Umeå University Medical Dissertations
New series No 1041 ISBN 91-7264-140-1 ISSN 0346-6612

From Epidemiology and Public Health Sciences
Department of Public Health and Clinical Medicine
Umeå University, SE-90185 Umeå, Sweden

Perspectives on intimate partner violence, focusing on the period of pregnancy

Kerstin E. Edin

Umeå 2006

Epidemiology & Public Health Sciences, Department of Public Health and Clinical Medicine
Obstetrics and Gynaecology, Department of Clinical Sciences
The National Graduate School of Gender Studies
Umeå University, SE-90185 Umeå, Sweden.

Epidemiology and Public Health Sciences
Department of Public Health and Clinical Medicine
Umeå University
SE-901 85 Umeå, Sweden

Cover: Kerstin E. Edin
Printed by Print & Media, Umeå University, Umeå, 2006

Abstract

The aim of this thesis was to examine – from different perspectives – intimate partner violence (IPV) against women, focusing on the period of pregnancy, with the object of increasing the available knowledge about this complex subject area, in a Swedish context.

The specific aims were: i) to assess the experience, knowledge, attitudes and routines of midwives working in antenatal care regarding IPV against pregnant women; ii) to explore discourses with special reference to IPV, gender and the period of pregnancy of professionals running various intervention programs for men inclined to violence; and iii) to illuminate experiences in women subjected to IPV by analyzing their stories about becoming and being pregnant as well as meeting antenatal care providers.

Three studies were carried out using a combination of quantitative and qualitative methods. Questionnaires sent to all midwives working at antenatal care clinics in the county of Västerbotten were processed by statistical methods and content analysis. The qualitative research interviews followed the 'grounded theory', 'discourse analysis' or 'narrative analysis' approach.

The results indicate the complexity of the problem of IPV from the viewpoints of both professional actors and the women. **The midwives,** although knowledgeable about IPV and certainly experts on pregnancy, felt uncertain regarding IPV and rarely asked direct questions of pregnant women, because the midwives perceived the subject to be difficult and taboo and they lacked guidelines to help them tackle the issue. **The professionals** in men's programs intended men to take full responsibility for their own violent behavior. They viewed violent men as rather ordinary but yet deviant in certain respects such as in interplay, communication, relationships and in their views of women. The professionals described gender stereotypes and attributed and generalized certain masculine characteristics to aggressiveness. They also believed that pregnancy could be a potential trigger for conflicts and violence. Nevertheless, pregnancy and sensitive relational topics did not constitute significant parts of the intervention programs. Despite good intentions to change concepts of masculinity, the professionals' discourses appeared to be rather lacking in reflection and even counter-productive. **The women** who had been subjected to violence described their complex lives as being terrible nightmares where their lovers turned into perpetrators. Two women left their relationships during pregnancy because of life-threatening violence whereas the others mostly kept up a front, hiding the IPV from the antenatal care staff and others while they trod a fine line between hope and despair or waited for the right moment to leave.

In addition to women's stories about IPV during pregnancy, two professional groups presented shared dilemmas regarding taboos and sensitive matters outside ordinary practice. Midwives were proficient but had no action plan to recognize and meet the complexity of the abused pregnant women's situation involving concealment, balancing and decision-making. Professionals in programs for men were explicitly confronting men's violence and wanted also to challenge masculinity in their clients. However, their discourse lacked depth by, for instance, their overlooking of sensitive relational topics in dialogues with men.

Keywords: spouse abuse, pregnancy, prenatal care, midwifery, process assessment, professional practice, professional discourse, causality, gender identity, personal narratives.

Sammanfattning på svenska

Målet med denna avhandling var att undersöka partnerrelaterat våld mot kvinnor i Sverige från olika perspektiv och med ett särskilt fokus på graviditetsperioden.

Syftet var: 1) att ta reda på barnmorskors erfarenheter, attityder och rutiner angående partnerrelaterat våld mot gravida kvinnor inom mödravården; 2) att utforska hur personer som arbetar inom olika program för våldsbenägna män (inom och utom kriminalvården) talar om manligt och kvinnligt och om partnerrelaterat våld, speciellt i förhållande till graviditet; och 3) att belysa kvinnors erfarenheter av att bli och vara gravid samtidigt som de var utsatta för våld i relationen, samt deras möten med barnmorskorna på mödravårdscentralen.

Data för tre studier samlades in under åren 1998-2003 med kvantitativa och kvalitativa metoder. En enkät skickades till alla yrkesverksamma mödravårdsbarnmorskor i Västerbotten och analyserades statistiskt och med innehållsanalys. Forskningsintervjuerna utfördes och analyserades enligt 'grundad teori' (för att skapa teoretiska förklaringsmodeller), 'diskursanalys' (för att visa hur ett gemensamt språkbruk konstruerar 'sanning') och 'narrativ metod' (för att tolka och återberätta innebörden i personliga berättelser).

Resultaten från de studier som lade grunden till denna avhandling visar på problemets komplexitet, både från de professionellas och från kvinnornas perspektiv. Barnmorskorna (artikel I) var yrkeskunniga men också kunniga om partnerrelaterat våld mot kvinnor, men utan PM eller andra riktlinjer, så blev de osäkra och ställde sällan direkta frågor eftersom ämnet ansågs vara känsligt och tabubelagt. De professionella (artikel II-III) som arbetade med våldsbenägna män i olika program (inom eller utanför kriminalvården) krävde att män skulle ta ansvar för sitt våld. De ansåg att våldsamma män var tämligen vanliga män men avvikande i särskilda avseenden såsom i samspel, kommunikation, nära relationer och i deras kvinnosyn. De professionella beskrev stereotyper om könsskillnader och hur aggressivitet kan starta på olika sätt hos olika typer av män och ansåg också att graviditet kan utlösa konflikter och våld. Likväl så ingick i programmen vanligtvis inte känsliga frågor, om t.ex. graviditet och samlevnad, och trots en god vilja och avsikt att skapa en 'ny maskulinitet', så tycktes deras strategier och tankegångar rent av kunna motverka deras egna goda syften. Kvinnorna (artikel IV) som hade varit utsatta för våld beskrev hur deras liv hade varit komplicerade och blivit till en mardröm då deras hjärtevän hade förvandlats till en förövare. Två kvinnor bröt upp från sina relationer under graviditeten på grund av livshotande våld medan de andra för det mesta höll uppe en fasad och dolde det pågående våldet inför barnmorskan och andra alltmedan de gick balansgång mellan hopp och förtvivlan eller väntade på rätt tidpunkt att ge sig av.

Förutom kvinnornas berättelser om partnerrelaterat våld under graviditet (artikel 4) så presenterades två professionella grupper och deras gemensamma svårigheter gällande tabun och känsliga frågor utanför det man vanligtvis sysslade med i sin profession (artikel 1-3). Barnmorskorna var yrkeskunniga men hade ingen handlingsplan för att kunna bemöta och identifiera komplexiteten i våldsutsatta gravida kvinnors situation som ofta består i att dölja och balansera. De professionella i program för män konfronterade tydligt mäns våld och hade ambitionen att utmana deras maskulinitet, men då de i samtalen exempelvis förbisåg att ta upp vissa känsliga frågor kan utfallet ifrågasättas.

Original papers

The thesis is based on the following papers:

I. Edin KE, Högberg U. Violence against women will remain hidden as long as no direct questions are asked. *Midwifery*, 2002; 18: 268-78.

II. Edin KE, Dahlgren L, Högberg U, Lalos A. "The pregnancy put the screws on", discourses of professionals working with men inclined to violence. *Men and Masculinities*, in press.

III. Edin KE, Lalos A, Högberg U, Dahlgren L. Violent men: ordinary and deviant. Discourses of professionals working with men inclined to violence. *The Journal of Interpersonal Violence,* in press.

IV. Edin KE, Dahlgren L, Lalos A, Högberg U. "Keeping up a front". Narratives about intimate partner violence and pregnancy. Submitted.

Paper I was published by Elsevier Science and no permission was needed to reprint, whereas Papers II and III were reprinted with the permission of Sage Publications.

Contents

ABSTRACT 3

SAMMANFATTNING PÅ SVENSKA 4

ORIGINAL PAPERS 5

INTRODUCTION 8
- The outset – a bucket of ice-cold water 8
- The research area 8
- Definitions of violence 10
- Prevalence of intimate partner violence during pregnancy 12
- Causes and associated factors 13
- Health effects 17
- Rationale for my study 19

OBJECTIVES 21

THE RESEARCH PROCESS 22
- Analytical frames 23
- Informants 26
- Contributions from quantitative and qualitative approaches 28
- Ethical aspects 36

MAIN FINDINGS AND DISCUSSIONS 38
- The complexity of living in a violent relationship 38
- The antenatal care 46
- Trustworthiness 51

CONCLUSIONS 54
- Implications 56

ACKNOWLEDGEMENTS 58
- Closing words 61

REFERENCES 62

PAPER I 73

PAPER II 87

PAPER III 109

PAPER IV 129

Introduction

The outset – a bucket of ice-cold water

People quite often ask me why I am doing research about violence and pregnancy since it appears to be a very depressing choice. A lot of what we come across in life happens gradually with one step leading to the next or else just through coincidences for which we can often give no reasons. At other times, and perhaps more seldom, something suddenly happens that immediately changes our direction. I can in fact remember the exact moment when I all of a sudden decided to embark on this subject area. But before going into detail, I will 'set myself in context' by sharing a summary of my professional background.

Apart from working as a registered nurse in intensive care, neurosurgery and child health-care, my main professional career has been as a midwife within delivery and maternity care. When I met pregnant women, an abundance of questions often arose, especially regarding labour and delivery. In my daily work I often called routines into question and speculated about the reasons for obstetrical complications as well as repeatedly reflected on why the experience of giving birth could differ so much from one woman to another. While some experienced the events as natural and reasonably trouble free with the duration and the pain endurable and transitory, for others it was all contrived, cheerless, long drawn-out and unbearable. I was often touched and affected by women with negative experiences of birth and was puzzled about the causal connections. Those thoughts gave rise to ideas for a pilot interview study and on starting the Public Health masters program in 1997-1998 my plan was to continue in that direction towards a Masters thesis.

During a seminar called 'Gender Perspective in Public Health', one Wednesday in the middle of October 1997, the lecturer talked about inequity in healthcare. Mention was made more or less in passing, of a study regarding violence against pregnant women. Interviews had been carried out at antenatal clinics in Gothenburg, Sweden, and the preliminary results from an unpublished study showed a prevalence of around 10 % (Hedin et al., 1999). It was as if, in that moment, someone had poured a bucket of ice-cold water over me and I can still feel the shivers of cold when I bring back the memory. It was easy to imagine intimate partner violence as an ever-present stress-factor that could never be separated from women's personal experience and feelings about becoming and being pregnant, as well as giving birth. After this awakening I put many prior research thoughts aside and just had to find out more about a reality that was more or less unknown to me despite many years as a clinical midwife.

The research area

The research area will be presented to provide a broad picture of the current level of knowledge from research relevant to the focus of this thesis, namely intimate partner violence (IPV) against women during the period of pregnancy. However, passages about violence and IPV in general are included to the extent that they contribute to the specific understanding of IPV and pregnancy.

Violence as an international public health issue

International perspectives

According to the WHO report '*World report on violence and health*', violence is globally the leading cause of death among people aged 15-44 years and hence an international public health issue. Violence can be self-directed, within groups or interpersonal between individuals in families or in the community (Krug et al., 2002; WHO, 2005). WHO (1996) has defined violence as:

> *"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."*

The violence that women are subjected to most commonly is interpersonal violence committed by an intimate partner (Krantz & Garcia-Moreno, 2005; Tjaden & Thoennes, 2000; Krug et al., 2002) and it is the major explanation of women's poor health (WHO, 2005). International research shows that from 10% up to 69% of women, at some time in their lives, have experienced physical violence from a male partner. IPV comprises all kinds of behaviour that results in sexual, physical or psychological harm to the partners (Krug et al., 2002). Both female and male partners commit IPV and it takes place in heterosexual as well as in homosexual relationships (Burke & Follingstad, 1999; Tjaden & Thoennes, 2000; Krug et al., 2002; Balsam et al., 2005).

There seems to be a process of change resulting in fewer differences between men's and women's behavior regarding physical violence (Steen & Hunskaar, 2004) and a number of studies point out that women can be as violent as men (Straus, 1999). Similar assault rates for men and women have been found in family conflict studies where both men and women have been questioned. This is in sharp contrast to crime studies (reported violence) where the rate of assaults by men is very much higher (Strauss, 2005). However, the bulk of studies indicate that men are the main culprits behind IPV (Tjaden & Thoennes, 2000; Krug et al., 2002; Espinosa & Osborne, 2002; Wathen & MacMillan, 2003; Shadigan & Bauer, 2004). IPV is seldom described as being initiated by the woman (WHO, 2005). Rather, women seem to use violence out of frustration or for self-protection while men use it to exercise dominance (Straus, 1999; Espinosa & Osborne, 2002; Lawson, 2003). Moreover, men's violence against women apparently has far more serious consequences than women's violence against men (Cascardi et al., 1992; Zlotnick, 1998; Straus, 1999; Lawson, 2003; Hamberger, 2005).

Swedish perspective

In Sweden, with a population of about nine million, the reported incidence of violence against women during the year 2005 was 24 097 or 267 per 100 000 inhabitants (BRÅ, www.bra.se). Three quarters of the perpetrators were regarded as close acquaintances and most of the violence took place indoors (BRÅ, 2004). The Swedish statistics regarding violence against women are approximately the same as for other western countries (Eriksson & Pringle, 2005). It is important, however, to consider the difficulties and uncertainties when comparing official crime statistics from different countries. Statistics are not produced in the same way and diverse cultural values and statutes affect the numbers. It can even be a problem to interpret numbers within a single country such as Sweden. The reported violence against women, for instance, has doubled since 1982 according to Swedish official statistics (BRÅ, 2004). BRÅ states, however, that while the numbers are correct the actual increase in violence is difficult to assess because during this 20-year period there has been a change in societal values in Sweden (BRÅ, 2002). It has been estimated that only one in four or five women subjected to violence in Sweden report the violence, but new legislation that offers better support to abused women may have increased the tendency to report it (BRÅ, 2001). Moreover, both increased media attention and activities originating in women's liberation movements and shelters, have acted on a changed view in society regarding violence against women in general (idem). Furthermore, a variety of educational programs about the issue has been offered to various occupational groups that come in contact with the problem such as the police, judiciary, healthcare and social service workers (idem). See also under '*Violence with fatal outcomes*', p. 18.

Two extensive national surveys regarding violence against women have lately (1999-2000) been carried out in Sweden. One of them, called 'ULF', was carried out by the Institute of Swedish Statistics (SCB) and included structured interviews showing that 3,9 % of women aged 16-64 years, during the last year had been subjected to violence, 1,5% from a close acquaintance and 0,7% in their own home (BRÅ, 2002). The other survey, 'The captured queen', comprised mailed questionnaires to 10 000 women revealing that 3 % of women aged 18-64 years had been subjected to physical violence by an intimate partner in the last year (Lundgren et al., 2001). The two studies are, however, difficult to compare because they differ in both design and definitions (BRÅ, 2002), see such discussions below.

Definitions of violence

For it to be possible to quantify violence and to make comparisons, precise definitions of violence are crucial (Gazmararian et al., 1996; Saltzman, 2004; Tjaden, 2004). Regarding the term IPV, there is a strict definition according to the US 'National Centre for Injury Prevention and Control' (CDC); an 'intimate partner' might be a current or former sex or dating partner whether or not the couple have lived together, and 'violence' includes physical violence, sexual violence, threats of physical or sexual violence and psychological/emotional violence but only when it occurs in the context

of the already listed acts of violence (in addition, each of the various forms are defined according to CDC). When other forms of violence are included (such as stalking or purely emotional violence) or variations of the given definitions, the recommendation is to be as precise as possible about any modifications (Saltzman, 2004). Moreover, even exact definitions may provide false security, since the same term may have different social and cultural meanings for different people and this is perhaps particularly true when it comes to definitions of sexual and psychological/emotional violence (WHO, 2005). Violence exists as a true reality, but is also a discursive construct with a complex signification and explanation that is related to personal and interpersonal daily social life and as such changes over time and varies among individuals and groups of societies and cultures (Hearn, 1998), see also '*Analytical frames*' p. 23.

In truth, IPV was not the term of choice from the very beginning of the three studies included in this thesis. Rather, IPV was found to best match the content of what the informants talked about. When the questionnaires were sent out for the first study, for instance, the form included a written definition of the term 'abuse' towards pregnant women which included physical and sexual violence. The definitions referred to the AAS (Abuse Assessment Screen) that was developed by the "Nursing Research Consortium on Violence and Abuse"; physical abuse was defined as being hit, slapped, kicked or otherwise physically hurt by someone and sexual abuse as anyone forcing the woman to participate in sexual activities (Parker et al.,1993). For the second and third study, the concept of violence was not defined a priori, but was developed and discussed with the respondents. Taking into account the respondents' discourses of violence, the term IPV was considered to be the best match, even more precisely as the focus was on male intimate partner violence against women. In Paper IV, it is stated that 2 of the 14 pregnancies involved solely psychological violence and thus not IPV as defined by CDC (Saltzman, 2004). This is not to say that mental violence (or stalking) is essentially less important, on the contrary, research shows that such violence has severe consequences for psychological and physical health (Coker et al., 2002; Davis et al., 2002). However, it is both complex and more problematic to define and measure (WHO, 2005).

Apart from the term IPV, which is used in this thesis, there are a variety of terms for 'violence against women' with similar meanings such as 'gender-based violence', 'sexualized violence', 'wife battering' and 'domestic violence'. The big advantages with the first two terms is that they highlight gender as related to violence but may at the same time fail to encompass the complexity of violence as in the interaction between individual, contextual and socio-cultural factors (Heise, 1998). Moreover, these terms for most people could be related to heterosexuality and the term 'sexualized violence' could possibly be understood as dealing just with sexual violence. The term 'wife battering' appears to deal only with married couples, excludes female violence and is unlikely to be associated with same-sex relationships. The term 'domestic violence' has been widely used in research and typically stands for 'men's violence against women', yet it could equally imply violence occurring between any partners within the domestic sphere and thus even include children.

Prevalence of intimate partner violence during pregnancy

International studies regarding the prevalence of violence against women during pregnancy present figures ranging from 1-20% (Saltzman et al., 2003; Jasinski, 2004; Shadigian & Bauer, 2004) and in some developing countries even up towards 28 % (Valladares et al., 2005; WHO, 2005). The main explanation for the wide variation seems to lie in the differing cultural contexts (WHO, 2005). Another explanation is the variety in study designs used (Gazmarian et al., 1996; Espinosa & Osborne, 2002; Campbell et al., 2004; Jasinski, 2004), including how ethical and safety factors have been dealt with for all parties concerned (Ellsberg et al., 2001). Methodological variations that affect the number of unrecorded cases are easy to find simply by comparing a small number of studies (Edin, 1999; Ellsberg et al., 2001). These can be summarized in a number of questions: *asked when* – at the beginning, in the end or after the pregnancy, just once or repeatedly on different occasions; *asked by whom* – healthcare personnel or someone else, someone that the woman could trust, a female or a male asking the questions, had the person adequate training and support, if asked more than once was it by the same or a different person; *asked how* –in connection with other routine questions or in a separate interview, were standardized instruments or pre-printed forms used; *asked about what* – mild or severe physical violence, sexual and psychological violence, definitions used, if any; *sample questioned* – representative of the study population (age, class, ethnicity, low or high risk pregnancies etc.); *asked where* – setting, culture, country.

In Sweden, two prevalence studies on IPV against women during pregnancy have been published to date. The first was carried out in 1996-1997 with the use of standardized questionnaires in personal interviews with 207 pregnant women at antenatal care clinics (Hedin et al., 1999). The findings were that during their current pregnancy 2.9 % had been seriously threatened, 4.3 % had been exposed to serious violence and 3.3 % to sexual violence. In the second study, 1038 pregnant women were asked standardized questions during two antenatal care appointments. This showed a prevalence of 1.3 % subjected to physical abuse and 2.8 % when the year preceding the pregnancy was included (Stenson et al., 2001).

The two studies summarized above are enough to provide examples of methodological diversity. In the first, smaller study, the sample included only Swedish-born pregnant women (with a Swedish-born partner) selected from among women unaccompanied by their partners and sitting in the waiting area. A single researcher met all the women once, conducted the interviews in a private room and used the SVAW ('Severity of Violence Against Women') scale (Marshall, 1992) which results in allocating types of violence into 46 categories including sexual and physical violence. These categories are not, however, directly comparable with other common definitions, as they give figures that appear to overlap and are thus hard to interpret (Hedin et al., 1999). The other study was carried out by regular midwives and the questions were posed in privacy, but either squeezed in as a part of other routines, or on occasions when the midwives could find excuses to talk to the women away from their

partners. The assessment took place during two of the women's ordinary antenatal care visits, using four standardized questions according to a modified version of AAS (Parker et al., 1993). For immigrant women, the forms were translated into the five most commonly used foreign languages and female interpretors were also used. The study presented figures for physical violence during pregnancy, but only the lifetime prevalence regarding sexual violence (Stenson et al., 2001).

Causes and associated factors

The exact correlation between pregnancy and IPV is not at all clear but studies indicate that violence is linked to changes, stress and conflicts within the relationship (Dye et al., 1995; Jasinski, 2004). However, power and several interrelated and intersectional factors need to be included to fully cover the causal complexity of IPV (Heise, 1998; Yllö, 2005). Moreover, in many comparisons between abuse and non-abuse, it is generally difficult to determine whether associated factors are the causes or the effects of the violence, or even both. Nevertheless, several studies present many, and often rather congruent, demographic and lifestyle factors associated with IPV against pregnant women (Espinosa & Osborne, 2002; Shadigian & Bauer, 2004). However, it is not possible to simply say that certain groups or sections of society are exempt from the risks to either becoming perpetrators or of being subjected to violence (Espinosa & Osborne, 2002; Shadigian & Bauer, 2004).

Does pregnancy increases the risk of violence?

Regardless of exactitude in prevalence, IPV against pregnant women is undoubtedly a public health problem (Gazmarian et al., 1996; FHI, 2005), but it is still not yet known whether or not pregnancy increases the risk of violence. Clinically based studies generally indicate that pregnancy is a risk factor, whereas national investigations do not (Jasinski, 2004). Moreover, there is no consensus about whether pregnancy restrains or escalates ongoing violence (idem) even if there are studies which indicate that pregnancy is a trigger, especially in relationships with ongoing serious violence (Helton & Snoddgrass, 1987; Helton et al. 1987; Campell et al., 1992; Parker et al., 1993, 1994; Curry et al., 1998). It has in fact also been shown that expecting a first child as well as having an unplanned or unwanted pregnancy is a significant risk factor for IPV (Jasinski, 2001).

It is clear, however, that pregnancy does not imply protection from violence (Jasinski, 2004; Shadigian & Bauer, 2004). Violence during pregnancy is in most cases a continuation of preceding violence but pregnancy can even initiate violence (Saltzman et al., 2003; WHO, 2005). In violent relationships, the violence is usually a recurrent event (McFarlane et al., 1996) and it seems rare to experience violence only during pregnancy and neither before nor after (Jasinski, 2004). Indeed, violence during pregnancy strongly predicts the risk of subsequent violence (Shadigian & Bauer, 2004). Furthermore, a number of studies identify the months immediately following delivery as a more risky time, compared to both before and during pregnancy (Gielen et al. 1994; Hedin, 2000; Bowen et al., 2005).

A combination of risk factors

For obvious reasons, the combination of many associated risk factors adds to the level of stress that is connected with pregnancy and parenthood and might thus increase the risks of violence. These factors include low socio-economic status, poor social network and a general situation of pressure and disagreement within the family (Jasinski, 2004). Studies also indicate a significant association between IPV and one or both of the partners' using drugs, alcohol or tobacco (Espinosa & Osborne, 2002; Yang et al. 2006). If the antenatal care personnel try to influence unhealthy maternity behavior, such as smoking for the sake of the unborn child, the impact may be marginal if the violence continues (Campbell, 2002; Espinosa & Osborne, 2002). Moreover, the relation between substance abuse and violence has been shown to be stronger during pregnancy than of other times and could result in problems and unhealthy behavior that is particularly negative during maternity (Martin et al., 2003).

Ethnicity and culture

Results from studies that do not incorporate ethnicity and cross-cultural issues might be very difficult to use (Sahin& Sahin, 2003; Jones, 2005). Research results are inconsistent regarding differences between ethnic groups and it is currently impossible to determine whether or not ethnicity is an independent risk factor (Espinosa & Osborne, 2002). The majority of studies regarding ethnicity have to date been carried out in North America and have included mostly white, Afro-Americans and Hispanics. Even if more and more studies are coming from other parts of the world, there is still a great need for further multi-country studies including a wide spectrum of varying ethnicities and cultures (Sahin& Sahin, 2003; Jones et al., 2005; Pallitto et al., 2005; WHO, 2005).

Social status and attitudes

Women identified as being at greater risk of suffering IPV during pregnancy compared to other women include: those with lower levels of social support (Curry et al., 1998; Jewkes, 2002; Jasinski, 2004; Heaman, 2005; Khosla, 2005); younger and unmarried women (Jasinski, 2004; Heaman, 2005); women with a low socio-economic status such as limited schooling and income (Torres et al., 2000; Castro et al., 2003; Bohn et al., 2004; Jasinski, 2004); women who are house-wives (Castro et al., 2003); and women who are expected to be traditional wives and mothers (Torres et al., 2000). There is also evidence, albeit contestable, that culturally more tolerant attitudes (both on an individual and a societal level) towards violence against women are determining factors for higher risks of abuse (Torres et al. 2000; Jewkes, 2002; Campbell et al., 2004). Research from developing countries, connected with finding ways to influence women's status and the social rank in order to counteract violence, shows that education is one of the factors that seems to empower women (Jewkes, 2002; Koenig et al., 2003). It has been pointed out that supportive social networks, both on an individual and on a societal level – including judicial institutions, are of great importance in counteracting IPV and allowing women to overcome violence (Ellsberg, 2000).

Unintended pregnancies

Short intervals between pregnancies have been reported to be related to partner violence (Parker et al., 1994; Jacoby et al., 1999) as well as mistimed, unplanned and unwanted pregnancies (Gazmararian et al., 1995; Kaye et al., 2006). Although the links and reasons behind them are manifold and the knowledge limited, IPV unmistakably affects a woman's right to make decisions regarding reproduction and birth control resulting in unintended pregnancies (Heise, 1998; McCarraher et al., 2005; Pallitto et al., 2005). A pregnancy might be seen as menacing by the man if it was not his decision and if he views the pregnancy as mistimed or unwanted it could certainly fuel violence (Jasinski, 2004). Pregnancy can also cause jealousy of the foetus that gets in the way of the couple's togetherness and obstructs her caring for him and hence triggers violence (Campbell et al., 1993). Better means of measuring gender aspects and different inter-relational factors are needed to increase understanding of the complexity of women's control of fertility and decision-making (Heise, 1998; Pallitto et al., 2005; Pallitto & O'Campo, 2005). Studies identify partner violence as one of the underlying factors when women decide to terminate a pregnancy (Glander et al., 1998; Kaye et al., 2006). In fact, a Swedish study showed that as many as 12% of women undergoing legal abortion became pregnant while they were subjected to pressure or threat from their partner (Kero et al., 2001). Unintended pregnancies are not correlated only to IPV but also to maternal morbidity and mortality due to illegal abortions and even with unintended, but not terminated pregnancies, there is a harmful influence on the health of the mother and the child (Pallitto & O'Campo, 2005). Generally speaking, it appears that the statistics for IPV and unintended pregnancies contain many of the same complex and interrelated risk factors when it comes to both abortions and continuing pregnancies.

Gender orders

It is impossible to not include gender aspects when writing about IPV, since the link between power, gender inequality and IPV is repeatedly described in research literature (Babcock, 1993; Heise, 1998, Jejeebhoy, 1998; Heise et al., 2002; Jewkes, 2002; Firestone et al., 2003; Yang et al., 2006), indicating that violence is a way of maintaining authority (Jewkes, 2002; Yang et al., 2006). Yet many other important intersectional power structures as well as interrelated individual, situational and sociocultural factors need to be included to cover the causal complexity of IPV (Heise, 1998; Yllö, 2005; Eriksson & Pringle, 2005).

Even if much of the research shows that patriarchal gender orders correspond to higher risks of abuse (Babcock, 1993; Heise, 1998; Heise et al., 2002; Jewkes, 2002; Firestone et al., 2003; Yang et al., 2006), nevertheless, the correspondence does not seem to be linear. Some research even points out that very traditional gender believes protect women from violence (Campbell, 1992; Schuler et al., 1996; Firestone et al., 2003). The main explanation for this seems to be that there are fewer power struggles compared to societies and relationships where gender positions are questioned and

undergoing change (Firestone et al., 2003; Hautzinger, 2003). In addition, it is possible that in societies with strong traditional gender belief, disclosure of violence is suppressed (Firestone et. al, 2003).

Ongoing gender conflicts might be one of the reasons why Sweden has not yet managed to reduce men's violence against women, despite clear norms regarding gender equality, especially in comparison with other countries (although the fatal violence has decreased, see p. 18). Equity in Sweden might be something that exists only on paper and does not fully affect families, or perhaps the problem is still too multifaceted and needs to be approached in more profound ways (Eriksson & Pringle, 2005). Despite the complexity, with several causes at several levels and IPV being part of a dynamic interplay and power game, most studies question one partner at a time and very little reserach has been carried out regarding direct interrelation and communication between the partners (Lawson, 2003).

The violent man

The hierarchy and plurality of masculinities together with other social dynamics imply tension and an order of rank between men in relation to women (Connell, 2005). Certain masculinities are more powerful and central than others and serve as hegemonic models for men, although mostly as concepts and neither entirely legitimate nor fully accomplished in reality (idem). In particular situations, however, men might use various strategies to defend male dominance such as pressure, threat and ultimately even violence (Connell, 1995; Hearn, 1998). When a man is violent towards an intimate partner, he may confirm his power as he is 'being a man' (Hearn, 1998).

Studies explaining men's violence have referred to a diversity of biological, social, individual, psychological and psychopathological factors and have been criticized for presenting individual explanations that men could use as excuses when they need instead to accept full responsibility for their own violent behavior. However, others have emphasized that knowledge about causality is valuable, if it is used as a tool to better prevent and reveal male violence and to improve the effectiveness of treatment programs for men inclined to violence (Lawson, 2003; Holtzworth-Munroe & Meehan, 2004).

A frequent and recurrent finding which is explained by 'social learning theory' is that men who grew up with violence in the family of orgin are more likely to become abusive (Walker & Browne,1985; Castro et al., 2003; Delsol & Mangolin, 2004). Other examples of negative childhood experiences are those arising from parental attachment difficulties and neglect, which seem to lead to problems with affect control in adult relationships (Lawson, 2003).

With reference to IPV and pregnancy, the research subjects are mainly women and in investigations they often even speak for their male partners and many of the stated associated factors are true for both the partners, for example young age (Castro et al., 2003), lifestyle and health behaviors such as smoking, alcohol and drug use (Espinosa & Osborne, 2002) and other shared social and socio-economic factors. Men with little

education (Kyriacou et al., 1999; Nasir & Hyder, 2003; Torres & Hae-Rae, 2003), low income (Nasir & Hyder, 2003; Torres & Hae-Rae, 2003), no employment (Kyriacou et al., 1999; Fisher et al., 2003) and those under stress (Purwar et al., 1999) have been shown to be more prone to exert IPV. In a qualitative interview study with perpetrators of IPV (Tilley & Brackley, 2005), the men's relationships were described as being socially isolated, ambivalent and appeared to be immature with problems of jealosy, difficulties with anger and conflict resolution and the violence as reciprocal. The men had traditional gender ideas where they objectified their partners, justified and diminished the violence and saw it as a private problem.

The results from research regarding male violence during the childbearing period is incongruent and it is therefore difficult to point out what, if anything, is different during pregnancy compared to othertimes (Jasinski, 2004). However, it is known that high levels of stress, disagreements and social strain in a relationship increase the risk of violence (Jasinski, 2001). Consequently, it seems that pregnancy, being a demanding event and representing a transition period, could be another stress factor and as such an additional risk factor for violence, especially in young couples, in first time parents and if the pregnancy is undesired (Jasinski, 2001, 2004), cf '*Unintended pregnancies*' p 15. When women have been asked about men's reasons for being violent during pregnancy, they report that the men are jealous because of the baby and that they feel abandoned when women care for the children instead of them (Campbell, 1993).

Health effects

Medical complications

Violence during pregnancy may jeopardize two individuals at the same time, namely the mother and the unborn baby. There are certainly a variety of psychosocial consequences but women subjected to violence during pregnancy are at risk of suffering both physical problems and medical complications (Parker et al., 1994; Dye et al., 1995; McFarlane et al., 1996; Curry et al., 1998; Espinosa & Osborne, 2002). The following have been reported to be significantly associated with IPV during pregnancy: insufficient maternal weight gain, bleeding, anaemia and infections (Parker et al., 1994) including sexually transmitted infections and HIV (Campbell, 2002). Some of the risks to the mother and baby could partly be imputed to the late entrance of abused women into antenatal care (Gazmarian et al., 1995; Goodwin et al., 2000; Jasinski, 2004) as well as fewer clinical visits compared to other pregnant women (Espinosa & Osborne, 2002). The associated risk factors for health that are related to IPV are difficult to differentiate and assess separately (Jasinski, 2004) and appear to display multiple interactions with both synergistic and confounding effects (Rothman & Greenland, 1998).

Effects on mental health

Pregnant women in abusive relationships are commonly more despondent regarding pregnancy, more worried about delivery and about becoming a mother than are other women (Campell et al., 1992; Dye et al., 1995). IPV has a negative effect on mental health that often leads to various forms of emotional distress (Romito et al., 2005; Valladres et al., 2005) and depression during pregnancy (Campbell et al., 1992; Horrigan et al., 2000; Espinosa & Osborne, 2002; Lovisi, 2005; Martin, 2006) and in the postpartum period (Jasinski, 2004). Moreover, a threefold interrelation between depression, substance abuse and violence during pregnancy has been shown (Horrigan et al., 2000).

Violence with fatal outcomes

Femicide, the homicide of women (Campbell et al., 2003) is the ultimate result of violence against women and is described as being correlated to pregnancy, for adolescent women in particular (Krulewitch et al., 2003). A Finnish study shows that the highest risk of violent death for women (femicide and suicide) is related to pregnancies and more precisely, to the termination of early pregnancies, especially in younger women, whereas there is a reduced risk for women who chose to continue their pregnancies (both compared to non-pregnant women and women with a legal abortion) (Gissler et al., 2005). If women also break up the relationship after a legal abortion, the risk of violence might be increased even further because of both the termination of the pregnancy (Gissler et al., 2005) and her leaving (Walker et al., 2004; Rodriguez et al., 1996). As many as 30-50% of femicides are committed by a current or previous intimate partner (Guth & Pachter, 2000) and in most cases there was violence previously in the relationship (Walton-Moss & Campbell, 2002). A study from the US showed that women who have been subjected to violence during pregnancy, have, a much increased risk of attempted or completed femicide compared to other women (McFarlane et al., 2002). Other studies have presented additional risk factors such as large age difference between the partners, substance use, accusations of sexual infidelity and threats of separation (Aldridge & Browne, 2003). Mental illness is also a significant cause of intimate partner homicide (Aldridge & Browne, 2003; Farooque et al., 2005). Several other identifiable factors have also been found to lead up to femicide, such as having the abuser's stepchild in the home, forced sex, the woman leaving to be with another partner, stalking and if the woman had previously been threatened with a weapon. Protective factors for femicide were if the partners had never cohabited and that the man had been arrested for IPV (Campbell et al. 2003).

In Sweden, the official statistics show that IPV against women claims the lives of about 16 women per year (1990-2003) but fatal violence has decreased by 30% compared to the period 1971-1980, which may reflect a change of attitudes towards violence against women (BRÅ, 2002). Three explanations for this decline have been pointed out; first, an increased awareness of and attention paid to the problem as well as more shelters for women; second, improvements in emergency care that may

save more victims of severe violence; and third, amendments to the laws supporting women plus promotion of the willingness to report. Examples of changed legislations are; since 1982 abuse in the private sphere has come within the domain of public prosecution service and the report can not be withdrawn; in 1998 a new regulation made it possible to sentence someone for diverse violations and add together events that have happened at different times; from 2003 a ban on visiting could cover larger geographic areas and also the couples' joint residence (BRÅ, 2001; BRÅ, 2002). See also under '*Swedish perspectives*' p. 10.

Pregnancy outcome

Studies are not in agreement regarding IPV against women during pregnancy and the effects on the baby. Explaining a negative pregnancy outcome appears to be most straightforward when the woman is subjected to physical trauma of the pregnant abdomen (Murphy et al., 2001; Campbell, 2002; Rachana et al., 2002). All other explanations seem to be related to the woman's generally unhealthy situation (such as a poor weight gain, stress, depression) with very complex and interrelated risk patterns (Jasinski, 2004; Pallitto et al., 2005). Nevertheless, despite inconsistent research results (Campbell, 2002), many studies have presented an association between IPV and several negative outcomes for the baby (Jejebhoy, 1998; Covington et al., 2001; Rachana et al., 2002), such as intrauterine or neonatal mortality (Janssen et al., 2003; Nasir & Hyder, 2003; Pallitto et al., 2005), and an increased risk of infant and child mortality (Åsling-Monemi et al., 2003). Although much debated, several studies have shown a significant relation between IPV and the baby having a reduced birth weight (Bullock & McFarlane, 1989; Parker et al., 1994; Fernandez & Krueger, 1999; Murphy et al. 2001; Valladares et al., 2002; Lipsky et al., 2003; Nasir & Hyder, 2003; Jasinski, 2004; Neggers et al., 2004; Pallitto et al., 2005). Moreover, violence against women has also been associated with preterm labour (Dye et al., 1995; Curry et al., 1998; Covington et al., 2001; Rachana et al., 2002) and foetal growth retardation (Campbell et al., 2000) and one of the explanations mentioned, is a possible neuroendocrine response to stress (Valladares, 2005).

Rationale for my study

Given my background as a midwife and my experience of having been blinkered regarding the subject area of IPV and pregnancy, the question was where I should start my own path to discovery. That there was a need for useful research became evident from an evaluation of the research area regarding the physical, psychological and social consequences of violence for the pregnant woman and the resulting risks to the unborn child. However, the literature also showed highly variable prevalences, inconsistencies and limitations in the research about IPV and pregnancy. My main concern, as a midwife in Sweden, was not the exact prevalence or the interrelated risk-factors, not because such knowledge is irrelevant, quite the opposite. My priority, however, was to arrive at a more comprehensive and deeper understanding that would

enable myself and others to better meet the needs of pregnant women, primarily in a Swedish setting. When I started the first study regarding the subject area of IPV and pregnancy in 1998, not many extensive qualitative studies had been carried out and most of the research originated in North America. Although this has changed to some extent, the current literature, apart from a lack of multi-country and cross-cultural research, still lacks a more profound understanding of the very complex factors underlying IPV against women and its severe consequences (Jasinski, 2004; Pallitto et al., 2005; WHO, 2005).

With this as my starting point, I decided to focus on issues that took their point of departure in my own professional field. My work set its sights on the midwives working in antenatal care (Study 1, Paper I), followed by professionals working with men inclined to violence (Study 2, Papers II and III) and finally women who had been subjected to violence during pregnancy (Study 3, Paper IV, see Fig. 1). Originally, the aim was also to include men and a pilot study was carried out with four men, but the data began to get too extensive and more than could fit into a single thesis so that part of the project was temporarily put on hold. For the same reason, some of the rich data from the third interview study with women had to be put aside for the present.

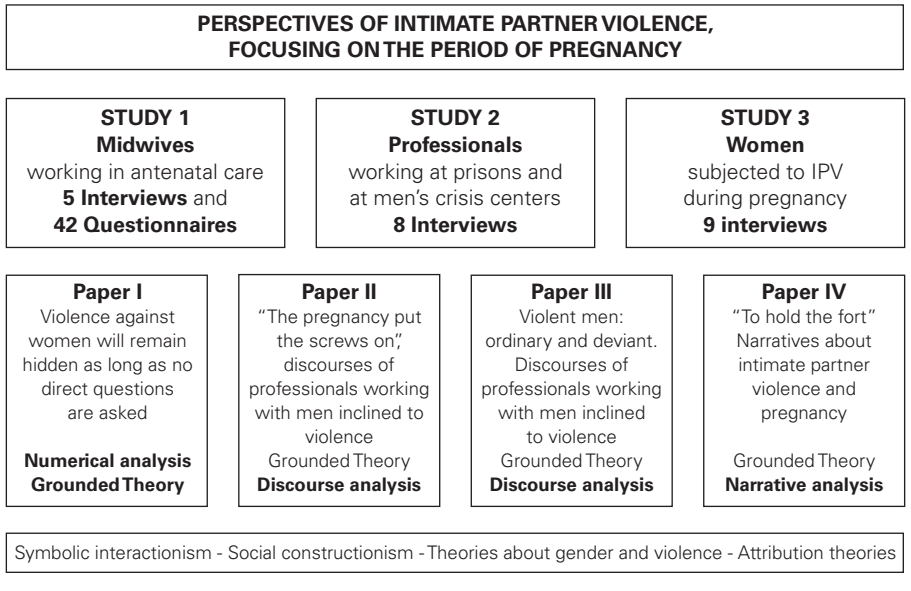

Figure 1. The thesis in summary; Studies 1-3, Papers I-IV and the use of triangulation.

Objectives

The general objective

The general objective for this thesis was to describe and analyze intimate partner violence from different perspectives, focusing on the period of pregnancy in a Swedish setting. The viewpoints investigated were those of midwives, of professionals working with men inclined to violence and of women who had been subjected to IPV during pregnancy.

Specific objectives

1. To assess the experience, knowledge, attitudes and routines regarding violence against pregnant women among **midwives** working at antenatal clinics in the county of Västerbotten, Sweden (Paper I).
2. To explore the discourses of **professionals** working with men inclined to violence with special reference to intimate partner violence, focusing on gender, the period of the partner's pregnancy (Paper II) and on the professionals' causal attribution (Paper III).
3. To understand, represent and give a voice to **women** who had been subjected to IPV during the period of pregnancy. The centre of attention was the women's experience of becoming and being pregnant, their meetings with the antenatal care system and their strategies for carrying on (Paper IV).

The research process

The ambition with the three studies in this thesis was to represent different perspectives on IPV during pregnancy and to construct knowledge by analyzing them both separately and interactively. In doing this, a qualitative approach was, for the most part, found to be the necessary choice given the complex, difficult and multifaceted subject area. Qualitative research provides the researcher with an opportunity to use themselves as a tool in the study setting and thus to construct knowledge in dialogues and interplay with the informants (Kvale, 1996). However, the first study came to include one quantitative component as a part of the emergent design that also resulted in changing tracks a few times and the process could well be compared with an expedition setting off with the plan of taking one step at a time (Kvale, 1996; Starrin et al.,1997). The approach chosen provided many opportunities to learn from bad as well as from good steps and to benefit from the knowledge and experience acquired during the course of the studies. Using and learning from different perspectives provided a chance to achieve a more balanced and profound description and understanding of the topic, as well as the realization that research and knowledge are a matter of endless construction and reconstruction.

When one or more different methods are used in the same research project as a combination between or within the qualitative and quantitative paradigms, it is often referred to as 'methodology triangulation' (Dahlgren et al., 2004). For the three studies that laid the groundwork for this thesis, a somewhat pragmatic approach to triangulation was taken comprising both quantitative and qualitative methods, actors with different view about the subject area and diverse theoretical angles of approach. Undoubtely, the interdisciplinary and multicultural research environment in which my doctoral studies took place has also been a true part of the triangulation. First, my workplace at the Epidemiology Unit at Umeå University is like the hub of the world, with multicultural and multi-country research projects as well as masters and doctoral students from a variety of professional backgrounds from many different countries and continents. Moreover, my employment as a doctoral student has been in collaboration between the Department of Epidemiology and Public Health Sciences and the National Graduate School of Gender Studies (that offered the opportunity to spend one month abroad among researchers within the topic area). In addition, the tutors in the research group represented three different disciplines; obstetrics & gynaecology, social work and sociology, respectively.

Below, I will give a description of the core properties of the study triangulation; firstly my choice of analytical frames, secondly a presentation of the views of different informants, and finally how contributions from quantitative and qualitative approaches were integrated (cf Figures 1 and 2).

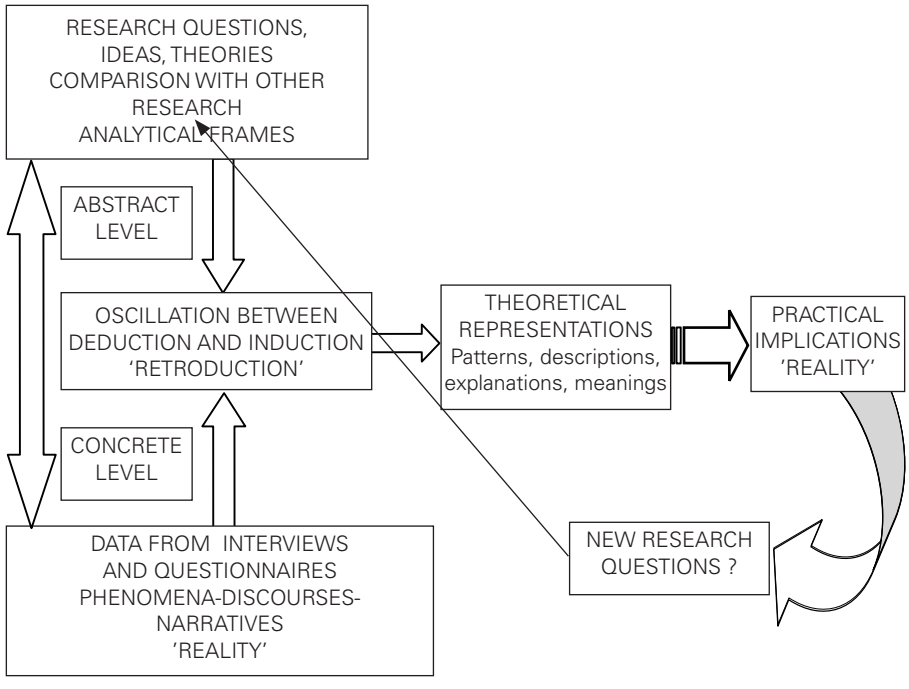

Figure 2. The 'retroduction' in the research process as an oscillation between abstract and concrete.

Analytical frames

In general, a conscious attempt was made not to let preconceived theories and ideas unnecessarily constrain the research process. Instead, in deciding on research questions and participating in the interviews, the challenge was to keep an open mind in order to find something new (Starrin et al., 1997). Nevertheless, certain theoretical premises about the view of knowledge were an inescapable part of the pre-understanding and indeed were useful in the research process where methods were chosen with regard to what best suited the material. Consequently, it was quite natural to take into account both 'Symbolic interactionism' (Paper I) and 'Social constructionism' (Papers II-IV) as theoretical frameworks for the studies, since they represent some of the more important foundations in the use of 'Grounded Theory', 'Discourse analyse' and 'Narrative analysis' (Burr, 2003). Moreover, 'Social constructionism' formed the basis for explaining gender and violence as well as attribution. 'Attribution theory' was used as a tool to understand and discuss the causes underlying constructed discourses about violence.

The choice of theoretical frames, however, was not made with the aim of testing hypotheses or generating gauges for theoretically grounded variables. Instead, the analysis was grounded in the evidence discovered in the data collected from questionnaires and interviews, preliminary images were constructed and confronted with the analytic

frames in a way that can be characterised as an oscillation between data and emerging ideas, views, patterns and theories (Dahlgren et al., 2004). Ragin (1994) describes this process as 'retroduction' (Figure 2) which is similar to what is called abduction in other methodologies such as the 'Grounded Theory' approach. To carry out research as it is described in this thesis, in which the ambition is to generate patterns of understanding from social particulars, is metaphorically like travelling along a semantic road (Abbott, 2004); starting from a concrete and common sense understanding of the research object and moving on searching for patterns, descriptions, explanations and meanings until one hopefully arrives at something more theoretical, abstract and not previously known. The theories, described below, function as an analytical frame (Ragin, 1994) that helped seeing different phenomena and to discover theoretical representations and implications for practice.

Symbolic interactionism

Symbolic interactionism (SI) is probably the most important part of the 'Grounded Theory' (GT) foundation and elucidates how our own and other's identities are constructed through people's daily interplay (Burr, 2003). According to SI, knowledge as well as people's identities are formed through interaction, taking the roles of others, and by generalizing from previous experience. The self of an individual emerges from social structure and social situations and develops in a continuous process of interaction. Its two parts, the *I* and *Me*, also interact with each other, where *I* is an intentional, emotive and impulsive actor whereas *Me* is the receiver of feedback from the social environment and reflects on this '*I* action' and tries to increase control. The process is primarily formed in communication with significant others, people who might change and have different importance during the course of life (Dahlgren et al., 2003). This social interplay constructs the perception and understanding of reality and provides symbolic meanings through negotiations, hence, truth in this sense is not set and fixed but is relative and changeable since it is subjectively observed and created in shared cultural contexts. Interaction in everyday life is more or less unconscious, since people have learned to generalize, predict and act on the basis of certain socially constructed maps. However, if something new and unexpected comes up, the meanings might need to be reinterpreted, which is in line with the methodology of GT. Within SI as well as within GT research, the intention is to rethink and reconstruct the picture of reality (Spradley, 1979; Dahlgren et al., 2004).

Social constructionism

Social constructionism (SC), just like SI, also questions and challenge knowledge as an objective unbiased truth and instead invites suspicions regarding conventions and assumptions about reality. Knowledge is valid for a certain point in time and space, is viewed as constructed in social, interactive processes and in particular through the use of language, changes over time, is specific to and a product of history, politics, culture and society. Since the construction of knowledge includes and excludes certain

standpoints, it is to a great extent governed by power and entails social consequences (Burr, 2003). The view of power (in the construction of knowledge) together with the view of language, not just as meanings or as a mirror of the interacted reality but rather as actually constructing reality in the communicative interplay with others, are probably the most obvious differences between SC and SI (Burr, 2003; Dahlgren et al., 2004).

Theories on gender and violence

Gender is a normative and socio-cultural construct that largely positions men as superior to women. While the construct is not static, changes are usually slow since they imply power shifts and require interactions and negotiations (Kimmel, 1987; Connell, 1995; Edley, 2001). In a relationship the gender positions can be understood as a construct with separated gender orders but also as interactive processes with certain – but invisible – restricted conceptions and expectations, that if transgressed may initiate resistance as well as violence (Hirdman, 1988; 2001). However, when picturing gender orders, one needs to include perspectives that comprise different interrelated power dynamics including the complexity of personal, situational, cultural and social factors (Heise, 1998; Connell, 2005). A focus on gender discourses is specifically included in Papers II-III (professionals) and in the discussion of the results in Paper IV (women).

Violence is real but is discursively constructed, consequently the meaning of violence is multifaceted and differs among individuals in different groups of societies and cultures with different interpersonal and structural implications (Hearn, 1998). Because violence is socially defined, a violent act cannot be assessed independently of its social representation or of the power positions of the participants involved (Lloyd, 1997).

Attribution Theory

Attribution can be defined as the "process of assigning a cause to one's own or others' behavior" (Hogg & Vaughan, 1995, p. 82). 'Attribution Theory' (AT) deals with attitudes of a mostly cognitive nature and is an important part of people's discourses. In Paper III, AT was used as a tool to explain how the professional discourse might have been constructed with respect to the reasoning about the underlying causes to IPV.

To make events in everyday life understandable, people find causes mostly without thinking, rather unconsciously as out of a tacit and social knowledge. Now and then people consciously attribute for their own and other's behavior and for certain events, particularly when the deeds are negative, socially undesirable, unforeseen or if the actor had several choices (Augoustinos & Walker, 1995; Hogg & Vaughan, 1995). AT aims to explain how people attribute causes, the reasons behind the attribution and individual variations and inconsistencies (Augoustinos & Walker, 1995). The sorts of attributions people make may have important emotional effects, and may influence their self-image and their relationships with others (Hogg & Vaughan,

1995). Attribution changes over time, is altered by new facts and differs among various classes, cultures, ideologies, age and social groups. AT assumes dynamic changes, since it implies that people may think critically about their own and others' attribution resulting in new social comprehension (Augoustinos & Walker, 1995).

There are some common patterns in attribution (Augoustinos & Walker, 1995); it is for instance more likely that a person will identify a single cause of an action rather than many. If the consequences of two events are similar and happen close to each other in time, their causal connection will also be perceived as being more reliable than if there is a single occurrence. Moreover, the more one explanation is preferred, the more unlikely that others are to be used. As a consequence, explanations that agree with preconceptions are more easily accepted while those that are odd and different might simply be dropped. Moreover, actors are likely to be very concrete and blame the situation (*external attribution*), whereas the bystanders have a tendency to be abstract and to hold the actors responsible (*internal attribution*). People commonly accept credits for their own successes but often deny responsibility for their failures. Apart from being done by habit and convenience, attributions are often (consciously or unconsciously) self-serving, socially desirable and for one's own benefit. People often react analogously to the negative effects of certain actions and hence attribute causes personally and emotionally (Augoustinos & Walker, 1995).

Informants

The three studies of this thesis included informants with different and complementary viewpoints; midwives providing care for pregnant women (Paper I), professionals (in various professions) that regularly met men inclined to violence (Paper II and III) and women who had been subjected to violence during pregnancy (Paper IV). For this purposive sampling, the number of informants in each group of respondents was not determined from the outset, but considering time and resources available, the initial plan was to include 5 midwives and at most 10 professionals and 10 women. The sample could, however, be enlarged or cut down if this was deemed justified (Kvale, 1996).

Midwives in antenatal care

Midwives (Paper I) working in antenatal care in Sweden are largely responsible for contraceptive consultations with women and for providing antenatal care. During the period of pregnancy they typically have some ten appointments with each pregnant woman (often together with the partner) in addition to parental education. The midwives, therefore, have the chance to get to know individual couples quite well and could be expected to acquire information regarding psychosocial matters during the women's pregnancies. This was the background to the decision to question midwives working in antenatal care to find out about their knowledge, experience, attitudes and routines regarding violence against women during pregnancy. Initially, five experienced (≥5 years work experience) midwives working in antenatal care were

interviewed (in the fall of 1998). In addition, questionnaires were mailed to all 51 midwives (42 answered) working at the 36 antenatal care clinics in the county of Västerbotten (spring 1999). See also Paper I.

Professionals meeting violent men

Professionals working with men inclined to violence (Paper II and III) were interviewed between May 2002 and June 2003 at different locations in Sweden; two at a crisis center for men, three at a probation family center and three at two prisons (one of them an open institution). The aim of the sampling was to select a few respondents from a variety of professionals leading different kinds of intervention programs (within and outside the treatment of offenders) for men inclined to violence, excluding programs within forensic and psychiatric care as well as programs particularly for sexual offenders. It became clear during the course of the study that the programs were markedly diverse, not only due to different clientele (degree of violence, motivation for change etc.) but also with respect to their agenda, theoretical foundations, interventions models and professional education and experience. Nevertheless, the assortment in the study obviously represented what men in reality might come across when participating in different programs for men inclined to violence in Sweden.

Finding informants was a prolonged process mostly because many professionals felt that their experience did not match the study aims. The final sample of two women and six men included two psychologists, four trained social workers and two prison officers who solely were educated within the prison establishment (three of the eight were also certified psychotherapists). The informants' experience of leading treatment for men inclined to violence ranged from 2–13 years and none was meeting only violent men. They all had additional assignments, as well as previous experience, within the prison establishment, family therapy, psychiatry, social services etc.

The professionals were at first seen as a source of information about violent men (in relation to pregnancy and gender), since it was thought they could probably share useful experience gained from the numerous of men they had met over the years. While this was true, it became increasingly apparent that the interviews contained professional discourses representing constructed knowledge rather than basic facts about violent men. The sample was intended to locate these professional discourses and as such they were viewed as mirroring larger prevailing discourses in society as well as among other professionals and programs. See also Papers II and III.

Women subjected to IPV

Women who had been subjected to intimate partner violence during pregnancy (Paper IV) were sampled through intermediary contacts with staff at women's shelters and then via a group leader for women at a probation family center. The staff was informed by letter about the aim of the study and they in turn forwarded written information to women they found eligible. Of the women identified in this way, only one dropped out. The first three interviews were carried out in 2001 and the remaining six in

2003. The nine women interviewed were asked in particular about violence during pregnancy, the violence they talked about had gone on in 10 relationships and 14 pregnancies (1.5 – 20 years prior to the interviews). All the women had experienced grievous physical and sexual violence or threats of such violence during pregnancy. Only one of the women and two of their abusive partners were born outside of Sweden. Apart from two break-ups during pregnancy, the women separated from their violent partners when their last child was a toddler. Every respondent had received support from either a women's shelter or a probation family center and they all appeared to have left their partners permanently. See also Paper IV.

Contributions from quantitative and qualitative approaches

For the first study, the plan was to give a questionnaire about IPV and pregnancy to all the midwives working at antenatal clinics in the county of Västerbotten. However, at that stage it was hard to know exactly where to start and what questions would be relevant. For this reason, qualitative research interviews were first carried out to gain more insight into the midwives' experience and world of ideas. In the event, the interviews served not only as preparation for the questionnaires, but also both interviews and questionnaires provided valuable data that supported and supplemented each other in the analysis.

Qualitative research methods were used in all three studies (Papers I-IV), but before describing differences between the methods used and what they had in common, a short presentation of the quantitative part (Paper I) is presented. See Fig. 1.

The questionnaires

The questionnaires were based on earlier interviews with midwives working in antenatal care (as mentioned above). Attached to the form was information about confidentiality, study objectives and a definition of the term 'abuse' as used in the questionnaires. The questionnaire comprised multiple-choice questions but offered generous space for free comments. The midwives were first asked very general questions about antenatal care and their own professional experience, followed by more specific questions about abuse. The midwives were asked to estimate roughly, how many of their clients had revealed the occurrence of violence during or before pregnancy, over the last year in the antenatal clinic. Since the number of observations was low and scattered in a big sample (not a normal distribution), estimations of significance were calculated using Poisson approximation (Campell & Machin, 1990). 85% (42/51) of the midwives answered the questionnaires. The midwives' free comments in the questionnaire were subjected to content analysis informed by the first steps in 'Grounded Theory' (see p. 31) using only substantive coding, with no theoretical coding (Starrin et al., 1997).

Interviews following a Grounded Theory approach

A total of 22 qualitative research interviews were carried out in the three studies (Fig. 1). The interview design was inspired by various scholars of qualitative research (Spradley, 1979; Lincoln & Cuba, 1985; Riessman, 1993; Kvale, 1996; Starrin et al., 1997) but followed principally the lines of 'Grounded Theory' (GT) approaches. However, the interviews came to be pragmatic and very much governed by the research questions and the respondents. Consequently, the interviews with the midwives and the professionals followed a quite different approach to those with the women. The most confrontational stance was taken with the professionals working with men (Paper II and III) whereas a more relaxed position characterized the interviews with women (Paper IV) and the interviews with midwives came down somewhere in between (paper I). For more details about '*Interaction in interviews*', see page 30.

Interviews in practice

When starting up the first study, the choice of GT was rather straightforward as it was a well-known option and a method that includes much good practical advice about the research process from start to finish (cf. Spradley, 1979; Lincoln & Cuba, 1985; Starrin et al., 1997). Following this advice, all the interviews were carried out with an open and curious mind. This does not imply that the interviews started from nothing, devoid of any pre-understanding on the part of the interviewer, as was sometimes presumed to be the correct way in early applications of GT. Instead, when selecting research questions, preparing mind maps and deciding on interview questions, one's own preconceived knowledge and experience should not be ignored but dealt with by recognizing oneself (KEE) as a tool in the interplay and construction of research knowledge (cf. Kvale, 1996; Johansson, 2005).

Carry out qualitative research interviews is learning by doing, similar in many ways to producing art in that it requires both craftsmanship and creativity. One important goal for interviews is to encourage a dialogue and thereby construct knowledge through interaction between interviewer and interviewee (Kvale, 1996). This means that different respondents can never receive exactly the same 'stimuli' from the interviewer from one interview situation to another even if the same mind maps and inquiry forms are used (Mishler, 1986). Moreover, the respondents' reports have to be viewed as their subjective understanding of reality, an understanding that had been constructed and reconstructed several times before the selection of a particular story in the actual interview situation (Riessman, 1993; Crossley, 2000).

For each of the 22 interviews, an undisturbed setting was of high priority and there were many preliminaries to ensure that the respondents were relaxed and would open up as well as to create confidence and to show the respondents the interviewer-position was one of an open, compassionate and non-judgmental listener. Plenty of time was therefore scheduled for each interview and always started with an open chat about just anything. The study and the interviewer were also presented and the informants were invited to pose questions before the formal interview began. The recorded interviews

lasted from about 45 minutes up to more than two hours (sometimes with a break). For all the interviews, 'semi-structured open ended questions' were used following themes and mind maps and were backed up with detailed questions that allowed for an emergent design (including digressions).

The purpose of each interview was to find something new and to start the analyses as an ongoing process as early as during the interviews. The best way to pursue this method is to go back and forward between reality and data as much as possible to allow the analyses from one interview to guide the next and to modify questions from interview to interview (Starrin et al., 1997). In reality this was not fully possible, but memos, summaries and preliminary analyses were noted soon after each interview. Notes became especially important when two accidentally blank recordings were discovered (study 2). The detailed memos were like a pot of gold making it still possible to include these interviews in the study.

Interactions in interviews

The interaction during interviews and from one interview to another, changes and includes power and the different positions of the interviewer and the respondents owing to such aspects as gender, age, race, class, professional expertise and personal experience (Davies & Harré, 2001). The author (KEE) conducted all the interviews and the fact that the respondents met someone who was a midwife, a middle-aged woman, mother of four and working at the university, probably had both inhibiting and liberating effects on the dialogues.

When interviewing the midwives in antenatal care (Paper I), I was knowledgeable about midwifery, although not specifically from antenatal care. This pre-understanding and familiarity was present but was actively restrained to keep an open and curious mind. It was, however, helpful in formulating good questions and it allowed me to grasp easily the general situation at the antenatal care clinics. Moreover, I consciously kept a low profile regarding my university affiliation since I felt this was open to negative interpretation. The interviewees did not know that I was going to ask about abuse since the subject had been specified as 'health risks in pregnant women'. This approach was motivated by a desire to obtain richer information about the clinical care in general instead of just focusing on violence.

In contrast to the interview setting with midwives, the practice of professionals working with men inclined to violence (Papers II and III) was largely unfamiliar. To counteract needless prejudices and misunderstandings, there were thorough preparations; such as examining closely available material from the different institutions, reading related material for example about prison establishment and correctional treatment, and making study visits. This activity generated questions and a desire to find out more. In short, the process of constructing knowledge on the part of the interviewer started well before the interviews actually took place. In the initial contacts with the professionals (letters, e-mails, faxes, phone-calls), the informants initially gave the impression that they were not particularly knowledgeable about IPV and

pregnancy. However, gradually they came to realize that most of their clients were indeed fathers and this insight seemed to bring a lot to their conscious attention and eventually resulted in them having a lot to tell. During the interviews, the dialogues were quite confrontational owing to the fact that both were experts (although in different areas) and asking curious but tough questions came quite easy to me as a novice in their area.

No specific preparations were deemed necessary for the interviews with the women who had been subjected to IPV during pregnancy (Paper IV), because the aim was primarily to share their stories. However, there was a great deal of preparation to ensure better confrontation of prejudices, to improve my understanding of the area and also to better recognize the prevailing discourses that the interviewees had come across in conversations with group leaders for abused women. I looked at written material regarding the programs concerned and also joined a study circle (following a set handbook) for a period of several weeks at one women's shelter. During the interviews, it became evident that my position (as a midwife, mother of my own children etc.) helped to empower the women to open up and to tell stories that they had found impossible to tell to anyone before (cf '*Trustworhiness*', p. 51).

Three different approaches used for data analysis and description

Grounded Theory

Further analysis of the recorded interviews was grounded in the data. Fourteen verbatim transcripts were made by the author and the remaining six by hired personnel (for technical reasons two of the interviews were never recorded, see p. 30). Small revisions were made to the transcripts to improve legibility. Pauses and interjections etc. were not marked in the transcripts since the main emphasis was on understanding and grasping the meaning of what the respondents said and not on linguistic analysis. To gain familiarity with the data, the text was read carefully several times and open codes were assigned arising from identification of certain words and expressions. Starting from these open codes, selective coding started where particular words and clauses were represented as codes and categories; some were discarded and others were linked together, forming and implying associations and ideas (Dahlgren et al., 2004). To avoid misconceptions and false ideas about the essence of the text, throughout this analysis process there was frequent reference back and forth in the original text and the coding.

Initially, as described above, the analyses for studies 1-3 followed the same line that was largely informed by 'Grounded Theory' (GT) and was an excellent way of getting to know the material and start to see patterns and get main ideas. However, from a certain point the analyses in the three studies took different paths: Study 1 continued with a GT approach (Paper I); Study 2 moved to 'Discourse Analysis' (Papers II and III) and Study 3 to 'Narrative Analysis' (Paper IV), see Figure 3.

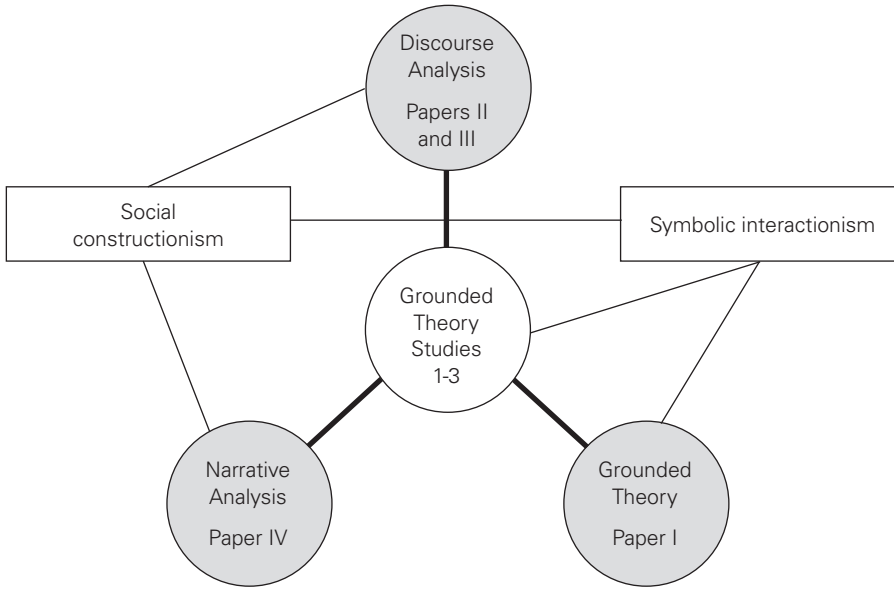

Figure 3. Grounded Theory as a methodological base for Studies 1–3.

For Paper I (midwives), the analysis continued to follow an open-minded discovery-oriented strategy intended to generate theories informed by GT (Dahlgren et al., 2004). The selective coding (from the initial open coding) was outlined by hand using a large sheet of paper (some 1.5 x 2 m) on the floor. Some patterns gradually emerged including subcategories, categories and relationships between. The method allowed each individual coding to be tracked all the way back to the text and the recordings, making it possible to check that the coding was indeed grounded in the data. The analysis finally resulted in two main categories 'The midwife with the sensitive ear' and 'You can't tell from the outside' that together framed a theoretical model for Study 1. They two main categories were together representatively labeled with the metaphor 'Beating about the bush'. In Figure 4, there are examples of some subcategories (from the initial open and further selective coding) that provided the basis for the categories and finally, the two main categories that led to the idea for a theoretical model (as described in Paper I).

Difficult to disclose (c)
- hard to interpret (sc)
- the woman conceals things (sc)
- afraid to lose her only security (sc)
- poor protection (sc)

Must get to know her and have strong reasons before asking (c)
- establish a contact (sc)
- go further (sc)
- careful choice of words but being straight (sc)
- the person who tells (sc)

↓

'You cannot easily tell from the outside'
(one of two main categories)

The midwife tries to create a comprehensive picture of the woman (c)
- poor standard routine questions (sc)
- difficult questions (sc)
- good to have questions that you address to everyone (sc)

The midwife tries to conduct a dialogue (c)
- the midwives must listen and try to understand (sc)
- sometimes you don't get the gist of it (sc)

↓

'The midwife with the sensitive ear'
(the other of the two main categories)

↓

'You cannot easily tell from the outside' +
'The midwife with the sensitive ear'
(both main categories)

↓

Theoretical model of the interpretative meeting between the midwife and the pregnant woman explained as a social process (see Paper I)
'BEATING ABOUT THE BUSH'

Figure 4. Examples of some of the categories (c) and subcategories (sc) that lead to the two main categories and finally to a theoretical model (described in Paper I).

Discourse Analysis

Discourse Analysis (DA) as used for Study 2 (Papers II and III) was not planned in beforehand, but the interviews with the professionals generally turned out to be rather different from the others (with the midwives and the women), characterized by lively dialogues and interplay, based in the informants' willingness to argue. Some of interviews were particularly confrontational, sometimes even provocative when we evidently recognized each other as experts. In the ongoing analysis process, and after several steps in the coding (with big outlines on the floor just as in Study 1) and the rejection of various suggestions, the idea developed of trying DA. The path from 'Grounded Theory' to DA was not twisted since the two methods can be regarded, at least to some extent, as mutually complementary (Dahlgren et al., 2004). The decision to use DA resulted in an interpretation somewhat focused on differences and similarities in professional discourses grounded in the interview data. Below follows a short theoretical description of what is meant by 'discourse' and DA (cf. *'Social constructionism'* , p. 24) and how DA was introduced into the analysis process:

Discourses are complex, as is reality; they conflict, change with culture, society and time, and include the past, present and future (Fraser, 1997; Hall, 2001). A discourse is the way language is used in communication so as to constitute meaning in a changing process of interaction among people. Discourses are socially constructed and serve as a means for people to orient themselves in various situations and social environments so as to understand reality; they are context dependent and have a function both in ordinary people's everyday lives as well as in professional life. The different and shifting meanings of words and expressions present in a discourse mirror, form and express the understanding of a constructed and constructive reality (Fraser, 1997; Dahlgren et al., 2004; Hall, 2001). Moreover, discourses are expressions of power through inclusions and exclusions, that is, what it is or is not permissable or thinkable to say (Hall, 2001; Taylor, 2001).

Analyzing a discourse implies looking at language in use and patterns in that use in order to find a shared understanding of a social reality (Taylor, 2001). In the analysis of discourses one might find how informants agreed or disagreed and how the language used can maintain control, resistance, struggles, constraints and inconsistencies. The results of a discourse analysis can challenge, and thereby cause changes in meaning and understanding and therefore also have a potential power in processes of change (Taylor, 2001). The interpretation of discourses involves power and is always incomplete since it includes certain viewpoints and excludes others (Taylor, 2001; Hall, 2001).

In Study 2, the eight interviews with professionals working in programs for men inclined to violence presented standpoints that were regarded as mirroring larger discourses (Connell, 1995) and as rerepresenting scientific and theoretical knowledge, influences from other immediate professional disciplines as well as societal and political currents. Moreover, since the professionals were authorities, they were considered as the bearers of knowledge and power. In the practice of their profession,

their knowledge might unreservedly have been viewed as the 'truth' or as becoming the 'truth' (Hall, 2001). Thus their professional discourses were characterized by a very important power aspect.

In practice, after becoming well acquainted with the material (after the first steps in coding informed by GT), nuances, contradictions, connections and interrelations with regards to the subject area were identified to reveal whether something was missing or unclear. Summaries and outlines were written to obtain an overview and to understand the meaning of the discursive components, and to find patterns and analytical concepts of value for the research question. In order to counteract possible misinterpretation, the analytical concepts, the first codings and the original text were repeatedly compared by moving back and forth within the material. Finally, certain major themes were recognized, such as dichotomies, stereotypes, omitted subjects and contradictions in the professional discourses.

Narrative analysis

There was no plan to use Narrative Analysis (NA) in Study 3. Instead, just as in Studies 1 and 2, the initial intention was to follow a GT approach. However, when the transcribed interviews were read and the first steps in coding done, the striking coherence of the stories spontaneously invited the simple translation of excerpts (from Swedish into English), since many parts of the interviews were so rich, expressive and powerful. Yet, that was neither feasible nor sufficient. On the other hand, the thought of consistently using GT and turning the stories into theoretical models seemed less than the ideal choice, and rather unappealing. With the plan of keeping close to the stories, NA was chosen as the method for the analysis as the intention was to understand the meanings articulated by the respondents and to represent the voices of these women by expressing that meaning (cf. Mishler, 1986). This approach, of course, still required interpretations, since "narratives are interpretative and, in turn, require interpretation" (Riessman, 1993, p.22).

Usually a narrator is supposed to have a reason for telling a story and is expected to include causal aspects, some temporal order and a plot. However, there is no precise way of defining what a narrative is (Riessman, 1993). One broad definition is; a narrative represents how people create meanings from a connected succession of actions, events and happenings (idem). Narrative research presents both the mirrored view of the narrators' retold constructed reality, that is jointly constructed between interviewer and interviewee, and a particular, preferred story (Mishler, 1986) – the choice of one narrative over another (Crossley, 2000). Narrative analysis seeks to interpret the interpersonal and social context and to answer questions about 'what was said' (content) and 'how' it was told (Riessman, 1993). The main emphasis in the analysis for Study 3 (Paper IV) was put on the personal experience and meaning in stories told by women who had been subjected to violence during pregnancy, and less on how the stories were told.

The coding resulted in minor and major categories and connecting ideas and iden-

tified important tracks that could form an outline for the narratives (cf. Kvale, 1996; Dahlgren et al., 2004). This does not imply that pieces could simply be put together to form one uniform narrative, because the individual narratives included many variations as well as contrasts and contradictions (Riessman, 1993; Hydén, 2000). The intention with the NA approach was not to lose the original voices but, as far as possible, to bring out the variations fully. Moreover, the interpreted meaning of the stories was continuously questioned, to identify probable alternative understandings (cf. Riessman, 1993). The narratives were retold, sometimes as individual parts or as many voices interwoven into more or less connected and multifaceted stories about becoming and being pregnant while being subjected to IPV (cf. Kvale, 1996). See also Paper IV.

Ethical aspects

The studies were all assessed by the local Ethics Committee at the Faculty of Medicine, Umeå University.

All the respondents received written information about confidentiality and were also informed about the right to withdraw from a study at any time, and they were of course not obliged to answer questions they found intrusive or simply did not want to answer. Moreover, they were informed that the interviews would be recorded and the recordings and their transcripts would only be available to the members of the research group. All the respondents were offered copies of the interview transcripts (some accepted, but most refused). The respondents were also assured that the recordings would be kept in a safely locked storage facility.

During the interviews, every effort was made to show respect for the interviewees and to support and facilitate the meeting, as well as to encourage the respondents' part of the dialogue (cf. Hydén, 2000), see also '*Interviews in Practice*', p. 29.

Ethical and security recommendations regarding study design in research on violence against women have been presented from an extensive experience from multi-country studies (Ellsberg et al., 2001, 2002; Garcia-Moreno, 2002). For each woman included in Study 3 (Paper IV), the women's shelters or the Probation Service were asked to act as intermediary contacts, to ensure the women's safety. All the women had already left their violent relationships and seemed in different ways to be (or to have been) supported individually and in empowering group discussions run by the services.

The locations were all well suited for undisturbed interviews; some were selected by the contacts and others chosen by the respondents. For all the interviews, the interviewer (KEE) was prepared and well-read in the subject area and consciously adopted a respectful and non-judgmental position towards the women. Moreover, after many years spent working as a nurse-midwife I considered myself to be trained in listening and in dialoging with women (cf. Ellsberg et al., 2001). The aim was to have empathetic but not therapeutic conversations (cf. Kvale, 1996; Johansson, 2005) but the limits might sometimes appear fluid, because through telling stories, people

might find ways to change (Crossley, 2000). It seemed that several of the women in this study found it helpful to tell their stories, finding new assumptions and telling details about a pregnancy that had not been told before. Apart from this, they also said that it was important to tell the stories for the sake of others. As a listener, it was important to have a supportive attitude because the narratives were very emotional, sometimes tearful and therefore difficult to tell. After the interviews, the women were asked how they felt and if they had unpleasant feelings or reactions afterwards and they were assured that they could talk to someone. In addition, they were offered the chance to call the interviewer (KEE) if they wanted to add something or just wanted to talk (two of the women did so, one twice). The women's stories were about their past, but they were still very dramatic and obviously there was a lot of sorrow remaining since they all seemed, in different ways, to be suffering from the after-effects of what they had gone through. It was touching as an interviewer to take part in all of this, and to ventilate the feelings after, one colleague and a caring research group were always willing to listen.

Main findings and discussions

The three studies compromising this thesis included data from 64 individuals (questionnaires 42, interviews 22; see '*Informants*', p. 26) and revealed three different viewpoints that produced a multifaceted picture of IPV during pregnancy. The intention in the following section is to tell a story with the abused pregnant women (Paper IV) as the protagonists, yet not solely from their viewpoints, but to include those of other actors connected with the issue, namely the midwives (Paper I) and the professionals (Papers II and III). Despite many different and nuanced perspectives, several, general connected ideas became apparent during the data analyses and these will be delineated to emphasize ideas, with the intention of increasing our understanding of IPV. The purpose is also to reveal, question and challenge discourses about IPV. The perspectives will be presented both one at a time and linked together, since they all have interesting connections and something to tell about the woman and her partner while she was expecting a baby and living in a relationship with ongoing IPV.

The complexity of living in a violent relationship

The women told stories about their entire lives, from growing up, to leaving home, to entering adulthood and meeting different men and then focused their stories on the men they fell in love with, got pregnant with, were their companions during delivery, were the fathers of their newborn babies; these men who simultaneously used violence and with whom they later broke up. The women's stories gave their perspectives on their partners who became violent, and these profiles will be compared with the professionals' discourses about men inclined to violence. The centre of attention here will be on the relationships that included ongoing IPV, but with a specific focus on the period when the women became and were pregnant.

Powerful or powerless?

The professionals, in general, explained men's violence as an issue of power and control. However, in individual conversations and group discussions they learned to know men as insecure, weak and afraid of losing power and control in their relationships. The professionals described violence as a response to fear and threats originating in jealousy and low self-esteem. They thus seemed to have a split picture of the violent man as both rigid and tough and insecure and weak (Paper II). When this view is compared with that of the women, the jealousy is described and it is even possible to get a picture of the men as having problems, but they are not described as powerless, which is understandable given that the women lived under more or less constant threat. It seemed, however, as if the men could show weakness and gentleness towards the women in certain situations and there are examples of the need to be cared for like a child and even eliciting in the women's feelings that they might be able to save their relationship if they could only love the man some more.

The reason for the façade the men present to the women may be found in 'communicating gender' in the relationship; the men could admit their weaknesses in

front of the professionals but if they did so in front of their partners they would lose the control they so badly wanted and thereby also lose their masculinity. When a man stands before his female partner, violence demonstrates masculinity and power – 'being a man' – and represents the way she has learned to know him as a man (Hearn, 1998).

Normal or deviant?

As described in Paper III, the discourses of professionals meeting men inclined to violence included generalizations regarding aggressiveness. From these discourses there emerged various 'ideal types' of violent men: the macho man who attacked immediately; the man who stored up his anger only to explode suddenly; and the persuasive man who put up with almost anything until he ultimately became furious. While the professionals certainly considered violence as abnormal behaviour, they also affirmed that any man could become violent. Yet this view comprised inconsistencies because violent men were described as not just having problems with aggression but also having deviant views of women, strange interactions with others, and a different language and way of communication compared to most other men. The programs aimed to offer a way out to men who lacked the tools to manage their relationships and aggressive behaviour.

The professional discourses took a seemingly self-inconsistent stance that implied that the violent men were regarded as both 'normal' and 'deviant' and this could be explained in different ways. 'Normal' and 'deviant' might be understood as contradictions as well as two separate discourses which, depending on the context, could be used differently. For example, when talking about responsibility in violent men, either the one or the other discourse could make sense, depending on the reasoning and whether seen from a societal or individual perspective.

In a Swedish context, the concept of normality might have been the opportunistic and expected way in this society of understanding 'violent men like any other men' and thus, consciously or unconsciously, this view is a self-serving choice of attribution for the professionals (cf. Augoustinos & Walker, 1995). In addition, deviancy could have been a tactic for keeping 'that kind of men' at a distance from themselves and their own relationships, as a convenient attribution to confirm the professionals' own normality (cf. Augoustinos & Walker, 1995; Kimmel, 1996). Moreover, the limits between normal and deviant might be very fluid and therefore hard to define. Nevertheless, this composite picture is compatible with attribution theory which claims that there may be many reasons for preferring one causal explanation over another (Augoustinos & Walker, 1995). Cf. '*Attribution theory*', p. 25.

In the intervention programs for men, they were confronted with their violent behaviour as being deviant and inexcusable. Stopping the violence was most probably sufficient motivation to run the programs (cf. Fox, 1999). The professionals, however, also spoke about attempting to change the men's views of masculinity and of teaching them strategies for showing emotion and verbal expressions. Yet, the

professional discourses comprised a dichotomized description of diverse and opposite gender positions, which if applied in the programs might have preserved and supported stereotypical beliefs that are in fact related to violence (cf. Heise, 1998; Heise et al., 2002) and therefore opposed to what the professionals aimed to achieve. Moreover, the professionals did not fully challenge the deviant behaviour observed in men, namely their gendered way of becoming 'men', such as in the interplay of close relationships, sexuality and parenthood (cf. Hearn, 1998). Such sensitive topics were largely ignored in the programs. See further Papers II and III.

The view of violent men as both normal and deviant was also evident in the interviews with women (Paper IV). The men were, according to women's retrospective stories, as one would expect, largely depicted as antagonists. Despite this, the women also described their partners' positive sides such as that they functioned well in certain respects and some were said to be very socially competent and liked by people around. By 'keeping up a front' and not revealing the situation to others, the women participated in protecting what was going on behind closed doors. Consequently, with some exceptions, outside the family the partners appeared to be quite ordinary people. One woman told about how some acquaintances had been really surprised when they learned about the violence and that they took it for granted that it represented an isolated incident instead of the actual long-term violence.

From the narratives – with their examples of forced subordination, very derogatory and vulgar language, the severity of emotional, sexual and physical violence – it would be difficult, or even impossible, to view the men as normal, functioning partners in relationships. Moreover, some women could compare with other men they had had relationships with, and some had also become pregnant by, and even from that perspective, the violent relationships in the narratives could only be described as disastrous.

When the women talked about their violent partners, the picture seemed to hover between normal and deviant, sometimes incorporating rather sharp contrasts, referred to by one woman as "Dr Jekyll and Mr Hyde" depicting how the better side could very quickly and without previous warning turn into the evil one.

To tackle the ambivalence

In the ongoing relationships, the women (Paper IV) might have had many reasons for trying to see their violent partners as basically normal and so save their own and their partner's self-respect (which happens even in non-violent relationships, cf. Kalman, 2002). To achieve this, the women may have considered their own subordination to be 'love' and tried to understand and excuse their partners' needs 'to be men' and thus play down their partners' deviant behaviour (Kalman, 2002). The professionals (Paper II) described this as the women's gendered empathy trap by which they adjust themselves to and permit the violence to happen without the men incurring any consequences thus perpetuating their victimisation. These ideas are related to what in Sweden has been called the 'normalization process' and implies that a woman first

actively adapts herself to male norms as a way of stopping the violence and then increasingly assumes a submissive position until finally she internalizes the partner's norms as her own (Lundgren, 2001).

It seems that adjustments in a relationship are reciprocal and actually all intimate partners make these adjustments, to a greater or lesser extent. The gender positions can be understood not only as separated gender orders but also as interactive processes with specific but invisible restricted concepts and expectations, that if transgressed may initiate resistance as well as violence (Hirdman, 1988, 2001). The professionals (Paper III) described examples, seen in their clients, of overly flexible men and initially 'super partners'. These men ultimately became aggressive and violent after being compliant for a long time trying to win their partner's attention and love.

According to the women's stories (Paper IV), and in contrast to the 'normalization process' (Lundgren, 2001), women's adjustments were much more complex (Hydén, 2001; Holmberg & Enander, 2004). While trying to foresee a change or imagine an end, the women still recognized their relationships as deviant. To adapt, to tackle the ambivalence and contradictions and to strike a balance between normal and deviant, seems rather to have been a way to survive and not to reflect an acceptance of the violence on the women's part. Instead, the women had questioned the violence and the relationship as being all wrong and had offered a lot of resistance, although it seemed that the pregnancy made this harder and at the same time made it inopportune to break up. Apart from the two who left while pregnant, one because of life-threatening violence and the other because of the threat of such violence, the women left when the last baby was a toddler. One woman was even persuaded to move back in with her violent partner to avoid being a single mother and another planned to leave but was too frightened because of her partner's unpredictable behaviour.

Other researchers have presented similar results of divided feelings that make the decision to break up hard (Helton & Snoddgrass, 1987; Goldner et al., 1990; Rosen & Bird, 1996). Moreover, pregnancy itself adds hopes and dreams related to the romanticized image of pregnancy, and the mother-to-be may value having a father for the baby instead of being a single parent (Lutz, 2005a). To leave a relationship is in itself stressful; to do it while being subjected to violence is even more demanding (Rodriguez et al.,1996; Walker et al., 2004) and to consider this during a pregnancy simultaneously exposes a woman to three difficult stress factors (Lutz, 2005b).

The lover turned perpetrator

The nine women interviewed (Paper IV) had all been subjected to severe physical, sexual violence or threats of such violence during at least one of their pregnancies. The physical violence included all forms of serious and even life-threatening violence and three of the women had even been kicked in their pregnant abdomen or jumped on. Emotional violence was a major thread running through the women's stories about their relationships with IPV and profoundly also affected their experience of being pregnant (cf. '*The pregnancy put the screws on*', p. 45).

The beginnings of the relationships were described like any other love story. While continuing to display passionate and affectionate sides, the men at some point started to change and also to be violent, and this came to play the major part in what the women described as a terrible nightmare. To have someone to confide in seems to have been the exception for the women and instead their lives became quite restricted and some described being cut off from their former circle of acquaintances. This agrees fairly well with research that has shown isolation to be both a consequence of violence and essential for its continuation (Heise, 1998).

Despite the 'nightmare', the women carried on by such means as nurturing 'rosy dreams, or hopes for a change for the better, and from a desire to defend the relationship and not give up the thought of having a family. The relationships became complex with negative, wicked behaviour and violence balanced to some extent by positive elements. Some women even spoke of such things as long-standing friendship, passion, love, strong feelings and a belief they were meant for each other. For two of the women it was still possible to have a reciprocal and good sexual life, where their partners were gentle and paid them attention, in this way making them feel noticed and respected. Two women had planned pregnancies and spoke about their babies as love children and the result of their decision to consummate the relationship, rather than believing that pregnancy would improve the relationship or reduce the violence.

For the most part, however, the narrated relationships consisted of an ever present fear and insecurity, not knowing what was going to happen next. No matter what the women did, as far as adapting, obeying and trying to calm the partners down, mostly nothing helped. Sex was sometimes effective in countering violence, but left the women with feelings of repugnance, emptiness and disgust. The descriptions of sexual life were negative (apart from the two women mentioned above) and in one way or another were seen as a part of the violence. The women were either physically forced to have sex or felt they had no other choice. One woman learned to avoid showing sadness since his comforting turned into forced sex and the more resistance she showed the more sexually aroused he became. Some described sexual acts as rape, for one it happened almost every night, over and over, even when she was pregnant, until the very last week. Another woman had perhaps her most horrifying experience when she was at the very end of her pregnancy and was raped in the shower while she wept but did nothing. The women's partners, however, probably did not consider their actions to constitute rape, such as in the first case the woman said he considered sex his 'right' and in the other case she offered no resistance. There were, however, examples of the partner's reactions and insolent comments concerning having intercourse when the women did not actively take part, such as she was "expressionless" and it was "just like penetrating a mattress".

The women's descriptions of sex hinted at silent and uncommunicative love acts with no room for foreplay, discussions about contraceptives or other forms of protection and might explain why the pregnancies were often unplanned and not the result of a shared decision. An extreme example was the partner who hid the woman's contracep-

tive pills and hurt her to force her remove the IUD she had had fitted, criticized her after she had legal abortions and made her pay because he had decided to make her pregnant at all costs. Since the same man was described as extremely dominant and neglectful and ignored her when she was expecting, pregnancy could have been his way of keeping her subjugated, as described in other research (Coggins & Bullock, 2003). When women are living in a relationship with a violent partner, they usually have very limited control over their sex life and fertility and they thus become unintentionally pregnant more often than other women (Campbell et al., 2000; Coggins & Bullock, 2003; Pallitto & O'Campo, 2004; Pallitto et al., 2005). See further Paper IV.

According to the professionals who met men inclined to violence (Papers II and III), their clients generally denied ever using sexual violence. But men's statement can be questioned for several reasons. First, the term 'sexual violence' probably was interpreted by the men as something very different from what they believed they had participated in (according to what the professionals described, see below) and the same is most likely true for the term 'rape'. The ways in which the men were asked about sexual violence can also be questioned. In one program, for instance, the clients answered written standardized questions at enrolment. Moreover, veracious, self-reporting was unlikely given that the men viewed sexual violence as sensitive and taboo and as a low status crime and that the institutions were obliged to report knowledge about rape. Accordingly, the issue was also a sensitive one for the professionals and apart from the men's denial it seemed to be almost unmentionable and was further complicated by their duty to report it. Despite the professionals' own understanding that men and women view sex in different ways, that men may see sex as their right, use women for sex and use sex as a part of acts of violence, sex and sexual violence was largely avoided issues. There was thus hardly anything in the intervention programs that would lead men to reveal sexual violence.

In addition, the professionals' own definition and interpretation of the term 'sexual violence' was partly something specific and different from involuntarily sex. Someone suggested sexual violence was probably more commonly committed by men with drug problems and various personality disorders. The discourses gave the impression of (presumably unconscious) attempts to keep the sensitive issue of sexual violence at a distance, to marginalize it and to view it as fairly uncommon or as mainly concerning other men outside the intervention programs. This view supported the professionals' belief that they did not have sexual offenders in the programs – just fairly ordinary men (cf. '*Normal or deviant?'* p. 39).

All in all, an obvious clash emerged between the perspectives of the women and the professionals regarding sex and violence (Papers II–IV). For the women sex was as a common, coerced, forced or reluctant part of the IPV; they used the term rape and reported the negative and longs-lasting effects. The professionals, on the one hand, recognized the women's perspective although not usually through the men's confessions, but on the other seemed to accept the taboos and the men's denials, as if all their clients were exceptional cases. Consequently, they did not give this any

space and neither confronted men about sex related to violence nor emphasized their responsibility, as they did with other forms of violence regardless of the standpoints the men presented.

Other studies report that sexual violence is a large part of IPV (Coggins & Bullock, 2003). One third and up to half of physically abused women are also subjected to sexual violence (Heise et al., 2002) and women in IPV relationships have very restricted control over their sexuality (Campbell et al., 2000; Coggins & Bullock, 2003; Pallitto & O'Campo, 2004; Pallitto et al., 2005). However, the way the subject of sex and sexual violence was handled in the programs for men (paper II, III), might have sustained the understanding of sexual violence as uncommon. Furthermore, it may then, unintentionally, also have supported the view that sex is an eroticization of dominance and is supposed by men to be just a related part of sex or a backdrop to their violent acts (cf. Hearn, 1998). Accordingly, sex and sexual violence are viewed by violent men as components of tacit heterosexuality, kept separate from their definition of violence and hence absent in their talk about violence. Sexuality is one of the most central arenas where masculinity is constructed and acted out (Hearn, 1998; Messerschmidt, 2000), but according to interviews with the professionals, issues related to sexuality were largely omitted in their discussions with the men in their programs which might then leave stereotypes and gender dichotomies unchallenged (cf. '*Normal or deviant?*' p. 39).

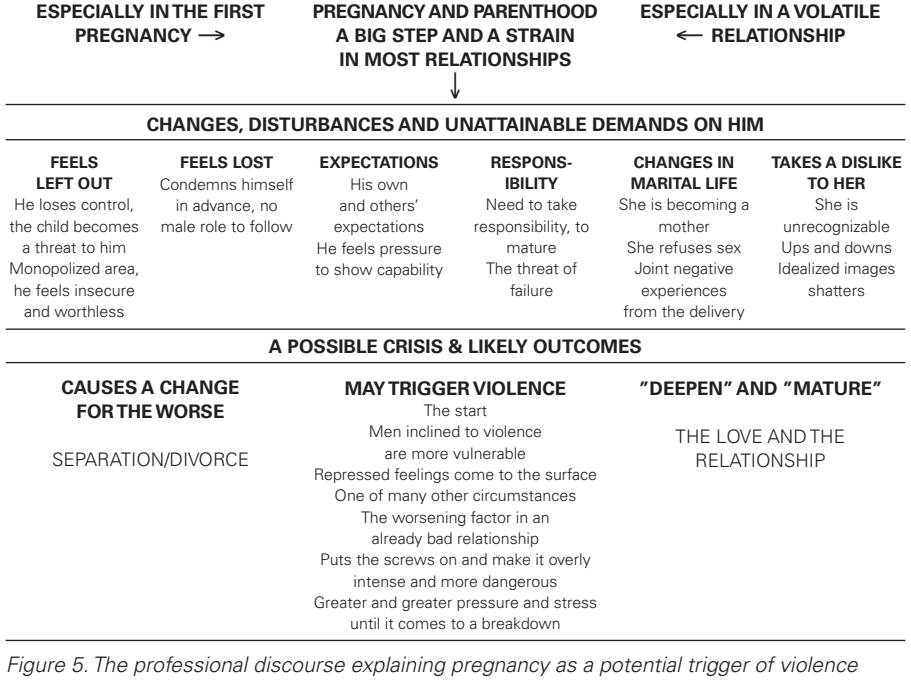

Figure 5. The professional discourse explaining pregnancy as a potential trigger of violence

The pregnancy put the screws on

The professionals (Paper II) did not say that pregnancy is a cause of violence but that pregnancy together with other circumstances can trigger violence, especially when it is the first child that is expected and in volatile relationships (Fig. 5). According to the nine women's narratives (Paper IV), they were subjected to violence in fourteen pregnancies in total. In five cases the IPV clearly started or restarted with the pregnancy (the first joint child for four) and was described as a turning point when the relationships changed for the worse, although for three of them the relationships were quite volatile even before. For the others it seemed that the pregnancy largely made the ongoing violence worse, kept it about the same or made the already difficult relationship even more complicated. Being pregnant with the violent partners was mostly described as a terrible and frightening experience and none described pregnancy as a calming or protective factor.

The women perceived the partners as generally rather uninvolved in the pregnancy; they changed for the worse, stopped showing positive feelings and became irritated, worried, tense and uncommunicative. The women were often stressed, and very afraid of violent acts and the effects on the unborn baby. 'Ordinary' everyday life was perhaps even worse with an endless sequence of psychological violence and their partners oppressing and controlling them and acting as if they owned them, their pregnant bodies and their expected babies. While the partner might appear proud of the baby, he could suddenly treat it as worthless, as when he became violent. Six of the nine women could compare with very different and positive previous pregnancies in non-violent relationships and were aware of the considerable contrast. The violent partners were not concerned about them, gave them no supportive care or sympathy because they were pregnant and the women could neither really enjoy nor fully take in the growth and the quickening of the foetus. The women instead described their condition as being in a depressed state of mind, lonely, lacking appetite and extremely weary. Moreover, the women did not get to feel that they were good mothers since they were constantly criticized and belittled and some partners even questioned or regretted their paternity.

Seeing it from different sides

The stories told by the women (Paper IV) gave some hints and ideas about the partners and their bad temper and reactions related to the pregnancy and how this resulted in an initiation, recommencement or escalation of the violence. The studies presented in this thesis, however, do not give the partners' side of the stories. The professionals' discourses regarding the changes, disturbances and demands on men during their partners' pregnancy suggested that pregnancy could be seen as a possible trigger of violence and might well explain at least some of what was going on in the fourteen narrated pregnancies (Fig. 5).

Examining the findings in the two studies with professionals and women respectively, it is easy to find connections but also contrasts between their points of view

regarding the partners' side of the matter. The professionals (Papers II and III) linked the violence to such things as discontentment and displeasure within the relationship, often related to the men's deviant and overly idealized view of women that sooner or later had to break down, for example when she became pregnant with his resulting dislike of her. This view is particularly well exemplified by one woman's story (Paper IV). Her partner felt ashamed of her pregnant body, did not want to be seen with her, called her a 'fat and ugly toad' and did not even allow her to travel with him in the car on their way to work.

The professionals described expectant fathers as feeling lost, left out and threatened (Paper II) while the women (Paper IV) told quite different stories. The women described how their partners' deliberately ignored both them and their pregnancies, how they did not seriously care about the baby and did not try at all to take part or get close. However, it seems unlikely that the couples in a relationship with ongoing IPV, would be able to engage in open-minded discussions about each other's feelings regarding the pregnancy. Indeed, according to both the women and the professionals, the couples were instead often engaged in a very deviant interplay using a negative, defensive language that lead to misunderstandings and disputes (Papers III and IV). Moreover, just as with paradoxical messages regarding power it might have been impossible for the men to show such feelings as being left out and vulnerable as expectant fathers; such feelings were probably viewed as showing the women that they were incapable and this would have been incompatible with their masculinity (cf. Hearn, 1998; *'Powerful or powerless?'* , p. 38).

The antenatal care

In Sweden, midwives working in antenatal care are responsible for birth education classes and all the routine care of pregnant women, including a visit after the delivery. Women are referred to physicians only if something is found to be abnormal. The Swedish National Board of Health and Welfare (in Swedish; '*Socialstyrelsen*') provides national regulations and recommendations for antenatal care, but for certain psychosocial matters the guidelines are vague or even non-existent. Consequently, the subject of violence against women is handled quite differently in different counties and antenatal care clinics throughout the country. As regards the antenatal care clinics mentioned in study one and three (Papers I and IV), no routines or guidelines regarding IPV were in place at the time when the studies were carried out.

Both the study with the midwives (Paper I) and that with the women (Paper IV) presented pictures of encounters at the antenatal clinic, but from different viewpoints. The two sides could be generalized and described with the help of two metaphors; for the midwives "beating about the bush" (in Swedish: *'att gå som katten kring het gröt'*) and for the women "keeping up a front". It goes without saying that these attitudes in combination do not promote disclosures of IPV. The following sections present the main aspects of the two metaphors and finally discuss the consequences.

"Beating about the bush"

The midwives (Paper I) had worked within antenatal care for on average about 16 years but their own experience of violence against pregnant women was limited and the unrecorded cases were unknown because of hidden statistics. Consequently, even if the midwives were well-informed regarding the subject area, their knowledge was rather theoretical.

To get a hint of how often the midwives had met women known to be subjected to physical and sexual violence in recent times, they were asked to estimate roughly the number of such women among their enrolled pregnant clients during the preceding year. The frequency was 0.6% – very low compared to national (1.3-4.3%) (Hedin et al., 1999; Stenson et al., 2001) and international (1-38%) prevalences (Saltzman et al., 2003; Jasinski, 2004; Shadigian et al., 2004; WHO, 2005). Although the midwives' approximations were retrospective, they provided an indication of how much IPV during pregnancy came to their knowledge (and one can reasonably expect that, if anything, the numbers provided by the midwives were overestimations). Yet, most of the midwives recalled cases when they had suspected abuse but were unable to confirm it. They reported their reasons for their suspicions, such as an intuitive feeling that something was wrong, women missing appointments and women being insecure, rushed and turning down attempts to extend contacts. Moreover the midwives believed that it could be a sign of violence when women had a lot of fears and worries as well as a controlling partner or difficulties in the family.

The midwives found it hard to talk to pregnant women about violence since they felt that the subject was regarded as taboo and asking a direct question would be very sensitive. It was seen as extremely difficult to be certain when interpreting the signs of abuse since one could not easily tell from the outside, one had to know the woman and to have very strong reasons before explicitly asking about IPV. The midwives said they did not have written guidelines either for assessment or for intervention of IPV at the antenatal clinic. Instead, they handled the issue of violence as they did to get that of vague psychosocial problems, namely, they tried to be open and receptive in creating dialogues and in establishing good contacts with the women. If this was hampered for various reasons, the midwives could for example propose the woman be given more frequent or longer appointments and could in different ways encourage her confidence until the midwife found it appropriate to ask the sensitive questions. However, the midwives rarely reached the point where they dared to ask, that is, they tended to indulge in 'beating about the bush'.

'Keeping up a front'

The women concealed the ongoing IPV in most situations and as one woman said, she "became a specialist in lying". The reasons for this were complex but seemed to be closely related to the ambivalence between recognizing their situation as all wrong, hoping for a change and accusing themselves of being a part of the problem. More-

over, disclosing the IPV was the same as revealing their own stupidity in allowing the violence to go on.

Two of the women had left their partners during pregnancy because of life-threatening violence. For the others, a lot was going on behind the façade while they were 'keeping up a front' and trying to make others believe that everything was all right. Women weighted the pros and cons of staying or leaving and apart from love, the hope of better days and the wish to not give up their dreams and they were afraid and uncertain about leaving. Two women mentioned financial dependency, which might be less of a problem in a Swedish context than in many other countries because most women here are gainfully employed, there are generous public social insurance systems and low-cost public childcare. However, separations can still change one's financial status and security and is thus a relevant factor for most women even in Sweden (cf. Anderson & Saunders 2003; Walker et al., 2004). The two women mentioned were, however, probably in quite unusual situations compared to most other women in Sweden. Their partners kept control over the finances by, for example, transferring money to their own accounts and signing away properties for their own profit.

Women pictured their lives as characterized by a day-to-day strategy to find the power to endure rather than break up the relationship. At the same time as they were visualizing them ending; they expressed a sense of not finding a way out of their very complex and strange situations. While seeing no other choice but to carry on, and despite oscillating between love and hate, hope and despair, they used a lot of different tactics to maintain balance between resistance and adaptation in order to survive (cf. *'The lover turned perpetrator'*, p. 41).

The women described how, for example, they tried to keep out and conduct themselves in such a way as to avoid certain behaviours to prevent their partners' outbursts. However, such attempts were largely unavailing because the reasons for the aggression were rarely obvious but were instead very strange and unpredictable, and once an outbreak started little could be done to stop it. Another and more doable way was to find ways to endure the violence or even to use repressive mechanisms. Moreover, horrified for the sake of the unborn baby, the women fend off, backed down, tried to calm themselves and even used sex to appease the man and thus to defuse the whole situation. Nevertheless, the women also described how they actively offered resistance such as by questioning his behaviour, refusing sex, sharply telling their partners to stop the violence out of care for the baby, by using self-protection and even fighting back.

In all this, the women became more and more isolated and largely, and with a few exceptions, were cut off from former social networks at the same time as they were 'keeping up a front' in relation to others.

Enrolment at the antenatal clinic

The women interviewed were all enrolled at antenatal clinics where it was not routine practice to ask direct questions about violence (cf. Paper I), accordingly, the existence of IPV was mostly unknown at the clinics, just as it was for other people around the

women (cf. '*Keeping up a front',* p. 47). The women's descriptions of the antenatal care appointments were either quite negative or neutral. They had problems remembering the midwives (although this is probably quite common), they did not clearly understand the role of the midwives and one was even unsure if she had in fact met a midwife. The appointments were perceived by some to be standard medical checks and by others as threatening events where they had to hide or lie or the scheduled times were simply skipped. It would have been menacing and shameful to reveal that they stayed in a situation where they were subjected to violence since that was the same as accepting it. At the same time as suffering a lot of pain and ambiguity, the women used a great deal of energy in enduring their relationships and in such an unstable situation, keeping appointments was demanding because they would not letting someone in and being questioned. It seemed as if keeping their distance and saving face in front of others, including the midwives, was a survival mechanism. In addition, several of the women did not know the midwives as people they could have complete confidence in and they were even regarded as authorities and in that sense menacing to the women.

The midwives knew about the violence in only three of the fourteen pregnancies with IPV mentioned. This was, however, helpful to just one of the women, while the other two were referred to other professionals, but were not really helped by any of them. Before getting to the example of the helpful and compassionate meeting, a comparison is presented between the viewpoints of the midwives and the women subjected to IPV, in an attempt to understand why meetings between them commonly failed to generate trust.

The categories, printed in italics (cf. Fig. 3 in Paper I) are followed by both the midwives' (**M**) and women's (**W**) positions as described in more detail in Papers I and IV.

Avoid antenatal care

M: it was to be expected that women subjected to IPV might choose not to show up at the clinic.

W: that was exactly what some women did since they did not want anyone to ask questions or interfere as they felt threatened or they had visible bruises.

Vague standard questions

M: used pre-printed questions from the antenatal care records about subjects such as tobacco and alcohol, but had no questions or other guiding principles regarding IPV.

W: none of the women mentioned being asked about violence, but three spontaneously decided to tell the midwife.

Poor communication

M: the midwives said it was hard to get close to some women.

W: antenatal care was seen as mainly somatic check ups and the midwives were not necessarily regarded as trustworthy so the women kept their distance.

The man guards

M: men were invited to the appointments and it was seen as important to get them involved. Nevertheless, those men who attended all the time were sometimes met with suspicion and they made it impossible for the midwives to ask about violence.

W: only one woman told about having a partner who always went with her to the appointments (and he was adorable to the midwife), for the others it seemed as if the partners were rather uninvolved.

The woman conceals

M: when violence was suspected it was difficult to get close and to gain the women's confidence, despite prolonged and more frequent appointment and even trying to get clues from colleagues. Instead of asking direct questions, they were 'beating about the bush'.

W: there were many ways to keep their distance from someone they did not want to make contact with but wanted to hide from, such as staying home when injured, covering bruises with clothing, lying, not telling, being reserved so as not to let the midwife in and in short, 'keeping up a front'.

Despite all the obstacles described above, the midwives thought about the possibility of deepening the dialogue, listening, being aware and looking for signs and waiting for the right moment to ask. As asking was regarded as very difficult, sensitive and taboo they needed to be almost sure – not just suspicious – before questioning the women. What also might be questioned is whether the resistance in midwives to ask intrusive questions might mirror a prevailing wishful thinking about pregnancy that does not necessarily reflect most women's real life situations, but instead overly positive and romantic. Moreover, midwives might even be responsible for maintaining and reconstructing that particular discourse of pregnancy, which is undoubtedly at odds with IPV (cf. '*Discourse analysis*', p. 34).

To sum up and according to the interview results (Papers I and IV), instead of asking straight questions the midwives continued their interpretive process which was like 'beating about the bush' while the women were 'keeping up a front'. This can be seen as a vicious circle that can be explained as a reciprocal interplay; the midwife did not get close and became insecure because the woman concealed things and the woman did not open up because the midwife was uncertain and suspicious and that prevented both disclosure and support from taking place. But there was one exception as follows:

One woman found pleasure in visiting the midwife. This was in contrast to her experience from a previous pregnancy when she also was subjected to violence. The difference seemed to have been a combination of herself, the nature of her relationship and the midwife she met at that time. During the earlier pregnancy, the relationship had been fragile and new and the experience of violence was overwhelming and hard

to put into words. The memories of the antenatal care appointments in that pregnancy were somewhat diffuse; she could not remember going there much at all but what she kept in mind was seeing the midwife as an authority and the memories aroused threatening and negative feelings. In the later pregnancy, things had changed for her and with her relationship and she had had opportunities for deeper self-reflection. In that position she met a midwife who did not lecture her but simply sympathized with her, who allowed openness and tears and this was enough to meet the woman's needs. Although she did not leave her partner until some time after pregnancy, those appointments became very important to her.

Trustworthiness

The interpretation and representation of complex realities are imperfect and incomplete since (just like knowledge in general) they are constructed, contextually dependent, time-bound and contingent (Riessman, 1993; cf. *'Analytical Frames'*, p.23). It is important, therefore, to continually have evaluative discussions to reflect on every step during the research process to avoid possible limitations, uncertainties, deviations and biased interpretations (Kvale, 1996; Taylor, 2001). Since the quality of qualitative research depends on its trustworthiness, reflection and questioning discussion were important throughout the research process for all three studies compromising this thesis. Trustworthiness is multidimensional, just like qualitative research itself, yet it is often described in technical terms such as conformability, dependability, credibility and transferability (Lincoln & Guba, 1985; Dahlgren et al., 2004). Below, some summarized discussions are presented (see also discussions in Papers I-IV).

Doing qualitative research means using oneself as an instrument. Accordingly, one inescapable factor that undoubtedly affected the outcome of the three studies up to the point of writing this sentence was myself as an investigator (cf. *'Interaction in interviews'*, p. 30). This 'midwife bias' of mine (besides that of being a woman, a spouse, a parent etc.) has certainly left its imprint in the construction of the research questions, in readings, meeting informants, data interpretation, analyses and finally when re-representing the viewpoints of the informants in the reports delivered. However, my own standpoints have deliberately and systematically been cultivated through extensive study, openness, curiosity, and interactions with collaborators. It was nevertheless impossible, of course, and probably not even desirable to eliminate this bias. In fact, on several occasions it was evident that the 'midwife bias' was useful and advantageous, particularly when interviewing women who had been subjected to violence.

A less obvious, but perhaps more serious bias, is theoretical pre-understanding (including study design) originating in predominantly mainstream traditions within the subject area, since it is easier to conform than to challenge (Mishler, 1986). There are, however, two sides to this, on the one hand being open and counteracting fixed ideas and on the other realizing the necessity to relate to and include previous research (Taylor, 2001). Moreover, knowledge cannot be constructed from a void because it

reflects not just the present but also the past (Burr, 2003). Preconceptions regarding 'IPV and pregnancy', 'gender' etc. might have influenced not only the research questions themselves but also the way the studies were carried out. Potentially negative effects deriving from these preconceptions in the three studies compromising were dealt with by way of (1) allowing an *emergent design;* (2) *triangulation,* i.e. permitting interplay between different theories, methods and the three viewpoints of midwives, professionals and women, which produced not just separate perspectives but in their juxtaposition, furthered a deeper understanding of a complex subject area; (3) by keeping detailed *audit trails:* i.e. saving notes, memos, sketches, preliminary and finally analyses to make it possible to check how interpretations were made and how well they were grounded in the recorded data; and (4) by *regular discussions* of the interpretations in the research group that represented an interdisciplinary research environment (cf. *'The research process'* p. 22).

In each of the three studies plenty of time was set aside for each interview (including time for the respondents to get information and to put questions before the recorded interview started), creating the possibility of building trust and of entering into the details of the subject area in more depth. For practical reasons such as time and money, one interview was planned and carried out with each person; in hindsight a second interview would probably have been useful. Some respondents received the interview transcriptions to read (all were offered that chance), some contacted me (KEE) afterwards to talk, to make comments or to pose questions but none wanted to revise the transcripts of the interviews.

One difficult decision in qualitative research is to determine an appropriate sample size. To do as Kvale proposed (1996, p. 102) – "interview as many subjects as necessary to find out what you need to know" – seems simple enough but the reality is a little more complicated. Most studies are constrained by time and resources, so the approximate sample size may have to be decided at the commencement of a study. The exact number of interviews was not decided beforehand for any of the studies included in this thesis, so that more respondents could be added if needed. This was in line with the inductive attempt to generate knowledge from data (and not to test a hypothesis) in order to reach theoretical 'redundancy'. Just the right sample size is not too many and not too few but enough to allow the point to be reached where further interviews seem unnecessary and where they probably add little or negligible new knowledge with which to answer the stated research questions (Kvale, 1996).

With respect to transferability, the results in Paper I are of obvious relevance whenever routines are developed for IPV interventions and especially in the context of antenatal care. The professionals (Papers II and III) engaged in intervention programs for violent men showed considerable variation in their backgrounds, work settings, agenda and some set the tone more than others. Yet, the discourses were largely consistent across the respondents and it therefore seems highly plausible that they reflected larger discourses. While the results are probably transferable in Sweden to intervention programs for violent men, more importantly, they could form a starting

point for further discussions about curricula and professional discourses regarding male violence. For the sampling in Study 3 (Paper IV), the personnel who helped recruit respondents from the women's shelters and the probation centre were informed in detail about the aim of the study and the sampling intentions. Nevertheless, we had no direct control over additional exclusion and inclusion criteria that might have been applied. Therefore, we may have come into contact with the most talkative women, those subjected to particularly serious violence, or women who, in other ways, may not be representative of pregnant women subjected to IPV in general. However, given the coherent picture that emerged from the interviews, and the results that could be compared to previous research, there is no reason to suspect that the results of this research are extreme. Instead, within the limits of the conclusions, the results are transferable to other women subjected to IPV in the period of pregnancy.

Conclusions

The subject of this thesis is beyond question a public health problem (FHI, 2005). The objective was to study intimate partner violence (IPV) focusing on the period of pregnancy in a Swedish context. The design was emergent and triangulation was used enabling interplay between theories, methods and the different viewpoints of midwives, of professionals working with men inclined to violence and of women who had been subjected to IPV during pregnancy. Combining different perspectives, as in this thesis, not only provides a more comprehensive and complex picture than otherwise, but it also exposes contradictions and disagreements.
A few selected conclusions from the thesis will be stated below, followed by some implications for practice and future research.

IPV during pregnancy as horror, hope and resistance

All the women's abusive relationships started as love-stories that gradually turned into stories of suffering severe physical, sexual and emotional violence (Paper IV). Yet the women maintained that their relationships had both negative and positive sides, despite the violence and they even accused themselves of being a part of the problem. Rather than being a calming factor, all the women described how their pregnancies made their relationships even more complicated and took matters to the extreme of horrifying experiences. The women negotiated their difficult situations by trying to strike a balance between forbearance, love, adjustment, subordination and active resistance, while hoping for a change or for the right time to leave. It seemed to have been particularly untimely to break up during pregnancy; only two broke up and those were for life-threatening reasons. Moreover, the women coped with their difficult situation by 'keeping up a front', hiding their situation from others and thereby forcing themselves into social isolation.

The antenatal care encounters

With one exception, none of the women subjected to violence during pregnancy had positive experiences of the antenatal care they received (Paper IV). Some of the reasons for this became obvious when the stories told by the women and the interviews with the midwives were juxtaposed. The midwives (without routines for IPV assessment and intervention) were afraid to pose sensitive and potentially offensive questions even when they suspected the abusive relationships. The women on the other hand were threatened by proximity to someone who could reveal their situation and accordingly they hid behind a façade and even missed appointments. The combination of midwives 'beating about the bush' and the abused women 'keeping up a front' is obviously incompatible with optimal antenatal care of pregnant women subjected to IPV. Among the three women that had revealed the violence to the midwife, only one felt that she had received the support she wanted and needed.

Contrasting pictures of violent men

With few exceptions, the women interviewed described deficient or obstructed fertility control, rape and forced sex as an inescapable part of the IPV. In contrast, the professionals meeting violent men said that practically all their clients denied ever having been sexually violent. Yet, the professionals acknowledged that men and women may have different definitions of sexual violence.

The women claimed that if the ongoing violence did not remain about the same, the pregnancy was the point at which it started or became worse and none mentioned that pregnancy functioned as a protective factor. In the professionals' experience, pregnancy was a period that could make impossible demands on male partners, who felt they were left out and had lost control and it could therefore trigger violence, especially if the relationship was volatile and they were first-time parents. The women, on the other hand described their partners as being far from left out but that instead they kept themselves at a distance and were interested neither in them nor in their pregnancies, and made the women feel unwanted and unworthy as mothers.

The professionals described violence as the result of complex situations and interplay and not simply an issue of 'power and control'. Women gave a picture of their violent partners as 'Dr Jekyll and Mr Hyde' which agrees with how the professionals described the men as ordinary but yet deviant in their views of women and in communication and interplay with others. Moreover, the professionals gave a multifaceted picture of violent men; they displayed poor self-confidence, were weak, fearful and powerless but they gained toughness and control through their violence. While the women also provided a complex picture, they lived under constant threat of violence and the men's violent outbreaks produced unequivocal terror.

The Professional discourses might counteract their own good intentions

There were obvious disagreements between the views of some of the professionals and some of the women. It was clear from the professionals' discourses that men inclined to violence might be regarded as both normal and deviant, but their ways of 'being a man' were displayed differently in their intimate relationships compared to most other situations including participating in programs. If they found reasons to be aggressive in the relationship, some men attacked immediately, others built up aggression and exploded unexpectedly or ultimately after trying other solutions. The violence might be understood as a response to their poor ability to communicate their feelings of weakness and helplessness to their spouses. Their violence seemed to be an attempt to express their masculinity and to maintain their position as 'being a man'. An obvious conclusion from this is that men will not stop their violent behaviour unless their thwarted view of masculinity and their inability to communicate in close relationships are tackled.

The professionals very clearly intended to make men accept responsibility for and stop their violence and they also wanted to change their views on masculinity. However, their discourses appeared to be unreflective and even counterproductive.

Sex and sexual violence were regarded as sensitive and difficult issues and were largely omitted from the programs and accordingly, the client's denial of having committed sexual violence was not challenged. Similarly, other relational 'gender constructional' issues concerning close relationships, such as pregnancy and parenthood, were also commonly excluded from the programs for men inclined to violence. With the stories told by the abused women in mind, challenging views of masculinity seems urgent, but this will probably be ineffective without discussing it in relation to intimate and relational matters.

Implications

Intimate partner violence (IPV) is very complex on both individual and societal levels and deals with power structures regarding gender and social status, but it is also related to such aspects as psychosocial and drug problems. Accordingly, there can be no simple solution to IPV. Nevertheless, given the results presented in this thesis it is possible to identify some specific areas where it is possible to intervene and where improvements are possible.

Antenatal care

Midwives need to pose direct questions about IPV to all pregnant women as part of the routine surveys at antenatal clinics. For Sweden in particular, national recommendations from the National Board of Health and Welfare would be desirable. However, the good news in Sweden is that during the last few years, in the antenatal care programs of several counties including the two counties concerned in this thesis, routine assessments including questions about violence in relationships have been implemented.

Posing questions is a good start. According to the results of this thesis, however, women's ambivalence and complex relationships render decision-making difficult. Consequently, midwives (as well as other health professionals) need properly functioning professional networks not only to support themselves but also for complementary consultations for the women subjected to IPV. Midwives need to listen, to be non-judgemental, patient and empathetic in order to empower the women to find their own solutions. Perhaps most importantly, the midwives need to understand that making decisions, such as about leaving, is a process and not a one-off event.

Research is needed to evaluate discourses, assessments and intervention programs in antenatal care and to develop and improve the routines and networks used to date. The possible side effects of a more direct approach to reveal the existence of IPV, such as the risk that some women may avoid visiting the midwife, need to be evaluated. Studies also need to bring in other perspectives, not only the pregnant woman's but how a disclosure of IPV may affect the rest of the woman's family, such as the father and the siblings of the expected baby.

In Sweden and probably in many other countries, men are almost always with the women when they give birth. This invites several interesting research questions,

such as, can violent men still be supporters when their partners give birth, and if so, how does that affect the woman in labour, the delivery process and the assisting staff (especially if IPV is known)? These thoughts inevitably bring some data to mind (from Study 3 in this thesis, although not included in the results) about the women's delivery experiences, and provide ideas to further analyses and also wider studies.

Intervention programs for men inclined to violence

The professionals working with men inclined to violence, themselves questioned the way certain issues regarding 'changing views of masculinity' were handled in the intervention programs. This represents a significant potential for change.

Just like many other normative discourses, masculinities are not stable constructs but can be reconstructed in interactions and negotiations with others. The challenge lies in the possibility of changing male discourses, performed in interplay and communication with others. The professionals in the programs are authorities and have the knowledge and power of possessing the 'truth' and as such, might exert a decisive influence on men inclined to violence. The professionals need to bring in what the men prefer to leave out, that is sensitive and difficult questions dealing with close and intimate relationships such as those about sexuality, pregnancy and parenthood. If the professionals introduce relational topics with examples from the men's own everyday life, it might present them with many opportunities to confront and oppose the men's own discourses and hence change their attitudes and thereby even reduce violence.

There is a great need for studies evaluating intervention programs for men. Specifically, as far as I know, not many studies have been carried out regarding professional discourses in such programs and hopefully this thesis will set a challenge and initiate fruitful discussions leading to more research.

When the studies of this thesis were carried out, the viewpoints of the violent men were present in our minds but absent in research practice. I hope in future to expand my pilot interviews with violent men regarding IPV and at the same time also explore related issues such as sexuality, fertility control, pregnancy and parenthood.

To end, I will dedicate this thesis to the unending construction of knowledge. Much needs to be said and done regarding intimate partner violence and my sincerest desire is to make not only a contribution, but also to inspire others to call into question the prevailing approaches to knowledge in this area, including those used in this piece of work.

Acknowledgements

My doctoral studies would not have been possible without generous grant providers. My student position was supported by the *National School of Gender Studies,* Umeå University and the *Women's Department,* the University Hospital, Umeå. The research projects were supported by the *Swedish Research Council* and by the *County Council of Västerbotten,* Sweden. Excellent working facilities were provided by the *Epidemiology and Public Health Sciences* in collaboration with *Obstetrics and Gynaecology,* Umeå University, Sweden.

Life truly goes on, with all its ups and downs, while the years of doctoral studies pass. I am thankful for the gift of having had colleagues, true friends, family and many other caring, helpful and encouraging people around me for life and work. However, some added something extra to this doctoral period. This is a splendid opportunity to thank them since there are not many such opportunities in life, if any, when one gets to do so, at least not in public.

I would like to thank:

Stig Wall and administrative assistant *Anna-Lena Johansson;* you opened the door and welcomed me into a multidisciplinary, multicultural and cross-cultural department.

Ulf Högberg, my main tutor, for your good judgement, patience and for believing in my capacity, my tutor *Ann Lalos* for your warmth and wisdom and *Lars Dahlgren* for your sociological knowledge and for pulling my leg. I thank all the three of you for fruitful discussions and much laughter.

Mary Ellsberg, who is an inspiring person and has been a great pioneer at our department regarding the subject area of IPV. *Elliette Valladares,* doing important collaborative IPV research in Nicaragua. *Yegomawork Gossaye, Yemane Berhane* and all the other research collaborators I met while I was visiting Ethiopia, for your warm hospitality, I miss the 'injira'.

Ingrid Mogren for being a friendly office roommate and *Jerzy Pilch* for always being willing to lend a helping hand whenever computer problems arose. *Hans Stenlund* for introducing me to Mr Poisson and *Lennart Nyström,* the living reminder of the course I missed.

Berit Edvardsson, you became my friend when we started up the doctoral group together, and one of our lively dialogues even set fire to the sauna at IKSU. To all the others in the *EPI doctoral group,* Swedish and from abroad, you have been a great support and we have had so many interesting conversations. I will cross my fingers for you all until your work is finished.

As to the rest of the EPI division, I will include you all, although *un-named.* I am grateful for every smile and encouraging word in any encounters, whether during coffee breaks, seminars or in the hallways. That warmth has been the reason why even ineffective work days were valuable.

Pia Olsson, Jonas Liljequist and *Britta Lundgren,* for giving valuable comments at the mid-seminar, just as *Ann Öhman* and *Hildur Kalman* did at the pre-dissertation.

Thank you, Hildur for reading an apposite poem, now included in the thesis (see p. 61).

Thank you *Pat Shrimpton* for being my English stylist, you are so pleasant and professional.

Monika and *Carola*, our Wednesday lunch meetings at 'Björken' allowed us to speak our minds as midwives and PhD students, while we made jokes and took turns to have the blues.

Britta Lundgren and *Lena Eskilsson* with the administrative assistance of *Monica Forsell-Allergren* at the The National Graduate School of Gender Studies, contrary to my prejudices the ceiling has been amazingly high and the atmosphere so open and warm. *Bo Nilsson* for being a great 'sounding board' always giving valuable theoretical comments. All the *'Gender PhD students',* we had widely differing worlds at the start, but have gradually learned to appreciate each other. Thank you *Kerstin Engström* for friendship and fun, kick-sled rides during the December working week in the backwoods of Missenträsk.

The National Graduate School of Gender Studies gave me the financial opportunity to spend one month abroad to extend my international perspectives. *Tom Pearson,* at the University of Rochester, USA, showed kind generosity and introduced me to many fascinating researchers during my stay, my gratitude to all of you. *Robert Berg,* thank you for the Volvo rides while sharing memories from your younger days in Sweden, before I was even born. *Danielle Thomas Taylor,* for being so passionate, you gave me the inspiration to create an IPV inquiry card for antenatal care. *Susan Horwitz,* thank you for having the courage to go against the mainstream. Two people in Rochester became very special to me; *Diane Morse* you are not just the most energetic person I have ever met but also one of the warmest; *Michael Weitzman,* besides being a committed fighter for Public Health, I found a kindred spirit and a friend in you. In Baltimore, *Jacqueline Campbell,* thank you for welcoming me to the Johns Hopkins University and for encouraging me in my qualitative research approach. *Kathryn Laughon,* despite being at the end of your pregnancy and soon to defend your own PhD thesis, you kindly took me everywhere to introduce me to people within 'the field' and I will always remember your thoughtfulness. *Barbara Parker,* I so much appreciated the coffee and inspiring conversation in your beautiful country home.

Thank you to all my colleagues working at the *Women's Department* at the University Hospital, Umeå. *Berit Lindgren,* thank you for being my tutor in my very first period as a midwife in 1979 and for becoming a friend of our family. All the members of the *home-birth midwife group* are very special to me, having given me the possibility to leave the theories, roll up my sleeves and return to midwifery in a spirit of community. *Maria Sahlén,* my colleague and confidant; each time it is a pleasure to meet you and soon we will go long-distance skiing in the mountains again. Thank you for the collaboration when we recently had the privilege of developing a question card to help midwives ask about violence. *Lena Broström,* our long-standing triad broke down when our valued friend Barbro passed away too early last year (no one can take

her place), but I am indeed thankful that you remain as my friend, for all the times we have baked thin crisp-bread in your baking house, for a shared recycling disease, black humour and frankness.

Gun Pettersson, thank you for being a great instructor and source of inspiration to me; doing handicraft with you was like balm to my soul.

Stephen Goldin, you saved my life when it was as darkest, thank you for being a compassionate listener and a true friend.

To my mother *Anna-Britha Colling,* thank you for your prayers and saying "jag tror det kommer att gå bra, det brukar det ju göra". I would also like to thank my older brothers *Lars* and *Mats Lindén* and their families and my big family-in-law with *Ing-Marie* and *Matz Edin* at its head.

Ben, my companion through more than 30 years; thank you for all the good days and for believing in my ability to do whatever I decided to do (well, maybe not handball) and throughout my doctoral period, for logical penetrations and strict but fair text revisions and for becoming an expert at understanding my 'Swenglish'. To our four children *Linnéa, Veronika, Viola* and *Karl-Martin,* you are 'the apples of my eye' and *Michael, Jonas* and *Mattias* are great matches. I love you all from the bottom of my heart.

Closing words

Before finally ending this cover-story, I want to extend special thanks to all the 64 informants, without them the research and writing this thesis could never had been done.

The midwives, you have my admiration in your never-ceasing efforts to learn and to adjust, always trying to give the best possible psychosocial and obstetrical care to pregnant women. Thanks to all of you, my colleagues.

The professionals, the interviews were quite confrontational but there was still room for much reflection and humour. I got to know about your persistent efforts to find ways to develop the means to counteract men's violence. I sincerely hope my reports are not interpreted as criticism, but instead, as a positive challenge that will inspire you and others to start up many constructive discussions. I am on your side.

The women, I remember tears and laughter and your words often echo in my mind. I want to thank you for sharing your heart-breaking stories, by giving you a poem written by Pär Lagerkvist (1891-1974), first in Swedish and then in a free translation into English.

Min älskade kommer inte åter,
men min kärlek kommer åter till mig
Det jag levat kommer inte åter,
men livet är åter hos mig.
(Från diktsamlingen '*Den lyckliges väg*', 1921)

My beloved will not come back,
but my love comes back to me.
What I have lived will not come back,
but life is back in me.
(From the collection of poems *'Den lyckliges väg'*, 1921)

References

Abbott A (2004) *Methods of Discovery. Heuristics for the Social Sciences*. London: W.W. Norton & Company.

Aldridge ML, Browne KD (2003) Perpetrators of spousal homicide: a review. *Trauma, Violence & Abuse* 4(3), 265-276.

Anderson DK, Saunders DG (2003) Leaving an abusive partner: an empirical review of predictors, the process of leaving, and psychological well-being. *Trauma, Violence & Abuse* 4(2), 163-191.

Åsling-Monemi K, Pena R, Ellsberg MC, Persson L-Å (2003) Violence against women increases the risk of infant and child mortality: a case referent study in Nicaragua. *Bulletin of the World Health Organization* 81(1), 10-16.

Augoustinos M, Walker I (1995) *Social cognition, an integrated introduction*. London: Sage Publications.

Babcock JC, Waltz J, Jacobson NS, Gottman JM (1993) Power and violence: the relation between communication patterns, power discrepancies, and domestic violence. *Journal of Consulting and Clinical Psychology* 61(1), 40-50.

Balsam KF, Rothblum ED, Beauchaine TP (2005) Victimization over the life span: a comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinical Psychology* 73(3), 477-487.

Bohn DK, Tebben JG, Campbell JC (2004) Influences of income, education, age, and ethnicity on physical abuse before and during pregnancy. *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 33(5), 561-571.

Bowen E, Heron J, Waylen A, Wolke D (2005) Domestic violence risk during and after pregnancy: findings from a British longitudinal study. *BJOG* 112(8), 1083-1089.

BRÅ, Brottsförebyggande rådet (2001) *Dödligt våld mot kvinnor i nära relationer.* [Fatal violence against women in intimate relationships] Stockholm: The Swedish National Council for Crime Prevention., No. 11.

BRÅ, Brottsförebyggande rådet (2002) *Våld mot kvinnor i nära relationer, en kartläggning*. [Violence against women in intimate relationships, an overview] Stockholm: The Swedish National Council for Crime Prevention., No. 14.

Bullock LF, McFarlane J (1989) The birth-weight/battering connection. *American Journal of Nursing* 89(9), 1153-1155.

Burke LK, Follingstad DR (1999) Violence in lesbian and gay relationships: theory, prevalence, and correlational factors. *Clinical Psychology Review* 19(5), 487-512.

Burr V (2003) *Social Constructionism*. London/NY: Routledge.

Campbell J, García-Moreno C, Sharps P (2004) Abuse during pregnancy in industrialized and developing countries. *Violence Against Women* 10(7), 770-789.

Campbell JC (1999) Sanctions and sanctuaries: Wife beating within cultural contexts. In *To Have and To Hit: Cultural Perspectives on Wife Beating*. Counts DA, Brown JK, Campbell JC (Eds) Urbana and Chicago: University of Illinois, pp 261-285.

Campbell JC (2002) Health consequences of intimate partner violence. *Lancet* 359(9314), 1331-1336.

Campbell J C, (1992) Wife-battering: Cultural contexts versus Western Social sciences. In *Sanctions and sanctuary: cultural perspectives on the beating of wives.* A Counts, JK Brown, JC Campbell (Eds.) Boulder: Westview Press, pp 229-285.

Campbell JC, Poland ML, Waller JB, Ager J (1992) Correlates of battering during pregnancy. *Research in Nursing & Health* 15(3), 219-226.

Campbell JC, Webster D, Koziol-McLain J, Block C, Campbell D, Curry MA, Gary F, Glass N, McFarlane J, Sachs C, Sharps P, Ulrich Y, Wilt SA, Manganello J, Xu X, Schollenberger J, Frye V, Laughon K (2003) Risk factors for femicide in abusive relationships: results from a multisite case control study. *American Journal of Public Health* 93(7), 1089-1097.

Campbell JC, Woods AB, Chouaf KL, Parker B (2000) Reproductive health consequences of intimate partner violence. A nursing research review. *Clinical Nursing Research* 9(3), 217-237.

Campell MJ, Machin D (1990) *Medical statistics a common sense approach*. New York: Alan R. Liss Inc.

Cascardi M, Langhinrichsen J, Vivian D (1992) Marital aggression. Impact, injury, and health correlates for husbands and wives. *Archives of Internal Medicine* 152(6), 1178-1184.

Castro R, Peek-Asa C, Ruiz A (2003) Violence against women in Mexico: a study of abuse before and during pregnancy. *American Journal of Public Health* 93(7), 1110-1116.

Coggins M, Bullock LF (2003) The wavering line in the sand: the effects of domestic violence and sexual coercion. *Issues in Mental Health Nursing* 24(6-7), 723-738.

Coker AL, Davis KE, Arias I, Desai S, Sanderson M, Brandt HM, Smith PH (2002) Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine* 23(4), 260-268.

Connell RW (1995) *Masculinities*. Los Angeles: University of California Press.

Connell RW, Messerschmidt JW (2005) Hegemonic masculinity, rethinking the concept. *Gender & Society* 19(6), 829-859.

Covington DL, Hage M, Hall T, Mathis M (2001) Preterm delivery and the severity of violence during pregnancy. *Journal of Reproductive Medicine* 46(12), 1031-1039.

Crossley ML (2000) *Introducing narrative psychology, self trauma and the construction of meaning*. Buckingham: Open University Press.

Curry MA, Perrin N, Wall E (1998) Effects of abuse on maternal complications and birth weight in adult and adolescent women. *Obstetrics and Gynecology* 92(4 PT 1), 530-534.

Dahlgren L, Emmelin M, Winkvist A (2004) *Qualitative Methodology for International Public Health*. Epidemiology and Public Health Sciences, Umeå University.

Davies B, Harré R (2001) Positioning: The discursive production of self. In *Discourse theory and practice, a reader*. Wetherell M, Taylor S, Yates SJ (Eds) London: Sage Publications, pp 261-271.

Davis KE, Coker AL, Sanderson M (2002) Physical and mental health effects of being stalked for men and women. *Violence and Victims* 17(4), 429-443.

Delsol C, Margolin G (2004) The role of family-of-origin violence in men's marital violence perpetration. *Clinical Psychology Review* 24(1), 99-122.

Dye TD, Tollivert NJ, Lee RV, Kenney CJ (1995) Violence, pregnancy and birth outcome in Appalachia. *Paediatric and Perinatal Epidemiology* 9(1), 35-47.

Edin K (1999) Det syns inte så lätt utanpå. Om misshandel av gravida kvinnor och 5 mödravårdsbarnmorskors beskrivningar av hur verkligheten ser ut bland gravida kvinnor i Västerbotten. [It's hard to tell from the outside. On abuse of pregnant women and the experience of five midwives working at prenatal clinics in the county of Västerbotten, Sweden] *Master Thesis in Public Health, Umeå University* 1999: 21.

Edin KE, Högberg U (2002) Violence against pregnant women will remain hidden as long as no direct questions are asked. *Midwifery* 18(4), 268-278.

Edley N (2001) Analysing masculinity; interpretative repertoires, ideological dilemmas and subject positions. In *Discourse as data, a guide for analysis*. Wetherell M, Taylor S, Yates SJ (Eds) London/New Delhi/Thousand Oaks: Sage Publications, pp 189-228.

Ellsberg MC (2000) *Candies in hell, research and action on domestic violence against women in Nicarargua*. Umeå: Umeå University Medical Dissertations, New Series., No. 670.

Ellsberg MC, Heise L (2002) Bearing witness: ethics in domestic violence research. *Lancet* 359(9317), 1599-1604.

Ellsberg MC, Heise L, Pena R, Agurto S, Winkvist A (2001) Researching domestic violence against women: methodological and ethical considerations. *Studies in Family Planning* 32(1), 1-16.

Eriksson M, Pringle K (2005) Introduction: Nordic issues and dilemma. In *Tackling men's violence in families, Nordic issues and dilemmas*. Eriksson M, Hester M, Keskinen S, Pringle K (Eds) Bristol: Policy Press, pp 1-12.

Espinosa L, Osborne K (2002) Domestic violence during pregnancy: implications for practice. *Journal of Midwifery & Women's Health* 47(5), 305-317.

Farooque RS, Stout RG, Ernst FA (2005) Heterosexual intimate partner homicide: review of ten years of clinical experience. *Journal of Forensic Sciences* 50(3), 648-651.

Fernandez FM, Krueger PM (1999) Domestic violence: effect on pregnancy outcome. *Journal of the American Osteopathic Association* 99(5), 254-256.

FHI, Statens Folkhälsoinstitut (2005) Ett genusperspektiv på folkhälsopolitiken [Development from a gender perspective]. Chapter 6 in *Folkhälsopolitisk rapport 2005:45* [The 2005 Public Health Policy Report] Stockholm: The National Institute of Public Health.

Firestone JM, Harris RJ, Vega WA (2003) The impact of gender role ideology, male expectancies, and acculturation on wife abuse. *International Journal of Law and Psychiatry* 26(5), 549-564.

Fisher M, Yassour-Borochowitz D, Neter E (2003) Domestic abuse in pregnancy: results from a phone survey in northern Israel. *Israel Medical Association Journal* 5(1), 35-39.

Fox KJ (1999) Changing violent minds: discursive correction and resistance in the cognitive treatment of violent offenders in prison. *Social Problems* 46(1), 88-103.

Fraser N (1997) Structuralism or pragmatics? On discourse theory and feminist politics. In *The second wave-a reader in feminist theory*. Nicholson L (Ed) London: Routledge, pp 380-395.

Garcia-Moreno C (2002) Recommendations and conclusions from the International Conference on the Role of Health Professionals in Addressing Violence against Women. Naples, October 2000. *International Journal of Gynaecology and Obstetrics* 78 Suppl 1, S129-S131.

Gazmararian JA, Adams MM, Saltzman LE, Johnson CH, Bruce FC, Marks JS, Zahniser SC (1995) The relationship between pregnancy intendedness and physical violence in mothers of newborns. The PRAMS Working Group. *Obstetrics and Gynecology* 85(6), 1031-1038.

Gazmararian JA, Lazorick S, Spitz AM, Ballard TJ, Saltzman LE, Marks JS (1996) Prevalence of violence against pregnant women. *JAMA* 275(24), 1915-1920.

Gazmararian JA, Petersen R, Spitz AM, Goodwin MM, Saltzman LE, Marks JS (2000) Violence and reproductive health: current knowledge and future research directions. *Maternal and Child Health Journal* 4(2), 79-84.

Gielen AC, O'Campo PJ, Faden RR, Kass NE, Xue X (1994) Interpersonal conflict and physical violence during the childbearing year. *Social Science & Medicine* 39(6), 781-787.

Gissler M, Berg C, Bouvier-Colle MH, Buekens P (2005) Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *European Journal of Public Health* 15(5), 459-463.

Glander SS, Moore ML, Michielutte R, Parsons LH (1998) The prevalence of domestic violence among women seeking abortion. *Obstetrics and Gynecology* 91(6), 1002-1006.

Goldner V, Penn P, Sheinberg M, Walker G (1990) Love and violence: gender paradoxes in volatile attachments. *Family Process* 29(4), 343-364.

Goodwin MM, Gazmararian JA, Johnson CH, Gilbert BC, Saltzman LE (2000) Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996-1997. PRAMS Working Group. Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal* 4(2), 85-92.

Guth AA, Pachter L (2000) Domestic violence and the trauma surgeon. *American Journal of Surgery* 179(2), 134-140.

Hall S (2001) Focault: power knowledge and discourse. In *Discourse theory and practice, a reader*. Wetherell M, Taylor S, Yates SJ (Eds) London: Sage Publications, pp 72-81.

Hamberger LK, Guse C (2005) Typology of reactions to intimate partner violence among men and women arrested for partner violence. *Violence and Victims* 20(3), 303-317.

Hautzinger S (2003) Researching men's violence, personal reflections and etnographic data. *Men and Masculinities* 6(1), 93-106.

Heaman MI (2005) Relationships between physical abuse during pregnancy and risk factors for preterm birth among women in Manitoba. *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 34(6), 721-731.

Hearn J (1998) *The violences of men*. London: Sage Publications.

Hedin LW (2000) Postpartum, also a risk period for domestic violence. *European Journal of Obstetrics, Gynecology, and Reproductive Biology* 89(1), 41-45.

Hedin LW, Grimstad H, Moller A, Schei B, Janson PO (1999) Prevalence of physical and sexual abuse before and during pregnancy among Swedish couples. *Acta Obstetricia et Gynecologica Scandinavica* 78(4), 310-315.

Heise L, Ellsberg M, Gottmoeller M (2002) A global overview of gender-based violence. *International Journal of Gynaecology and Obstetrics* 78 Suppl 1, S5-14.

Heise LL (1998) Violence against women: an integrated, ecological framework. *Violence Against Women* 4(3), 262-290.

Helton AS, McFarlane J, Anderson ET (1987) Battered and pregnant: a prevalence study. *American Journal of Public Health* 77(10), 1337-1339.

Helton AS, Snodgrass FG (1987) Battering during pregnancy: intervention strategies. *Birth* 14(3), 142-147.

Hirdman Y (1988) Genussystemet-reflexioner kring kvinnors sociala underordning. [The gender system – reflexions about women's social subordination] *Kvinnovetenskaplig tidskrift* 3(4), 49-63.

Hirdman Y (2001) *Genus, om det stabilas föränderliga former*. [Gender, about the changeable forms of stability] Lund: Liber.

Hogg MA, Vaughan GM (1995) *Social Psychology*. London: Prentice Hall.

Holmberg C, Enander V (2004) *Varför går hon? Om misshandlade kvinnors uppbrottsprocesser.* [Why does she leave? On the separation process of abused women]. Ystad: Kabusa böcker.

Holtzworth-Munroe A, Meehan JC (2004) Typologies of men who are maritally violent: scientific and clinical implications. *Journal of Interpersonal Violence* 19(12), 1369-1389.

Horrigan TJ, Schroeder AV, Schaffer RM (2000) The triad of substance abuse, violence, and depression are interrelated in pregnancy. *Journal of Substance Abuse Treatment* 18(1), 55-58.

Hydén M (2000) Att lyssna till en kör av röster: Den berättarfokuserade intervjun. [Listening to a chorus of voices, interviews focusing on narratives] *Socialvetenskaplig tidskrift* 2, 137-158.

Hydén M (2001) Misshandlade kvinnors uppbrott: en motståndsprocess. [Separation of abused women: a process of resistance]. In *Det motspänstiga offret* [The noncompliant victim]. Åkerström M, Sahlin I (Eds) Lund: Studentlitteratur, pp 92-118.

Jacoby M, Gorenflo D, Black E, Wunderlich C, Eyler AE (1999) Rapid repeat pregnancy and experiences of interpersonal violence among low-income adolescents. *American Journal of Preventive Medicine* 16(4), 318-321.

Janssen PA, Holt VL, Sugg NK, Emanuel I, Critchlow CM, Henderson AD (2003) Intimate partner violence and adverse pregnancy outcomes: a population-based study. *American Journal of Obstetrics and Gynecology* 188(5), 1341-1347.

Jasinski JL (2001) Pregnancy and Violence Against Women: An Analysis of Longitudinal Data. *Journal of Interpersonal Violence* 16(7), 712-733.

Jasinski JL (2004) Pregnancy and domestic violence: a review of the literature. *Trauma, Violence & Abuse* 5(1), 47-64.

Jejeebhoy SJ (1998) Associations between wife-beating and fetal and infant death: impressions from a survey in rural India. *Studies in Family Planning* 29(3), 300-308.

Jewkes R (2002) Intimate partner violence: causes and prevention. *Lancet* 359(9315), 1423-1429.

Jones SM, Bogat GA, Davidson WS, von Eye A, Levendosky A (2005) Family support and mental health in pregnant women experiencing interpersonal partner violence: an analysis of ethnic differences. *American Journal of Community Psychology* 36(1-2), 97-108.

Kalman H (2004) Gender, oppression and human dignity. In *A Passion for Freedom. Action, Passion and Politics. Feminist Controversies. Proceedings of the Xth International Symposium of Women Philosophers,. Barcelona oct-2002*. Birulés F, Peña Aguado MI (Eds) Barcelona: University of Barcelona, pp 330-333.

Kaye DK, Mirembe FM, Bantebya G, Johansson A, Ekstrom AM (2006) Domestic violence as risk factor for unwanted pregnancy and induced abortion in Mulago Hospital, Kampala, Uganda. *Tropical Medicine & International Health* 11(1), 90-101.

Kero A, Högberg U, Jacobsson L, Lalos A (2001) Legal abortion: a painful necessity. *Social Science & Medicine* 53(11), 1481-1490.

Khosla AH, Dua D, Devi L, Sud SS (2005) Domestic violence in pregnancy in North Indian women. *Indian Journal of Medical Sciences* 59(5), 195-199.

Kimmel MS (1987) Rethinking "Masculinity"; New directions in research. In *Changing men, new directions in research on men and masculinity*. Kimmel S (Ed) London: Sage Publications, pp 9-24.

Koenig MA, Ahmed S, Hossain MB, Khorshed Alam Mozumder AB (2003) Women's status and domestic violence in rural Bangladesh: individual- and community-level effects. *Demography* 40(2), 269-288.

Krantz G, Garcia-Moreno C (2005) Violence against women. *Journal of Epidemiology and Community Health* 59(10), 818-821.

Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R (Eds) (2002) *World report on violence and health*. Geneva: World Health Organisation.

Krulewitch CJ, Roberts DW, Thompson LS (2003) Adolescent pregnancy and homicide: findings from the Maryland Office of the Chief Medical Examiner, 1994-1998. *Child Maltreatment* 8(2), 122-128.

Kvale S (1996) *Interviews, an introduction to qualitative research interviewing*. Thousand Oaks: Sage Publications.

Kyriacou DN, Anglin D, Taliaferro E, Stone S, Tubb T, Linden JA, Muelleman R, Barton E, Kraus JF (1999) Risk factors for injury to women from domestic violence against women. *New England Journal of Medicine* 341(25), 1892-1898.

Lawson DM (2003) Incidence, explanations and treatment of partner violence. *Journal of Counseling and Development* 81(1), 19-49.

Lincoln YS, Cuba EG (1985) *Naturalistic inquiry*. London: Sage Publications.

Lipsky S, Holt VL, Easterling TR, Critchlow CW (2003) Impact of police-reported intimate partner violence during pregnancy on birth outcomes. *Obstetrics and Gynecology* 102(3), 557-564.

Lloyd S (1997) Defining violence against women. In *Violence against women*. Bewley S, Friend J, Mezey GB (Eds) London: RCOG press, pp 3-12.

Lovisi GM, López JR, Coutinho ES, Patel V (2005) Poverty, violence and depression during pregnancy: a survey of mothers attending a public hospital in Brazil. *Psychologie Médicale* 35(10), 1485-1492.

Lundgren E (2001) *Våldets normaliseringsprocess – två parter – två strategier*. [The normalization process of violence – two parties- two strategies] Stockholm: Riksorganisationen för kvinnojourer och tjejjourer i Sverige.

Lundgren E, Heimer G, Westerstrand J, Kalliokoski A-M (2001) *'Captured Queen', Men´s violence against women in 'equal' Sweden – a prevalence study*. Stockholm: Brottsoffermyndigheten.

Lutz KF (2005a) Abused pregnant women's interactions with health care providers during the childbearing year. *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 34(2), 151-162.

Lutz KF (2005b) Abuse experiences, perceptions, and associated decisions during the childbearing cycle. *Western Journal of Nursing Research* 27(7), 802-824.

Marshall LL (1992) Development of severity of violence against women scales. *Journal of Family Violence* 7, 103-121.

Martin SL, Beaumont JL, Kupper LL (2003) Substance use before and during pregnancy: links to intimate partner violence. *American Journal of Drug and Alcohol Abuse* 29(3), 599-617.

Martin SL, Li Y, Casanueva C, Harris-Britt A, Kupper LL, Cloutier S (2006) Intimate partner violence and women's depression before and during pregnancy. *Violence Against Women* 12(3), 221-239.

McCarraher DR, Bailey PE, Martin SL (2005) The relationship between birth predictedness and violence during pregnancy among women in La Paz And El Alto, Bolivia. *Maternal and Child Health Journal* 9(1), 101-112.

McFarlane J, Campbell JC, Sharps P, Watson K (2002) Abuse during pregnancy and femicide: urgent implications for women's health. *Obstetrics and Gynecology* 100(1), 27-36.

McFarlane J, Parker B, Soeken K (1996) Abuse during pregnancy: associations with maternal health and infant birth weight. *Nursing Research* 45(1), 37-42.

Messerschmidt JW (2000) Becoming "Real Men" adolescent masculinity challenges and sexual violence. *Men and Masculinities* 2(3), 286-307.

Mishler EG (1986) *Research Interviewing, context and narrative*. Cambridge, MA: Harvard University Press.

Murphy CC, Schei B, Myhr TL, Du Mont J (2001) Abuse: a risk factor for low birth weight? A systematic review and meta-analysis. *CMAJ* 164(11), 1567-1572.

Nasir K, Hyder AA (2003) Violence against pregnant women in developing countries: review of evidence. *European Journal of Public Health* 13(2), 105-107.

Neggers Y, Goldenberg R, Cliver S, Hauth J (2004) Effects of domestic violence on preterm birth and low birth weight. *Acta Obstetricia et Gynecologica Scandinavica* 83(5), 455-460.

Nilsson L (2004) Misshandel mot kvinnor och barn [Abuse against women and children]. In *Brottsutvecklingen i Sverige 2001-2003, BRÅ-rapport 2004:3* [The total accumulated number of reported crimes in Sweden 2001-2003]. Dolmén L (Ed) Stockholm: BRÅ, Brottsförebyggande rådet, pp 65-83.

Pallitto CC, Campbell JC, O'Campo P (2005) Is intimate partner violence associated with unintended pregnancy? A review of the literature. *Trauma, Violence & Abuse* 6(3), 217-235.

Pallitto CC, O'Campo P (2004) The relationship between intimate partner violence and unintended pregnancy: analysis of a national sample from Colombia. *International Family Planning Perspectives* 30(4), 165-173.

Pallitto CC, O'Campo P (2005) Community level effects of gender inequality on intimate partner violence and unintended pregnancy in Colombia: testing the feminist perspective. *Social Science & Medicine* 60(10), 2205-2216.

Parker B, McFarlane J, Soeken K (1994) Abuse during pregnancy: effects on maternal complications and birth weight in adult and teenage women. *Obstetrics and Gynecology* 84(3), 323-328.

Parker B, McFarlane J, Soeken K, Torres S, Campbell D (1993) Physical and emotional abuse in pregnancy: a comparison of adult and teenage women. *Nursing Research* 42(3), 173-178.

Purwar MB, Jeyaseelan L, Varhadpande U, Motghare V, Pimplakute S (1999) Survey of physical abuse during pregnancy GMCH, Nagpur, India. *Journal of Obstetrics and Gynaecology Research* 25(3), 165-171.

Rachana C, Suraiya K, Hisham AS, Abdulaziz AM, Hai A (2002) Prevalence and complications of physical violence during pregnancy. *European Journal of Obstetrics, Gynecology, and Reproductive Biology* 103(1), 26-29.

Ragin C (1994) *Constructing Social Research*. Thousand Oaks: Pine Forge Press.

Riessman CK (1993) *Narrative Analysis. Qualitative Research Methods Series*. Newbury Park: Sage Publications., No. 30.

Rodriguez MA, Quiroga SS, Bauer HM (1996) Breaking the silence. Battered women's perspectives on medical care. *Archives of Family Medicine* 5(3), 153-158.

Romito P, Molzan Turan J, De Marchi M (2005) The impact of current and past interpersonal violence on women's mental health. *Social Science & Medicine* 60(8), 1717-1727.

Rosen KH, Bird K (1996) A case of woman abuse, gender ideologies, power paradoxes and unresolved conflicts. *Violence Against Women* 2(3), 302-321.

Rothman KJ, Greenland S (1998) *Modern Epidemiology*. Philadelphia: Lippincott-Raven.

Sahin HA, Sahin HG (2003) An unaddressed issue: domestic violence and unplanned pregnancies among pregnant women in Turkey. *European Journal of Contraception & Reproductive Health Care* 8(2), 93-98.

Saltzman LE (2004) Definitional and Methodological Issues Related to Transnational research on Intimate Partner Violence. *Violence Against Women* 10(7), 812-830.

Saltzman LE, Johnson CH, Gilbert BC, Goodwin MM (2003) Physical abuse around the time of pregnancy: an examination of prevalence and risk factors in 16 states. *Maternal and Child Health Journal* 7(1), 31-43.

Schuler SR, Hashemi SM, Riley AP, Akhter S (1996) Credit programs, patriarchy and men's violence against women in rural Bangladesh. *Social Science & Medicine* 43(12), 1729-1742.

Shadigian EM, Bauer ST (2004) Screening for partner violence during pregnancy. *International Journal of Gynaecology and Obstetrics* 84(3), 273-280.

Spradley JP (1979) *The ethnographic Interview*. Washington: Library of Congress in Publication Data.

Starrin B, Dahlgren L, Larsson G, Styrborn S (1997) *Along the Path of Discovery*. Lund: Studentlitteratur.

Steen K, Hunskaar S (2004) Gender and physical violence. *Social Science & Medicine* 59(3), 567-571.

Stenson K, Heimer G, Lundh C, Nordstrom ML, Saarinen H, Wenker A (2001) The prevalence of violence investigated in a pregnant population in Sweden. *Journal of Psychosomatic Obstetrics and Gynaecology* 22(4), 189-197.

Straus MA (1999) The controversy over domestic violence by women: A methodological, theoretical, and sociology of science analysis. In *Violence in intimate relationships*. Arriaga XB, Oskamp S (Eds) Thousand Oaks, CA: Sage Publications, pp 17-44.

Straus MA (2005) Women's violence toward men is a serious social problem. In *Current controversies on family violence*. Loseke DR, Gelles RJ, Cavanaugh MM (Eds) Newbury Park: Sage Publications, pp 55-77.

Taylor S (2001) Evaluating and applying discourse analytic research. In *Discourse as data, a guide for analysis*. Wetherell M, Taylor S, Yates SJ (Eds) London/New Delhi/Thousand Oaks: Sage Publications, pp 311-330.

Tilley DS, Brackley M (2005) Men who batter intimate partners: a grounded theory study of the development of male violence in intimate partner relationships. *Issues in Mental Health Nursing* 26(3), 281-297.

Tjaden P (2004) What is Violence against women? Defining and measuring the problem. A response to Dean Kilpatrick. *Journal of Interpersonal Violence* 19(11), 1244-1251.

Tjaden P, Thoennes N (2000) *Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey*. Washington (DC): NIJ.

Torres S, Campbell J, Campbell DW, Ryan J, King C, Price P, Stallings RY, Fuchs SC, Laude M (2000) Abuse during and before pregnancy: prevalence and cultural correlates. *Violence and Victims* 15(3), 303-321.

Torres S, Han HR (2003) Women's perceptions of their male batterers' characteristics and level of violence. *Issues in Mental Health Nursing* 24(6-7), 667-679.

Valladares E (2005) *Partner violence during pregnancy, psychosocial factors and child outcomes in Nicarargua*. Umeå: Umeå University, Medical dissertations. New Series., No. 976.

Valladares E, Ellsberg M, Peña R, Högberg U, Persson LA (2002) Physical partner abuse during pregnancy: a risk factor for low birth weight in Nicaragua. *Obstetrics and Gynecology* 100(4), 700-705.

Valladares E, Peña R, Persson LA, Högberg U (2005) Violence against pregnant women: prevalence and characteristics. A population-based study in Nicaragua. *BJOG* 112(9), 1243-1248.

Walker LE, Browne A (1985) Gender and victimization by intimates. *Journal of Personality* 53(2), 179-195.

Walker R, Logan TK, Jordan CE, Campbell JC (2004) An integrative review of separation in the context of victimization: consequences and implications for women. *Trauma, Violence & Abuse* 5(2), 143-193.

Walton-Moss BJ, Campbell JC (2002) Intimate partner violence: implications for nursing. *Online Journal of Issues in Nursing* 7(1), 6.

Wathen CN, MacMillan HL (2003) Interventions for violence against women: scientific review. *JAMA* 289(5), 589-600.

WHO (1996) *Global Consultation on Violence and Health. Violence, a global health priority*. Geneva: World Health Organisation.

WHO (2005) WHO multi country study on women's health and domestic violence against women. In *WHO multi country study on women's health and domestic violence against women*. Garcia-Moreno C, Jansen H, Watts C, Ellsberg M (Eds) Geneva: World Health Organisation, pp 204.

Yang MS, Yang MJ, Chou FH, Yang HM, Wei SL, Lin JR (2006) Physical abuse against pregnant aborigines in Taiwan: prevalence and risk factors. *International Journal of Nursing Studies* 43(1), 21-27.

Yllö KA (2005) Through a Feminist Lens: "Gender, Diversity, and Violence: Extending the Feminist Framework". In *Current controversies on family violence*. Loseke DR, Gelles RJ, Cavanaugh MM (Eds) London: Sage Publications, pp 19-34.

Zlotnick C, Kohn R, Peterson J, Pearlstein T (1998) Partner Physical Victimization in a National sample of American families, relationship to psychological functioning, psychosocial factors and gender. *Journal of Interpersonal Violence* 13(1), 156-166.