4078	45.0
21.	CHILD21	3.4222	1.4692	45.0
22.	CHILD22	5.4889	1.5466	45.0
23.	CHILD23	1.8444	1.3135	45.0
24.	CHILD24	4.5111	1.4081	45.0
25.	CHILD25	2.5556	1.6727	45.0

N of Cases = 45.0

Statistics for	Mean	Variance	Std Dev	N of Variables
Scale	111.0000	201.3182	14.1887	25

Inter-item Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.0971	-.4947	.8064	1.3010	-1.6302	.0898

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Alpha if Item Deleted
CHILD1	105.4889	197.5283	.0546	.8862	.7370
CHILD2	106.5111	173.7101	.5075	.8146	.7043
CHILD3	107.2667	187.1545	.2291	.6073	.7276
CHILD4	105.9333	194.6091	.0841	.8797	.7380
CHILD5	105.4889	203.3465	-.1006	.7941	.7500
CHILD6	107.5111	168.3010	.6357	.8023	.6931
CHILD7	105.2667	199.0182	-.0068	.7237	.7438
CHILD8	107.8667	190.2091	.1520	.6503	.7342
CHILD9	105.1333	198.4818	.0501	.7372	.7359
CHILD10	105.0667	199.5182	.0321	.5780	.7357
CHILD11	108.1778	181.1495	.3494	.8606	.7179
CHILD12	106.5333	184.5273	.5455	.6690	.7118
CHILD13	107.4889	184.2101	.3046	.7076	.7216
CHILD14	106.4000	179.0182	.5129	.6166	.7077
CHILD15	105.2889	187.9374	.3312	.7615	.7209
CHILD16	104.9333	188.2909	.3009	.8092	.7224
CHILD17	105.4889	183.3465	.3239	.8237	.7200
CHILD18	107.7111	176.8465	.5132	.8799	.7060
CHILD19	107.8000	173.4818	.5127	.8917	.7038
CHILD20	105.4667	187.7091	.3014	.5905	.7222
CHILD21	107.5778	186.2949	.3208	.7779	.7208
CHILD22	105.5111	199.4828	-.0127	.7454	.7433
CHILD23	109.1556	189.1343	.2895	.6509	.7232
CHILD24	106.4889	199.7556	-.0106	.7031	.7416
CHILD25	108.4444	177.0253	.4829	.8900	.7077

Reliability Coefficients 25 items

Alpha = .7324 Standardized item alpha = .7290

Ideal Child Scale

RELIABILITY ANALYSIS - SCALE (ALPHA)

		Mean	Std Dev	Cases
1.	IDEAL1	6.5778	.5431	45.0
2.	IDEAL2	2.4222	1.1380	45.0
3.	IDEAL3	1.8889	1.2472	45.0
4.	IDEAL4	6.4000	.7508	45.0
5.	IDEAL5	6.4222	.8391	45.0
6.	IDEAL6	1.9111	.9960	45.0
7.	IDEAL7	6.8000	.4573	45.0
8.	IDEAL8	2.1111	1.1525	45.0
9.	IDEAL9	6.3111	.7331	45.0
10.	IDEAL10	6.5333	.6252	45.0
11.	IDEAL11	1.5333	1.1201	45.0
12.	IDEAL12	4.4444	.9428	45.0
13.	IDEAL13	2.3111	1.5348	45.0
14.	IDEAL14	3.9556	.9760	45.0
15.	IDEAL15	6.1778	.9118	45.0
16.	IDEAL16	6.4222	.6567	45.0
17.	IDEAL17	6.1333	.7261	45.0
18.	IDEAL18	2.2889	1.0362	45.0
19.	IDEAL19	2.2667	1.0745	45.0
20.	IDEAL20	5.6667	1.2968	45.0
21.	IDEAL21	2.1556	1.0862	45.0
22.	IDEAL22	6.1333	.9439	45.0
23.	IDEAL23	1.7111	1.3919	45.0
24.	IDEAL24	4.4000	1.3212	45.0
25.	IDEAL25	1.6444	1.0478	45.0

N of Cases = 45.0

Statistics for Scale	Mean	Variance	Std Dev	N of Variables
	104.6222	62.0586	7.8777	25

Inter-item Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.0458	-.5750	.7055	1.2806	-1.2270	.1048

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Alpha if Item Deleted
IDEAL1	98.0444	63.3162	-.1796	.6795	.6219
IDEAL2	102.2000	54.0727	.3998	.7111	.5692
IDEAL3	102.7333	57.7909	.1430	.6465	.6044
IDEAL4	98.2222	64.5404	-.2525	.7556	.6343
IDEAL5	98.2000	64.8909	-.2616	.7600	.6387
IDEAL6	102.7111	53.6192	.5106	.7177	.5593
IDEAL7	97.8222	63.1949	-.1851	.6597	.6197
IDEAL8	102.5111	58.5283	.1249	.7006	.6059
IDEAL9	98.3111	63.0374	-.1303	.7607	.6241
IDEAL10	98.0889	61.2192	.0458	.7575	.6091
IDEAL11	103.0889	50.6283	.6384	.8276	.5361
IDEAL12	100.1778	58.0586	.2165	.7468	.5944
IDEAL13	102.3111	51.7192	.3617	.7952	.5690
IDEAL14	100.6667	55.2727	.4020	.7016	.5730
IDEAL15	98.4444	57.5253	.2677	.7713	.5892
IDEAL16	98.2000	62.4364	-.0780	.5647	.6183
IDEAL17	98.4889	61.9828	-.0395	.6575	.6168
IDEAL18	102.3333	54.4545	.4270	.7562	.5683
IDEAL19	102.3556	57.0980	.2344	.8429	.5917
IDEAL20	98.9556	58.3162	.1040	.7600	.6106
IDEAL21	102.4667	53.8909	.4382	.7910	.5653
IDEAL22	98.4889	59.1646	.1379	.8134	.6029
IDEAL23	102.9111	51.2646	.4443	.6249	.5563
IDEAL24	100.2222	62.4495	-.1023	.5182	.6403
IDEAL25	102.9778	54.7495	.4005	.8073	.5713

Reliability Coefficients 25 items

Alpha = .6074 Standardized item alpha = .5452

Correspondence from author of the Child Grid

McCormick

From:
To:
Sent: Thursday, April 05, 2001 4:04 PM
Attach: F GRID Paper minus test retest.dot; FAMILY GRID.dot
Subject: Family Grid

To Rachel McCormick.
From Hilton Davis (forwarded by Linda, PA)

Dear Ms McCormick,

Thank you very much indeed for your letter of 18th March. I apologise for not replying sooner, but I have been out of the country working for the past 3 weeks.

Your study sounds really interesting in an important area for intervention.

We have been using the Family Grid in a number of studies, but unfortunately have not published very much on it recently. There always seems to be something else to do. Nevertheless, I enclose a very rough draft paper for your information. It is clearly unpublished and is likely to remain so until we have a significant amount of time to actually get it together. Nevertheless, I thought it might be useful for you to see as it might be helpful. I am sending it as an attachment to this message. As a result of that work we have actually shortened the Family Grid as a whole and I attach a copy of the new version for your information.

I hope the work is successful. If you need any further information please let me know.

With very best wishes.

Yours sincerely,

Hilton Davis
Professor of Child Health Psychology

Appendix 3

Pilot Study

A pilot study was carried out to check the clarity of the questionnaire and ensure that the questions asked were appropriate and acceptable to participants. The questionnaire included the following measures:

- Demographic questionnaire -devised by researcher
- Reproductive health questionnaire -adapted from routine ante-natal questions
- Abuse questionnaires -partly devised by researcher and also adapted from the Abuse Assessment Screen (AAS, Parker & MacFarlane, 1991)
- General Health Questionnaire (GHQ –12, Goldberg, 1992)
- The Child Grid - extracted from The Family Grid (Davis, 1997).

The pilot participants were obtained through a social work contact who distributed five questionnaires to work colleagues whom were known to have experienced domestic violence and five questionnaires to colleagues who had not. The work colleagues included social workers, local council workers and administrative staff.

A feedback form was attached to each questionnaire so that participants could comment on the time taken to complete the questionnaire and express any difficulties with the questions asked (see attached). The average time taken by the pilot group to complete the questionnaire was 26 minutes (range 20 to 40) which was acceptable to participants.

One participant indicated difficulties in understanding the Child Grid section. However, as only one person had difficulties with the scale and it has been used with different populations, it was felt unnecessary to alter this. The instructions provided in the questionnaire were taken verbatim from the instructions provided with the scale.

A further participant expressed concern at the appropriateness of asking questions related to forced sexual contact and child abuse. These comments were considered and discussed further with professionals in the area and two of the pilot participants. These participants had submitted their names on the returned questionnaires and had agreed to be contacted if necessary regarding feedback. They were contacted by telephone and e-mail and asked directly about the difficulties highlighted. The general opinion was that it was useful to include these items, as they may be important factors in the study. Therefore, the items remained unchanged in the questionnaire.

A number of questions, although they provided additional information, were not considered necessary for the analysis and were therefore eliminated. For example, some of the excluded questions provided information about the partners of participants. As a number of participants were likely to have had more than one partner and in some cases former not current partners were the perpetrators of domestic violence, it was difficult to achieve clarity on information about abusive partners without asking additional questions. The primary aim of the study relates to women and their children, therefore the decision was taken to be specific and concise with an easy to complete questionnaire rather than over-inclusive with an instrument that would take longer to complete. Table 1 illustrates the questions which were eliminated from the questionnaire and gives a brief rationale for their exclusion.

Table 1 Questions eliminated from the questionnaire following the pilot study

Questionnaire section	Question	Reason for elimination
1	If currently living with a partner, approximately how long have you been living together?	Would need additional questions to clarify the significance of this information
1	Is your partner in paid employment?	Not directly necessary for the study
1	What is your current family income?	Not directly necessary for the study
3	If yes, was this your current partner, ex-partner or both?	This question yields the same response as question 1.2 in this section
4	How old are your children?	Not directly necessary for the analysis
4	Do you children share the same birth father?	Not directly necessary for the analysis
4	How many pregnancies have you had?	This information can be obtained from subsequent questions.

One further question was added to the questionnaire, this was a direct question related to whether participants had experienced violence whilst pregnant with the child they chose to focus on in the latter section of the questionnaire. This was added simply to provide clarification for the researcher.

Descriptive analysis of the pilot study

A short descriptive analysis was carried out with a selection of the pilot data to examine the characteristics of the sample and to identify any potential problems in analysis.

Table 2 Mean scores of participants on the variables age, number of children and General Health Questionnaire (GHQ-12) scores.

	Domestic Violence (n=5)	Non Domestic Violence (n=5)
Mean age of participants	37.6	32.6
Mean number of children	2	2.2
Mean GHQ score of participants	3	2

GHQ-12 cut-off score to indicate caseness is 3 / 4 using the binary scoring method.

As shown in Table 2, there was a mean age difference of five years between the two groups, with the domestic violence participants being slightly older. There was little difference between the mean number of children of participants in each group. Although there appears to be little difference between the mean GHQ scores of both groups, the mean score for the domestic violence group falls within the clinical caseness range for this scale.

Further analysis of the demographic data highlighted that nine participants were of white UK origin and one participant was of Black Caribbean origin. This participant was in the domestic violence group. In terms of marital status, four participants in the non-domestic violence group were married; one was living as married. In the domestic violence group, two participants were married, one was living as married, and two were separated.

Table 3 illustrates that all five participants in each group were in some form of employment.

Table 3 Employment status of participants

	Domestic Violence (n=5)	**Non Domestic Violence (n=5)**
Employed full-time	2	3
Employed part-time	3	2
In educational training	0	0
Not employed or in training	0	0

In relation to the experience of abuse, three of the five participants in the domestic violence group had experienced physical violence during pregnancy. When asked to the focus on a specific child, three participants in the domestic violence group chose a female child, whilst in the general group all the participants focused on a male child.

Table 5 Mean group scores of the Child Grid discrepancy means

	Domestic Violence (n=5)	**Non Domestic Violence (n=5)**
Group mean scores of child-ideal discrepancy means	1.27	1.11

Based on the normative data for this scale, a mean discrepancy of 2.0 or more indicates a problematic relationship between mother and child.

As shown in Table 5, although the mean scores for the two groups fall within the non-clinical range of the child-ideal scale, the mean for the domestic violence group is slightly higher than the non-domestic violence group.

The pilot study highlighted a number of points that needed addressing for the main study:

- Ensure a wider representation of participants from ethnic minorities,
- Ensure that participants from the general population are matched as far as possible on the demographic details namely age, marital status and employment status.

This was not fully attempted for this pilot study because the primary aim here was to check clarity of the questionnaire. This aim was achieved.

Letter to pilot participants and feedback form

Lancashire Doctorate in Clinical Psychology Course
Whitegate Drive Health Centre
156, Whitegate Drive
Blackpool

Dear

RE: Research into Domestic Violence in Pregnancy

Thankyou for agreeing to take part in this pilot study concerning the above mentioned research project. Enclosed is a questionnaire with an information sheet and consent form which I would be grateful if you could fill in.

I would appreciate any comments you may have on the questions and the information sheet, regarding clarity, ease to fill in, and applicability. Attached to this letter is a small form to fill in after you have completed the questionnaire. Please return the form with the questionnaire in the prepaid envelope. Thanks once again for taking the time to help.

Yours Sincerely

Rachel McCormick
Trainee Clinical Psychologist

PILOT QUESTIONNAIRE

Approximately how long did it take you to read the information and consent forms and complete all the questions?

Were there any aspects of the questions or information supplied that you did not understand or took you a while to work out? If yes, please highlight these.

Were there any questions that you felt were irrelevant to the nature of the study? If yes, please state these.

Was there anything not included which you feel should have been? If yes, please state.

Whilst understanding the difficult nature of this subject, were there any questions that you felt were particularly hard to answer? If yes, please state.

You are welcome to make additional comments on the back of this sheet.

Appendix 4

Final Version of Questionnaire

Information Sheet for Participants

My name is Rachel McCormick, I am a Trainee Clinical Psychologist employed in the NHS. I am conducting a study exploring domestic violence during pregnancy and the possible future difficulties for children. The purpose of the study is to help inform professionals working with children and their families where a history of domestic violence in the family may contribute to current difficulties.

To carry out the study, I need a variety of participants including women who have experienced violence during pregnancy, women who may have experienced violence but not whilst pregnant and women who have not experienced domestic violence at all.

Attached is a set of questions covering a variety of areas. Although there are a number of pages, the questions are straightforward and take approximately half an hour to complete. The questionnaires are confidential and will not be seen by anyone else but the researcher. Your decision on whether to take part in the study will not affect any help or services that you receive now or in the future.

If you wish to participate, on the next page is a consent form which you need to read carefully and tick the relevant box. The consent form stays attached to the questionnaire but you can remove this information sheet if you wish and keep it for future reference.

If any questions are unclear or you wish to discuss an aspect of the study either before completing the questionnaire or after, I can be contacted on . Please leave a message and I will contact you as soon as possible.

I am aware that answering some of the questions may well be difficult and upsetting. If this should be the case and you wish to speak to someone, there are a number of contacts on the last page of the questionnaire who would be happy for you to get in touch and who are aware of this study.

I would like to express my sincere thanks in anticipation of your taking part in this important study.

Rachel McCormick

Lancashire Doctorate in Clinical Psychology Course.

Consent Form for Questionnaire Participants

- I have carefully read the information on the previous page and am aware of what the study is about and that I need to complete the attached questionnaire.

- I know that I can contact the Researcher to ask questions about the study before completing the questionnaire and after I have filled it in.

- I know that should I need to talk to someone after completing the questionnaire, there are a number of places that I can contact.

- I know that I don't have to complete the questionnaire if I don't want to and am aware that this will not affect any help that I receive.

- I know that if I change my mind, I can withdraw from the study at any time and that this will not affect any help that I receive.

- I know that any information I give in this questionnaire will remain confidential.

Any complaints about the study should be addressed to: Head of School, School of Psychology, University of Wales, Bangor, Gwynedd, LL57 2DG.

Consent:

I agree to participate in this study by completing the attached questionnaire

☐ Please put tick in box if you have read the above and are willing to take part in the study

Research Questionnaire into Domestic Violence

Section1

1) How old are you? (please state in box) ☐

2) What is your ethnic origin? (please tick appropriate box)

White UK ☐ White other ☐ please specify----------

Black African ☐ Black Caribbean ☐ Black other ☐ please specify

Indian ☐ Pakistani ☐ Asian other ☐ please specify----------

Any other ethnic group ☐ please specify----------

3) What is your marital status? (please tick appropriate box)

Married ☐ Living as married ☐ Separated ☐ Divorced ☐

Widowed ☐ Single ☐

4) What is you current employment status?

Employed full-time ☐ Employed part-time ☐ In educational training ☐

Not in paid employment or training ☐

Section 2

PLEASE READ THIS CAREFULLY.

I would like to know if you have had any medical complaints and how your health has been in general, *over the last few weeks.* Please answer ALL the questions simply by circling the answer which you think most nearly applies to you. Remember that I want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

HAVE YOU RECENTLY:

1.	**been able to concentrate on whatever you're doing?**	Better than usual	Same as usual	Less than usual	Much less than usual
2.	**lost much sleep over worry?**	Not At all	No more than usual	Rather more than usual	Much more than usual
3.	**felt that you are playing a useful part in things?**	More so Than usual	Same as usual	Less useful than usual	Much less useful
4.	**felt capable of making decisions about things?**	More so Than usual	Same as usual	Less so than usual	Much less capable
5.	**felt constantly under strain?**	Not At all	No more than usual	Rather more than usual	Much more than usual
6.	**felt you couldn't overcome your difficulties?**	Not at all	No more than usual	Rather more than usual	Much more than usual
7.	**been able to enjoy your normal day-to-day activities?**	More so than usual	Same as usual	Less so than usual	Much less than usual
8.	**been able to face up to your problems?**	More so Than usual	Same as usual	Less able than usual	Much less able
9.	**been feeling unhappy and depressed?** usual	Not At all	No more than usual	Rather more than usual	Much more than
10.	**been losing confidence in yourself?**	Not At all	No more than usual	Rather more than usual	Much more than usual
11.	**been thinking of yourself as a worthless person?**	Not At all	No more than usual	Rather more than usual	Much more than usual
12.	**been feeling reasonably happy, all things considered?**	More so than usual	About same as usual	Less so than usual	Much less than usual

Section 3

1) Have you ever been hit, slapped or otherwise physically hurt, at any time by a partner?
(please tick appropriate box)

Yes ☐ No ☐

If yes, was this your : current partner? ☐ ex-partner? ☐ or both? ☐

2) Has a partner ever forced you, at any time, to have sexual activities?
(please tick appropriate box)

Yes ☐ No ☐

If yes, was this your : current partner? ☐ ex-partner? ☐ or both? ☐

3) If applicable, please state, approximately, how long ago it was when a partner last physically hurt you ----------.

4) When you were pregnant, were you ever hit, slapped or otherwise physically hurt by a partner? (please tick appropriate box)

Yes ☐ No ☐

Section 4

1) How many children do you have? (please state) ----------

2) Have you ever experienced a miscarriage before 12 weeks? (please tick appropriate box)

Yes ☐ No ☐

If yes, please state how many if you have experienced more than one----------

3) Have you ever experienced a miscarriage after 12 weeks? (please tick appropriate box)

Yes ☐ No ☐

If yes, please state how many if you have experienced more than one----------

4) Have you ever experienced a stillbirth? (please tick appropriate box)

Yes ☐ No ☐

If yes, please state how many if you have experienced more than one ----------

Section 5

The following pages require you to think about just one child under the age of 16, answer the questions thinking about the same one child throughout. Please read the following instructions carefully:

- If you have **not** experienced physical or sexual violence from a partner, please think of any one of your children under 16.

- If you have experienced violence from a partner, but **not** during pregnancy, think about any child of yours, under 16, who was born after the first violent incident.

- If you have experienced violence whilst pregnant, think of any child, under 16, who you were pregnant with and experienced violence during that pregnancy.

1) What is the sex of your child? (please tick appropriate box) male ☐ female ☐

2) How old is your child now? (please state) ----------

3) Did you experience domestic violence whilst pregnant with this child?

Yes ☐ No ☐ If yes, please describe briefly ----------

---

4) Did you experience any physical and/or mental health problems whilst pregnant with this child?

Yes ☐ No ☐ If yes, please describe briefly ----------

---

5) Did you experience any problems during labour or birth with this child?

Yes ☐ No ☐ If yes, please state ----------

---

6) Did you experience any physical and/or mental health problems following the birth of this child?

Yes ☐ No ☐ If yes, please describe briefly ----------

-

7) Approximately, what was your child's weight at birth? (please state) ----------

8) When was your child born? before 37 weeks ☐ at 37 weeks or after ☐

9) Whilst you were pregnant, was your partner at that time the father of your unborn child? (please tick appropriate box)

Yes ☐ No ☐

10) Was this child planned? (please tick appropriate box)

Yes ☐ No ☐

11) Was the discovery of the pregnancy:

a happy event? ☐ an unhappy event? ☐ Neither? ☐

12) Whilst you were pregnant with this child, did your partner (or ex-partner) show any feelings of:

anger towards your unborn child? (please tick appropriate box) Yes ☐ No ☐

jealousy of your unborn child? (please tick appropriate box) Yes ☐ No ☐

If yes to any of the above, please provide brief examples of what was said or done to make you think your partner was angry/ jealous of your unborn child----------

---

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13) Whilst pregnant, did you have any concerns for the safety of your child? (please tick appropriate box)

Yes ☐ No ☐

If you had concerns, please describe briefly what these concerns were----------

---

14) Has your child had contact with any of the following services? If yes to any of these, please state reason for contact and whether he/she is still involved. Please use space provided;

Paediatrician Yes ☐ No ☐ ----------

Social Worker Yes ☐ No ☐ ----------

Educational Psychologist Yes ☐ No ☐ ----------

Clinical Psychologist Yes ☐ No ☐ ----------

Speech and Language Therapist Yes ☐ No ☐ ----------

Child Psychiatrist Yes ☐ No ☐ ----------

Education Welfare Officer Yes ☐ No ☐ ----------

---

15) Have you ever been concerned that your child may be at risk from abuse?

Yes ☐ No ☐

If yes, briefly explain ----------

16) To your knowledge, has your child ever been physically or sexually abused?

Yes, physically abused ☐ Yes, sexually abused ☐

Yes, both ☐ No, neither ☐

17) If yes to the previous question, was your child abused by:

(please tick box, if appropriate, more than one box can be ticked)

Yourself? ☐ Their father? ☐ A step-father? ☐

Another family member? ☐ A significant other? ☐ A stranger? ☐

Section 6

Instructions for the following questions

This is the final part of the study. In this next set of questions, you are asked to consider what your child is like.

On the following page entitled 'My child' there are 25 scales on which to rate your child. The first scale is 'happy' to 'miserable' and is to be completed in the following way:

If you think your child is extremely miserable please put a cross in square 1.

If you think your child is generally miserable put a cross in square 2.

If you think your child is quite happy put a cross in square 5 and so on.

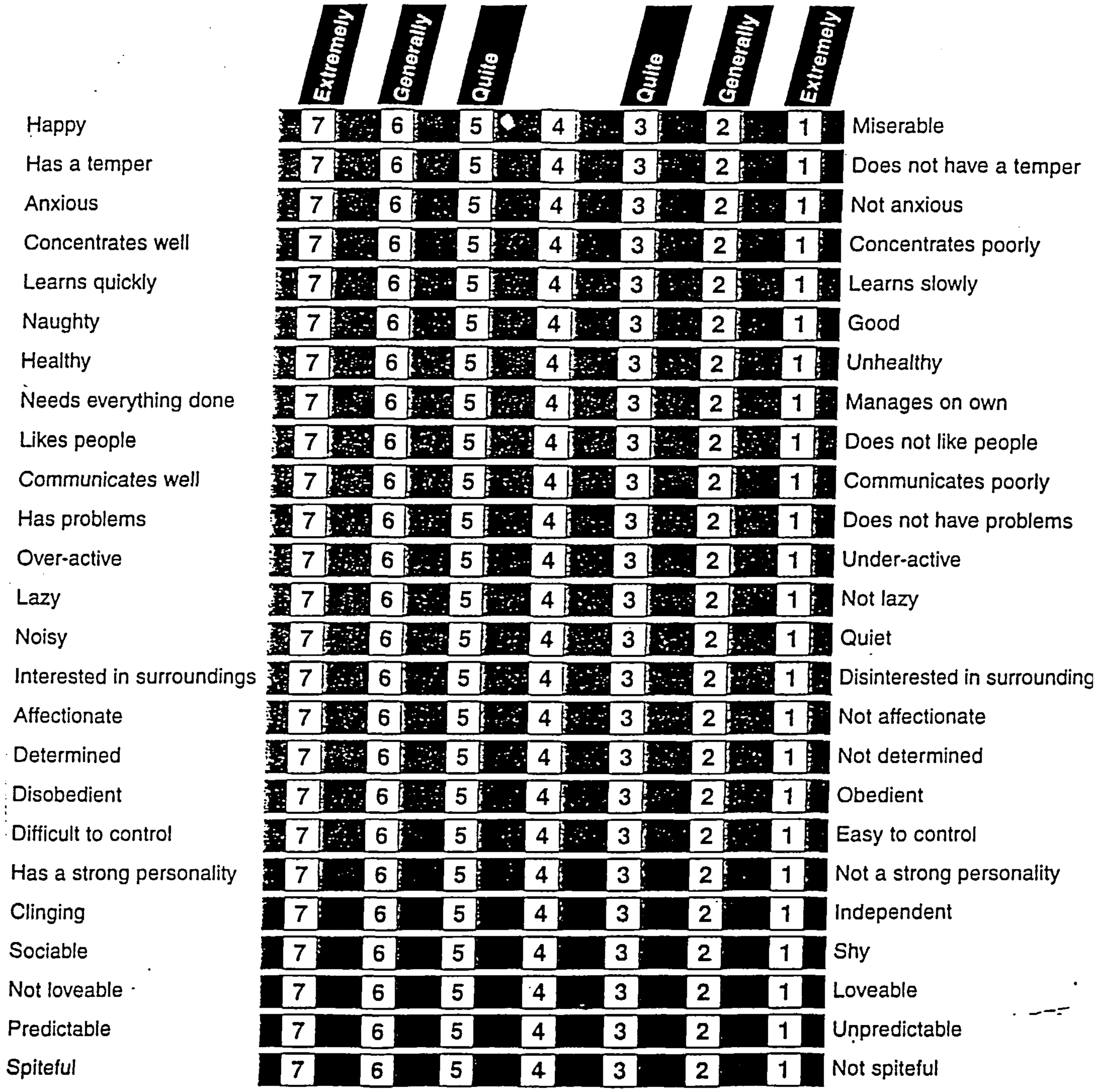
On the other hand, if your child is an extremely happy child, please put a cross in square 7.
Put a cross in one square for each line and complete all the scales, working quickly to give your very first impression.

The page entitled 'My child as I would like her/him to be ideally' is completed in the same way. You work down each scale rating your child, as you would like them to be.

My Child

	Extremely	Generally	Quite		Quite	Generally	Extremely	
Happy	7	6	5	4	3	2	1	Miserable
Has a temper	7	6	5	4	3	2	1	Does not have a temper
Anxious	7	6	5	4	3	2	1	Not anxious
Concentrates well	7	6	5	4	3	2	1	Concentrates poorly
Learns quickly	7	6	5	4	3	2	1	Learns slowly
Naughty	7	6	5	4	3	2	1	Good
Healthy	7	6	5	4	3	2	1	Unhealthy
Needs everything done	7	6	5	4	3	2	1	Manages on own
Likes people	7	6	5	4	3	2	1	Does not like people
Communicates well	7	6	5	4	3	2	1	Communicates poorly
Has problems	7	6	5	4	3	2	1	Does not have problems
Over-active	7	6	5	4	3	2	1	Under-active
Lazy	7	6	5	4	3	2	1	Not lazy
Noisy	7	6	5	4	3	2	1	Quiet
Interested in surroundings	7	6	5	4	3	2	1	Disinterested in surroundings
Affectionate	7	6	5	4	3	2	1	Not affectionate
Determined	7	6	5	4	3	2	1	Not determined
Disobedient	7	6	5	4	3	2	1	Obedient
Difficult to control	7	6	5	4	3	2	1	Easy to control
Has a strong personality	7	6	5	4	3	2	1	Not a strong personality
Clinging	7	6	5	4	3	2	1	Independent
Sociable	7	6	5	4	3	2	1	Shy
Not loveable	7	6	5	4	3	2	1	Loveable
Predictable	7	6	5	4	3	2	1	Unpredictable
Spiteful	7	6	5	4	3	2	1	Not spiteful

My Child as I would like Her/Him to be Ideally



Thank you for taking the time to complete this questionnaire, I would be grateful if you could take a few minutes more to check that you have answered all the questions.
At the bottom of this page are numbers that you can contact should you feel the need to discuss any of the issues covered in this study.

The second stage of the study involves an interview carried out by me, taking no longer than an hour; this can take place at a venue of your choice. I am particularly keen to interview women who have experienced violence during pregnancy and women who did not but experienced violence at other times from a partner.
If you may be willing to take part in the interview stage, there are a number of ways that you can volunteer. You can include your name; address and/or telephone number on this sheet and either return it with the questionnaire or return it separately. Any contact details you give will remain confidential. Alternatively, you can contact me on the number given on the front sheet of this questionnaire.

If you are interested in participating in the second stage of the study, I will contact you to provide more information about the interview and ask if you definitely wish to take part. Please complete any of these details if you would like me to contact you about the next stage of the study:
Name:
Address:

Telephone Number:
Email address:

CONTACT DETAILS (please contact any of the following should you feel the need)

Appendix 5

Descriptive Statistics for the DV and non-DV Groups

DV

age of participant

Statistics[a]

age of participant

N	Valid	27
	Missing	1
Mean		34.2222
Median		35.0000
Std. Deviation		5.6659
Skewness		-.760
Std. Error of Skewness		.448
Kurtosis		1.076
Std. Error of Kurtosis		.872
Minimum		19.00
Maximum		45.00

a. experience of physical abuse = yes

ethnic group

Statistics[a]

ethnic group

N	Valid	28
	Missing	0
Mean		1.4643
Median		1.0000
Std. Deviation		1.4268
Skewness		3.126
Std. Error of Skewness		.441
Kurtosis		9.339
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		7.00

a. experience of physical abuse = yes

Non-DV

age of participant

Statistics[a]

age of participant

N	Valid	24
	Missing	0
Mean		37.0833
Median		36.0000
Std. Deviation		5.9485
Skewness		.294
Std. Error of Skewness		.472
Kurtosis		-.988
Std. Error of Kurtosis		.918
Minimum		27.00
Maximum		47.00

a. experience of physical abuse = no

ethnic group

Statistics[a]

ethnic group

N	Valid	24
	Missing	0
Mean		1.1667
Median		1.0000
Std. Deviation		.8165
Skewness		4.899
Std. Error of Skewness		.472
Kurtosis		24.000
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		5.00

a. experience of physical abuse = no

marital status

Statistics[a]

marital status

N	Valid	28
	Missing	0
Mean		2.8571
Median		2.5000
Std. Deviation		1.9190
Skewness		.693
Std. Error of Skewness		.441
Kurtosis		-.942
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		6.00

a. experience of physical abuse = yes

marital status

N	Valid	24
	Missing	0
Mean		1.7917
Median		1.0000
Std. Deviation		1.3181
Skewness		1.910
Std. Error of Skewness		.472
Kurtosis		3.513
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		6.00

a. experience of physical abuse = no

employment status of participant

Statistics[a]

employment status of participant

N	Valid	28
	Missing	0
Mean		2.5714
Median		2.0000
Std. Deviation		1.2301
Skewness		.016
Std. Error of Skewness		.441
Kurtosis		-1.641
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		4.00

a. experience of physical abuse = yes

employment status of participant

N	Valid	24
	Missing	0
Mean		2.3750
Median		2.0000
Std. Deviation		.9696
Skewness		.385
Std. Error of Skewness		.472
Kurtosis		-.678
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		4.00

a. experience of physical abuse = no

ghq-12 score of participant

Statistics[a]

ghq-12 score of participant

N	Valid	28
	Missing	0
Mean		4.1429
Median		2.5000
Std. Deviation		4.2226
Skewness		.802
Std. Error of Skewness		.441
Kurtosis		-.750
Std. Error of Kurtosis		.858
Minimum		.00
Maximum		12.00

a. experience of physical abuse = yes

ghq-12 score of participant

N	Valid	24
	Missing	0
Mean		1.2917
Median		.0000
Std. Deviation		1.7062
Skewness		1.049
Std. Error of Skewness		.472
Kurtosis		-.140
Std. Error of Kurtosis		.918
Minimum		.00
Maximum		5.00

a. experience of physical abuse = no

number of children of participant

Statistics[a]

number of children of participant

N	Valid	28
	Missing	0
Mean		2.5000
Median		2.0000
Std. Deviation		1.0715
Skewness		.778
Std. Error of Skewness		.441
Kurtosis		.487
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		5.00

a. experience of physical abuse = yes

number of children of participant

N	Valid	24
	Missing	0
Mean		2.0417
Median		2.0000
Std. Deviation		.8587
Skewness		-.084
Std. Error of Skewness		.472
Kurtosis		-1.668
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		3.00

a. experience of physical abuse = no

number of pregnancies

Statistics[a]

number of pregnancies

N	Valid	28
	Missing	0
Mean		3.3571
Median		3.0000
Std. Deviation		1.9667
Skewness		1.095
Std. Error of Skewness		.441
Kurtosis		.994
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		9.00

a. experience of physical abuse = yes

Statistics[a]

number of pregnancies

N	Valid	24
	Missing	0
Mean		2.6250
Median		2.0000
Std. Deviation		1.5269
Skewness		.781
Std. Error of Skewness		.472
Kurtosis		-.037
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		6.00

a. experience of physical abuse = no

number of miscarriages/stillbirths

Statistics[a]

number of miscarriages/stillbirths

N	Valid	28
	Missing	0
Mean		.7857
Median		.0000
Std. Deviation		1.1339
Skewness		1.439
Std. Error of Skewness		.441
Kurtosis		1.322
Std. Error of Kurtosis		.858
Minimum		.00
Maximum		4.00

a. experience of physical abuse = yes

Statistics[a]

number of miscarriages/stillbirths

N	Valid	24
	Missing	0
Mean		.5000
Median		.0000
Std. Deviation		1.0215
Skewness		2.536
Std. Error of Skewness		.472
Kurtosis		6.444
Std. Error of Kurtosis		.918
Minimum		.00
Maximum		4.00

a. experience of physical abuse = no

birthweight of focus child

Statistics[a]

birthweight of focus child

N	Valid	28
	Missing	0
Mean		6.9679
Median		7.0400
Std. Deviation		1.1881
Skewness		-1.176
Std. Error of Skewness		.441
Kurtosis		3.781
Std. Error of Kurtosis		.858
Minimum		3.00
Maximum		9.06

a. experience of physical abuse = yes

birthweight of focus child

N	Valid	24
	Missing	0
Mean		7.5200
Median		7.5700
Std. Deviation		1.1993
Skewness		.243
Std. Error of Skewness		.472
Kurtosis		.265
Std. Error of Kurtosis		.918
Minimum		5.11
Maximum		10.02

a. experience of physical abuse = no

timing of birth

Statistics[a]

timing of birth

N	Valid	28
	Missing	0
Mean		1.9286
Median		2.0000
Std. Deviation		.2623
Skewness		-3.520
Std. Error of Skewness		.441
Kurtosis		11.183
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

timing of birth

N	Valid	24
	Missing	0
Mean		1.9167
Median		2.0000
Std. Deviation		.2823
Skewness		-3.220
Std. Error of Skewness		.472
Kurtosis		9.124
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

gender of focus child

Statistics[a]

gender of focus child

N	Valid	28
	Missing	0
Mean		1.4286
Median		1.0000
Std. Deviation		.5040
Skewness		.305
Std. Error of Skewness		.441
Kurtosis		-2.060
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

gender of focus child

N	Valid	24
	Missing	0
Mean		1.3750
Median		1.0000
Std. Deviation		.4945
Skewness		.551
Std. Error of Skewness		.472
Kurtosis		-1.859
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

age of focus child

Statistics[a]

age of focus child

N	Valid	28
	Missing	0
Mean		8.5000
Median		9.0000
Std. Deviation		3.9487
Skewness		.010
Std. Error of Skewness		.441
Kurtosis		-.742
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		15.00

a. experience of physical abuse = yes

age of focus child

N	Valid	24
	Missing	0
Mean		9.3333
Median		9.5000
Std. Deviation		4.6966
Skewness		-.185
Std. Error of Skewness		.472
Kurtosis		-1.509
Std. Error of Kurtosis		.918
Minimum		2.00
Maximum		15.00

a. experience of physical abuse = no

experience of domestic violence with child

Statistics[a]

experience of domestic violence with child

N	Valid	28
	Missing	0
Mean		1.4643
Median		1.0000
Std. Deviation		.5079
Skewness		.151
Std. Error of Skewness		.441
Kurtosis		-2.135
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

experience of domestic violence with child

N	Valid	24
	Missing	0
Mean		2.0000
Median		2.0000
Std. Deviation		.0000
Std. Error of Skewness		.472
Std. Error of Kurtosis		.918
Minimum		2.00
Maximum		2.00

a. experience of physical abuse = no

problems during pregnancy

Statistics[a]

problems during pregnancy

N	Valid	28
	Missing	0
Mean		1.6786
Median		2.0000
Std. Deviation		.4756
Skewness		-.809
Std. Error of Skewness		.441
Kurtosis		-1.456
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

problems during pregnancy

N	Valid	24
	Missing	0
Mean		1.8333
Median		2.0000
Std. Deviation		.3807
Skewness		-1.910
Std. Error of Skewness		.472
Kurtosis		1.792
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

problems during labour

Statistics[a]

problems during labour

N	Valid	28
	Missing	0
Mean		1.5357
Median		2.0000
Std. Deviation		.5079
Skewness		-.151
Std. Error of Skewness		.441
Kurtosis		-2.135
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

problems during labour

N	Valid	24
	Missing	0
Mean		1.8333
Median		2.0000
Std. Deviation		.3807
Skewness		-1.910
Std. Error of Skewness		.472
Kurtosis		1.792
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

problems post-natally

Statistics[a]

problems post-natally

N	Valid	28
	Missing	0
Mean		1.5714
Median		2.0000
Std. Deviation		.5040
Skewness		-.305
Std. Error of Skewness		.441
Kurtosis		-2.060
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

problems post-natally

N	Valid	24
	Missing	0
Mean		1.6667
Median		2.0000
Std. Deviation		.4815
Skewness		-.755
Std. Error of Skewness		.472
Kurtosis		-1.568
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

father of focus child

Statistics[a]

father of focus child

N	Valid	28
	Missing	0
Mean		1.0000
Median		1.0000
Std. Deviation		.0000
Std. Error of Skewness		.441
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		1.00

a. experience of physical abuse = yes

father of focus child

N	Valid	24
	Missing	0
Mean		1.0417
Median		1.0000
Std. Deviation		.2041
Skewness		4.899
Std. Error of Skewness		.472
Kurtosis		24.000
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

was the pregnancy planned

Statistics[a]

was the pregnancy planned

N	Valid	28
	Missing	0
Mean		1.4643
Median		1.0000
Std. Deviation		.5079
Skewness		.151
Std. Error of Skewness		.441
Kurtosis		-2.135
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

was the pregnancy planned

N	Valid	24
	Missing	0
Mean		1.2500
Median		1.0000
Std. Deviation		.4423
Skewness		1.233
Std. Error of Skewness		.472
Kurtosis		-.531
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

feelings about the pregnancy

Statistics[a]

feelings about the pregnancy

N	Valid	28
	Missing	0
Mean		1.3214
Median		1.0000
Std. Deviation		.6118
Skewness		1.798
Std. Error of Skewness		.441
Kurtosis		2.302
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		3.00

a. experience of physical abuse = yes

feelings about the pregnancy

N	Valid	24
	Missing	0
Mean		1.0833
Median		1.0000
Std. Deviation		.2823
Skewness		3.220
Std. Error of Skewness		.472
Kurtosis		9.124
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

partner anger about pregnancy

Statistics[a]

partner anger about pregnancy

N	Valid	28
	Missing	0
Mean		1.7857
Median		2.0000
Std. Deviation		.4179
Skewness		-1.473
Std. Error of Skewness		.441
Kurtosis		.176
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

partner anger about pregnancy

N	Valid	24
	Missing	0
Mean		2.0000
Median		2.0000
Std. Deviation		.0000
Std. Error of Skewness		.472
Std. Error of Kurtosis		.918
Minimum		2.00
Maximum		2.00

a. experience of physical abuse = no

partner jealousy of pregnancy

Statistics[a]

partner jealousy of pregnancy

N	Valid	28
	Missing	0
Mean		1.7857
Median		2.0000
Std. Deviation		.4179
Skewness		-1.473
Std. Error of Skewness		.441
Kurtosis		.176
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

partner jealousy of pregnancy

N	Valid	24
	Missing	0
Mean		2.0000
Median		2.0000
Std. Deviation		.0000
Std. Error of Skewness		.472
Std. Error of Kurtosis		.918
Minimum		2.00
Maximum		2.00

a. experience of physical abuse = no

concerns about safety of unborn child

Statistics[a]

concerns about safety of unborn child

N	Valid	28
	Missing	0
Mean		1.6071
Median		2.0000
Std. Deviation		.4973
Skewness		-.464
Std. Error of Skewness		.441
Kurtosis		-1.928
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

concerns about safety of unborn child

N	Valid	24
	Missing	0
Mean		1.9167
Median		2.0000
Std. Deviation		.2823
Skewness		-3.220
Std. Error of Skewness		.472
Kurtosis		9.124
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

agencies involved with child

Statistics[a]

agencies involved with child

N	Valid	28
	Missing	0
Mean		1.9643
Median		2.0000
Std. Deviation		1.1049
Skewness		.784
Std. Error of Skewness		.441
Kurtosis		-.741
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		4.00

a. experience of physical abuse = yes

agencies involved with child

N	Valid	24
	Missing	0
Mean		1.2500
Median		1.0000
Std. Deviation		.4423
Skewness		1.233
Std. Error of Skewness		.472
Kurtosis		-.531
Std. Error of Kurtosis		.918
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = no

risk of abuse of child

Statistics[a]

risk of abuse of child

N	Valid	28
	Missing	0
Mean		1.7143
Median		2.0000
Std. Deviation		.4600
Skewness		-1.003
Std. Error of Skewness		.441
Kurtosis		-1.076
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		2.00

a. experience of physical abuse = yes

risk of abuse of child

N	Valid	24
	Missing	0
Mean		2.0000
Median		2.0000
Std. Deviation		.0000
Std. Error of Skewness		.472
Std. Error of Kurtosis		.918
Minimum		2.00
Maximum		2.00

a. experience of physical abuse = no

actual abuse

Statistics[a]

actual abuse

N	Valid	28
	Missing	0
Mean		3.3214
Median		4.0000
Std. Deviation		1.2488
Skewness		-1.404
Std. Error of Skewness		.441
Kurtosis		.035
Std. Error of Kurtosis		.858
Minimum		1.00
Maximum		4.00

a. experience of physical abuse = yes

actual abuse

N	Valid	24
	Missing	0
Mean		4.0000
Median		4.0000
Std. Deviation		.0000
Std. Error of Skewness		.472
Std. Error of Kurtosis		.918
Minimum		4.00
Maximum		4.00

a. experience of physical abuse = no

perpetrator of abuse of focus child

Statistics[a]

perpetrator of abuse of focus child

N	Valid	28
	Missing	0
Mean		6.3214
Median		7.0000
Std. Deviation		1.8268
Skewness		-2.007
Std. Error of Skewness		.441
Kurtosis		2.515
Std. Error of Kurtosis		.858
Minimum		2.00
Maximum		8.00

a. experience of physical abuse = yes

perpetrator of abuse of focus child

N	Valid	24
	Missing	0
Mean		7.0000
Median		7.0000
Std. Deviation		.0000
Std. Error of Skewness		.472
Std. Error of Kurtosis		.918
Minimum		7.00
Maximum		7.00

a. experience of physical abuse = no

Score of positiveness

Statistics[a]

score of positiveness

N	Valid	24
	Missing	4
Mean		1.5854
Median		1.4600
Std. Deviation		.7983
Skewness		1.527
Std. Error of Skewness		.472
Kurtosis		3.673
Std. Error of Kurtosis		.918
Minimum		.40
Maximum		4.12

a. experience of physical abuse = yes

score of positiveness

N	Valid	22
	Missing	2
Mean		.8982
Median		.7400
Std. Deviation		.5634
Skewness		.773
Std. Error of Skewness		.491
Kurtosis		.593
Std. Error of Kurtosis		.953
Minimum		.00
Maximum		2.28

a. experience of physical abuse = no

Appendix 6

Procedure for Interview Analysis

Qualitative analysis was an appropriate method for examining the semi-structured questions in the interviews. Content analysis was selected as the strategy to use; it is considered useful in exploratory studies, provides a structure for extracting themes from text and allows for the counting of frequency of themes, thereby giving an indication of their significance (Robson, 1993). The analysis followed five stages:

1. 'Immersion' in the data – words/phrases were written out, read and re-read.
2. Themes were extracted from the text.
3. Themes were translated into categories and organised under the six areas that the interviews aimed to cover, experience of abuse in general, experience of abuse in pregnancy, reactions to the abuse, relationship with children, support and overall reflections. These were collated onto an inter-rater schedule.
4. Level of inter-rater agreement was calculated.
5. The most frequently occurring themes were highlighted.

Inter-rater agreement was established by calculating the mean percentage of agreement on themes across the four interview transcripts; this was found to be 75.5 percent.

Reference

Robson, C. (1993) *Real World Research: A resource for scientists and practitioner-researchers*. Oxford: Blackwells.

INTER-RATER SCHEDULE

Please indicate with a tick in the relevant box if a particular theme appears in each of the interview transcripts. Leave the box blank if the theme does not appear in a particular interview.

Experience of abuse in general

A Themes	1	2	3	4
1 Abuse began early in the relationship				
2 Abuse came unexpectedly				
3 There were early warning signs				
4 Abuse escalated over time				
5 No context to the abuse				
6. Abuse in context of bad mood				
7 Indications of problems in partner's childhood				
8 Physical violence ended when interviewee ended relationship				
9 Continuation of verbal/emotional abuse after end of relationship				

Experience of abuse in pregnancy

B Themes	1	2	3	4
1 Pregnancy not wanted by partner				
2 Abuse occurred in all pregnancies with that partner				
3 Abuse same during pregnancy as at other times				
4 Interviewee had physical health problems whilst pregnant				
5 Partner 'warmed' to pregnancy later on				
6. 'Honeymoon' period after birth of child				
7 Abuse began again within a few weeks of the birth				
8 Partner jealous of pregnancy				

Relationship with children born following DV in pregnancy

C Themes	1	2	3	4
1 Positive reaction from partner at birth of children				
2 Hope that the birth would change partner				
3 Concern for the child once born re: father's behaviour				
4 Interviewee overprotective of children				
5 Child aggression problems reported				
6. Interviewee connects child aggression to violence witnessed				
7 Child other emotional problems				
8 Acknowledgement of difficulties in mother-child relationships				
9 Indication of attempts to improve relationships				

Reactions to the abuse

D Themes	1	2	3	4
1 Detrimental and lasting effect on maternal mental health				
2 Partner insults on personhood (e.g. useless, worthless)				
3 Interviewee would try and keep out of way of partner				
4 Interviewee would try to do things 'right'				
5 Thought they could change their partner				
6 Spent a lot of time out of the house when pregnant				
7 Expressed concerns about the safety of unborn child				
8. Confused feelings at being pregnant				
9 Children witnessed the abuse				
10 Children drawn into the abuse (e.g. made to watch)				
11 Acknowledgment that abuse has had an impact on the children				

Support

E Themes	1	2	3	4
1 Very few people told about abuse				
2 Limited or no support from family				
3 Examples of poor support from services				
4 Key person/event made a difference				
5 Expressed fear about ending relationship				
6. Reference to interviewee's readiness to end relationship/leave				

Overall Reflections

F Themes	1	2	3	4
1 Reference to devastating impact on/ruining family				
2 Reference to effects on relationships				
3 Reference to maternal overprotectiveness				
4 Child lack of trust/wariness of others				
5 Wouldn't tolerate abusive relationship again				
6. Awareness of lasting impact of abuse on the family				
7 Reference to improvements over time				

Frequency of Themes in the Interviews

	No. times occurred out of 4 interviews
Experience of abuse in general	
Abuse began early in the relationship	3
Abuse came unexpectedly	2
There were early warning signs	2
Abuse escalated over time	4
No context to the abuse	1
Abuse in context of bad mood	3
Indications of problems in partner's childhood	3
Physical violence ended when interviewee ended the relationship	4
Continuation of verbal/emotional abuse after end of relationship	4
Experience of Abuse in Pregnancy	
Pregnancy not wanted by partner	2
Abuse occurred in all pregnancies with that partner	2
Abuse same during pregnancy as at other times	4
Interviewee had physical health problems whilst pregnant	2
Partner 'warmed' to pregnancy later on	2
'Honeymoon' period after birth of child	3
Abuse began again within a few weeks of the birth	3
Partner jealous of pregnancy	1
Reactions to the Abuse	
Detrimental and lasting effect on maternal health	4
Partner insults on personhood (e.g. useless, worthless)	4
Interviewee would try to keep out of way of partner	4
Interviewee would try to do things 'right'	3
Thought they could change their partner	3
Spent a lot of time out of the house when pregnant	2
Expressed concerns about the safety of the unborn child	2
Confused feelings at being pregnant	2
Children witnessed the abuse	4
Children drawn into the abuse (e.g.made to watch)	1
Acknowledgement that abuse has had an impact on the children	4

Maternal Relationship with Children	
Positive reaction from partner at birth of children	2
Hope that the birth would change partner	3
Concern for the child once born re: father's behaviour	3
Interviewee overprotective of children	3
Child aggression problems reported	4
Interviewee connects child aggression to violence witnessed	4
Child other emotional problems	4
Acknowledgement of difficulties in mother-child relationships	3
Indication of attempts to improve relationships	4
Support	
Very few people told about abuse	3
Limited or no support from family	3
Examples of poor support from services	3
Key person/event made a difference	3
Expressed fear about ending relationship	3
Reference to interviewee's readiness to end relationship/leave	2
Overall Reflections	
Reference to devastating impact on/ruining the family	3
Reference to effects on relationships	4
Reference to maternal overprotectiveness	3
Child lack of trust/wariness of others	3
Wouldn't tolerate abusive relationship again	2
Awareness of lasting impact of abuse on the family	3
Reference to improvements over time	4

Appendix 7

Statement of Word Counts

	exc. refs, tables, app	inc. refs, tables, app
Ethics Proposal	**3, 752**	**8, 622**
Literature Review	**4, 789**	**7, 382**
Research Paper	**4, 892**	**7, 292**
Critical Review	**2, 609**	**3, 589**
Additional Appendices		**7, 507**
TOTAL	**16, 042**	**34, 392**