

Domestic and family violence in pregnancy and early parenthood

Overview and emerging interventions

Monica Campo

KEY MESSAGES

- Women are at an increased risk of experiencing violence from an intimate partner during pregnancy.
- If domestic and family violence already exists, it is likely to increase in severity during pregnancy.
- Young women, aged 18–24 years, are more likely to experience domestic and family violence during pregnancy.
- Unintended pregnancy is often an outcome of an existing abusive relationship.
- Poor birth outcomes (such as low birth weight, premature birth) and post-natal depression are associated with domestic and family violence during pregnancy.
- The long-term effects of exposure to domestic and family violence in utero are just emerging.
- There are several promising interventions for preventing and reducing violence during pregnancy.
- Pregnancy and early parenthood are opportune times for early intervention as women are more likely to have contact with health and other professionals.

In Australia, violence against women is a serious public health and social problem with substantial numbers of women and children affected (Australian Bureau of Statistics [ABS], 2013). Many instances of violence go unreported and it is therefore not possible to measure the true extent of violence against women in Australia (Phillips & Vandenbroek, 2014). This paper provides an overview of the issues relevant to understanding domestic and family violence during pregnancy and then examines implications for practice and some promising interventions for responding to domestic and family violence and preventing future violence.

Research suggests that women are at greater risk of experiencing violence from an intimate partner

during pregnancy and post partum. According to the 2012 ABS' Personal Safety Survey (2013):

- Thirty-six per cent of women over the age of 18 have experienced physical or sexual violence by a known perpetrator since the age of 15 ($n = 3,106,500$).
- Of those women, 22% experienced physical violence during pregnancy by a *current partner* and 25% have experienced violence during pregnancy from a *previous partner*.
- Of those who experienced violence during pregnancy by a previous partner, 25% indicated that the violence first occurred during pregnancy.

Another Australian study of 1,507 first time mothers found that 29% of mothers experienced intimate partner violence before their child turned four (Gartland, Woolhouse, Mensah, Hegarty, Hiscock, & Brown (2014).

Internationally, research suggests that domestic and family violence during pregnancy is widespread and that violence often begins during pregnancy or, if violence already existed, increases in severity during pregnancy and into the first

month of motherhood (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; James, Brody, & Hamilton, 2013; United Nations Children's Fund [UNICEF], 2015). Indigenous women are at a greater risk of experiencing domestic and family violence during pregnancy (Taft, Watson, & Lee, 2004) as are younger women (Quinlivan, 2000; Taft et al., 2004).

Box 1: Definitions

Various terminologies are used in policy, practice and research to describe violence experienced by women, and their children. The Australian Government's *National Plan to Reduce Violence Against Women and their Children* (Council of Australian Governments [COAG], 2009) adopts the United Nations definition. The United Nations defines violence against women as: any act of gender-based violence that causes "physical or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty" (United Nations, 1993). This can include a host of specific forms of violence experienced by women and girls including sexual violence, intimate partner violence and domestic and family violence as well as practices that are harmful to women and girls such as female genital mutilation and forced marriage (United Nations, 1993; World Health Organization [WHO], 2010).

Intimate partner violence, or domestic violence generally, describes violence perpetrated by a current or previous partner and is the most common form of violence against women (Phillips & Vandenbroek, 2014; WHO, 2010;). Domestic violence or family violence are the terms commonly used to describe violence perpetrated against women in the home. Family violence is a broader term encapsulating violence between family members as well as intimate partners (Phillips & Vandenbroek, 2014). Family violence is the preferred term in Indigenous populations as it better captures kinship and extended family relationships in Indigenous communities (COAG, 2009). Intimate partner violence, domestic violence and family violence include behaviours that are coercive and controlling and include physical abuse, emotional/psychological abuse, sexual abuse, financial deprivation and social and cultural isolation (COAG, 2009). Sexual violence includes sexual harassment, sexual bullying, sexual coercion, unwanted touching or kissing, as well as sexual assault (Tarczon & Quadara, 2012). Sexual violence can occur in intimate relationships and/or family contexts as well as in community or work contexts.

This paper uses the term domestic and family violence, and intimate partner violence where appropriate.

Factors associated with domestic and family violence during pregnancy

There are a number of factors identified as being linked to the higher likelihood of experiencing domestic and family violence in pregnancy. However, it is important to note that gender inequality is recognised as the underlying determinant of all forms of violence against women (Heise & Fulu, 2014; United Nations, 1993; WHO, 2010). A consistent finding across a broad range of research examining perpetration has identified a strong association between adherence to traditional gender roles/norms, violence-supportive attitudes and the perpetration of violence against women (Fulu et al., 2013; Our Watch, ANROWS, & VicHealth, 2015; WHO, 2010). How this intersects with other individual factors remains important (WHO, 2010).

Pregnancy as a trigger for perpetrator jealousy and control

Studies have found that traditional attitudes towards gender roles, such as the belief that men should control and dominate a relationship and household, or that women should perform domestic duties and be always emotionally and physically available to men, are linked to perpetration of domestic and family violence in pregnancy (Bacchus, Mezey, & Bewley, 2006; Brownridge et al., 2011; Burch & Gallup, 2004; Jasinski, 2004; Moore, Frowirth & Miller, 2010; Pallitto, Campbell, & O'Campo, 2005).

Pregnancy has been identified as a time of greater autonomy and self-awareness for women and as such pregnancy may symbolise "autonomous control over her body and her independence from her partner" (Bacchus et al., 2006, p. 595). Since control is a significant aspect of domestic and family violence, violent or abusive men may find pregnancy threatening and seek to re-exert control over their partners (Bacchus et al., 2006; Jasinski, 2004). Women's preoccupation with their

baby and their lesser physical and emotional availability during pregnancy may limit their ability to perform expected traditional caring and homemaker roles, leading to an increase in violence (Brownridge et al., 2011; Jasinski 2004; Mercedes, 2015; Pallitto et al., 2005). Sexual violence and coercion have been identified as features of domestic violence during pregnancy and post-partum as pregnancy may limit a perpetrator's assumed entitlement and free access to his partner's body (Bacchus et al., 2006).

Women interviewed for Bacchus and colleagues (2006) study described physical and sexual violence and an increase of jealous and possessive behaviour, as well as accusations of infidelity, by their partners during pregnancy. Burch and Gallup's (2004) survey of 284 male perpetrators in a US domestic violence treatment program found that men also reported an increase of severity of violence during their partner's pregnancy, as well as escalations of jealous and possessive behaviour such as checking up on their partner's whereabouts, restricting partner's activities outside the home and restricting partner's contact with family and friends.

Existing violence

Violence experienced from an intimate partner *before* pregnancy is the strongest risk factor for predicting domestic and family violence during pregnancy (James et al., 2013). While pregnancy may sometimes act as a protective factor (Mercedes, 2015), several studies find that women are at risk of experiencing greater severity of violence during pregnancy (Baird, 2015; Charles & Perreira, 2007; James et al., 2013; Mercedes, 2015). Brownridge and colleagues' literature review (2011) suggested, for example, that existing verbal or psychological abuse prior to pregnancy was associated with the onset of physical violence during pregnancy. Risk of homicide by an intimate partner has also been found to increase during pregnancy in several studies (Campbell, Garcia-Moreno, & Sharps, 2004; Macy, Martin, Kupper, Casanueva, & Guo, 2007).

Young women

Younger women are at greater risk of experiencing violence from an intimate partner during pregnancy and in early motherhood (Brownridge et al., 2011; Gartland, Hempill, Hegarty & Brown, 2011; Jasinski, 2004; Quinlivan, 2000; Taft et al., 2004) and are, in general, at greater risk of experiencing intimate partner violence or sexual

violence compared to older women (ABS, 2013). In Taft et al.'s (2004) study of 14, 784 women aged 18–24, pregnancy was associated with an increase in experiencing partner violence. Of the women in the study who had ever had a pregnancy (around 17% of total cohort) 27% reported partner violence, compared with 8% of the younger women who had never been pregnant. This represents an increase of 230% (Taft et al., 2004, p. 326). Other studies suggest that young women are at greater risk of experiencing reproductive control from an intimate partner resulting in an unintended pregnancy and/or forced termination (Miller et al., 2010). However Taft et al. noted that it is not clear whether young women in their study become pregnant as a result of the violence (e.g., through sexual coercion, reproductive control), whether young women who become pregnant were more likely to experience domestic violence, or “whether both situations occur” (2004, p. 329). Further research into young women's experiences of domestic violence in pregnancy is needed.

Unintended pregnancy and reproductive control

There is a strong correlation in the research between unintended pregnancy and domestic and family violence (Campbell et al., 2004; Charles & Perreira, 2007; James et al., 2013; Mercedes, 2015; Pallitto et al., 2005) and several studies establish a significant link between the termination of pregnancy and domestic and family violence (Taft et al., 2004; Wokoma, Jampala, Bexhell, Guthrie, & Lindow, 2014). Reproductive control, coercion and sexual assault by an abusive partner may result in both unintended pregnancies and forced terminations of pregnancy (Gee, Mitra, Wan, Chavkin, & Long, 2009; Miller et al., 2010; Moore, Frowirth, & Miller, 2010). For example, in Moore et al.'s (2010) research, women described various ways in which abusive partners had controlled their reproductive and sexual choices including sabotaging their contraception; refusing to use contraception; rape; and attempting to influence the outcome of pregnancies (e.g. by controlling women's access to abortion or forcing an unwanted abortion). Similarly, Miller and colleagues (2010) reported that 35% of 1,278 women attending a family planning clinic in the USA said they had experienced reproductive control, which included contraception sabotage and pregnancy coercion. **This research suggests that restricting reproductive autonomy may be an extra mechanism through which violent partners control and abuse women.**

Effects of intimate partner violence during pregnancy

Domestic violence during pregnancy is associated with several negative health and mental health outcomes for the foetus, mother and child (Brownridge et al., 2011; Howard, Oram, Galley, Trevillion, & Feder, 2013). These effects might include:

- complications in pregnancy and birth including:
 - low birth weight (Gentry & Baily, 2014; Murphy, Schei, Myhr & Du Mont, 2001)
 - premature labour and miscarriage (Garcia-Moreno et al., 2005; Sharps, Laughon, & Giangrande, 2007)
 - foetal stress and/or trauma (Howard et al., 2013; Mercedes, 2015)
- maternal substance abuse and smoking (Baily & Daugherty, 2007; Brownridge et al., 2011)
- maternal depression/anxiety/post-natal depression (Brownridge et al., 2011; Howard et al., 2013; Taft, 2002)
- sexually transmitted infections (Mercedes, 2015; Taft, 2002).

Emerging research has focused on the long-term effects of in-utero exposure to domestic and family violence and the role of maternal stress (Martinez-Torteya, Bogat, Levendosky, & von Eye, 2015; Mercedes, 2015). Neurobiological research suggests that newborns exposed to domestic and family violence in utero are born with high levels of stress-related hormones (Mercedes, 2015). A study from the USA, for example, found that exposure to domestic and family violence in utero predicted externalising and internalising problems at age 10 years (as reported by both mothers and children) (Martinez-Torteya et al., 2015). Higher levels of cortisol secretion (linked to stress) were found in children exposed to in-utero domestic and family violence and this was thought to contribute to these long-term effects. The effects of domestic and family violence on infants and children are well established in the literature and are reviewed in the CFCA publication *Children's Exposure to Domestic and Family Violence* (Campo, 2015).

Implications for service provision and practice

Pregnancy and the postpartum period can be a “critical window of opportunity for interventions”

(Macy, Martin, Sullivan, & Magee, 2007, p. 296) because it is time when women come into contact with various health care and other allied professionals. Furthermore, pregnancy may act as an impetus for women to leave a violent relationship (although research on this is inconsistent) (Edin, Dahlgren, & Högberg, 2010). There is limited evidence for the efficacy of interventions to reduce domestic and family violence in pregnancy (Martin, Acara, & Pollock, 2012); however, there are some promising areas of practice. The next section of this paper will examine universal, perinatal and postnatal services/interventions for responding to domestic and family violence in pregnancy.

Universal screening

There is a considerable amount of research regarding universal screening for domestic and family violence and sexual assault in health and social support service settings; for example, in antenatal care provision and other health care settings (Baird, Saito, Eustace, & Creedy, 2015; O'Doherty et al., 2014). Universal screening usually involves a test or set of questions administered by a health/social work professional to detect domestic and family violence. The aim of screening is to elicit disclosure and consequently refer the woman to relevant community and legal services (Wall, 2012; Taft, 2002). The Australian Government Department of Health's (2013) Clinical Practice Guidelines for medical and health care workers recommend that all women are asked about domestic and family violence at their first antenatal visit. Universal screening has been found to increase disclosures but there is little evidence to suggest that screening leads to increased referrals or reduces abuse (O'Doherty et al., 2014). As a result, debates about the benefits and risks of routine screening are ongoing (Spangaro, Zwi, & Poulos, 2009; Wall, 2012), and, within antenatal services in Australia, uptake of universal screening assessments has been poor (Baird et al., 2015).

One cause for concern is that there is often a lack of protocols and policies in place to support universal screening within health care and social support settings. For example, health providers may be poorly trained to respond to disclosures or have limited or misconstrued understandings of domestic and family violence. As a result, responses to disclosures may be dealt with inadequately or even dangerously—for example, by breaching confidentiality and speaking to the abuser (Taft, 2002; Baird et al., 2015). A further issue with screening is that it tends to conceptualise domestic and family

violence as a disease that can be “detected” rather than a social problem (Spangaro et al., 2009; Taft, 2002). In this view, screening involves simply “asking a question” and may prioritise increasing numbers of disclosures rather than ensuring quality of care or women’s safety (Spangaro, et al., 2009; Taft, 2002).

Despite these issues, some argue that the act of enquiring about domestic and family violence itself may be beneficial, as it plays the role of raising awareness of intimate partner violence and validating for women that violence is unacceptable (Spangaro et al., 2009; Wall, 2012). However, it is important that a screening assessment program is well-developed and evaluated and that there are clear protocols, policies and procedures in place, adequate safety planning for women, and good collaboration with other services (Hamberger, Rhodes & Brown, 2015; Spangaro et al., 2009; Taft et al., 2015).

An example of a well-designed and tested model is the MOVE model developed for maternal and child health nurse (MCHN) screening of domestic and family violence in Victoria (Taft, et al., 2015). MOVE is theory-informed, designed in conjunction with MCHNs, and includes a self-administered checklist, which means women experiencing domestic and family violence are able to decide themselves whether or not, and when, to disclose (Taft, et

al., 2015). A randomised controlled trial found MOVE resulted in significant improvements in safety planning and greater opportunities for discussing domestic and family violence compared to women receiving normal care.

Another example of a universal screening program is discussed in Box 2.

Counselling interventions

Screening for domestic and family violence may be more effective in reducing future violence when delivered in conjunction with supportive counselling (if domestic and family violence is disclosed) (Jahanfar, Howard, & Medley, 2014; Kiely, El-Mohandes, El-Khorazaty, Blake & Gantz, 2011). A randomised study from the USA tested the effectiveness of short, evidence-based behavioural intervention for pregnant women who had disclosed domestic and family violence in a health care setting (Kiely et al., 2011). The intervention involved providing information about domestic and family violence and the development of a safety plan. Information about community support services and resources were also provided. For women who participated in the intervention, there was a reduction in domestic and family violence and better pregnancy outcomes compared to women who received standard antenatal care.

Perinatal and postnatal parent–infant therapy

Therapeutic responses that focus on fostering mother/infant bonding and attachment, based on relational trauma and attachment theory, are an emerging promising approach to responding to mothers during the perinatal and postnatal period (Bogat, Levendosky, von Eye, & Davidson, 2011; Bunston, 2008; Bunston, Pavlidis & Cartwright, 2015; Lieberman, Diaz, & Van Horn, 2011). In this model, it is thought that experiencing domestic and family violence during pregnancy and early parenthood may affect infants’ attachment to caregivers and their psychosocial development (Lieberman et al., 2011). Perinatal and postnatal parent–infant therapies, therefore, aim to ameliorate the short- and long-term effects on mother and child wellbeing by building strong attachment relationships through play-based therapy (Bunstan, 2008). Parent–infant psychotherapy can begin during pregnancy as it is thought mothers begin to develop internal representations of themselves as mothers during this time (Bogat et al., 2011).

Box 2: Strengthening hospital responses to family violence (Victoria)

The Royal Women’s Hospital in conjunction with Bendigo Health and Our Watch, is currently running a pilot program aimed at strengthening hospital responses to family violence. The pilot, which is funded through Victoria’s *Action Plan to Address Violence against Women and Children 2012–2015*, aims to increase staff competence in identifying and responding appropriately to women experiencing domestic and family violence (Our Watch, 2015; Royal Women’s Hospital, 2015). The pilot program is expected to be finished by mid 2015 and is working towards producing a “transferable model for identifying and responding to family violence”, which can assist other services in strengthening their responses to violence against women and children (Our Watch, 2015).

Home visitation programs

Home visitation and peer mentoring programs during pregnancy and early parenthood may reduce future incidents of domestic and family violence among vulnerable families (Bair-Merritt et al., 2010; Sharps, Campbell, Batty, Walker, & Bair-Merritt, 2008; Taft et al., 2011). Unlike health care screening in which women may fear being judged by health care professionals (Taft, 2002, Wall, 2012), home-visitation programs facilitate an environment conducive to non-judgemental, friendly support, advice and advocacy, particularly when delivered via lay people rather than professionals (e.g., peer support or community mentors) (Small, Taft & Brown, 2011). Box 3 describes a home-visitation mentoring trial program for pregnant women and new mothers.

Box 3: Mothers' Advocates in the Community (MOSAIC)

MOSAIC is a home-visitation mentoring intervention for at-risk/vulnerable pregnant women and new mothers (with children under 5 years), developed by the Judith Lumley Centre, Melbourne (Kerr, Taft & Small, 2009; Taft et al., 2011).

The intervention was designed to reduce domestic and family violence and depression for participants and strengthen mother-child bonding. Mentors (including culturally appropriate mentors) were recruited from the community and trained to deliver non-professional advice and offer friendship, advocacy, parental support and referrals to services (e.g. domestic and family violence services) in vulnerable women's homes.

In a randomised study of the intervention, 215 women (referred by general practitioners and maternal and child health nurses) took part in a 12-month program, which involved weekly home visits from local mothers trained and supervised as mentors.

Results from the study showed a decrease in the incidence of domestic and family violence among participants but weaker evidence in the reduction of depression and increased parental-child bonding.

Community education programs

As described above, domestic and family violence is found to increase in early motherhood as well as pregnancy. Community education programs aimed at new parents are an emerging area for primary prevention of violence against women and first-time parents are key target group (Flynn,

2011; Heise & Fulu, 2014; Walden & Wall, 2014). These programs are based on a public health model of preventing violence before it occurs by tackling the key determinants of violence—gender inequality—via public education delivered at the universal level. As Flynn (2011, p. 1) surmises the transition to parenthood represents:

... a window during which it is possible to engage and work with both men and women when traditional notions of parenthood are exerting a powerful influence on how they approach and negotiate their parenting roles. The decisions that couples make during this key stage of life can have important consequences on the level of equality within their relationship, and between men and women more generally.

There is a good deal of knowledge and literature on the outcomes of parenting education programs to prevent child maltreatment (see e.g. Holzer, Higgins, Bromfield, & Higgins, 2006) but less is known about the effectiveness of parenting education programs to prevent domestic and family violence. Box 4 describes a community education program aimed at new parents and delivered in maternal and child health settings.

Box 4: Baby Makes 3

The Victorian Health Promotion Foundation (VicHealth) developed the Baby Makes 3 program in conjunction with the Whitehorse Community Health Centre in outer Eastern Melbourne. It is a primary prevention program that aims to increase parents' and health workers' capacity to build equal and respectful relationships, and is delivered via a 3-week discussion/seminar program covering topics relevant to new parents. It also involves a one-off information session for first-time fathers, and a workforce capacity-building workshop for maternal and child health nurses.

An small scale evaluation suggested that participation in the program had allowed parents to become aware of how traditional attitudes to gender and parenting roles were shaping their families, had fostered a greater understanding of gender norms and expectations, and had resulted in a "significant shift in couples' attitudes characterised by greater understanding of their partners' role and greater support for gender equality in new families" (Flynn, 2011, p. 2). A further model of the program is currently under evaluation.

Conclusion

Rates of violence against women are unacceptably high in Australia. A range of international research suggests that domestic and family violence often begins during pregnancy or, if violence already existed, increases in severity during pregnancy and into the first month of motherhood. Women who experience violence during pregnancy are more likely to suffer complications in pregnancy, birth and post-partum and are more likely to experience depression, trauma and anxiety. Exposure to domestic and family violence in utero and infancy is thought to have long-term effects on children's wellbeing. However, as a time of transition and a time when women come in to contact with health and social services, pregnancy may be an optimal window of opportunity for early intervention. There are several promising approaches for working with women and families during pregnancy and early parenthood that might be beneficial.

References

- Australian Bureau of Statistics. (2013). *Personal Safety Survey, Australia, 2012*. Canberra: ABS.
- Bacchus, L., Mezey, G., & Bewley, S. (2006). A qualitative exploration of the nature of domestic violence in pregnancy. *Violence against women, 12*(6), 588–604.
- Bailey, B. A., & Daugherty, R. A. (2007). Intimate partner violence during pregnancy: Incidence and associated health behaviors in a rural population. *Maternal and Child Health Journal, 11*(5), 495–503.
- Baird, K. (2015). Women's lived experience of domestic violence during pregnancy. *The Practicing Midwife*, March 2015.
- Baird, K., Saito, A., Eustace, J., & Creedy, D. K. (2015). An exploration of Australian midwives' knowledge of intimate partner violence against women during pregnancy. *Women and Birth*, In Press.
- Bair-Merritt, M. H., Jennings, H. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., & Duggan, A. K. (2010). Reducing maternal intimate partner violence after birth of a child: A randomized controlled trial of the Hawaii Healthy Start home visitation program. *Archives of Pediatric and Adolescent Medicine, 164*(1), 16–23.
- Bogat, G., Levendosky, A. A., von Eye, A., & Davidson, W. S. II. (2011). Effects of intimate partner violence on the attachment relationship between mother and child: Data from a longitudinal study beginning during pregnancy. In S. A. Graham-Bermann & A. A. Levendosky, (Eds.), *How intimate partner violence affects children* (pp. 19–46). Washington: American Psychological Association.
- Brownridge, A., Taillieu, L., Tyler, A., Tiwari, A., Chan, K. L., & Santos, S. C. (2011). Pregnancy and intimate partner violence: Risk factors, severity, and health effects. *Violence Against Women, 17*(7), 858–881.
- Bunston, W. (2008). Baby lead the way: Mental health group work for infants, children and mothers affected by family violence. *Journal of Family Studies, 14*, 334–341.
- Bunston, W., Pavlidis, T., & Cartwright, P. (2015). Children, family violence and group work: Some do's and don'ts in running therapeutic groups with children affected by family violence. *Journal of Family Violence, 19*(4), 243–247.
- Burch, R. L., & Gallup, G. G. (2004). Pregnancy as a stimulus for domestic violence. *Journal of Family Violence, 19*(4), 243–247.
- Campbell, J. C., Garcia-Moreno, C., & Sharps, P. (2004). Abuse during pregnancy in industrialized and developing countries. *Violence Against Women, 10*, 770–789.
- Campo, M. (2015). *Children's exposure to domestic and family violence* (CFCA Paper 36). Melbourne: CFCA.
- Charles, P., & Perreira, K. M. (2007). Intimate partner violence during pregnancy and 1-year post-partum. *Journal of Family Violence, 22*(7), 609–619.
- Council of Australian Governments (COAG). (2009). *National plan to reduce violence against women and their children*. Canberra: COAG.
- Department of Health. (2013). *Clinical practice guidelines: Antenatal care – Module 1*. Canberra: Department of Health.
- Edin, K. E., Dahlgren, A. L., & Högberg, U. (2010). "Keeping up a front": Narratives about intimate partner violence, pregnancy, and antenatal care. *Violence Against Women, 16*(2), 189–206.
- Flood, M., & Pease, B. (2009). Factors influencing attitudes to violence against women. *Trauma, Violence and Abuse, 10*(2), 125–142.
- Flynn, D. (2011). *Baby Makes 3*. Melbourne: Whitehorse Community Health & VicHealth.
- Fulu, E., Xian, W., Miedema, S., Jewkes, R., Roselli, T., & Lang, J. (2013). *Why do some men use violence against women and how can we prevent it? Quantitative findings from the United Nations Multi-Country Study on Men and Violence in Asia and the Pacific*. Bangkok: UNDP, UNFPA, UN Women and UNV. Retrieved from <countryoffice.unfpa.org/timor-leste/?reports=7901>.
- Garcia-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women*. Geneva: WHO.
- Gartland, D., Hemphill, S. A., Hegarty, K., & Brown, S. J. (2011). Intimate partner violence during pregnancy and the first year post-partum in an Australian Pregnancy Cohort Study. *Maternal and Child Health Journal, 15*, 570–578.
- Gartland, D., Woolhouse, H., Mensah, F. K., Hegarty, K., Hisock, H., & Small, S. J. (2014). The case for early intervention to reduce the impact of intimate partner abuse on child outcomes: Results of an Australian cohort of first-time mothers. *Birth, 41*(4), 374–383.
- Gee, R. E., Mitra, N., Wan, F., Chavkin, D. E., & Long, J. A. (2009). Power over parity: Intimate partner violence and issues of fertility control. *American Journal of Obstetrics and Gynecology, 201*(2), 148.e1–7.
- Gentry, A., & Bailey, B. A. (2014). Psychological intimate partner violence during pregnancy and birth outcomes: Threat of violence versus other verbal and emotional abuse. *Violence and Victims, 29*(3), 383–92.
- Hamberger, K. L., Rhodes, K., & Brown, J. (2015). Screening and intervention for intimate partner violence in healthcare settings: Creating sustainable system-level programs. *Journal of Women's Health, 24*(1), 86–91.
- Heise, L., & Fulu, E. (2014). *What works to prevent violence against women and girls? State of the field of violence against women and girls: what do we know and what are the knowledge gaps?* Pretoria, South Africa: Medical Research Council. Retrieved from <rd.dfid.gov.uk/pdf/outputs/VAWG/What_Works_Inception_Report_June_2014_AnnexD_WG1_paper_State_of_the_field.pdf>.
- Holzer, P., Higgins, J. R., Bromfield, L., & Higgins, D. (2006). *The effectiveness of parent education and home visiting child maltreatment prevention programs* (NCPC Issues

- Paper no. 26). Melbourne: AIFS. Retrieved from <aifs.gov.au/cfca/publications/effectiveness-parent-education-and-home-visiting-chil>
- Howard, L., Oram, S., Galley, H., Trevillion, K., & Feder, G. (2013). Domestic violence and perinatal mental disorders: A systematic review and meta-analysis. *PLoS Med*, *10*(5), e1001452.
- Jahanfar, S., Howard, L. M., & Medley, N. (2014). Preventing or reducing partner violence against women during pregnancy: Review. *The Cochrane Database of Systematic Reviews. Issue 11*, Art. No.: CD009414.
- James, L., Brody, D., & Hamilton, Z. (2013). Risk factors for domestic violence during pregnancy: A meta-analytic review. *Violence Victims*, *28*(3), 359–380.
- Jasinski, J. L. (2004). Pregnancy and domestic violence: A review of the literature. *Trauma, Violence & Abuse*, *5*(1), 47–64.
- Kerr, C., Taft, A., & Small, R. (2009). *MOSAIC Project Manual: setting up a mentor project for mothers experiencing intimate partner/family violence*. Melbourne: Mother and Child Health Research, La Trobe University. Retrieved from <www.latrobe.edu.au/jlc/research/reducing-violence-against-women-and-children/mosaic>.
- Kiely, M., El Mohandes, A. A., El-Khorazaty, M. N., Blake, S.M. & Gantz, P. (2011). An integrated intervention to reduce intimate partner violence in pregnancy: A randomized controlled trial. *Obstetrics & Gynaecology*, *115*(2), 273–83.
- Lieberman, A. F., Diaz, M. A., & Van Horn, P. (2011). Perinatal child–parent psychotherapy: Adaptation of an evidence-based treatment for pregnant women and babies exposed to intimate partner violence. In S. A. Graham-Bermann & A. A. Levendosky, (Eds.), *How intimate partner violence affects children* (pp. 47–68). Washington: American Psychological Association.
- Macy, R., Martin, S. L. J., Sullivan, K., & Magee, M. L. (2007). Pregnancy associated deaths: The role of intimate partner violence. *Trauma, Violence and Abuse, Special Issue Part 1*(8), 135–148.
- Martin, S. L., Acara, J., & Pollock, M. D. (2012). *Domestic violence during pregnancy and the postpartum period*. Harrisburg, PA: VAWnet. Retrieved from <www.vawnet.org>.
- Martinez-Torteya, C., Bogat, G. A., Levendosky, A. A., & von Eye, A. (2015). The influence of prenatal intimate partner violence exposure on hypothalamic–pituitary–adrenal axis reactivity and childhood internalizing and externalizing symptoms. *Development and Psychopathology*, *April*(8), 1–18.
- Mercedes, M. (2015). Intimate partner violence against women during pregnancy: A critical reading from a gender perspective. *Review Colombiana Enfermeria*, *10*, 64–77. Retrieved from <www.uelbosque.edu.co/sites/default/files/publicaciones/revistas/revista_colombiana_enfermeria/volumen10/008_articulo-6-Vol10%20A10.pdf>.
- Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J. et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, *81*(4), 316–322.
- Moore, A. M., Frowirth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science & Medicine*, *70*(11), 1737–1744.
- Murphy, C. C., Schei, B., Myhr, T. L., & Du Mont, J. (2001). Abuse: A risk factor for low birth weight? A systematic review and meta-analysis. *Canadian Medical Association Journal*, *164*(11), 1567–1572.
- O’Doherty, L. J., Taft, A., Hegarty, K., Ramsay, J., Davidson, L., & Feder, G. (2014). Screening women for intimate partner violence in healthcare settings: Abridged Cochrane systematic review and meta-analysis. *BMJ*, *348*, g2913.
- Our Watch. (2015). *Strengthening hospital responses to family violence (Victoria)*. Melbourne: Our Watch. Retrieved from <www.ourwatch.org.au/What-We-Do-%281%29/%E2%80%8BStrengthening-Hospital-Responses-to-Family-Violen>.
- Our Watch, ANROWS, & VicHealth. (2015). *Change the story: A shared primary prevention of violence against women and their children in Australia*. Melbourne: Our Watch. Retrieved from <www.ourwatch.org.au/who-we-are/our-publications>
- Pallitto, C., Campbell, J., & O’Campo, P. (2005). Is intimate partner violence associated with unintended pregnancy? A review of the literature. *Trauma, Violence & Abuse*, *6*, 217–235.
- Phillips, J., & Vandenbroek, P. (2014). *Domestic and family violence in Australia: An overview of the issues*. Parliamentary Library Research Paper. Canberra: Parliament of Australia. Retrieved from <www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1415/ViolenceAust>.
- Quinlivan, J. (2000). *Study of adolescent pregnancy in Western Australia: The way forward. Children, young people and domestic violence*. Melbourne: Partnerships Against Domestic Violence.
- Royal Women’s Hospital. (2015). *Family violence: Providing women with a safe place*. Melbourne: Royal Women’s Hospital. Retrieved from <www.thewomens.org.au/news/providing-women-with-a-safe-place/>.
- Sharps, P. W., Campbell, J., Batty, M., Walker, K. S., & Bair-Merritt, M. H. (2008). Current evidence on perinatal home visiting and intimate partner violence. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *37*(4), 480–490.
- Sharps, P. W., Laughon, K., & Giangrande, S. K. (2007). Intimate partner violence and the childbearing year. *Trauma, Violence and Abuse*, *8*(2), 108–116.
- Small, R., Taft, A. J., & Brown, S. J. (2011). The power of social connection and support in improving health: Lessons from social support interventions with childbearing women. *BMC Public Health*, *11*(supplement 5), S4–S5.
- Spangaro, J., Zwi, A., & Poulos, R. (2009). The elusive search for definitive evidence on routine screening for intimate partner violence. *Trauma, Violence, & Abuse*, *10*(1), 55–68.
- Taft, A. (2002). *Violence against women in pregnancy and after childbirth: Current knowledge and issues in health care responses*. (Issues Paper 6). Sydney: Australian Domestic and Family Violence Clearinghouse.
- Taft, A., Watson, L., & Lee, C. (2004). Violence against young Australian women and association with reproductive events: A cross sectional analysis of a national population sample. *Australian and New Zealand Journal of Public Health*, *28*(4), 324–329.
- Taft, A., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. (2011). Mothers’ advocates in the community (MOSAIC): Non-professional mentor support to reduce intimate partner violence and depression in mothers. A cluster randomised trial in primary care. *BMC Public Health*, *11*, 178.
- Taft, A. J., Hooker, L., Humphreys, C., Hegarty, K., Walter, R., Adams, C., & Small, R. (2015). Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): A cluster randomised trial. *BMC medicine*, *13*(1), 150.
- Tarczon, C., & Quadara, A. (2012). *The nature and extent of sexual assault and abuse in Australia* (Australian Centre for the Study of Sexual Assault Resource Sheet). Melbourne: Australian Institute of Family Studies.
- United Nations. (1993). *Declaration on the Elimination of Violence Against Women*. Geneva: Office of the United Nations High Commissioner for Human Rights.

- United Nations Children's Fund (UNICEF). (2015). *Harmful connections: Examining the relationship between violence against women and violence against children in the South Pacific*. Suva, Fiji: UNICEF.
- Walden, I., & Wall, L. (2014). *Reflecting on primary prevention of violence against women: The public health approach* (ACSSA Issues No. 9). Melbourne: Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies. Retrieved from <www3.aifs.gov.au/acssa/pubs/issue/i19/index.html>
- Wall, L. (2012). *Asking women about intimate partner violence* (ACSSA Resource Sheet). Melbourne: Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies. Retrieved from <www3.aifs.gov.au/acssa/pubs/sheets/rs4/>
- Wokoma, T. T., Jampala, M., Bexhell, H., Guthrie, K., & Lindow, S. (2014). A comparative study of the prevalence of domestic violence in women requesting a termination of pregnancy and those attending the antenatal clinic. *BJOG: An International Journal of Obstetrics & Gynaecology*, *121*(5), 627–633.
- World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*. Geneva: WHO.

If you are experiencing family or domestic violence or sexual assault, or know someone who is, please call **1800RESPECT** (1800 737 732) or visit **www.1800respect.org.au**



Australian Government
Australian Institute of Family Studies
 Child Family Community Australia

© Commonwealth of Australia 2015
 With the exception of AIFS branding, the Commonwealth Coat of Arms, content provided by third parties, and any material protected by a trademark, all textual material presented in this publication is provided under a Creative Commons Attribution 3.0 Australia licence (CC BY 3.0) <creativecommons.org/licenses/by/3.0/au>. You may copy, distribute and build upon this work for commercial and non-commercial purposes; however, you must attribute the Commonwealth of Australia as the copyright holder of the work. Content that is copyrighted by a third party is subject to the licensing arrangements of the original owner.



The **Child Family Community Australia** (CFCA) information exchange is an information and advisory unit based at the Australian Institute of Family Studies, and funded by the Australian Government Department of Social Services. The CFCA information exchange collects, produces and distributes resources and engages in information exchange activities that help to protect children, support families and strengthen communities.

The Australian Institute of Family Studies (AIFS) is committed to the creation and dissemination of research-based information on family functioning and wellbeing. Views expressed here are those of the author and may not reflect those of the Australian Institute of Family Studies, the Australian Government, or the New South Wales Department of Community Services.

Australian Institute of Family Studies
 Level 20, 485 La Trobe Street
 Melbourne VIC 3000 Australia
 Phone: (03) 9214 7888 Fax: (03) 9214 7839
 Internet: <www.aifs.gov.au>

ISBN 978-1-76016-062-3; 978-1-76016-063-0 (PDF)