Domestic violence against pregnant women:
A Thai perspective

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This thesis submitted in the fulfilment of the requirements for the degree of Doctor of Philosophy in the School of Nursing and Midwifery, Griffith Health at Griffith University

January 2006

Abstract

Little is known about domestic violence experienced by Thai pregnant women. This exploratory descriptive study aimed to investigate the prevalence of domestic violence during pregnancy and immediate postpartum period among Thai women aged between 18 and 45 years. The study also aimed to investigate maternal and neonatal outcomes for childbearing women, the ways in which they dealt with domestic violence, barriers that inhibited them from seeking help or resisting violence, as well as the needs and support that would be helpful in dealing with domestic violence. A cohort of 421 women in their third trimester of pregnancy was recruited from two tertiary public hospital antenatal clinics located in Khon Kaen Province, Northeastern Thailand. Structured questionnaires were used. Participants were again contacted at six weeks postpartum either in person at the family planning clinics or by telephone. Two hundred and seventy-four women were able to be contacted. The results showed that 53.7% of women reported psychological abuse, 26.6% experienced threats of and/or acts of physical abuse, and 19.2% experienced sexual violence during the current pregnancy. In the postpartum period, 35.4% of women reported psychological abuse, 9.5% reported threats of and/or acts of physical abuse, and 11.3% experienced sexual abuse. Women who were abused during pregnancy showed significantly poorer health status compared to non-abused women in role emotional functioning, vitality, bodily pain, mental health and social functioning. Women who experienced postpartum abuse reported significantly lower mean scores in mental health and social functioning than women who did not. Antepartum haemorrhage was also found to be statistically associated with physical abuse. No statistical differences were found between abuse status and neonatal outcomes. There were several strategies used by abused women in dealing with domestic violence to maximize their safety including crying, keeping quiet, leaving violent situations and temporarily staying with relatives, seeking help from others, and notifying local authorities. Support services that would be helpful for abused women in dealing with the problem included emotional support, social legal assistance, and community health promotion.

Domestic violence during pregnancy and after birth is an increasing but under-recognized problem in Thailand. It has pervasive consequences on maternal health. The findings from this study suggest more interventions and urgent domestic violence support services need to be established in this remote area of Thailand. This study also suggests routine screening for domestic violence should be established to provide effective early intervention and prevention of adverse consequences of violence, as pregnancy is a time when most pregnant women seek health care.

Statement of Originality

This work has not been previously submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another except where due reference is made in the thesis itself.

Some of the results presented in Chapter four and five have been published in conference proceedings as listed below:

1. Emmanuel, E., Sricamsuk, A., Creedy, D., & Cooke, M. (2005). Expecting the unexpected: A transcultural comparison of domestic violence in pregnancy. In Proceedings of the International Conference 23rd Quadrennial Congress 2005 "Nursing on the Move: Knowledge, Innovation and Vitality", Taipei, Taiwan, 21-27 May 2005.

2. Emmanuel, E., Sricamsuk, A., Creedy, D., & Cooke, M. (2005). Health adaptation of contemporary birthing women: A comparative study in Australia and Thailand. In International Network for Doctoral Education in Nursing. Taipei, Taiwan, 20-21 May 2005.

Amornrat Sricamsuk

January 2006

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Acknowledgement

I would like to express my gratitude and thanks to many people who have been part of my life in this long journey. Firstly, I would like to thank Professor Debra Creedy, my principal supervisor, for her endless support in every way during this process. Dr Marie Cooke whose encouragement and continuous support in reading and commenting on this work is also greatly appreciated. Professor Wendy Chaboyer has also supported me in this journey.

I would like to thank former Dean Wanapa Sritanyarat of the Faculty of Nursing, Khon Kaen University, Thailand for her support and sponsorship.

I gratefully acknowledge financial support from the Staff Development Project of Khon Kaen University, the Royal Thai Government and the Queensland Nursing Council.

I thank Paul Dickson for his statistical advice, and Erico Saito for assistance with the graphics. I would also like to acknowledge those people who helped me with the process of translation and/or content validity of the questionnaire: Ian Thomas, Associate Professor Kritaya Sawangchareon, Associate Professor Wiporn Senarak, Dr Sumon Pinjareon, Dr Chalida Thanattherakul and Assistant Professor Somporn Wattananukulkeiart. I thank them all.

I would like to acknowledge and thank all women who participated in this study, and staff at Khon Kaen Regional Hospital and Health Promotion Centre Region 6. Without their co-operation this study would not have been possible.

To my close friend, Chonlada Panthuchin, thank you for your assistance with data collection, encouragement, and constant support.

I also wish to extend a special thank you to the staff and my fellow postgraduates at the School of Nursing and Midwifery, Griffith University, especially, Brigid Gillespie, Ruth Cantrill, Dr Wendy McIntosh, Robyn Daskein, Dr Elizabeth Emmanuel, Jamie Fu, Jenny Chan and Lee Earle for sharing ideas, knowledge and providing a very warm and supportive environment, and to staff at the Belmont Private Hospital for their friendship.

Finally, I thank my mom, dad, and immediate and extended families, Associate Professor Wiporn Senarak, the Senarak's family, Associate Professor Wiphaporn Vorahan, the Vorahan's family, Cliff Cuckson, Dawn Hay, Dr Pilairuk Boonyai, Erico Saito, Ana Paula and the Saito's family for their love, understanding, emotional support and encouragement.

Chapter 1 : Introduction

Domestic violence is an important problem faced by societies around the world. While both men and women can be victims, it is far more common for women to suffer some form of domestic violence. Pregnancy and the early postpartum period is a time of risk for increased tension in the couple relationship and subsequent acts of violence may result. An understanding of the plight of pregnant women in Asian countries, particularly Thailand, is only beginning to emerge. The focus of this research is on Thai women's experience of domestic violence. This chapter presents a discussion of the definitions and types of domestic violence, the background for the present study, the incidence of domestic violence, and contributing factors as well as significance of the study. It also presents an overview of the remaining chapters in the thesis.

Definitions of Domestic Violence

Domestic violence against women is widely studied in fields such as anthropology, criminology, psychology and sociology and each discipline defines and measures domestic violence differently (Desai & Saltzman, 2001). These differences result in varying estimates that make it difficult to determine accurately the nature and magnitude of violence against women (Desai & Saltzman, 2001).

Some researchers define domestic violence in terms of physical violence and include only acts of pushing, hitting, slapping, kicking, or physically hurting in some other way (Martin, Mackie, Kupper, Buescher, & Moracco, 2001) while other studies include threats, actual acts of physical violence, and sexual violence (Marshall, 1992). Other researchers define domestic violence as physical, sexual and emotional abuse (McFarlane, Parker, Soeken, Silva, & Reed, 1999; Webster, Sweett, & Stolz, 1994).

The Australian Medical Association (1998) defines domestic violence in terms of abuse of power. It is the domination, coercion, intimidation and victimization of one person

by another within an intimate relationship by physical, sexual, or emotional means.

Healey (1998) describes domestic violence as a situation where one partner in a relationship uses violent and abusive behaviours in order to control and dominate the other partner. Healey argues that men are unlike women. Men generally use multiple forms of abusive behaviour to dominate their partners, particularly through the use, or threat of, sexual and physical violence. The use of these abusive behaviours result from traditional beliefs of male superiority and privilege whereby men believe that they have a right to impose their will and expect servitude from their female partner (Healey, 1998). Women on the other hand are more reluctant to inflict injury (Straus, 2005). According to Gelles (1993) much violence perpetrated by women tends to be in self-defence and that the injury inflicted by them, due to their size and strength, towards men appears to be less.

Terms used and Types of Domestic Violence

There are various terms used to describe violence in previous studies. Some researchers use the term 'battering" while others use "violence" or "abuse". Similarly, the term "domestic violence", "intimate partner violence", "partner abuse", "spouse abuse" and "battering" are often used interchangeably and refer to violence that happens between partners in an ongoing relationship regardless of whether they are married (ACOG, 1995). In studies undertaken in Australia, domestic violence is usually referred to as partner abuse, particularly physical violence between a male and female partner, and most commonly perpetrated by the male. A partner in this context is referred to as a person who has been or is having an intimate relationship with another person, such as a married or de facto partner, a boyfriend or girlfriend. Domestic violence also includes family violence, which refers to abuse that occurs in any relationship within households (Hegarty, Hinsmarsh, & Gilles, 2000).

From a health perspective, there are three major types of violence against women: physical, sexual, and emotional/verbal violence. However, the decision to include one, some, or all of these components in definitions of violence against women can differ amongst studies and disciplines (Gordon, 2000). Different definitions of violence against pregnant women can result in different estimates of incidence and prevalence (Desai & Saltzman, 2001). Furthermore, if domestic violence against women is limited to married pregnant women abused by their husbands, then incidence rates may be less than those found when violence against pregnant women by any current or former intimate partner (Desai & Saltzman, 2001).

In the present study, the definition of domestic violence is based on the definition provided by Healey (1998) as it comprehensively addresses the nature of various types of abuse. As such this study will focus on all forms of domestic violence: physical, sexual and psychological/verbal abuse, since physical violence is only one of the techniques used by the perpetrators. Often, the perpetrators' physical violence is accompanied by other forms of abuse that are destructive to the battered women's physical and psychological integrity (Parker, McFarlane, Soeken, Torres, & Campbell, 1993). In addition, individuals who engage in serious physical aggression against their partners tend to exhibit frequent abusive behaviours of all types and level of severity while individuals engaging in verbal or psychological abuse tend not to use physical violence toward their partners or if so, they do this in only episodic minor aggressive acts (Gordon, 2000). Therefore it is necessary to assess all types of violence as well as patterns of abuse over time.

The definitions of forms of violence used in the present study are as follows:
Physical abuse is the actual, attempted or threatened, use of any physical force with the intent to injure, control, hurt or make the women afraid of abusive male partner, for example, slapping, punching, kicking, shoving, choking, raising fists and pointing or using a weapon (Healey, 1998). Threatening and intimidating words and actions are used to instil fear and immobilize the woman into submission. Often the threat of

violence is coupled with the destruction of property belonging to the woman, including family pets. This serves as the man's warning to the woman that further harm will result if she does not comply with his wishes (Healey, 1998).

Sexual abuse is any coercive or unwanted sexual activity. Examples of sexual abuse are rape, forcing the woman to participate in undesired, painful or humiliating sexual acts, constantly accusing her of sexual infidelity, and expecting her to be sexually available when the partner wants sex as a matter of 'right' (Healey, 1998).

Psychological abuse includes emotional/verbal abuse, and threatening and intimidatory behaviours. Emotional/verbal abuse consists of behaviours intended to destroy a woman's self esteem and undermine her self-confidence. These behaviours include verbal interactions or exchanges. Examples of this type of violence include constant 'putdowns', and use of offensive and demeaning language, such as, lazy, fat, and ugly (Healey, 1998).

Although the majority of Thai families have extended membership, there are many potentially abusive relationships within families that could be classified as domestic violence that may include in-law relations. The present study focuses on only intimate male partners as the perpetrators of violence against female partners. Domestic violence perpetrated by intimate partners is emphasised because of the existence of an intense, continuing interpersonal relationship that can lead to the repetition of violence (Gordon, 2000). Furthermore, the interpersonal relationship of individuals involved in violence perpetrated by partners usually includes an emotional relationship of attachment, emotional and sexual intimacy, or dependency such that the physical and sexual violence occurs within an intimate relationship context (Gordon, 2000).

Background

Before the 1970s there was very little written about violence against women. Although the 'first wave' western feminists in the mid-nineteenth century identified domestic violence as an issue, concerns were gradually subsumed by the struggle to gain the vote for women (Irwin & Thorpe, 1996). As a result of the resurgence of the women's movement in the 1970s there was greater public awareness of the patriarchal structures that oppressed women. As a consequence of increased public awareness, domestic violence against women was placed on the political agenda. In Australia, as in other countries such as the United States, England, Ireland, Canada and many Western European countries, women's refuges and shelters were established during this time and were inundated with women and children seeking safety (Davies, 1994). The growth of the women's movement and the establishment of a network of refuges helped to raise awareness of violence in intimate relationships. Importantly, this increasing concern was recognized at a national political level particularly in England (Frost, 1999).

Prior to this time, domestic violence was viewed as a private issue and predominant patriarchal views emphasized the psychological deficiencies of victims and offenders (Grew, 1991). It was also thought to be confined to specific groups such as the poor, those affected by alcohol and Aboriginal people or ethnic minorities (Grew, 1991). The home was seen as a 'private' space over which men reigned and women were encouraged to modify their behaviour in an attempt to alleviate violence. Violence in the home was not viewed as a criminal act, nor a legal problem but as a civil matter. Women in these situations were 'victims' who spoke of fear, lack of money and no accommodation for themselves or children, if they seriously considered breaking this vicious cycle (Grew, 1991).

Nonetheless, the women's movement around Australia prompted a response from state governments. In July 1981, the New South Wales Task Force recommended legislative

and social reform, designed to provide victims with effective and adequate access to housing, finance and other services. In addition, police powers were clarified in 1983 and they were instructed to arrest offenders in domestic disputes. Violence against women or "wife beating" was then established as a criminal act in the late nineteenth and early twentieth century, and wife rape as a crime in most Australian states in the 1980s (Scutt, 1991). In Australia, governments sought to establish effective laws and men were required to cease their violence in the home, or at least be held accountable for it (Scutt, 1991).

Changes in public policy and legislation were slow to be introduced in Asian countries. In Thailand, the first historical record of women's efforts to obtain justice in relation to domestic violence was in 1867 (Lertsrisantad, 2002). However, a Thai law which gave men the right to beat, whip, give or sell their wives was only abolished in 1935 when the Civil Code was enacted (Lertsrisantad, 2002). It took until 1985 for the first shelter home to be established for women and children. In the same year Thailand also acceded to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (UNIFEM, 2000). Then, in 1989, the National Commission of Women's Affairs (NCWA) was established to promote and coordinate efforts for the advancement of women. The main responsibility of NCWA includes advising the government on women's issues, preparing submissions, policy statements and development plans for Cabinet for approval, and making recommendations on legislation affecting women's human rights and basic freedoms (UNIFEM, 2000). The legal status and rights of Thai women have been gradually improving as a result of the women's movement. This was seen particularly in 1997 when Constitution Sections 30, 31 and 53 were approved. Section 30 stated that men and women were equal and should receive equal protection according to the law. Section 31, similarly, stated that people have rights and freedom over their body and life. Torture, savagery or punishment should not be tolerated (Lertsrisantad, 2002). Section 53 established the right of children, youth and all family members to state protection from violence and unfair treatment (Pekanan & Wongsurawat, 2001).

Additionally, pressure from women's groups and non-governmental organizations led to significant changes such as the stationing of female police investigators in Bangkok to manage cases of violence against women. This service was later expanded in 1999 to Songkla and Chiangmai provinces in Thailand. Furthermore, in 1997 centres for the protection of children, youth and women were set up by the Royal Thai police and seven crisis centres were established in hospitals in the Bangkok Metropolitan area (Office of the National Commission on Women's Affairs, 2000). In 1998, one-stop service centres were also established and integrated within the Bangkok Metropolitan Administration's 60 health centres and seven city hospitals. The goal of the Centres is to provide support to meet the health, emotional and social needs of women who are victims of violence when they seek medical attention at a hospital or health centre (Office of the National Commission on Women's Affairs, 2000). Most recently, Cabinet approved policies and plans to eliminate violence against children and women as a national policy for both government and non-government agencies in May 2000 (Office of Women's Affairs and Family Development, n.d).

Prevalence of Domestic Violence

Domestic violence is a significant social and public health problem in many countries (Heise, 1995). In Australia, as in many other countries, it is now accepted that domestic violence is common (Hegarty et al., 2000). Although domestic violence may happen to both men and women, evidence indicates that women suffer disproportionately from abuse by their male partners. In fact, women are three times more likely than men to experience an episode of physical violence by their partners (Hegarty et al., 2000; Roberts, O'Toole, Lawrence, & Raphael, 1993).

Estimates of the incidence and prevalence of domestic violence vary, due to differences in definitions and sampling procedures (Gazmararian et al., 1996). For the purpose of the present study, prevalence is defined as a number of current cases per population at risk at a specific point in time (Public Health Agency of Canada (PHAC), 2002). In the

United States, approximately one in every five couples experienced at least one episode of violence during a one-year period (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995). In Australia, the Women's Safety Survey (Australian Bureau of Statistics, 1996) identified that one in twelve women who were married or in a de facto relationship had experienced some violence from their current partners. A study in Melbourne of 2,181 women surveyed through general practices and clinics found that 22% reported being physically assaulted by their partners during the previous 12 months (Mazza, Dennerstein, & Ryan, 1996). In Thailand, a study was jointly conducted by the Institute for Population and Social Research at Mahidol University, the Foundation for Women, and World Health Organisation (WHO). Of the 2,818 women in Bangkok and Nakhon Sawan surveyed in the study in 2000, 41% of participants in Bangkok and 47% in Nakhon Sawan had experienced physical and/or sexual violence (Archavanitkul, Karnjanajitra, Im-Em, & Lertsrisantad, 2003). This level far exceeds the levels reported in the U.S. and Australia.

Pregnancy and the postnatal period are times when women are vulnerable to violence (Mezey & Bewley, 1997), and intimate partner violence may begin or escalate during this period (McFarlane, Parker, Soeken, & Bullock, 1992). A survey conducted at the Royal Women's Hospital's Antenatal Clinic in Brisbane, Australia revealed that 8.9% of women experienced domestic violence during their pregnancy (Webster et al., 1994). Similarly a study conducted in Thailand found 12% of women were physically abused while pregnant (Thanaudom, 1996). Gazmararian et al. (1996) provided a comprehensive review of the numerous studies in the U.S. and other developed countries pertaining to violence during pregnancy between 1963 and 1995. The review revealed that the prevalence of violence during pregnancy ranged from 0.9% to 20.1% with the majority of prevalence rates between 3.9% and 8.3%.

The Problem

In Thailand, many dramatic cases of domestic violence are reported in the media.

Overall, however, domestic violence still receives little public attention (Quicker, 2002). One recent controversial case of domestic violence in Thailand in 2001 involved a former university lecturer who, in a jealous rage, beat his wife with an umbrella and a golf club resulting in her death. Because of his confession and record of "good conduct", he was charged with manslaughter, placed on a three-year probation and ordered to perform 50 hours of community service through teaching at an educational institution ("Safeguard women, say two groups," 2002). The court decision resulted in women's groups launching a campaign urging the public to send protest notes to the Attorney General's Office, and incited mass debate over gender bias in the justice system (Somsin, 2002). Police were also called to review the way they manage cases of domestic violence. Despite the political lobbying by women's groups, the court decision remained unchanged. This case and many others illustrate that domestic violence is a serious problem for Thai women and is a neglected issue in Thai society.

The prevalence of domestic violence during pregnancy is under-researched although existing reports on domestic violence with subgroups of the general population confirms that domestic violence is a significant problem for Thai women (Lertsrisantad, 2002). Only two Thai studies have investigated domestic violence during pregnancy and both were conducted in Bangkok (Thanaudom, 1996) and four other provinces in the Eastern Thailand (Deoisres, 2004). In addition, there are no official data concerning the percentage of Thai women being abused by their husbands or partners (Lertsrisantad, 2002). Lack of reliable statistical data on domestic violence makes it difficult to estimate the true extent of the problem in Thai society. Although the government recently approved policies and plans to eliminate violence, the situation of violence against women in Thai society is viewed as serious, complicated and worrisome by social commentators (Thajeen, 2002).

The few studies conducted in other countries (e.g., Martin et al., 2001; McFarlane et al., 1999; Webster et al., 1994) have identified a consistent presence of violence against childbearing women. However, research has not yet confirmed whether pregnant

women are at greater risk for domestic violence initiated during pregnancy. Nor has there been research with women who experience ongoing violence, whether the severity or frequency of violent incidents increases or decreases or whether violence ceases altogether during pregnancy (Ballard et al., 1998).

Contributing Factors

A number of important factors contribute to continued domestic violence against women. In Thailand, as in other countries, domestic violence is viewed as a private issue (Lertsrisantad, 2002) or is not viewed seriously (Thajeen, 2002). Police and members of public organisations often consider domestic violence as a private matter, not recognizing violence against women as a crime despite legislation to the contrary (Bhumiprabhas, 2001; Thajeen, 2002). In the Thai Criminal Code, police are required to 'only advise' couples, acting as mediators when one accuses the other of physical violence. They are not required to file a report, particularly when the injuries caused 'are not serious' or the incident is done 'for good intentions' (Poonyarat, 2002). Women who are victims of domestic violence also find that police and members of the public consider such acts as a domestic matter and no further action is taken or protection instituted (Bhumiprabhas, 2001). In addition, law enforcement officers and authorities, in particular the police have been known to be judgmental when dealing with victims of domestic violence (Pekanan & Wongsurawat, 2001). As a consequence, many women who experience domestic violence feel humiliated and do not report incidences to avoid the shame and guilt inflicted upon them by others.

Any existing laws against violence are often not enforced in Thailand (Thajeen, 2002). Although the 1997 Constitution created several possible opportunities for mechanisms to protect the rights of women and children at the national level, there is still an inadequacy in current Thai laws in regards to protecting victims of domestic violence or punishing perpetrators. This inadequacy has resulted in no absolute protection of rights for women and children. An example of this inadequacy or ambiguity in Thai

law can be seen in Section 276 of the Criminal Law Code which states that "*whoever has sexual intercourse with a woman who is not his wife, against her will, by threatening with any means whatsoever, by doing acts of violence, by taking advantage of the woman's inability to resist, or by causing the woman to mistake him for another person, is committing a crime*" (Pekanan & Wongsurawat, 2001, p. 75). This implies that marital rape is not recognized by the law as a crime and contradicts the intent to support the elimination of violence against women.

Another possible contributing factor that leads to continued violence against women in Thailand is that people in Thai society still place a good deal of blame on women for not acting "appropriately" or not being "careful". These attitudes lead to a situation where women are reluctant to disclose abuse or to take action to protect their rights (Thajeen, 2002). Frequently, abused women do not disclose abuse due to feelings of guilt, shame (Thajeen, 2002), fear of retaliation, humiliation, denial about the seriousness of the abuse, concern over confidentiality (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999), feelings of self-blame, and loyalty to the abuser (Heise, Raikes, Watts, & Zwi, 1994). The reluctance to disclose abuse is not only related to women's immediate personal safety but also the expected roles and responsibilities to their family, the possible economic impact of relationship breakdown and fear about police interference. In addition, the daily reality of living with abuse may alter many women's sense of identity and cause feelings of entrapment and disempowerment (Smith, Tessaro, & Earp, 1995). This can lower women's ability to assert themselves and disclose the abuse to health care providers.

The general view of women as sexual objects and a lack of respect for women's bodies are other important factors linked to violence against women in Thailand (Thajeen, 2002). This is particularly seen in the widespread forced prostitution of women and use of women for pornography. Thajeen (2002) argues all of these attitudes have their roots in the prevailing culture in Thai society and contribute to making the problem of violence against women serious, complicated and hard to solve.

Domestic violence is also linked to gender roles and inequality of gender status in Thailand. Although some writers argue that Thai women have high social and economic status, both within households and in the wider society (Jones, Havanon, & Mehta, 1997), others argue Thai women are also expected to display submissive or passive characteristics (Gray & Punpuing, 1999) while men are believed to be the "stronger sex" (Lertsrisantad, 2002). This expectation makes it difficult for women to assert their rights or aspirations. It also leads women to accept being submissive as a normal and expected part of their lives. Men, on the other hand, are perceived to be superior to women and may resort to violence as a rightful means to exert their authority.

The notion that the husband is the household head is a common belief in Thailand (Lertsrisantad, 2002). The position of "head" of the family entitles the incumbent to determine what this will mean for other family members and establishes a general notion of patriarchal authority (Horsfall, 1991). Women, on the other hand, whilst occupying all kinds of positions in public life, are supposed to find fulfilment in the roles of mother and wife (Mulder, 1996). They are seldom recognized as household heads (United Nations, 1995). As wives, women are expected to do their husbands' bidding and accept whatever treatment is meted out (Horsfall, 1991). In addition, women's mothering role neatly overlaps with their more general role of being responsible for the physical nourishment and emotional wellbeing of all family members. This can mean women physically and emotionally nurture husbands (Horsfall, 1991). The extensive nature of the patriarchal role, expectations of women in the family, in conjunction with the lack of comprehensive role expectations for men in the family, have ramifications with regard to the potential for violence by husbands towards their wives (Horsfall, 1991).

In summary, domestic violence often occurs between individuals behind closed doors and relates to issues of power and control, gender, and patriarchy. In Thailand, domestic violence against women is an increasing problem but continues to be a

neglected issue. Domestic violence against pregnant women receives limited public attention and is under-researched. Only two studies have investigated domestic violence during pregnancy in Thailand and little is known about the incidence and severity of domestic violence in this population. In order to provide appropriate health and welfare services, research is required to understand the extent of domestic violence in Thailand.

Significance of the Study

Domestic violence is being recognized as a social and public health issue, and pregnancy appears to be a particularly vulnerable period for violence against women (Mezey & Bewley, 1997). A number of studies have indicated that intimate partner violence may begin or escalate during pregnancy (Hillard, 1985; McFarlane et al., 1992). The effects of domestic violence on women's health and wellbeing are pervasive. It can impact significantly on a woman's physical, emotional and mental health (Queensland Health, 2000). These negative effects can be long lasting (Jaffe, Wolfe, Wilson, & Zak, 1986).

Abuse-related injuries including bruises, cuts, burns and scalds, concussions, broken bones and penetrating injuries from knives and other objects are frequently reported by women who experience abuse (Heise et al., 1994). In severe cases permanent disability and even death results. In the U.S. more than half the women murdered were killed by their male partners (Parker & McFarlane, 1991b). In addition to physical injuries, women who have been abused often experience a variety of less well defined somatic complaints such as chronic headaches, muscle aches, abdominal pain (Heise et al., 1994), gastrointestinal disorders and gynaecological problems (Hedin, 2000).

Abused women experience a high incidence of stress and stress- related illness such as post-traumatic stress syndrome, panic attacks, depression, suicide attempts, sleeping and eating disturbances, and low self-esteem (Sushma, 2000). They are also at a higher

risk of tobacco use, alcoholism and illicit drug use (Amaro, Fried, Cabral, & Zuckerman, 1990; Martin, English, Clark, Cilenti, & Kupper, 1996; McFarlane, Parker, & Soeken, 1996).

Violence during pregnancy may have adverse effects on the unborn child (McFarlane et al., 1992). Studies have shown that violence during pregnancy increases the risk of miscarriage, premature birth, placental abruption, preterm delivery, fetal injury, and infant low birth weight (Bullock & McFarlane, 1989; Mezey & Bewley, 1997; Webster, Chandler, & Battistutta, 1996). Further, domestic violence is associated with maternal death, premature rupture of membranes, spontaneous abortion, fetal death, and neonatal death (Covington, Justason, & Wright, 2001). Anemia, infections, and first and second trimester bleeding have also been found to be significantly higher for abused pregnant women than non-abused pregnant women (McFarlane et al., 1996; Parker, McFarlane, & Soeken, 1994).

In addition to health problems and poor obstetric outcomes for pregnant women, domestic violence has an economic cost to health care delivery, law enforcement, criminal justice systems, and social services (Sushma, 2000). Women who experience violence are more likely to have a greater number of hospital admissions during pregnancy (Webster et al., 1996). They also utilize a disproportionate share of health care services, making more visits to emergency departments, primary care settings, and mental health services than women who have not been abused (Coker, Smith, Mckeown, & King, 2000). Domestic violence has also been linked to marital and family breakdown in countries such as Australia (Brown, Frederico, Hewitt, & Sheehan, 2000).

The majority of published studies to date have been conducted in western developed countries such as the United Kingdom, the U.S. and Australia. Very few studies have focused on the experience of women in traditional Eastern cultures where women are

expected to be submissive and cultural norms may contribute to greater reticence to report domestic violence.

The present study aimed to investigate the prevalence of domestic violence among Thai pregnant women and explore their health outcomes. The findings from this study will contribute to increased knowledge on the frequency and severity of domestic violence among pregnant women, the risk factors associated with domestic violence, and adverse effects on maternal and neonatal health as well as pregnancy outcomes from a Thai perspective. The outcomes of this study will help to increase our understanding of resources that are perceived as helpful by abused women and barriers that may inhibit them from seeking help. Information derived from the study will contribute to an increased understanding of health care organizations about the early identification of abused women and provision of community resources. Additionally, it will provide the basis for guidelines that address referral mechanisms and early interventions to help women who have been abused. In particular, the study will contribute to the development of culturally specific educational programs on domestic violence aimed at health care professionals, community workers, people in communities and the women themselves. Finally, the findings from the study will help to raise awareness of domestic violence as a community problem and an important area for future policy development.

In summary although there is recognition of domestic violence against women in society, in Thailand it continues to be perceived as a private matter that is not addressed at the political, juridical and legal level. Research in the area has been scant and limited by the use of diverse definitions of domestic violence. Domestic violence among pregnant women has important implications for mothers and babies and deserves increased attention.

Overview of the Thesis

The thesis consists of six chapters. Chapter 1 introduced the study and provided an overview of definitions and types of domestic violence. This was followed with the background of the study, prevalence of domestic violence, the problem of domestic violence in Thailand, contributing factors and significance of the study.

Chapter 2 presents a review of the available literature on domestic violence during pregnancy. This chapter firstly addresses feminist perspectives on research about domestic violence, followed by an extensive literature review of domestic violence during pregnancy in Thailand and in other countries. This chapter includes a review of studies on domestic violence during the postpartum period, risk factors for domestic violence, adverse maternal and neonatal outcomes associated with domestic violence, target sites of injury as well as domestic violence screening in the antenatal period. This chapter demonstrates that available data are inadequate and there is a lack of research on domestic violence during pregnancy and following childbirth in Thailand.

Chapter 3 outlines the method used in the study. It firstly describes the rationale for the study followed by the research questions. This chapter then presents the study design, data collection sites, sample for the study, procedure used in undertaking the study and research instruments. A pilot study, translation process, data cleaning and screening as well as data analysis are also described. Finally, ethical considerations are outlined in this chapter.

Chapter 4 presents the analysis of results. The representative nature of participating women's characteristics are identified. Data in relation to the study's questions including prevalence of domestic violence during pregnancy and after birth, factors associated with domestic violence and women's health status are presented. Descriptive statistics such as mean, standard deviations and percentages are used. In addition, inferential statistics are used to determine the association between

demographic variables of women to abuse status and maternal outcomes. Findings of the study are demonstrated using tables and graphs. The validity and reliability of the standardized measures used in this study are described. Finally, this chapter presents four case studies that illustrate ways in which women who have experienced domestic violence managed the problem, the perceived causes of domestic violence, barriers that inhibited them from seeking help as well as their needs and support mechanisms they would find helpful in dealing with domestic violence.

Chapter 5 discusses the research findings in relation to the literature. Comparisons are made with other research studies in relation to the prevalence of domestic violence during pregnancy and following childbirth, risk factors of domestic violence and maternal and neonatal outcomes. This chapter discusses the similarities and differences between the present study and previous studies in terms of women's responses to domestic violence, their needs and supports, and barriers to seeking help.

Finally, Chapter 6 presents the conclusions drawn from this study, the implications and recommendations for education, practice and further research. The implications of this study explain the need for increasing community awareness on domestic violence in Thailand, particularly in the Northeast region through education programs, changes to nursing curricula, and preventive campaigns. Furthermore, there is a need for domestic violence screening in antenatal clinics and increased availability of health professionals at a hospital and/or health centres who can provide assistance to women who are victims of domestic violence. The need for shelter or crisis home establishment in the Northeastern Thailand and socio-legal reform are also paramount.

Chapter 2 : Literature Review

This chapter provides a review of literature on domestic violence during pregnancy and after birth. In the first instance, the conceptual frameworks for domestic violence are presented, followed by available studies on domestic violence in Thailand. Given the dearth of research on this topic in Thailand, studies on domestic violence during pregnancy and after birth in other countries will be presented by way of context. Risk factors associated with domestic violence will also be provided to depict a profile of women most at risk. Further, a review of adverse maternal and neonatal outcomes, target sites of injuries, and domestic violence screening in the antenatal period are included.

Conceptual Frameworks for Domestic Violence

There are various conceptual frameworks for domestic violence. This section describes three main frameworks associated with the following disciplines: (1) psychological (2) sociological and (3) feminism (Gelles & Loseke, 1993). These frameworks will help to provide an understanding of domestic violence and help to eliminate myths surrounding it.

Psychological perspective

Early psychological framework of domestic violence focused clearly on psychological and psychiatric factors (O'Leary, 1993). During this time it was assumed that one or both partners had certain abnormal characteristics that made them prone to domestic violence. For example, women were thought to be masochistic (Snell et al., 1964 cited in O'Leary, 1993) and men to have individual problems with loss of control and "excessive drive for aggressive behaviours" (Lorenz, 1966 cited in Browne & Herbert, 1997, p. 28), which is seen as the result of 'genetic make up' and/or 'adverse socialization experiences' (Lorenz, 1966 cited in Browne & Herbert, 1997).

Other psychological frameworks of domestic violence include psychopathology, psychodynamic, interpersonal interactive and social learning theory (Jasinski, 2001). All of these perspectives concentrate on characteristics of individual abusers. For instance, the psychopathology perspective suggests that men who are violent toward women have some sort of personality disorder or mental illness (Jasinski, 2001). The interpersonal interactive perspective focuses not only the characteristics of abusers but also the characteristics of the victims (Toch, 1969 cited in Browne & Herbert, 1997). In the social learning theory, violence in the home is viewed as a learnt behaviour from observing aggressive role models and/or exposure to violence (Jasinski, 2001). Although there is some evidence to support this observation, it does not account for a large number of abusers who do not have a childhood abuse history nor come from violent homes (Jasinski, 2001). The psychological explanation is also limited because it fails to address the issue of power and gender (Yllo, 1993). Further, this perspective does not provide answers as to why men with "mental illness" abuse their wives and not others such as their employees (Yllo & Bograd, 1988).

Sociological perspective

The core of the sociological perspective is the assumption that social structures have an affect on people and their behaviour (Gelles, 1993). Some sociologists have investigated risk factors and predictors of domestic violence. These factors include age, sex, socio-economic variables, social stress, and race and ethnicity (Gelles, 1993). Gelles and Cornell (1990) proposed that factors such as work pressures, unemployment, poverty and poor housing caused frustration and stresses at the individual level and as a consequence lead to violence in the family. However, some writers argue that this is a limited view since violence is not confined to families in the lower socio-economic groups but is spread across the class spectrum (Browne & Herbert, 1997). Sociologists also viewed family structure as a social institution that creates a high risk for violence (Gelles, 1993). Another sociological explanation of domestic violence is the resource theory proposed by Goode in 1971. Goode (1971 cited in Jasinski, 2001) suggested that violence is a resource used to derive power so

that a person lacking of power will utilize violence (resources) within the relationship. Although sociological perspectives employ psychological variables, family factors, and the broader social context into an understanding of domestic violence as a social issue, Yllo (1993) argued that sociological work was largely 'gender-neutral' and did not focus on the patriarchal nature of these social forces in the theories. In short social forces have led to gender inequality in the family allowing men to take control of the family and abuse their partners.

Feminist perspective

The basis of feminist perspectives on domestic violence originate from a social movement (Yllo, 2005). Researchers and clinicians using this basis view domestic violence against women as a form of social control that emerges directly from the patriarchal structure and the ideology of the family (Dobash & Dobash, 1979; Yllo & Bograd, 1988, Yllo, 1993, 2005).

Dobash and Dobash (1979) explained violence against women in terms of coercive control, which focused on the power and control that males exert over females or the subordinate position of women in society. This power and control occurs at both societal level and in the context of home and family. At the societal level, this can be seen as males occupying positions of power and control in government, religious organisations and society in general. Dobash and Dobash (1979) argued that just as males dominate females at the societal level, this also occurs in the context of the home and family. From this perspective, the main factors that contribute to violence between husbands and wives include the historically male-dominated social structure and socialization practices that teach men and women gender-specific roles (Jasinski, 2001; Pagelow, 1984).

Domestic violence from a feminist perspective also focuses on the relationship between cultural ideology of male dominance and structural forces that limit women's access to resources. Thus, violence against women becomes a method used by men to maintain

social control and power over women (Jasinski, 2001) and therefore is a result of the subordinate position women occupy in the social structure. This subordination is the cultural legacy of the traditional family (Jasinski, 2001). In other words, violence against women is one manifestation of a system of male dominance that has existed historically and across cultures (Yllo & Straus, 1990).

Some researchers have dismissed feminist perspectives on domestic violence (Steinmetz, 1987 cited in Yllo, 2005) and criticized these perspectives as narrow and unable to account for violence perpetuated by women (Dutton & Bodnarchuk, 2005). Feminist researchers on the other hand have argued that these models provide a very broad analysis of gender and power in society and provide fruitful insight into domestic violence while other perspectives do not adequately incorporate gender issues in their explanations (Yllo, 1993). Feminist perspectives are now becoming the dominant explanatory models for understanding domestic violence against women (Gelles, 1993). This is because of its major strength in the "praxis or advocacy approach" (Gelles, 1993, p. 41). The central focus of the feminist approach is about women's victimization as a social problem and the need to address the patterned, continuing, and harmful use of psychological and physical coercion to control and dominate women (Gelles, 1993).

As Parker and McFarlane (1991a, p. 63) argued "[p]hysical abuse of women, specifically the abuse of pregnant women, is central to women's condition and oppression" and as such the application of feminist principles to the proposed study was deemed to be appropriate, and could be used as a framework to make sense of the findings. By applying feminist principles in the proposed study, the researcher aimed to emphasize a reciprocal relationship and encourage participating women to be involved in research. Feminist principles require researchers to ensure trust and openness between the researcher and participating women by establishing rapport during the research process. In addition, researchers are required to continuously be reflexive in order to discard any distorted views and avoid making male-dominated

underlying assumptions through the researcher's own efforts to examine her own views, values, characteristics and assumptions (Im, 2000). Researchers are also required to determine the appropriateness and significance of the study by examining "whether the questions address women's concerns and whether the answers to these questions can serve women's interests and improve the conditions of women's lives" (Im, 2000, p. 116). These processes would help to ensure the relevance of the proposed study as relevance is another key indicator of rigor in feminist inquiry (Hall & Stevens, 1991).

Studies on Domestic Violence in Thailand

It is difficult to comprehend the extent of domestic violence in Thailand for a number of reasons. First, most studies undertaken have been unpublished. From the literature, it was found that most studies undertaken were dissertations for which no subsequent publications were located, and there are few research reports. Second, the occurrence of domestic violence is often underreported (Clongphayaban, 1999). Although there have been notorious cases of domestic violence against women in Thailand as outlined in the popular press, none have produced obvious social responses to the problem (Quicker, 2002). Finally, there are very few studies that actually employ some sort of theoretical perspective especially a gender perspective (Gray & Punpuing, 1999), thus in the present study feminist perspectives will be used to inform the study and make sense of the study findings.

From a search of the literature on domestic violence against women in Thailand, several studies were identified (e.g., Archavanitkul et al., 2003; Chaisetsampun, 2000; Chocksawat, 2003; Clongphayaban, 1999; Deoisres, 2004; Shuaytong, Phijaisanit, Isaranurug, & Weerawatthanodom, 1998; Thanaudom, 1996). Of these, only two studies addressed violence during pregnancy (Deoisres, 2004; Thanaudom, 1996). The prevalence of violence against Thai women as a whole ranged from 26.5% (Shuaytong et al., 1998) to 87.5% (Clongphayaban, 1999) while violence during pregnancy ranged

from 12% to 22.5% (Thanaudom, 1996) depending on the type of violence and definitions used.

The first study that addressed domestic violence in pregnancy was conducted by Thanaudom (1996). Four hundred pregnant women who attended an antenatal clinic at the Health Promotion Centre Region 1, Bangkok were surveyed during a two- week period. The results showed that 12% of pregnant women reported physical abuse, and 22.5% of women reported mental abuse in the past six months. The reported sites of injury were mainly on the face with slapping as the most common act of physical violence. This study, however, was limited in that the researcher asked pregnant women about violence in the past six months, and did not specify the gestational stage of the women. Therefore, it is difficult to determine when violence commenced and/or its frequency during pregnancy, or when women might be more vulnerable to domestic violence as the study did not assess violence experienced during each trimester. In addition, the study was unable to identify whether the violence increased or decreased around the time of pregnancy as the study did not extend to the postpartum period, nor did it examine the impact of domestic violence on pregnancy outcomes.

The second and most recent study on violence during pregnancy was conducted between April 2000 and August 2001 at 12 public hospitals in four provinces in Eastern Thailand (Deoisres, 2004). These provinces were Chon Buri, Rayong, Chachoengsao, and Chantaburi, which are developed coastal areas of Thailand. Results were presented at a conference but no peer-reviewed manuscript has been published to date. In this study, 481 pregnant women were surveyed for abuse on three occasions during their pregnancy (first, second, and third trimester of pregnancy). The Abuse Assessment Questionnaire developed by the researcher was used. The results showed that 271 (56.3%) women had experienced abuse during the year before pregnancy and 233 (48.4%) reported being abused during their current pregnancy. Among abused pregnant women, 218 (93.6%) were emotionally abused, 77 (33%) were physically abused, and 18 (7.7%) experienced sexual abuse, with the majority of perpetrators being husbands

(93%). This study however focussed not on only intimate male partners but also family and strangers as perpetrators of violence. Further the study included only women who attended antenatal clinic and gave birth at the same hospital.

Overall, there are relatively few studies on domestic violence against women in Thailand. Only two studies examined violence during pregnancy, and neither was undertaken in the Northeastern Thailand, which is the poorest region. Consequently, there is a dearth of information on domestic violence against pregnant Thai women. The next section will therefore review studies on domestic violence during pregnancy conducted in other countries to provide further detailed information.

Domestic Violence during Pregnancy in Other Countries

In this section all available studies on violence during pregnancy are summarized and presented in Table 2.1. These studies are discussed in terms of study characteristics, methods and findings. The researcher undertook a search of the major databases (Cinahl; Pubmed; Sociofile; Ovid, Blackwell Synergy, and Proquest) to retrieve English language publications for the reports on the topic of violence during pregnancy and after birth for the years 1970 through to 2005. The search parameters were combinations of key words or terms by which the relevant studies might be indexed. The key words used were 'violence against women', 'domestic violence', 'battered women', 'spouse abuse', 'partner abuse', 'intimate partner violence', 'violence during pregnancy', 'pregnancy complication', 'violence and after birth', 'postpartum and violence'. Reference lists of all relevant articles obtained were checked and additional potentially relevant articles retrieved.

The studies that met predetermined selection criteria were reviewed. Selection criteria included studies that focused on measuring the prevalence or incidence of violence against women before, during pregnancy and/or after birth; any type of violence, and

data from developed or developing countries. Based on these selection criteria, 28 studies were identified and reviewed.

Table 2.1: Summary of research on violence during pregnancy

Authors	Objectives	Sample	Settings	Measures	Violence Measure	Abuser	Findings
Amaro et al. (1990)	Describe the prevalence and patterns of violent incidents during pregnancy	1,243 pregnant women, English or Spanish speaking	Prenatal clinic of Boston City Hospital, USA	Interviews	"Were you physically threatened or abused, or were you involved in any fights or beatings?"	All contact	- 7% reported physical or sexual abuse during pregnancy
Bowen, et al. (2005)	Examine the rates of domestic violence (emotional and physical) during and after pregancy	7,591 pregnant women	Women's homes in Bristol Avon, Southwest England	Questionnaires administered at 18 weeks of gestation, and 8 weeks, 8 months, 21 months and 33 months postpartum	"Your partner was emotionally cruel to you" "You partner was physically cruel to you"	Partner	- 1% and 4.8% reported physical cruelty and emotional cruelty respective during 18 weeks of gestation - 2.9% and 10.8% reported physical cruelty and emotional cruelty respectively at 33 months postpartum
Campbell et al. (1992)	Determine prevalence of partner abuse and examine correlates of abuse during pregnancy	488 women at 2 to 5 days postpartum	Postpartum wards of 5 hospitals, Midwestern metropolitan area, USA	Interviews and chart reviews	"Hit, slapped, kicked, or otherwise physically hurt"	"The man you are with" and "anyone else"	- 4.2 % reported physically hurt by their partners before pregnancy - 7% were assaulted during pregnancy by their partners
Castro et al. (2003)	Identify the prevalence and types of violence experienced by pregnant women 12 months before and during pregnancy	914 women in their third trimester of pregnancy	27 prenatal health clinics in the state of Morelos, Mexico	Interviews	26 items of an instrument modified from the Index of Spouse Abuse (ISA) and Severity of Violence Against Women Scale (SVAW)	Partner	- 24.4% and 24.5% experienced abuse in the 12 months period before and during pregnancy respectively - 12.2% and 10.6% were physically abused before and during pregnancy respectively - 18.2% and 20.5% were emotionally abused before and during pregnancy respectively - 10.0% and 8.1% were sexually abused before and during pregnancy respectively
Guo et al. (2004)	Assess the prevalence of physical, emotional and sexual abuse during the 12 months before pregnancy, during and after pregnancy	12,044 women who had a child aged 6 to 18 months	32 communities of Tianjin, Liaoning, Henan, and Shaanxi Provinces, China	Face-to-face survey	Physical-"Had been beaten or pushed but without trauma, kicked punched, beaten up or physically abused with tools or weapons" Sexual- "Had been continuously pressured verbally to have sexual intercourse, physically forced to have sexual intercourse etc" Emotional- "Had been insulted, made to feel bad, humiliated, intimidate and threatened with a weapon.	Husband	- 12.6% had overall prevalence of violence occurring in any period (before, during, or after pregnancy) with 3.5 % experienced physical violence, 5.6% emotional and 8.0% sexual - 9.1% experienced abuse before pregnancy - 4.3% experienced abuse during pregnancy - 8.3% experienced abuse after birth (mean 11 months)

Table 2.1: Summary of research on violence during pregnancy (Continued)

Authors	Objectives	Sample	Settings	Measures	Violence Measure	Abuser	Findings
Hedin & Janson (1999)	Measure the prevalence, effects and character of psychological abuse	207 pregnant Swedish born women married to or cohabiting with Swedish born men	3 different antenatal clinics in Göteborg, Sweden	Personal interview combined with a standardized questionnaire	SVAW and the Psychological Maltreatment of Women Inventory (PMWI)	Husband / boyfriend, ex-partner	- 24.5% reported threats and/ or acts of violence during the last year - 44.4% experienced emotional/verbal abuse
Hedin et al. (1999)	Estimate the prevalence of threats and actual acts of physical and sexual abuse during pregnancy	207 pregnant Swedish born women married to or cohabiting with Swedish born men	3 different antenatal clinics in Göteborg, Sweden	Personal interview combined with a standardized questionnaire	SVAW for physical and sexual abuse	Husband, boyfriend, ex-partner	- 27.5% exposed to physical violence at some point in the past - 24.5% experienced threat, physical or sexual violence during the last year - During the current pregnancy 14.5% experienced symbolic, 14.5% threats of mild violence, 2.9% threats of moderate violence, 2.9 threats of serious violence, 11% mild violence, 4.3% minor violence, 2.4% moderate violence, 4.3% serious violence, and 3.3% sexual violence
Helton et al. (1987)	Measure the occurrence of battering during pregnancy among a selected population of pregnant women	290 random pregnant women aged 18-43	6 public and 2 private prenatal clinics, USA	Interviews	Hit, slapped, kicked or physically hurt	Male partner	- 8% reported battering during the current pregnancy, - 15% reported battering before the current pregnancy.
Hillard (1985)	Determine the extent of physical abuse	742 prenatal patients	University obstetrics clinics, Virginia, USA	Screening interviews and chart review	"Has anyone at home hit or tried to hurt you"	Anyone at home	- 10.9% experienced abuse at some point in the past - 3.9% reported abuse during the current pregnancy - 21% of women experiencing current abuse reported increased abuse, - 36% noting decreased abuse during pregnancy, and 43% reported no change
Irion et al. (2000)	Determine the prevalence of emotional, sexual or physical violence	244 pregnant women able to read French	Postpartum ward, Geneva, Switzerland	Self-administered questionnaire	Questions adopted from the Abuse Assessment Screen (AAS)	Husband, partner, or relative	- 18% reported the prevalence of emotional, physical, and/or sexual violence during lifetime - 7% reported the prevalence of violence during pregnancy
Johnson et al. (2003)	Determine the prevalence of domestic violence in pregnant women	500 consecutive pregnant women	Hull Maternity Hospital antenatal clinic, England	Questionnaire survey	Screening question asking if women had been physically or emotionally hurt by "partner or someone close to you". A modified version of the Abuse Assessment Screen	Husband, ex-husband, boyfriend, stranger, father, mother	- 17% reported experienced domestic violence - 3.4% experienced violence during pregnancy - 14.3% experienced emotional abuse - 14.7% experienced physical abuse
Lau (2005)	Determine the prevalence of intimate partner abuse	1200 postnatal women	Recruited in a university-affiliated regional public hospital but community based, Hong Kong	Self-administered questionnaire	The AAS and the Revised Conflict Tactics Scale (CTS-2)	Husband, ex-husband, ex-boyfriend	- 11.2% experienced abuse during pregnancy - 8.8% experienced psychological aggression - 4.1% experienced physical assault - 5.5% experienced sexual abuse

Table 2.1: Summary of research on violence during pregnancy (Continued)

Authors	Objectives	Sample	Settings	Measures	Violence Measure	Abuser	Findings
Leung et al. (1999)	Determine the incidence of violence against pregnant women	631 pregnant women attending their first antenatal clinic	Antenatal clinic in a teaching hospital, Hong Kong	Screening interviews	The AAS	All contact	- 15.7% were abused in the last year - 9.4% were sexually abused in the last year - 4.3% were physically abused during the current pregnancy
Martin et al. (2001)	Examine patterns of physical abuse before, during and after pregnancy	Representative sample (2,648 women) who delivered live-born infants	North Carolina, USA	Mailed and telephone survey	"Pushed, hit, slapped, kicked, or physically hurt in some other way"	All contact	- 6.9% had abused 12 months before pregnancy, - 6.1% reported abuse during pregnancy - 3.2% had postpartum abuse
Martin et al. (1996)	Examine violence before and during pregnancy, and relationships between violence and substance use	2092 prenatal women aged 20-30 years	Prenatal health department, North Carolina, USA	Self-reports	The AAS	All contact	- 26% reported being a victim of violence at some time in their lives - 23% experienced violence only before the current pregnancy - 2% had experienced violence both before and during current pregnancy - 3% experienced violence during pregnancy
McFarlane et al. (1999)	Describe timing and severity of abuse before and during pregnancy for African American, Hispanic and white Anglo American women	199 pregnant women	Public clinics in 2 geographic settings, USA	Interviews	The AAS then the ISA, Danger Assessment Screen (DAS) and SVAW to abused women	Current or former male partner	- 51.8% were abused both the year before and during pregnancy - 30.2% were abused the year before but not during pregnancy - Among 199 abused women, 18.1% were abused during pregnancy but not the year before.
McFarlane et al. (1992)	To assess the occurrence, frequency, and severity of physical abuse during pregnancy.	691 black, Hispanic, and white pregnant women	Public prenatal clinics, Houston, Texas and Baltimore, Maryland, USA	Screening and questionnaire	The AAS, then Conflict Tactics Scale (CTS) and ISA for all women, and DAS to abused women	Husband, boyfriend or family member	- 17% reported abuse during pregnancy - Abuse was recurrent with 60% of abused women reporting two or more episodes of assault.
Muhajarine & D'Arcy (1999)	Describe the prevalence of physical abuse during pregnancy	543 pregnant, 2nd trimester women receiving prenatal services, aged 15-40 years, English speaking	Publicly funded, community based health services Saskatoon, Canada	Interviews	The AAS	All contact	- 5.7% experienced physical abuse during pregnancy - 8.5% experiencing it within the 12 months preceding the 2nd interview

Table 2.1: Summary of research on violence during pregnancy (Continued)

Authors	Objectives	Sample	Settings	Measures	Violence Measure	Abuser	Findings
O'Campo et al. (1994)	Study the occurrence of verbal abuse and physical violence during pregnancy	358 low-income pregnant women	The Johns Hopkins Hospital Adult Obstetrical Clinic, USA	Interviews	The CTS	Someone close to	- 45% of the sample experienced only negative verbal interaction - 11% experienced moderate violence - 9.3% experienced severe violence during their pregnancies. - 4% of the women experienced severe violence more than four times during the 6 months preceding the interview
Parker et al. (1994)	Determine the incidence of physical and sexual abuse in a sample of adult and teen pregnant women	1,203 pregnant women (356 teens and 847 adults)	Prenatal clinics at Baltimore and Houston, USA	Interviews at the 1st prenatal visit and during the 2nd and 3rd trimesters	The AAS, ISA and DAS	"Partner" or "someone important to you"	- 24% reported physical or sexual abuse within the past year at their first prenatal visit. - 5% of nonabused women reported abuse beginning in the second or third trimesters. - 20.6% of teens and 14.2% of adults reported abuse during pregnancy
Parker et al. (1993)	Determine the amount of physical and emotional abuse before and during pregnancy	691 African, Hispanic, and white pregnant women (214 teens aged 13-19, 477 adults 20-42 years)	Prenatal clinics at Baltimore and Houston, USA	Interviews	The AAS, ISA and CTS	Husbands/ Ex-husband, boyfriend, stranger, other	- 26% reported physical or sexual abuse within the past year, - 21.7% of teens and 15.9% of adults experienced abuse during pregnancy (total 24.7%) - 16.9% of adults and 8.5% of teens indicated mental abuse according to the ISA nonphysical. - Mental abuse was significantly correlated with physical abuse for all subjects.
Peedicayil et al. (2004)	Determine the prevalence of physical violence during pregnancy	9,938 women aged 15-49 years	Rural, slum and urban non-slum areas of Bhopal, Delhi, Lucknow, Nagpur, Trivandrum and Vellore, India	Household survey	"Slap, hit or punch, kick, beat, use or threaten with weapon and harm in any other way"	Husband	- 13% reported the overall prevalence of violence during pregnancy - The life time experience, during pregnancy, of being slapped was 16%, hit 10%, beat 10%, kicked 9%, use of weapon 5% and harmed in any other way 6%
Rachana et al. (2002)	Assess the incidence of physical violence during pregnancy	7,105 pregnant women at the first trimester of pregnancy	Antenatal clinics of teaching hospitals, Saudi Arabia	Self- reports	"Physically hurt" or "Involvement in a physical fight during the 10 months before delivery"	Husband and in laws	- 21% reported physical violence during the 10 months before delivery
Savona-Ventura et al. (2001)	Identify the extent of domestic abuse in pregnant women	1,000 women in the first 2 days postpartum	2 government and 3 private hospitals in Malta and Gozo, central Mediterranean	Self-administered questionnaires	Physically hurt	Spouse/ partner	- 2.29% reported physically hurt during the last year - 1.53% being hurt during their current pregnancy - 0.8% experienced sexual abuse in the last year

Table 2.1: Summary of research on violence during pregnancy (Continued)

Authors	Objectives	Sample	Settings	Measures	Violence Measure	Abuser	Findings
Stewart & Cecutti (1993)	Determine the prevalence of physical abuse during late pregnancy	548 pregnant English speaking women at 20 weeks' or more gestation	Public clinic and private obstetric and family physician offices in 5 different sites, Toronto, Canada	Survey questionnaire	12 questions on abuse, including whether they had been physically abused	All contact	- 10.9% experienced physical abuse before their current pregnancy. - 6.6% experienced abuse during pregnancy - 66.7% of abused women received medical treatment for abuse
Webster et al. (1994)	Determine the extent of physical and psychological abuse of pregnant women	1,014 pregnant women able to read/write English (aged 16-44)	Public prenatal clinic, Brisbane, Australia	Self-report questionnaire	"Have you ever suffered any of the following examples of domestic violence at the hands of a family member or close friend?	A family member or close friend	- 29.7% had a history of abuse - 5.8% reported abuse during current pregnancy - 21.2% had emotional/ verbal abuse, 5.3% reported sexual abuse
Whitehead & Fanslow (2005)	Determine the prevalence of family violence (physical and sexual) in women seeking termination of pregnancy	62 out of 125 pregnant women	Health Waikato abortion clinic, New Zealand	Self-administered questionnaires	"Have you been hit, slapped or otherwise physically hurt by someone?" "Have you been pressured or forced to have sex"	Partner, family member, or someone else	- 50.8% reported life time prevalence of physical or sexual abuse - 5% reported physical abuse during pregnancy - 1.7% reported sexual abuse during pregnancy - 69% reported perpetrators were partner/person they became pregnant to
Wiist & McFarlane (1998)	Assess the severity of intimate partner violence to Hispanic pregnant women	342 Hispanic prenatal pregnant women	3 clinics of a public health department, southwestern United States	Interviews	The AAS and SVAW	Male intimate partner	- 30% had been threaten with death, 18% had been threaten with knife or gun, 40% had been punched, 33% had been kicked and 20% had been forced to have sex

Characteristics of existing studies

As summarized in Table 2.1, seventeen studies used public clinics or hospitals as settings for recruitment (e.g., Amaro et al., 1990; Castro, Peek-Asa, & Ruiz, 2003; Hedin & Janson, 1999; Hillard, 1985; Johnson, Haider, Ellis, Hay, & Lindow, 2003), three used both public and private clinics (Helton, McFarlane, & Anderson, 1987; Savona-Ventura, Savona-Ventura, Drengsted-Nielsen, & Johansen, 2001; Stewart & Cecutti, 1993). The remaining studies were carried out in postpartum wards (Campbell, Poland, Waller, & Ager, 1992; Irion, Boulvain, Straccia, & Bonnet, 2000), community health services (Muhajarine & D'Arcy, 1999) and general communities (Bowen, Heron, Waylen, Wolke, & the ALSPAC study team, 2005; Guo, Wu, Qu, & Yan, 2004; Lau, 2005; Martin et al., 2001; Peedicayil et al., 2004). In addition, the clinic-based studies were in geographically diverse areas. Sample sizes ranged from 62 to 12,044 women.

The primary objectives of most studies were similar. In 13 of the 28 studies the stated objective was to determine the prevalence of violence during pregnancy (e.g., Campbell et al., 1992; Castro et al., 2003; Guo et al., 2004; Hedin, Grimstad, Moller, Schei, & Janson, 1999; Lau, 2005). Three studies examined the incidence (Leung, Leung, Lam, & Ho, 1999; Parker et al., 1994; Rachana, Suraiya, Hisham, Abdulaziz, & Hai, 2002), and eight studied the occurrence, rates or the extent of domestic violence (e.g., Bowen et al., 2005; Helton et al., 1987; Hillard, 1985; O'Campo, Gielen, Faden, & Kass, 1994). Two studies examined patterns of violence (Amaro et al., 1990; Martin et al., 2001); only three studies examined either frequency or severity of violence during pregnancy (McFarlane et al., 1992; McFarlane et al., 1999; Wiist & McFarlane, 1998).

Study methods

There is a difference in data collection methods across studies. The majority of studies collected violence data using an interview (e.g., Amaro et al., 1990; Helton et al., 1987; Muhajarine & D'Arcy, 1999) while some combined interviews with either a chart review (Campbell et al., 1992; Hillard, 1985) or a standardized questionnaire,

a survey or self-administered questionnaires (e.g., Bowen et al., 2005; Hedin & Janson, 1999; Johnson et al., 2003; Lau, 2005; Peedicayil et al., 2004; Savona-Ventura et al., 2001; Stewart & Cecutti, 1993; Webster et al., 1994). The other study used a telephone survey (Martin et al., 2001).

The measures or instruments varied considerably between studies. For example, several studies assessed violence by asking a direct question about being "hit, slapped, kicked or physically hurt" (Campbell et al., 1992; Helton et al., 1987, Martin et al., 2001). On the other hand, some studies used the Abuse Assessment Screen (Leung et al., 1999; Martin et al., 1996; Muhajarine & D'Arcy, 1999) to identify violence in the past year, and during pregnancy. Other established instruments used in previous studies included the Index of Spouse Abuse (ISA), the Severity of Violence Against Women scale (SVAW), the Psychological Maltreatment of Women Inventory (PMWI), the Conflict Tactics Scales (CTS), the Revised Conflict Tactics Scales (CTS2) and the Danger Assessment Screen (DAS).

Additionally, types of violence under investigation varied between studies. Eight studies investigated only physical violence (Campbell et al., 1992; Helton et al., 1987; Hillard, 1985; Martin et al., 2001; McFarlane et al., 1992; Peedicayil et al., 2004; Rachana et al., 2002; Stewart & Cecutti, 1993). Several studies combined physical and sexual violence into one category and defined it as physical abuse (Amaro et al., 1990; Martin et al., 1996; Muhajarine & D'Arcy, 1999; Parker et al., 1994; Parker et al., 1993). One study investigated verbal and physical violence (O'Campo et al., 1994). Other studies investigated both physical and sexual violence (Hedin et al., 1999; Leung et al., 1999; McFarlane et al., 1999; Savona-Ventura et al., 2001; Wiist & McFarlane, 1998). Five studies included physical, sexual and psychological violence (Guo et al., 2004; Johnson et al., 2003; Lau, 2005; Parker et al., 1993; Webster et al., 1994). Clearly, the differences in definitions and types of violence can result in a wide variation in estimates of violence during pregnancy.

The perpetrators of violence also varied among studies. Eight studies asked women about violence perpetrated by anyone they came in contact with (e.g., Amaro et al.,

1990; Johnson et al., 2003; Leung et al., 1999; Martin et al., 1996; Martin et al., 2001; Whitehead & Fanslow, 2005). One study specified the abuser as "the man you are with" and "anyone else" (Campbell et al., 1992). In four studies, women were asked about their experience of violence by defining the perpetrators as "anyone at home" while two studies asked about violence by "someone close to you". Several studies included husbands, family members, friends (McFarlane et al., 1992; Webster et al., 1994) and strangers (Parker et al., 1993). The remaining eight studies limited the perpetrators to husbands, boyfriends, male partners or ex-partners (e.g., Castro et al., 2003; Hedin et al., 1999; Helton et al., 1987).

The time period of observations also varied considerably. A number of studies included the entire period of pregnancy (e.g., Amaro et al., 1990; Campbell et al., 1992), and some included reports of violence through the third trimester (e.g., O'Campo et al., 1994; Parker et al., 1994).

In the study by O'Campo et al. (1994) 358 low-income pregnant women were assessed for verbal abuse and physical violence during a one-year period. Participants were interviewed three times during the course of their prenatal care. The third interview assessed violence using the Conflict Tactics Scale. They found that 45% of women experienced verbal abuse, 11% experienced moderate physical violence and 9.3% experienced severe violence during their pregnancies. However, it was difficult to determine whether the events occurred during the same episode or at different times during the pregnancy. In addition, the severity or outcome of each violent episode was not investigated or whether these women sought medical care as a result of their abuse.

Several studies assessed violence during women's first antenatal care visit (e.g., Martin et al., 1996; Stewart & Cecutti, 1993). These studies were somewhat limited because any violence that occurred later in pregnancy would have not been detected. Additionally, several studies did not specify the gestation period of the pregnant women (e.g., Helton et al., 1987; Webster et al., 1994).

Findings of previous studies

In the studies under review, the percentage of women experiencing physical violence within the last year ranged from 2.3% to 27.5% (See Table 2.1) while rates of emotional abuse within the last year ranged from 8.5% to 45%. The prevalence of violence at some point in the past ranged from 10.9% to 27.5%. The prevalence of women experiencing physical violence during pregnancy ranged from 1.5% to 24.7% while sexual violence during pregnancy ranged from 3.3% to 8.1%. Emotional violence during pregnancy was reported between 12.2% and 21.2%.

Most studies that had similar rates of violence during pregnancy collected data from an interview and used similar measures of violence. The studies that found higher estimates of violence ranging from 17% to 24.7% were also similar to each other in design. Four of these studies used a combination of detailed tools in assessing violence, such as, Abuse Assessment Screen, Index of Spouse Abuse, Conflict Tactics Scale, and Severity of Violence Against Women scale (McFarlane et al., 1992; McFarlane et al., 1999; Parker et al., 1994; Parker et al., 1993). On the other hand, the study with the lowest estimate of violence during pregnancy (Savona-Ventura et al., 2001), asked a single, broad question about being "physically hurt" by a male partner. This particular study assessed violence on a self-report questionnaire provided to women in the first two days postpartum. Many of these design factors are likely to have influenced reported estimates of violence during pregnancy, and the rate of violence changed according to different definitions used.

In summary, most research on domestic violence during pregnancy has been undertaken in developed Western countries such as the United States, Canada and Sweden. The prevalence of violence among pregnant women varied widely and may have been related to the time period under investigation. The definition of a perpetrator also varied considerably including anyone at home or anyone who came in contact with the woman. A number of studies employed different definitions of violence and different research tools. Some studies combined physical violence with sexual violence and categorized it into physical violence. Furthermore, the majority of studies assessed only the physical component of violence, with few studies

investigating sexual and/or emotional violence as well. This review of the literature clearly shows a dearth of information on incidence of domestic violence among this vulnerable group in less developed countries. Research using a broader definition of domestic violence that includes not only physical violence but also psychological/emotional and sexual violence is also needed to comprehensively understand the different forms of violence since men tend to employ multiple forms of abusive behaviours to dominate and control their female partners (Healey, 1998). New investigations using standardized measures that focus on current partners/husbands as perpetrators of violence among pregnant women are also needed to help compare estimates of incidence of domestic violence between different populations and across studies. Therefore, the present study aims to investigate the prevalence of domestic violence perpetrated by current partners/husbands, among Thai pregnant women using a standardized questionnaire to improve our understanding of such complex issues.

Domestic Violence during the Postpartum Period

Although research on domestic violence before and during pregnancy is increasing, there is a dearth of research concerning abuse that occurs after infant delivery, a stressful time for many families (Martin et al., 2001). This section reviews previous studies on violence in the postpartum period.

While most studies have focused on the period before and during pregnancy, several have investigated domestic violence in the postpartum period. For example, Hedin (2000) surveyed 207 Swedish women using the Severity of Violence Against Women Scale at their 8-week postpartum visit. The response rate was 64%. The results showed that 32 out of 132 women (24.2 %) experienced threats, physical or sexual abuse postpartum. Of these 32 women, 22 had not been subject to abuse previously.

In a representative sample of women from North Carolina, Martin et al. (2001) examined patterns of physical abuse before, during, and after pregnancy. A sample of 2,648 women who recently delivered live infants was invited to participate in a

mail and telephone survey. The investigators assessed physical abuse during three periods: the twelve months before becoming pregnant, during pregnancy, and three months after delivery. The prevalence of abuse before pregnancy was 6.9% compared with 6.1% during pregnancy and 3.2% in the postpartum period. Perpetrators included current or former husbands/partners, family members, friends or someone else, with 76% of perpetrators being current or former husbands/partners. The investigators found that 77% of women abused after delivery were injured, 73% experienced pain the day after the abuse, 57% had sprains, bruises or small cuts, 9% had head, internal or permanent injuries, 8% had weapon wounds, and 6% had broken bones, severe cuts or burns. Although three quarters of these women had multiple types of injuries, only 23% received medical care for their injuries. The authors suggested that abuse in an earlier period was strongly associated with further abuse in subsequent periods. The findings from this study also suggest that intimate partner abuse occurs in the immediate postnatal period, and an opportunity exists for community, midwifery and child health care practitioners to identify this abuse.

However, in this study non-respondents were more likely than respondents to be young, unmarried, black, and have low education levels. In addition, women's ability to recall abusive events may vary as a function of the period asked about, with less recall of events that occurred in the more distant past. Moreover, the survey did not ask about the composition of women's households or whether they changed intimate partners during the three periods examined. Thus, the study was unable to determine the extent to which initiation or discontinuation of violence was associated with these types of alterations. Similarly, information was not available concerning types of abuse other than physical abuse, such as, psychological abuse. Finally, this study included only women who gave live births and findings may not be generalized to women with other types of pregnancy outcomes.

In summary the review of studies on domestic violence during the postpartum period identified a lack of consistency across studies in definitions of domestic violence or abuse. Moreover, the majority of previous research on domestic violence mainly focused on physical violence with few studies concentrating on psychological and

sexual violence. Other forms of abuse that are destructive to battered women's physical and psychological integrity can accompany physical abuse. Future research should therefore be expanded to address not only physical abuse but also psychological and sexual abuse. Additionally, some researchers combined physical and sexual violence and classified it as physical violence, which may limit the true nature of domestic violence.

The majority of previous studies focused on the prevalence or incidence of domestic violence with scant attention to the frequency and severity of domestic violence. Further information is needed about frequency, timing, and severity of violence, the body site of violence and extent of medical treatment given for injuries to obtain an informed view of violence against childbearing women.

The timing of data collection also varied among studies. Some researchers interviewed women only once or twice during pregnancy. The lack of contact with women may lead to an underestimation of violence at critical times. Furthermore, very few studies conducted a follow up interview after delivery. Therefore, it is not known whether the risk of domestic violence increases during pregnancy or after delivery. No study to date has included a 6-week postpartum follow up. A 6-week follow up may help to distinguish the issues and events that occur in the immediate postpartum period, which is characterized by rapid physical and mental changes compared to the later postpartum period. Data collection at 6-weeks postpartum may be useful because many women, particularly in Thailand, schedule a health care visit at this time, providing an opportunity for health service interventions.

A wide range of perpetrators was identified across studies. Most studies measured a combination of male intimate and non-intimate abusers such as parents, siblings and strangers, with few studies focusing on intimate male partners as the exclusive abusers. This inconsistency may contribute to different estimations of domestic violence. Clearly, intimate male partners such as husbands and partners need to be included since most acts of domestic violence are perpetrated by intimate partners.

Risk Factors for Domestic Violence

In an attempt to better understand domestic violence, researchers have sought to identify associated risk factors. In this section, risk factors of domestic violence are reviewed and presented. However, these risk factors only partially explain the association of domestic violence or women who are at risk while feminist perspectives will help to alert researchers to other factors as well.

Although domestic violence happens to women in all cultures regardless of social, economic and educational level (Hedin et al., 1999; Hegarty et al., 2000), five risk factors have been consistently associated with domestic violence. These are socio-demographic factors, history of previous abuse, lack of peer and family support, multiple ill-health risk factors, and characteristics of the male partner.

Socio-demographic factors are commonly associated with domestic violence. One cross-sectional Californian study employed a random computer-assisted representative sample, to investigate health and socio-economic factors associated with physical violence by male partners (Weinbaum et al., 2001). Women who were unmarried, had low education levels, low income, and unemployed were more likely to report severe physical violence than those who were not. These characteristics are similar to those identified in other studies (e.g., Hedin et al., 1999; Martin et al., 2001; Stewart & Cecutti, 1993; Thanaudom, 1996).

Another study also found that white women were more likely to be abused, and their abuse was more severe than that of Hispanic and Black women (McFarlane et al., 1992). Women who were young, had children in the household (Thanaudom, 1996; Weinbaum et al., 2001), had increased parity, unwanted pregnancy, and received Medicaid (Cokkinides & Coker, 1998) were at greater risk of domestic violence. Similarly, in a prospective study among 364 low-income women in West Virginia, Dye, Tollivert, Lee and Kenny (1995) found that women in their first pregnancy were nearly twice as likely as other women to have been abused during pregnancy.

Past abuse is associated with domestic violence. Previous studies found that a history of past abuse was a strong risk factor for subsequent abuse (Hillard, 1985; McFarlane et al., 1992). In a study on prevalence of physical abuse among 548 Canadian pregnant women, Stewart and Cecutti (1993) found that 6.6% (n = 36) of women reported abuse during the current pregnancy. Of the 36 abused pregnant women, 86.1% reported previous abuse, with 63.9% claiming that the abuse escalated during pregnancy. Furthermore, Martin et al., (2001) found a significant association between abuse before and during pregnancy. Women who were abused before pregnancy were also more likely to be abused during pregnancy and postpartum.

Another factor associated with domestic violence was lack of peer or family support. A one-year Canadian study was conducted to identify risk factors for physical violence among pregnant women receiving public prenatal services (Muhajarine & D'Arcy, 1999). The sample of 543 pregnant women, aged 15-40 years old, was interviewed in their second trimester and again late in their third trimester. The investigators found that physical abuse was associated with stress and lack of perceived support, which was defined as the number of people to whom the women could talk or get together with. Women who had higher scores for perceived stress associated with violence, and more negative life events in the last 12 months were at an increased risk of violence.

Women who are exposed to domestic violence are also likely to have multiple health risk factors. A prospective study of 1,243 pregnant women in Boston (Amaro et al., 1990) found that victims of violence were significantly more likely than non-victims to use alcohol and drugs. Similarly, other studies have found that women who had been physically abused during pregnancy were significantly more likely than non-abused women to use alcohol, illicit drugs and cigarettes regularly (Martin et al., 1996; Stewart & Cecutti, 1993). Additional studies reported abused women were more likely to be emotionally distressed, have unplanned pregnancies, an unhealthy diet (Stewart & Cecutti, 1993), and use more prescribed, over-the-counter and illegal

drugs during the pregnancy (Dye et al., 1995; Letourneau, Holmes, & Chasedunn-Roark, 1999; Stewart & Cecutti, 1993).

Finally, some characteristics of male partners have also been identified as risk factors for injury to women from domestic violence. For example, a case-control study by Kyriacou, et al. (1999) at eight large, university-affiliated emergency departments in the United States identified 256 intentionally injured women. Data were collected for periods of 3 to 15 months, depending on the study sites, during 1997 and 1998. They found that women at greatest risk for injury from domestic violence included those with male partners who were unemployed or intermittently employed, had less than a high-school education, were former husbands, estranged husbands, or former boyfriends of the women, and abused alcohol or drugs. Most interestingly, another study found that women whose partners had a drinking problem were 3.4 times more likely than those whose partners did not have a drinking problem to have been physically abused during pregnancy (Muhajarine & D'Arcy, 1999). Two Thai studies (Clongphayaban, 1999; Thanaudom, 1996) found that gambling by partners and ineffective communication patterns between husbands and wives were associated with an increased risk of domestic violence. Clinical reports have indicated that domestic violence during pregnancy is frequently related to the husband's jealousy or anxiety about the forthcoming birth (Koss et al., 1994).

A study by Wiemann, Agurcia, Berenson, Volk and Rickert (2000) found that abused pregnant women tended to have a partner with a history of police involvement, frequent substance abuse, and legal problems related to alcohol and drugs use. These findings suggest that assessing the characteristics of pregnant women's partners may provide important information regarding the safety of women.

In summary, domestic violence occurs worldwide and is not limited to any particular culture, socio-economic class or geographic area. Factors such as income, level of education, marital status, age, employment status, family support, and health risk behaviours of women and partners have been associated with domestic violence but there have been relatively few comprehensive studies conducted in Thailand.

Domestic Violence and Adverse Pregnancy Outcomes

Domestic violence during pregnancy is highly stressful to the pregnant woman and may subsequently affect the health of her unborn child (McFarlane, 1991). Previous studies have shown that violence during pregnancy affects women and may lead to pregnancy complications or adverse pregnancy outcomes. This section reviews related studies on the impact of domestic violence on pregnancy complications, followed by adverse consequences on women and neonates.

Pregnancy complications

Although there are indirect causes of adverse birth outcomes such as stress, anxiety, smoking or drug use in pregnancy (Grimstad, Schel, Backe, & Jacobsen, 1999), domestic violence is also associated with poor pregnancy outcomes and increases the risk of preterm birth. In a prospective cohort study in North Carolina, 545 women aged 13-40 years old who participated in a prenatal care coordination program in a county health department were assessed multiple times during pregnancy using the systematic violence assessment protocol (Covington et al., 2001). The study found that seven out of 13 women reporting prenatal violence directed at the abdomen delivered before term. Women reporting severe physical violence were significantly more likely to have a previous perinatal death or preterm birth even after controlling for age, race, previous poor birth outcomes, and alcohol use. This study was limited to women who had low-incomes and had a live singleton birth. Furthermore, the emphasis was on severe violence only which can lead to underestimation of the effects of abuse.

Fetal distress and fetal death have been reported in several studies. For example, in a prospective study examining the impact of violence on birth outcome among 370 pregnant women in West Virginia, Dye et al. (1995) found that women experiencing violence during their current pregnancy were more likely than other women to have fetal distress or fetal death even after controlling for maternal age and smoking status. They also found that infants of abused women were more likely to remain in hospital after their mother's discharge. This study however, only included low-income pregnant women.

The rate of stillbirth, miscarriage and abortion has also been reported in some studies. Hedin and Janson (2000) conducted a study among 207 pregnant Swedish women in a married or heterosexual relationship from three different antenatal clinics during a twelve-month period. The authors found that the proportion of miscarriages between abused and non-abused women was similar. However, a higher proportion of women in the abused group had undergone one or more abortions than those in the non-abused group.

Additionally, in a chart review of 1,014 pregnant women, Webster et al. (1996) found that both miscarriage and abortion were more commonly noted in women with abuse histories than non-abused women, and there was a trend toward an increased incidence of stillbirth. Another study identified that women who experienced physical violence during pregnancy were 1.5 times more likely to deliver by cesarean section (Cokkinides, Coker, Sanderson, Addy, & Bethea, 1999).

Other consequences of physical violence during pregnancy, particularly resulting from abdominal trauma, include fetal fractures, rupture of the mother's uterus, liver, or spleen, pelvic fractures, and antepartum haemorrhage (Sammons, 1981 cited in Newberger et al., 1992). Additionally, abdominal trauma may cause uterine contractions, premature rupture of membranes, and infection leading to early onset of labour and possible fetal loss (Newberger et al., 1992). Thus it appears that a variety of pregnancy complications such as antepartum haemorrhage, preterm birth, stillbirth, miscarriage and abortion are associated with domestic violence.

Maternal outcomes

Studies have shown that violence affects both physical and mental health of women. In terms of adverse physical health, a population-based study in California showed that victims of domestic violence were more likely to report chronic pain and poor physical health that limited activities of daily living (Weinbaum et al., 2001). Pain, decreased activities of daily living, and poor health affected women's ability to work and care for their children.

A significantly higher level of somatic complaints by victims of violence has been reported in some studies (Jaffe et al., 1986; McCauley et al., 1995). In addition, physical health problems requiring prescription medication or regular medical consultations including migraines, infections, gastrointestinal problems, hypertension, and musculoskeletal problems were reported among women who had been abused (Letourneau et al., 1999). Trauma-related injuries or serious physical injury may also result from domestic violence (Heise, 1993). Suicide and homicide have been found to be prevalent amongst abused women (Campbell, Poland, Walker, & Ager, 1992; Hillard, 1985). A United Nations case study on wife abuse in China found that 6% of serious injuries and death in Shanghai were caused by domestic violence (Wu, 1986 cited in Heise, 1993).

Domestic violence may also contribute to negative health behaviours in pregnant women such as, smoking and alcohol and drug dependence (Amaro et al., 1990; Letourneau et al., 1999; Martin et al., 1996). Newberger et al. (1992) argued that these behavioural risks were a reaction to the psychological distress of victimization. However, smoking, alcohol and drugs can independently adversely affect babies and mothers and needs to be controlled in statistical analyses of results.

In terms of mental health of women, several studies have reported an association between domestic violence and poor mental health. A telephone survey of 2,415 New Mexican women found that those who experienced intimate partner violence were more likely to be depressed (Tollestrup et al., 1999). Other studies also report that domestic violence victims are more likely to show signs of depression, anxiety (Jaffe et al., 1986), and symptoms related to posttraumatic stress disorder (Koss & Heslet, 1992).

The stress of domestic violence may also impact on day to day functioning of women. A population-based study in California found that victims of domestic violence were more likely to report not only poor mental health but also feelings of being overwhelmed, and limited daily activities due to feelings of sadness and depression (Weinbaum et al., 2001). Abused women have reported frequent tension

with their partner since becoming pregnant, and more arguments during pregnancy (Dye et al., 1995). Furthermore, a large proportion of domestic violence victims reported that they had been diagnosed with a mental health condition and sought mental health help in the past 12 months (Weinbaum et al., 2001).

It can be seen that domestic violence has long term negative health consequences on abused women and these effects include trauma related injuries, gastrointestinal and gynecological problems, somatic complaints, chronic pain, psychological distress, depression, suicide, self-harm and posttraumatic stress disorder.

Neonatal outcomes

Domestic violence during pregnancy affects not only maternal health but also infant outcomes. Although there are possible causes associated with low birth weight, such as, low socioeconomic status, poor nutrition, smoking, alcohol use, stress among mothers (Shiono et al., 1986 cited in Bullock & McFarlane, 1989) and lack of or inadequate prenatal care (Newberger et al., 1992; Showstack, Budetti, & Minkler, 1984), the association between domestic violence during pregnancy and low birth weight of infants, has been noted in several studies (Bullock & McFarlane, 1989; Parker et al., 1994).

In an ethnically stratified cohort study of 1,203 pregnant women receiving prenatal care in public clinics in Baltimore and Houston, Parker et al. (1994) found that women who had been abused during pregnancy delivered a significantly higher percentage of infants weighing less than 2,500 grams. Additionally, a study of 589 postpartum women aged 18 years and older found that women reporting abuse were twice as likely to deliver an infant less than 2,500 grams. The association persisted even when alcohol and tobacco use, age, race and adequacy of prenatal care were controlled (Bullock & McFarlane, 1989). Similarly, a study of 489 women aged between 18 and 35 years, found that 20% were victims of domestic violence and among these, 16% gave birth to low-birth weight infants compared with 6% of women in the non-abused group. This study, however, was limited to only public patients and women with singleton pregnancies (Fernandez & Krueger, 1999).

Some studies, however, found no association between abuse during pregnancy and birth weight or gestational age at delivery (Cokkinides et al., 1999; O'Campo et al., 1995; Quinlivan & Evans, 2001). For example, a case control study among 85 women who delivered low birth weight (less than 2500 g) babies, and 92 women with higher birth weight babies in Norway found no association between low birth weight and maternal anxiety score or history of abuse (Grimstad et al., 1999). This study however was limited due to potential recall bias because some women were interviewed immediately after birth and others up to a year after birth. Further, abused mothers with low birth weight (LBW) babies may have been less likely to participate in this study due to feelings of shame and guilt which could have resulted in underestimation of the relationship between abuse and LBW.

Neonatal problems including poor weight gain, feeding difficulties, jaundice, suspected and proven sepsis requiring screening and treatment, and irritability/possible withdrawal syndrome were also more likely to be diagnosed in infants of abused mothers (Quinlivan & Evans, 2001). In addition, the apparent relationship between severe violence and low Apgar scores, and neonatal intensive care was found among infants of women with low-incomes. The relationship persisted even after controlling for age, race, a previous poor birth outcome, and alcohol use (Covington et al., 2001).

Overall, studies on violence have investigated a range of pregnancy outcomes. Several studies included birth weight and preterm delivery (Bullock & McFarlane, 1989; Cokkinides et al., 1999; Parker et al., 1994; Quinlivan & Evans, 2001). Two outcomes, mean birth weight and incidence of low birth weight, were also found in more than one study (Bullock & McFarlane, 1989; Parker et al., 1994) to be statistically significant between abused and non-abused women. There are some factors that limit the use of previous studies in assessing the relationship between violence during pregnancy and pregnancy outcomes. These factors relate to design issues, such as timing of data collection and number of interviews, inadequate measures of confounding variables, and lack of documentation regarding the body

site of injury (Petersen et al., 1997). Despite these limitations, it is apparent that both babies and mothers suffer ill effects of abuse.

Target Sites of Injury

Previous studies have shown that the body sites of injury are linked to adverse birth outcomes. Some investigators assessed particular areas of the body that may be targeted during violent incidents. In a Canadian study of 548 pregnant English-speaking women at 20 weeks or more gestation, Stewart and Cecutti (1993) found that the abdomen of a pregnant woman was the main body area being hit by the perpetrator (63.9%), followed by the buttocks (13.9%), head and neck (11.1%) and extremities (11.1%). Battered women also reported blows to the breasts, and genitals accompanied by sexual assaults (Dobash & Dobash, 1979). The face was reported as the most common site of injury in a sample of 501 African-American, white, and Hispanic pregnant women (McFarlane, 1993).

Domestic violence that results in abdominal trauma is associated with adverse pregnancy outcomes (Newberger et al., 1992). It may also lead to poor access to prenatal care due to the controlling behaviours of partners. Since healthy women of childbearing age see health care providers primarily for routine gynaecologic care or only during pregnancy, it is important that all women seeking prenatal care receive domestic violence screening (Espinosa & Osbourne, 2002). The next section outlines various approaches to domestic violence screening in the antenatal period.

Disclosing Domestic Violence

Disclosure of domestic violence is an important issue. It requires privacy, trust, confidentiality and sensitive questioning by non-judgmental nursing staff (Johnson et al., 2003). It is suggested that routine screening be established based on the assumption that it will help to increase identification of women who are subjected to domestic violence, lead to early effective interventions and support, and subsequently a decreased exposure to violence and its harmful health consequences, both physical and psychological (Johnson et al., 2003; Ramsay, Richardson, Carter,

Davidson, & Feder, 2002). The following section presents approaches to domestic violence screening, followed by a discussion on the possible barriers to disclosure.

Approaches to screening

Previous studies demonstrate that a considerable number of women experience threats, physical, emotional and sexual abuse during pregnancy. It is therefore essential that routine screening for abuse during each prenatal visit with appropriate intervention be carried out in an attempt to interrupt the cycle of violence and prevent future trauma, enhance the safety of women and their unborn child, as well as prevent adverse health and economic consequences (Hedin et al., 1999; McFarlane et al., 1999). If women are not assessed for abuse, violence will remain undetected and untreated, placing women at risk for escalating abuse and further trauma (McFarlane et al., 1999). Furthermore, domestic violence, particularly physical abuse with the associated behaviours of power and control endemic to the cycle of violence, may function as a barrier to accessing prenatal care through forced avoidance (McFarlane et al., 1992). It has been reported, for example, that abused women are twice as likely to begin prenatal care during the third trimester than non-abused women (McFarlane et al., 1992). Similarly, women who have been experiencing physical violence were 1.8 times more likely to have delayed entry into prenatal care than women who had not experienced such violence (Dietz et al., 1997).

In the United States, the Surgeon General's Workshop on Violence and Public Health (1986) recommended that all women attending routine prenatal care receive screening and treatment for physical abuse since pregnancy is the time when healthy women have regular contact with health professionals. Moreover, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* denote prevention of violent and abusive behaviour as one of the 21 priority objectives for the United States (U.S. Department of Health and Human Services, 1990).

In 2000, 189 Member States of the United Nations (World Health Organization, 2005) set the Millennium Development Goals (MDGS) at the United Nations

Millennium Summit (World Health Organization, 2005). These goals are "internationally agreed development aspirations for the world's population to be met by 2015" (World Health Organization, 2005, p. xiii), and related directly to the importance of improving the condition of humanity throughout the world in the areas of "development and poverty eradication, peace and security, protection of the environment, and human rights and democracy" (UNIFEM, 2005, p. 5). In the advancement of women's right to gender equality, the Declaration pledges explicitly "to combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)" (UNIFEM, 2005, p. 5). The Declaration also recognizes "the importance of promoting gender equality and women's empowerment as an effectively pathway for combating poverty, hunger and disease and for stimulating truly sustainable development" (UNIFEM, 2005, p. 5).

In Queensland, the Domestic Violence Initiative (DVI) was developed in 1999 to incorporate domestic violence screening into routine history taking protocols in public prenatal clinics or emergency departments (Queensland Health, 2000). Standard protocols are recommended to be implemented in health care settings in the belief that early identification, supportive education, effective referral, ongoing support and follow-up for abused women could eventually reduce the prevalence of abusive injury (Wiist & McFarlane, 1998). It has been suggested that screening using direct questions facilitates disclosure and increases the identification of domestic violence (Covington, Dalton, Diehl, Wright, & Piner, 1997; Ramsay et al., 2002). In the United States, screening guidelines have been developed that include suggested ways to ask about domestic violence in a non-judgmental, professional and sensitive way (Flitcraft, Hadley, Hendericks-Matthews, McLeer, & Warshaw, 1992). Nevertheless, it is well known that most health care providers find it difficult to ask about domestic violence (Webster, Stratigos, & Grimes, 2001). This may be due to lack of confidence and inadequate training to ask about domestic violence as well as not having the skills to deal with a positive response (Newberger et al., 1992; Rodriguez, Bauer, & McLoughlin, 1999; Sugg & Inui, 1992).

Meanwhile, women who have been abused during pregnancy may not be ready to disclose the abuse on their first visit to a health facility, but are more likely to disclose after developing rapport with their service providers. Studies suggest that a direct and repeated abuse assessment by trained health professionals is appropriate and may facilitate disclosure and acceptance of assistance by women who are suspected of experiencing violence (Bacchus, Mezey, & Bewley, 2002; Gazmararian et al., 1996). Moreover, asking questions on domestic violence at the booking-in visit may be an intervention in itself, by making women aware that the hospital cares about them and their experience of violence. This also gives a woman knowledge about where to seek help if she does experience abuse at some time in the future (Queensland Health, 2000) and that they are likely to consider routine enquiry for domestic violence acceptable and relevant (Bacchus et al., 2002).

Barriers to disclosure

Routine screening about violence is acceptable to the majority of women and helpful in the early detection of violence. For example, a study in Brisbane reported that 98% of 1,263 women believed it was a good idea to ask women about domestic violence when visiting a hospital (Webster et al., 2001). Similarly, a study by Bradley, Smith, Long and O'Dowd (2002) found that 77% of women reported that it would be acceptable for a doctor to ask about abuse. However, health care experiences of women can also be a barrier to seeking help or disclosing abuse. Studies have shown that abused women's experiences with health care services are often negative, with abused women finding health care providers to be ineffective, unhelpful, blaming, unsupportive, disinterested, uncaring, uncomfortable, and intolerant of the patient's choice to stay in the relationship (Bowker & Maurer, 1987).

There are other barriers that inhibit women, particularly those living in rural areas, from seeking health care. These include poverty, under-insurance or lack of health insurance, shortages of health-care providers, and lack of public transportation systems. In addition, women living in rural areas may have less access to resources such as advanced education and job opportunities, that would make leaving an

abusive relationship easier (U.S. Department of Health and Human Services, 1998). Finally, domestic violence is more hidden in rural and remote areas because women are more isolated and want to protect their partners in communities where members are well known to each other (Alston, 1997).

In Thailand although there were national policies and plans established in 2000 to eliminate violence against women and children, screening for abuse during pregnancy is still rare in health care settings. Furthermore, there is currently no national policy for pregnant women to receive confidential consulting time during their maternity care visits nor is there routine enquiry about domestic violence at hospitals, particularly, in the Northeast region of Thailand (C. Panthuchin, Personal communication, November 19, 2002). There is increasing recognition that the degree to which health care agencies respond effectively to domestic violence has direct consequences for the safety and well-being of abused women (Allen, Bybee, & Sullivan, 2004). Supporting women experiencing domestic violence requires a comprehensive response from agencies across a variety of community sectors (Allen et al., 2004). Although research has suggested that abused women lack information about the full range of resources that exist in their communities and are uncertain about who to ask for help, there is also ample evidence that many health care professionals are ill-equipped to respond effectively to the needs of women (Peckover, 2003). These findings highlight the need for further research in this area.

Summary

Domestic violence is a significant social and public health problem in many countries. Three conceptual frameworks on domestic violence; psychological, sociological and feminist were discussed in this chapter to provide some understanding of the possible underlying dynamics of the problem. Feminist perspectives however provide an interpretative lens by which to understand violence against women. As domestic violence often occurs between individuals behind close doors and relates to issues of power and control, gender, and often arises from commonly held views of masculinity and male dominance, a feminist perspective was deemed to be appropriate for the proposed study. Violence is known to be

associated with socio-demographic factors, previous abuse, lack of peer and family support, multiple ill-health risk factors, and characteristics of male partners. It may also be exacerbated by alcohol, drugs or poverty and stresses in relationships.

Pregnancy is a period when women are at great risk of violence and intimate partner violence may begin or escalate during this period. Victimization of domestic violence during pregnancy is known to be linked to poor maternal and neonatal health and lead to one or more of the following intermediate risks. These include elevated physical and psychological stress; isolation and inadequate access to prenatal care and other health care services; behavioural risks such as cigarette smoking, alcohol use, and illegal drug use in reaction to the psychological distress of victimization; poor maternal nutrition as a consequence of financial privation or denial of nutrients as part of the victimization pattern, and adverse pregnancy outcomes.

Most research on violence during pregnancy has been conducted in Western countries, with little research addressing the experiences of Asian women, particularly Thai. There are only two research studies conducted in Thailand that investigated violence during pregnancy. However, there is a wide variation in estimates of domestic violence in Thailand and overseas. These differences in prevalence rates may be influenced by study design factors such as different definitions of violence, population sampled, and data collection time periods during pregnancy.

From the review of literature, there is a paucity of research on domestic violence during pregnancy in Thailand. Therefore, research is needed to determine the extent of domestic violence in Thai pregnant women. The present study investigated the prevalence and severity of domestic violence in a large sample of pregnant women receiving antenatal care at the clinics of two hospitals in the poorer region of Northeastern Thailand. The study aimed to investigate risk factors for domestic violence, pregnancy outcomes for mothers and neonates, perceived barriers that inhibit women from seeking help as well as support mechanisms. A better

understanding of domestic violence in Thai pregnant women will inform the development of future health and community services for these women as well as increase public awareness and inform health professional education.

Chapter 3 : Method

The present study focuses on domestic violence in Thai women. This chapter describes the research method used in the present study. In the first section, the rationale for the study is presented, followed by the study aims and study design. In addition, relevant information regarding data collection methods, sampling issues, settings, translation process of research instruments, and a pilot study are provided. The approach to data analysis is also described. Additionally, an outline of ethical issues will be presented.

Rationale for Method

The present study is predicated on several findings from the literature review. Firstly, there is a lack of research in the area of domestic violence during pregnancy in Thailand. Studies investigating the prevalence of domestic violence against pregnant women have been conducted in countries, such as the United States, Australia, and England. Studies conducted in Asia mostly apply to China, Bangladesh and the Philippines. In Thailand, there have been relatively few studies related to domestic violence and only two studies found to be related to pregnant women (Deoisres, 2004; Thanaudom, 1996). The first study was conducted in the capital of Thailand while the second was conducted in the provinces of Eastern Thailand. Both studies only accounted for a certain sector of the population.

Secondly, there are several design flaws in the previous Thai studies that relate mainly to sampling techniques, recall bias and inconsistent timeframes for data collection. Although both Thai studies surveyed women about their experience of domestic violence during pregnancy and used large samples, generalizations from the findings remain questionable. For example, the gestation of Thai pregnant women was not specified in the study conducted by Thanaudom (1996) who surveyed consecutive pregnant women at any gestational age who attended a prenatal clinic in Bangkok about the experience of domestic violence within the past six months. Furthermore, data was collected at one time point. Therefore, the study was unable

to determine whether the violence stopped or escalated during pregnancy. Furthermore, no Thai study has investigated domestic violence in the postpartum period.

Thirdly, no Thai study has investigated pregnancy outcomes associated with domestic violence. In regard to services, only two studies (Pekanan & Wongsurawat, 2001; Thanaudom, 1996) explored women's needs for services. For example, Thanaudom (1996) asked a question relating to women's need for counselling services, and Pekanan and Wongsurawat (2001), in a pilot study, investigated the need for reproductive services for victims of domestic violence. Therefore it could be argued that very little is known about the resources Thai women use or might find useful in dealing with violence and perceived barriers inhibiting women from seeking help.

Fourthly, there is an inconsistent and narrow definition of domestic violence in the published studies to date. For example, instruments have tended to focus on physical violence rather than other types of violence. This makes it difficult to draw conclusions about the findings and often has led to confusion in discussions on the prevalence or incidence of domestic violence.

Fifthly, the instruments used in previous studies in Thailand were limited. For example, the study by Thanaudom (1996) used the Index of Spouse Abuse to measure physical, psychological and sexual violence among pregnant women. However, this research instrument is likely to produce under-reporting on the degree or severity of abuse (Hudson & McIntosh, 1981).

Finally, both previous studies investigated the incidence of domestic violence in either central or Eastern Thailand and no study has been conducted in more remote sections of Thailand. The northeast region of Thailand is considered rural and is the poorest region in the country. Given the link between poverty and the incidence of domestic violence, research in this area may produce useful information for health service delivery and government policy.

Study Aims

The present study aimed to:

1. Determine the prevalence of domestic violence for Thai women aged between 18 and 45 years during pregnancy and the immediate postpartum period.
2. Identify adverse maternal and neonatal outcomes in women experiencing domestic violence compared to women who do not.
3. Identify resources women currently use or would find helpful in dealing with domestic violence.
4. Identify barriers that inhibit women from resisting violence and seeking help.

Research Design

The present research was an exploratory descriptive study underpinned by feminist research principles. This design is appropriate because little is known about the incidence of domestic violence and the experiences of women who experience domestic violence in Thailand. According to Polit and Hungler (1999), an exploratory study is undertaken when a new topic area is being investigated. It begins with some phenomenon of interest, and aims to investigate the full nature of the phenomenon, the manner in which it is manifested, and the other factors with which it is related. An exploratory study provides an in-depth exploration of a single process, variables, or concept, while a descriptive study examines a concept within a given population (Brink & Wood, 1998). The exploratory study is a flexible research design that provides an opportunity to examine all aspects of the problem. It is an initial step in the development of new knowledge (Brink & Wood, 1998).

The application of feminist principles is also appropriate for the present study. These principles were described by Duffy (1985), which included eight criteria as follows:

1) The principal investigator is a woman.
2) Feminist methodology is used (defined as a research approach characterized by one or more of the following: interaction between the

researcher and participant, non-hierarchical relation between the researcher and participant, expression of feelings, and concern for values).

3) The study has the potential to help participants, as well as researchers.
4) The research is focused on the experience of the woman (defined as having to do with how a woman lives through the topic of the research).
5) The purpose of the investigation is to study women (not nurses, patients, etc).
6) The word "feminist" or "feminism" is used in the report.
7) Bibliographic references to feminist literature are included.
8) Non-sexist language is used.

These principles are applied to the present study as a means of challenging domestic violence against women in an oppressive male-dominated Thai culture (Bograd, 1988).

The design of the study consisted of two phases and was conducted with a large sample of pregnant women in their third trimester and again during their six-week postpartum visit at family planning clinics. In Phase 1, personal information, prevalence of domestic violence before the current pregnancy and during pregnancy, adverse maternal outcomes, helpful resources in dealing with domestic violence and barriers inhibiting women from seeking help were gained using a questionnaire. In Phase 2, similar information to Phase 1 was collected but focussed on women's experiences during the postpartum.

Data collection sites

Thailand is a developing country with an area of 514,000 square kilometres. It is situated in Southeast Asia, bordering Myanmar to the west, Laos to the northeast, Cambodia to the east, and Malaysia to the south (United Nations, 2000). The country was known by the name of "Siam", and in 1949 the name of the country was changed to Thailand by an official proclamation (United Nations, 2000). Bangkok is

the capital city and Thai is the official national language, with Buddhism the predominant religion of the country (United Nations, 2000).

Thailand is divided into 4 regions within which are 76 provinces or "Jangwat". Each province is subdivided into districts or "amphoe", which are then subdivided into subdistricts or "King-amphoe", "Tambon" (groups of villages), "Muu-baan" (villages). The provincial capital is an "Amphoe Muang" or Muang district. The term "Muang" is also used loosely to mean metropolitian area (http://www.asiarooms.com/ThailandTravel/directories/provinces_list.html, retrieved January 30, 2003).

In July 2002, Thailand had a total population of 62,626,000 people. Of this, 31,530,000 were females, and 16,286,000 aged between 15-44 years old (Institute for Population and Social Research, 2002). The country's crude birth rate in 2002 was 14.0 per 1,000 while the crude death rate was 6.0 per 1,000 (Institute for Population and Social Research, 2002).

The present study took place in Muang District, Khon Kaen province (See Figure 3.1). Khon Kaen is one of the provinces in the Northeast region of Thailand. The northeast region consists of 19 provinces and covers a total area of more than 170,000 square kilometers, or roughly one-third of the entire country, and is bordered by Laos and Cambodia to the east (http://www.thailandlodgings.com/northeasternthailand/, retrieved January 30, 2003). This region has a complex history. Originally, it was a part of Khmer civilization, it was later influenced by Burmese Politics, and subsequently part of the Wiangchan kingdom.

In addition, the Northeast region of Thailand is referred to as "Isan" (pronounced E-San) and is the home of the "Laotian' or Isan Thai people. The term "Isan" denotes prosperity and vastness. In spite of prosperity being denoted in its name, the Northeast region is the poorest part of Thailand (http://www.military-discount.org/Asia/Thailand/ thailand_neast.htm, retrieved January 30, 2003). People in this part mainly speak Isan/Laos languages although Thai is an official language.

Socially the Isan people are considered “the lowest on the social status scale among Thai due to a combination of historical oppression, geographical isolation, poor soil, lack of infrastructure and persistence of the Lao language and cultural values. Isan people once outside the Northeast tend to carry this sense of inferiority with them” (DeNeui, 1991, no page number). The main language of Isan, distinct from Thai, however, creates a strong cultural bond between residents regardless of provincial origin (DeNeui, 1991). The majority of Isan people are Buddhists.

Figure 3.1: Map of Khon Kaen Province, Thailand

(http://www.thailandlife.com/map, retrieved January 30, 2003)

Khon Kaen, one of the provinces in the northeast, lies in the geographical heart of Thailand's sprawling northeast plateau. It was established in 1783 and is a major development centre and university city. The provincial capital is 449 kilometres northeast of Bangkok. The province covers an area of 10,886 square kilometres, and parts of which contain national and forest parks (http://www.welcomethai.com/khonkaen/khonkaen_city.htm, access 30 January 2003). Khon Kaen is the fourth largest city in Thailand with a population of 1,756,995 in 2001. Of these, 491,858 are females aged 15-49 years old (www.unescap.org/pop/database/thailanddata/northeast/KhonKaen.htm, retrieved February 10, 2003).

The main data collection sites of this study were the antenatal clinics of the two major tertiary hospitals situated in Muang District of Khon Kaen Province. These two hospitals were the Health Promotion Centre Region 6, and Khon Kaen Regional Hospital. The hospitals serve both public and private cases and are government-run. Furthermore, these hospitals have a similar hospital culture and serve clients with a similar profile.

The Health Promotion Centre Region 6 is a 150-bed public hospital run by the Department of Health, Ministry of Public Health. This hospital was established in 1987 and situated in the municipal area of Khon Kaen Province. This is a maternal and child health hospital and serves the people of Northeastern Thailand. The hospital operates every weekday from 0830 hrs until 1530 hrs. There are approximately 20 pregnant women visiting daily for their first visit at the hospital's antenatal clinic, and about 40 to 50 new and old cases attend the clinic per day (C. Puntuchin, Personal communication, November 5, 2002).

Khon Kaen Regional Hospital is a 714-bed public hospital and is also located in the municipal area of Khon Kaen province. It is situated approximately 200 metres away from the Health Promotion Centre Region 6. The hospital also provides services to the people of Khon Kaen and nearby provinces. The antenatal clinic at Khon Kaen Regional Hospital serves approximately 2,778 maternity patients per year (Khon Kaen Hospital, 2001).

These two hospitals were chosen as the settings for the present study because they are the largest tertiary hospitals providing maternal and child heath services to pregnant women in Khon Kaen and the provinces in Northeastern Thailand. Moreover, the researcher has lived in Khon Kaen and is employed as a nursing lecturer in the Ministry of Education for a number of years and as such is familiar with contemporary political and social issues in the province as well as the geographical area. The researcher had also established extensive networks within the area, which facilitated access to hospitals and clients.

Sample

Non-probability sampling was used in the study due to practical constraints, the sensitivity of the issue, and the research context. It was also assumed that some people would be more willing to participate than others. A cohort sample was therefore considered appropriate to reflect the incidence of domestic violence in the two settings. Inclusion criteria were as follows:

1. Pregnant Thai women aged between 18 and 45 years old.
2. Attending an antenatal clinic in one of the above hospitals during their third trimester of pregnancy.
3. Having postpartum follow up at the clinic of the above hospital or contactable by telephone.

In the present study, a cohort of 424 pregnant women who attended the antenatal clinic at the Health Promotion Centre Region 6 and Khon Kaen Regional Hospital in Khon Kaen Province, Thailand, were approached and invited to participate in this study. However, two women declined to participate due to transport problems while the other one was a foreigner (from the Philippines) and therefore did not meet the criteria. This resulted in the final sample of 421.

Research instruments

The three standardised instruments used in this study were translated in Thai language. The researcher obtained permission from the authors to use and translate the questionnaires. The procedure for translation is outlined in a later section.

The Psychological Maltreatment of Women Inventory (PMWI) - short version (Tolman, 1999) was used to measure the frequency of psychological abuse. The PMWI consists of 14 items categorized into two main groups: 1) dominance/isolation (7 items), and 2) emotional/verbal abuse (7 items). It is a rating scale of 1 = never, 2 = rarely, 3 = occasionally, 4 = frequently and 5 = very frequently. High total scores are associated with high degrees of dominance, isolation and emotional/verbal abuse. The Psychological Maltreatment of Women Inventory (PMWI) is sensitive for measuring the structure of power and control in abusive relationship (Hedin & Janson, 1999). This is an important measurement given the feminist perspective of the study. The PMWI was administered to participants in both phases. The reliability of the Psychological Maltreatment of Women Inventory (PMWI) has been reported for a sample of 407 men and 207 women (Tolman, 1989). The internal consistency coefficients for the women's subscales were 0.95 and 0.93 for domination-isolation and verbal-emotional scales respectively.

In addition, the Severity of Violence against Women Scale (SVAW) (Marshall, 1992) was used to measure the frequency of threats and severity of physical and sexual abuse. It contains 46 acts categorized into 1) Symbolic Violence, 2) Threats of mild violence, 3) Threats of moderate violence, 4) Threats of serious violence, 5) Acts of violence which divide into mild violence, minor violence, moderate violence, serious violence and sexual violence. The participants were asked to rate using a scale of 1 = never, 2 = once, 3 = a few times, and 4 = many times. A high total score is associated with a high degree of threats and acts of physical violence. The reliability of the SVAWS has previously been reported for a sample of college female students and a sample of community women (Marshall, 1992). In a study by Wiist and McFarlane (1998) an alpha coefficient for internal reliability of the SVAW was 0.89 for threats and 0.91 for actual violence. The SVAW makes a distinction between different levels of threats and actual acts of violence (Marshall, 1992) to determine the structure of power and control in abusive relationships (Hedin & Janson, 1999).

The SVAW has several strengths. For example, it can be used to assess an incident of violence or compare incidents. It can also differentiate women who have sustained different forms of violence. Employing this scale would allow the researcher to distinguish between the effects of sustaining physical violence from those associated with sustaining sexual violence or both (Marshall, 1992). The tool also makes explicit the assumption that even acts associated with minor harm become more harmful with repetition (Marshall, 1992).

The SF-12 Health Survey was used in this study. The SF-12 is a multipurpose short-form containing 12 questions from the SF-36 Health Survey (Ware, Kosinski, & Keller, 1996; Ware, Kosinski, Turner-Bowker, & Gandek, 2002). It is a much shorter, yet valid alternative to the SF-36. The SF-12 measures eight domains of health including physical functioning (PF), role physical (RP - role limitations due to physical problems), role emotional (RE - role limitations due to emotional problems), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), and mental health (MH). For each dimension the item scores are coded, summed and transformed on to a scale from 0 (worst possible health state measure by the questionnaire) to 100 (best possible health state). A 4-week recall period was used in the present study because the period of four weeks would capture a more representative and reproducible picture of recent health, not unduly affected by daily or momentary fluctuations (Ware et al., 2002). A high score on the scale indicates a high level of functioning.

A research tool measuring women's support networks, where women find support and ways they dealt with violence as well as barriers that inhibited them from seeking help, was developed by the researcher based on a review of the literature. This tool contained 7 open-ended questions. Three clinical experts in the area examined the questionnaires to ensure content validity of this instrument.

Translation process

The present study was conducted in Thailand by a Thai investigator with Thai women, and required the English versions (original version) of all instruments (the

Psychological Maltreatment of Women Inventory, the Severity of Violence against Women Scale and the SF-12 Health Survey) to be translated into Thai (target version). All research instruments were translated from English into Thai by two bilingual Thai nursing lecturers and the researcher.

Ten women with similar characteristics to the target sample then assessed the face validity of the instruments. If there was any misunderstanding the version was amended according to the women's suggestions. Then, the back-translation technique directed by Jones, Lee, Phillips, Zhang and Jaceldo (2001) was utilized. The translated Thai versions of all forms were translated back into English (original versions) by two bilingual colleagues who had not seen the original version. These included an English native speaking person who is fluent in Thai language and a bilingual Thai nurse colleague. Minor issues were identified during the translation process in particular from the original version to the translated or target version. The translators provided a Thai interpretation for the words "a bully" and "a clublike object" in the SVAW differently. These problems were overcome by a meeting held between the researcher and the two translators to discuss the agreed wordings for these two phrases. In relation to the back translation process, there was no other discrepancy between the two translators.

The findings of this study were translated from Thai into English by the investigator. The documents (the information sheet and informed consent) were also translated into Thai (target version) by the researcher.

Pilot study

A procedural pilot study was undertaken. The aim of this pilot study was to identify strengths and weaknesses in the research plan in order to improve the main study (Roberts & Taylor, 1998). The pilot study allowed the researcher to assess a number of issues. These included the feasibility of the main study, adequacy of the study design as well as the appropriateness of the study method. The researcher could also assess if the research instruments were useful and if not, alternatives could be chosen (Roberts & Taylor, 1998). Furthermore, this pilot study allowed the researcher to

address issues in terms of time taken to complete tools, recruitment issues, and the scope of questions as well as determine face and content validity of the questionnaire. Even though face validity should not be considered as acceptable evidence for the quality of a research instrument, Burns and Grove (1997) argued that it may be helpful for a measure to have face validity if other types of validity have also been demonstrated. Content validity is concerned with the relevance of the method of measurement including all the major elements to the content area being measured (Burns & Grove, 1997). The content validity of an instrument was obtained from three sources. These include a review of the literature, representatives of the relevant populations, and experts in the content area (Burns & Grove, 1997).

A procedural pilot study of the instruments with a sample of 10 women was conducted prior to the initiation of this study. Women in the pilot study were chosen from the same population as that used in the actual study. Since the major purposes of a pilot study were to give the investigator some experience with the instruments, method and participants (Brink & Wood, 1998), the data obtained in this pilot study were not included in the overall data analysis of this research. Little refinement, in terms of wording, was required on the instruments after the pilot study, and the investigator discovered some useful techniques, which were used to guide the interviews during the data collection process. These included the following points:

1. Eight out of 10 women preferred to be verbally asked questions on the instruments instead of completing the instruments by themselves. The underlying reasons for this were that the women felt that they were slow readers and would take a long time to complete the questionnaire, and two women could not read. Therefore, after explaining the nature of the study, individual participants were asked if they preferred to be interviewed or to complete the questionnaire by themselves.

2. The terms “literacy and illiteracy” were understood differently between the women and the researcher. Almost half the women said that they could read

and write, however, it was found later during the interview that they could read only simple words and write only their name.

3. The researcher learned from this procedural pilot study that the ratings of the PMWI needed to be defined such "rarely, sometimes, and frequently". From the pilot study, the researcher provided a definition of each response of the PMWI (for example, "rarely" - happening once in a six-month period, "occasionally" - happening once a fortnight, and "frequently" - happening at least once a week.

4. In regard to the SF-12, six women found it hard to answer Question 2B which asked whether their health limited them from climbing several flights of stairs and if so, how much. These women explained that they lived in a low set house or accommodation so had no stairs. The researcher then related this to when they had to cross the over-bridge opposite the hospital because most women use the over-bridge to access to the hospital. In addition, if the women still reported that they did not use the over-bridge, the researcher would ask them to think about if they had to climb several flights of stairs, how would they rate their health.

Procedure

The approach to data collection took into consideration that some women may have poor literacy skills. Furthermore, due to the sensitive nature of the topic, some women particularly those who identify abuse may be referred to existing hospital services for treatment and support. The researcher therefore explained the study to hospital staff who worked in a counselling service and arranged a mechanism for referral. All data for this study were gathered between July 2003 and February 2004 by the researcher and four research assistants, one was a nursing instructor and three were 4th year nursing students. These four research assistants received training from the researcher prior to commencement of data collection. The research assistants collected data for 4 weeks only during Phase 1 due to the commencement of the

university semester. The remaining data collection was conducted by the researcher. The study consisted of two phases in the data collection process.

Phase 1

Pregnant women who attended their third trimester antenatal visit and met the selection criteria, were approached by staff of the hospital to participate in the study. The researcher or research assistants explained the nature and purpose of the study. Upon obtaining informed consent, the researcher or research assistants administered a survey questionnaire to participants in a private room of the hospital. No partner, relative or child over the age of three was allowed to be present while the woman completed the questionnaire. In most cases women presented at the clinic with other support women. In the case where a woman was alone and had a child over the age of three years the research assistant supervised the accompanying child outside the interviewing room. All participating women were given a card containing telephone numbers and lists of agencies providing assistance to victims of domestic violence (See Appendix A). In Phase 1, the survey contained (section 1) participants' demographic information as follows:

1.1. Personal details including name, age, parity, education level, employment, monthly income, previous abortions and miscarriages, smoking habits, use of alcohol or drugs, non-prescription drug use, and expected date of delivery.

1.2. Family details including marital status, length of marriage, insurance status, family debt, number of people living in the same house, number of pregnancies, and place for postpartum follow up (6 weeks after birth).

All of these demographic data except age, expected date of delivery, length of marriage, number of people living in the same house and number of pregnancy, were categorized. For example, six categories of education level were used: did not attend school, completed year 6 and below, completed year 12, diploma/certificate, bachelor degree, and postgraduate. Five categories of monthly income were provided: less than 1,000 Baht, 1,000 - 5,000 Baht, 5,001 – 9,000 Baht, 9,001 – 20,000 Baht, and more than 20,000 Baht. Four categories of marital status were

used: married with a certificate, married without a certificate, de facto, and separated/other (e.g., divorced) (See Appendix B).

All women were asked about their partner's background including education, employment, monthly income, smoking habits and use of drugs and alcohol. Questions in relation to physical and mental health were asked using the SF-12 Health Survey (section 2). Women were also asked if they had experienced domestic violence in the year before, and during their current pregnancy (from the date of having no menstruation until the day of interview) using the Psychological Maltreatment of Women Inventory (section 3), and the Severity of Violence Against Women Scales (section 4). Women who identified abuse were then asked to identify helpful resources as well as family support networks and ways they dealt with violence, and barriers that inhibit them from seeking help. This series of questions was contained in an instrument developed by the researcher based on a review of the literature (section 5). This instrument contained seven open-ended questions. The antenatal questionnaire can be seen in Appendix B.

Phase 2

All women who participated in Phase 1 and consented to the follow up study, were asked to complete a questionnaire (See Appendix C) again at their 6-week follow-up visit post delivery. The 6-week follow up was chosen because this period distinguishes the issues and events that may occur in the immediate postpartum period, which is characterized by rapid physical and mental changes, from those that occur later in the postpartum period (Petersen, Saltzman, Goodwin, & Spitz, 1998). The 6-week period is also useful because in Thailand postpartum women schedule a health care visit at this time. In Thailand, a postpartum appointment for birthing women often takes place at the family planning clinics of the hospitals.

It is possible that some women would not attend their postpartum appointment at the hospital where their babies were born. Some attended postpartum care in a health centre at their village. This may be because of various factors such as distance from their hometown to the hospital and referral system where some women are required

to attend their follow up appointment in their catchment's area if they had a universal health care coverage. Therefore, in this study all participating women were asked if they would come to the selected hospital family planning clinics for follow up. If women answered "no" or "not sure", they were then asked if the researcher could contact them for a follow up interview by telephone. In this phase, 274 women were contacted after birth, with 96 interviewed face-to-face at the family clinics and 178 telephoned due to distance barriers. Schneider, Elliott, LoBiondo-Wood and Haber (2003) argued that telephone interviews may also allow the researcher to reach more respondents than face-to-face interviews. Interviews, either face-to-face or by telephone, are best used when the researcher may need to clarify the task for the respondent or is interested in obtaining sensitive or personal information.

In Phase 2 participants were asked about:

1. Type of birth, sex of the infant, infant's birth weight, antenatal complications, maternal complications during labor and after birth, the condition of newborn at delivery and after birth, and length of hospital stay.
2. Neonatal outcomes in terms of weight at 6 weeks, difficulty in feeding, and whether the baby required hospitalisation after birth. The researcher recorded babies' weight and height from the birth record booklets.
3. The women's physical and mental health using the SF-12 Health Survey.
4. Experience of domestic violence after delivery (from the day of giving birth until the day of this interview) by using the Psychological Maltreatment of Women Inventory (PMWI), and the Severity of Violence Against Women Scales (SVAW).
5. Resources women currently use or would find helpful in dealing with violence.
6. Barriers inhibiting them from seeking help.

Data Cleaning and Screening

A process of data cleaning and screening was utilized. Firstly, during the data entry process, the researcher performed a double entry of 10% of surveys. In this study 40 surveys for Phase 1 and 30 surveys for Phase 2 were double-checked and the entry

error rate was less than 1%. Secondly, prior to directly testing the data, participants' responses on the survey items were examined by visual checks and by using SPSS for Windows version 12.0 to identify any missing values or errors, and any "out of range" values in data entry. Examination through SPSS using Frequencies analysis revealed no missing data. After data cleaning and screening, the researcher commenced data analysis.

Data Analysis

The Statistical Packages for Social Science (SPSS for Windows-version 12.0) Program was used to analyze the data, for descriptive statistics, bivariate statistics and multivariate analyses. Cronbach's alpha was used to assess reliability (internal consistency) of research tools.

Descriptive statistics were used to obtain frequencies, means, and standard deviations. Total scores and sub-scores on standardized measures were summed to produce interval data. Bivariate analysis, using Chi-square test was used to examine the association between domestic violence (abused and non-abused groups) and the demographic variables, such as education level, employment, monthly income, and smoking habits. An analysis of variance (ANOVA) was used to compare the mean scores of domestic violence and variables with more than two groups such as marital status, drinking habits, and antenatal check ups. Post-hoc Tukey HSD test was also used to identify group differences. In addition, independent t-tests were used to test the difference between variables at interval level of measurement, such as age and abuse status. Independent t-tests were also used to examine the difference between groups of women who experienced domestic violence and those who did not in terms of health status as measured by the SF-12. A Bonferroni adjustment was applied when examining and comparing health status of women who were abused and those who were not. Field (2000) stated that the Bonferroni adjustment is achieved by dividing the probability value (0.05) by the number of t-tests conducted. It is used to control Type I error. General Linear Model Repeated Measures were also used to detect differences in group means of the SF-12 Health Survey between Phase 1 and Phase 2. If the assumption of Sphericity was violated, an adjusted degrees of

freedom was used (Field, 2000). Multiple regression was used to explore relationships between domestic violence (continuous dependent variables) and predictors such as age of women, number of live children, number of pregnancies, number of family members, and number of miscarriages. An alpha level of 0.05 was used for all statistical tests as appropriate.

Ethical Approval

Prior to data collection, the researcher obtained ethical approval from Griffith University Human Research Ethics Committee and the selected hospitals under the Ministry of Public Health in Thailand (See Appendix D).

On receiving ethical approval, the researcher met with staff of the hospital to explain the research design and methodology, and ask for their assistance with the recruitment of women. The women who met the study criteria were approached by staff at the hospital and asked if they were willing to speak with the researcher. It is believed that because staff at the antenatal clinic have an ongoing relationship with pregnant women and are available at all clinic hours, it will be more empowering to women if staff ask them for participation (Parker & McFarlane, 1991a). Verbal and written informed consent was obtained from each woman. If women had low literacy skills and fear of completing forms, the researcher read information in the consent form to women. The nature of the questions and process of the study were fully described to all participants in plain language. Participants' confidentiality and their rights to be involved or not in the study were explained. They were reassured that their participation in the study was entirely voluntary, and there was no coercion for women to participate in the study. Anonymity was also assured. The women were also reassured that their participation would not have any impact on the care given by staff at the hospital. In addition, the women were informed that they could stop participating at any time, particularly if they felt they were jeopardizing their own safety (Desai & Saltzman, 2001). The women were also given opportunities to ask questions, and to decline or accept the invitation to participate in this study (See Appendix E and F for an Information Sheet and Consent Form, respectively).

The researcher adhered strictly to principles on researching domestic violence against women (World Health Organization, 1999). Sensitivity and attention to safety and confidentiality were ensured (World Health Organization, 1999). In this study the safety of all women was prioritised and protected. Participants' names and addresses were not attached to their data, instead code numbers were assigned. A list linking the code numbers and women's names was documented but accessible only to the investigator and kept separately in a secure cabinet in an office at the university. Another strategy used to ensure women's safety was that all women who participated in the study were given a help card containing social and counselling services for domestic violence, and phone numbers of others health services (See Appendix A). If a woman indicated violence, the researcher would then ask if she needed help and referred them to a counselling or social service at the hospital. This information was provided to support women's own decision-making and provide them with possible options. The researcher ensured that the research was conducted in an ethical and appropriately sensitive manner. Participants were administered a survey in a non-judgmental manner in a private setting without the male partner or another individual being present.

Upon the completion of the study, the name list and data were stored separately in a secure, locked filing cabinet in an office provided by Griffith University.

In summary, this study utilized an exploratory descriptive design to determine the prevalence and severity of domestic violence during pregnancy and following childbirth of Thai women attending antenatal clinics at two tertiary hospitals in Khon Kaen Province, Northeastern Thailand. Women's health and neonatal outcomes as well as helpful resources in dealing with domestic violence, and barriers inhibiting women from seeking help were also explored in this study. Data were collected through the use of face-to-face and telephone interviews. Informed consent was obtained and the rights of all participated women were protected. Data analysis included the use of descriptive and inferential statistics. The following chapter will present the findings from the study.

Chapter 4 : Results

Introduction

This chapter presents the analysis of results using descriptive and inferential statistics. Firstly, the response rate achieved in this study is reported, followed by demographic characteristics of women and partners. The validity and reliability of the standardized measures are provided. The prevalence of domestic violence (that is, a number of current cases per population at risk at a specific point in time) is presented. Women were asked to retrospectively recall violence prior to the current pregnancy, and report violence in the last trimester and at six weeks postpartum. For each form of violence (that is, psychological, physical and sexual), data are presented for the antenatal (Phase 1) and postnatal period (Phase 2). This chapter also presents factors associated with domestic violence, women's health status and neonatal outcomes as well as a statistical model of domestic violence and women's health. Finally, this chapter presents several case studies to reveal the strategies used by women when dealing with domestic violence, their needs, and barriers to seeking help.

Response Rate

The study included two phases of data collection. In the first phase four hundred and twenty four women at 32-week gestation or more were approached to participate in the study. Two pregnant women refused to participate due to transport problem and one did not meet the selection criteria relating to Thai citizenship. A total of 421 women participated in the first phase of the study. The second phase was a follow up of participating women at 6 weeks following childbirth. Two hundred and seventy-four women were contacted in the second phase whereas one hundred and forty-seven women were lost to follow-up, giving a response rate of 65%. This is an acceptable level of participation in a survey (Barriball, 1999).

Women's Demographic Characteristics

Demographic characteristics are shown in Table 4.1. Their characteristics could not be compared with statistics for the population of Thai birthing women due to the lack of national statistics data in Thailand. The sample age was between 18 and 40 years with the mean age of 26 years (SD = 5.3 years). Four categories of marital status used in Thailand include: married with a certificate, married without a certificate, de facto and separated. Almost half the women in the sample were married with no certificate (n = 208, 49.4%). A further 44.7% of women (n = 188) were married with a certificate, 5.2% (n = 22) were in a de facto relationship and 0.7% (n = 3) were separated from their partners. The women who reported being separated from their partner at that time stated this was due to abuse.

Over half the sample (57.7%) had a relationship of less than five years with a mean of 4.9 years (SD = 3.9, range 1-25 years). Educational level was grouped according to the highest level of education completed. One third of women (31.8%) completed primary school, 44.2% achieved all or part of their high school education, 17.1% achieved a certificate or diploma, 6.4% achieved a bachelor degree and 0.5% had completed postgraduate studies.

The largest proportion of women (39.4%) reported "home duties" as their occupation at the time of the survey, closely followed by laboring work (31.4%). Women reported working as farmers (14.3%), traders/sellers (10.2%), government officers (2.1%), own business (1.2%), employed in co-operatives (0.5%) and technicians (0.2%). Only a small proportion of women (0.7%) reported being a "student" as their occupation. Over forty percent (n = 179, 42.5%) of women reported having a monthly income of between 1,000 and 5,000 Baht (AUD $35 – 172; in late 2003 the exchange rate was approximately AUD $1.0 = 29.0 Baht), and 40.6% (n = 171) as having no income. Less than 12% of women (n = 47, 11.2%) reported having an income of between 5,001 and 9,000 Baht (AUD $172 – 310), or higher (n = 24, 5.7%).

Two hundred and ninety-two women (69.3%) lived in an extended family arrangement while 129 women (30.7%) lived in a nuclear family. The majority of women (n = 333, 79.1%) lived in their own or parent's house. Women also reported living in a house of a relative or their parent in-law (n = 36, 8.6%), living in government accommodation (n = 22, 5.2%) or renting a house, flat or a room (n = 30, 7.1%).

Health care cover was also investigated. Women were asked about the possession of a health care card. The majority of women (n = 352, 83.6%) had some kind of health care card with only a small number of women (n = 69, 16.2%) not having any type of health care card. The types of health care cards reported were the Golden Card or the universal health care coverage card for Thai people who do not possess a Social Security Card or a Government Card (n = 218, 61%). A Social Security Card is provided to those who work in non-government organizations/companies (n = 109, 30%), and a Government Card is provided to government officers (n = 26, 7.4%).

Table 4.1: Women's demographic characteristics

Demographics of women	Study sample n (%)
Age	
15 – 19	38 (9.0)
20 – 24	151 (35.9)
25 – 29	125 (29.8)
30 – 34	72 (17.0)
35 – 39	31 (7.3)
40 – 44	4 (1.0)
Marital status	
Married (no certificate)	208 (49.4)
Married (with certificate)	188 (44.7)
De facto	22 (5.2)
Separated	3 (0.7)
Length of relationship (years)	
Less than 5 years	243 (57.7)
5-10 years	144 (34.2)
More than 10 years	34 (8.1)
Education of women	
Primary school	134 (31.8)
High school	186 (44.2)
Diploma/certificate	72 (17.1)
Bachelor degree	27 (6.4)
Postgraduate	2 (0.5)
Occupation of women	
Home duties	166 (39.4)
Laborer	132 (31.4)
Farmer	60 (14.3)
Seller/trader	43 (10.2)
Government employees	9 (2.1)
Private business	5 (1.2)
Student	3 (0.7)
Employed in cooperative	2 (0.5)
Technician	1 (0.2)
Salary of women	
Below 1,000 Baht	171 (40.6)
1,000 - 5,000 Baht	179 (42.5)
5,001 - 9,000 Baht	47 (11.2)
9,001 – 20,000 Baht	21 (5.0)
More than 20,000 Baht	3 (0.7)

Women's Obstetric Details

Table 4.2 presents the obstetric history of women in the study. There were 52% (n = 219) multiparous (has delivered a previous live infant) and 48% (n = 202) nulliparous (has never given birth to a child) women in the sample at Phase 1. The number of visits to the antenatal clinic (ANC) was also reported with almost all women (99.3%) attending at least four antenatal appointments during pregnancy. Only two women (0.8%) had one or two antenatal visits. The first antenatal check up of women varied across the sample with nearly half the women (n = 203, 48.2%) having their first visit before 13 weeks gestation. Relatively few women (n = 9, 2.1%) had the first antenatal check up between 29-32 weeks of gestation or at 33-40 weeks gestation (n = 4, 1%).

The majority of women had a vaginal or spontaneous birth (n = 201, 73.4%). There was a lower rate of instrument-assisted deliveries than surgical delivery. Sixty-two women (22.6%) gave birth by caesarean section while 11 women (4%) delivered by vacuum extraction. None of the women gave birth by forceps. The length of hospital stay was also measured. Over forty-five percent (n = 124, 45.3%) of women were hospitalized at least 4 days or more; 41.6% (n = 114) were hospitalized for 3 days. Only 0.4% (n = 1) of women were in the hospital for one day, and 12.8% (n = 35) hospitalized for two days.

The gender of infants in this sample was 52.6% (n = 144) male and 47.4% (n = 130) female. Relatively few women (n = 21, 7.7%) gave birth to a low birth weight infant (less than 2500 grams). There were 63 infants (23%) who had complications after birth. The majority of those infants had jaundice (n = 41, 15%) followed by infections (n = 11, 4%). Relatively few infants were stillborn (n = 2, 0.7%) or had birth trauma (n = 1, 0.4%). After being discharged from a hospital, 21.9% of infants (n = 60) were readmitted to a hospital, health centre or a private clinic. The reasons for readmission were having flu-like symptoms (n = 24, 8.7%), gastrointestinal problems such as constipation or diarrhoea (n = 12, 4.4%), eye and umbilicus infections (n = 10, 3.6%), skin problems (n = 8, 3%), jaundice (n = 2, 0.7%), heart problems (n = 1, 0.4%), kidney problems (n = 1, 0.4%), hypothyroidism (n = 1,

0.4%) and falling off the cot (n = 1, 0.4%). Twelve percent (n = 33) of infants were reported to have feeding difficulties.

Table 4.2: Women's obstetric history

Obstetric history	Study sample n (%)
Parity	
Nulliparous	202 (48.0)
Multiparous	219 (52.0)
First antenatal check up	
Before 13 weeks gestation	203 (48.2)
13-20 weeks	159 (37.8)
21-28 weeks	46 (10.9)
29-32 weeks	9 (2.1)
33-40 weeks	4 (1.0)
Number of antenatal visits	
Once	1 (0.4)
Twice	1 (0.4)
Three	-
Four or more	272 (99.3)
Type of delivery	
Normal or spontaneous	201 (73.4)
Caesarean section	62 (22.6)
Vacuum	11 (4.0)
Forceps	-
Length of hospital stay	
One day	1 (0.4)
Two days	35 (12.8)
Three days	114 (41.6)
Four days or more	124 (45.3)
Gender of infants	
Female	130 (47.4)
Male	144 (52.6)
Weight of infants	
Less than 2,500 grams	21 (7.7%)
2,500 grams or more	253 (92.3%)
Previous birth to low birth weight child	
No	132 (48.2)
Yes	11 (4.0)
This was the first child	131 (47.8)

Table 4.2: Women's obstetric history (continued)

Obstetric details	Study sample n (%)
Infants' complications after birth	
Jaundice	41 (15.0)
Infection	11 (4.0)
Hypoglycemia	4 (1.5)
Skin problem	2 (0.7)
Neonatal death	2 (0.7)
Hypothyroidism	2 (0.7)
Birth trauma	1 (0.4)
Readmission to a hospital/health centre/clinic of infants after discharged	
No	214 (78.1)
Yes	60 (21.9)
Reason for readmission	
Influenza	24 (8.7)
Gastrointestinal problem	12 (4.4)
Infection e.g., eye and umbilicus infection	10 (3.6)
Skin problem (allergy)	8 (3.0)
Jaundice	2 (0.7)
Heart problem	1 (0.4)
Kidney problem	1 (0.4)
Accidental injury	1 (0.4)
Hypothyroidism	1 (0.4)

Maternal complications were identified for the antenatal and postnatal periods (as outlined in Table 4.3). Over eighteen percent (n = 50, 18.2%) of women reported some form of complication during pregnancy. The majority of these women (n = 17, 6.2%) reported having pregnancy related diseases such as diabetes, thyroidism, and hypertension, with 5.1% (n = 14) reporting premature labor. Ten women (3.6%) had antepartum haemorrhage. Relatively few women had premature rupture of the membranes (n = 5, 1.8%), vaginal infections (n = 3, 1.1%) or chest infections (n = 1, 0.4%). None of the women reported having a sexually transmitted disease or previous fetal death.

Women also reported complications during and after birth. Complications during birth were abnormal infant position (n = 14, 5.1%), premature rupture of the membranes (n = 5, 1.8%), infant distress (n = 2, 0.7%), and placenta previa (n = 2, 0.7%). Women also reported a relatively low incidence of postnatal complications.

These included postnatal infection (n = 8, 3%), postnatal haemorrhage (n = 7, 2.6%), perineal tear wound (n = 3, 1.1%) and hypertension (n = 2, 0.7%).

Table 4.3: Complications of women during pregnancy, during and after birth

Women's complications	Study sample n (%)
Complications during pregnancy	
Pregnancy related diseases e.g., diabetes, thyroidism, hypertension, anemia	17 (6.2)
Premature labor	14(5.1)
Antepartum haemorrhage	10 (3.6)
Premature rupture of membrane	5 (1.8)
Vaginal infection	3 (1.1)
Chest infection	1 (0.4)
STDs	-
Fetal death	-
Complications during birth	
Abnormal infant's position	14 (5.1)
Premature rupture of membrane	5 (1.8)
Infant distress	2 (0.7)
Placenta previa	2 (0.7)
Postnatal complications	
Postnatal infection	8 (3)
Postnatal haemorrhage	7 (2.6)
Tear wound	3 (1.1)
Hypertension	2 (0.7)

Negative health behaviours of women were also investigated (as outlined in Table 4.4). A very small proportion of women (1.2%) smoked cigarettes at the time of the survey while 98.8% (n = 416) of women were non-smokers. The majority of women (94.5%) never drank alcohol and only 5.5% reported drinking alcohol on rarely or an occasional basis. Thirty-six women (8.6%) reported engaging in some type of gambling. None of women in the sample reported using any type of illicit drugs.

Table 4.4: Negative health behaviours of women

Negative health behaviours	Study sample n (%)
Cigarette use	
No	416 (98.8)
Yes	5 (1.2)
Alcohol use	
Never	398 (94.5)
Rarely	15 (3.6)
Occasionally	8 (1.9)
Frequently	0 (0)
Illicit drug use	
No	421 (100)
Yes	0 (0)
Gambling	
No	385 (91.4)
Yes	36 (8.6)

Characteristics of Women's Partners

The mean age of the women's partners was 29.3 years (SD = 6.14, range 16 to 55 years). Table 4.5 outlines the characteristics of the women's partners. Less than half of all partners completed all or part of their high school education (41.3%) followed by primary school (32.1%), diploma/certificate (18.5%), bachelor degree (6.4%) and postgraduate studies (0.2%). A very small proportion of partners (0.7%) did not attend any school at all, while one woman didn't know about her partner's education. Over half the partners worked as laborers (58.2%). Women also reported their partners worked as farmers (14.3%), owned a private business (9%), were traders/sellers (8.3%), government employees (5.9%), or unemployed (1.2%). In regards to income of partners, 53.9% had a monthly income of between 1,000 and 5,000 Baht (AUD $35 –172).

Table 4.5: Characteristics of partners

Demographic	Study Sample n (%)
Partner's age	
Less than 20 years	10 (2.4)
20 – 24	85 (20.2)
25 – 29	142 (33.7)
30 – 34	104 (24.7)
35 – 39	50 (11.9)
40 – 44	23 (5.5)
45 - 49	5 (1.2)
50 - 55	2 (0.5)
Education of partners	
Did not attend school	3 (0.7)
Primary school	135 (32.1)
High school	174 (41.3)
Diploma/certificate	78 (18.5)
Bachelor degree	27 (6.4)
Postgraduate	1 (0.2)
Currently in high school	2 (0.5)
Don't know	1 (0.2)
Occupation of partners	
Laborer	245 (58.2)
Farmer	60 (14.3)
Private business	38 (9.0)
Seller/trader	35 (8.3)
Government officer	25 (5.9)
Mechanics	6 (1.4)
Unemployed	5 (1.2)
Student	4 (1.0)
Employed in cooperative	3 (0.7)
Salary of partners	
No income	11 (2.6)
1,000 – 5,000 Baht	227 (53.9)
5,001 – 9,000 Baht	103 (24.5)
9,001 – 20,000 Baht	68 (16.2)
More than 20,000 Baht	10 (2.4)

Table 4.6 presents negative health behaviours of partners. It can be seen that two thirds of partners were cigarette smokers (n = 257, 61%), and occasionally drank alcohol (n = 195, 46.3%). A small number of partners were gamblers (n = 54, 12.8%) or illicit drug users (n = 1, 0.4%).

Table 4.6: Negative health behaviours of women's partners

Negative health behaviours	Women's partners n (%)
Cigarette use	
No	164 (39.0)
Yes	257 (61.0)
Alcohol use	
Never	82 (19.5)
Rarely	111 (26.4)
Occasionally	195 (46.3)
Frequently	33 (7.8)
Illicit drug use	
No	420 (99.8)
Yes	1 (0.2)
Gambling	
No	367 (87.2)
Yes	54 (12.8)

Comparisons between Women Lost to Follow-up at Phase 2 and Study Participants

A total of 421 women participated in Phase 1 of the study. However, 147 women (34.9%) were lost to follow up in Phase 2 at 6 weeks postpartum. Women who could not be contacted following the birth were more likely to be older ($\bar{X}$ = 26.7 years, SD = 5.24, t = -1.98, p<.05), multiparous ($\bar{X}$ = 2.11, SD = 0.85, t = -3.64, p<.05), and have completed only primary school level of education ($\chi^2(3) = 10.82$, p<.05). Their partners were more likely to have monthly incomes of between 1,000 and 5,000 Baht (AUD $35 –172) ($\chi^2(3) = 12.52$, p<.05). There were no statistically significant differences for occupation, monthly income, marital status, and abuse status (psychological abuse, physical abuse, sexual abuse). There were also no significant differences in terms of partner's age, education level, occupation, and negative health behaviours between women who participated in Phase 1 and 2, and those who participated in Phase 1 only.

Reliability of Instruments

Three standardized instruments were used in this study: the Psychological Maltreatment of Women Inventory (PMWI), Severity of Violence Against Women Scale (SVAW) and SF-12 Health Survey. The reliability of these three standardized instruments was tested using Cronbach's alpha. Table 4.7 outlines the reliability coefficients of all scales and subscales.

Psychological Maltreatment of Women Inventory (PMWI)

The PMWI was used to measure psychological abuse and consisted of 2 subscales: emotional/verbal and dominance/isolation. The reliability of the PMWI has previously been reported (Tolman, 1989). In the present study, the reliability coefficients for emotional/verbal subscale of the PMWI were good for both phases (Phase 1 α = .84 and Phase 2 α = .85). On the other hand, the reliability of the dominance/isolation subscale was acceptable for Phase 2 (α = .75) but low for Phase 1 (α = .66). However, the overall reliability coefficients for the PMWI were good for both phases (n = 421, α = .84 for Phase 1; n = 274, α = .86 for Phase 2).

Severity of Violence Against Women Scale (SVAW)

The internal reliability of the SVAW was established with its overall reliability coefficient being high for both phases (α = .93 and .96 for Phase 1 and 2 respectively). The reliability coefficient was also calculated for each subscale of the SVAW at both phases. The reliability of all subscales of the SVAW was high except one subscale, the sexual subscale, which had a low reliability coefficient (α = .59) for Phase 1 but an acceptable level (α = .70) for Phase 2.

SF-12 Health Survey

The Cronbach's alpha value for the SF-12 was calculated for each phase of the study. In this study, the Cronbach's alpha value for the SF-12 during pregnancy was .72 (Phase 1) and at 6 weeks postpartum (Phase 2) was .80.

Table 4.7: Reliability of scales and subscales

Scales/Subscales	During pregnancy (Phase 1) α	After birth (Phase 2) α
PMWI		
Emotional/verbal	.84	.85
Dominance/isolation	.66	.75
Overall	**.84**	**.86**
SVAW		
Threats dimension	.91	.94
Symbolic acts	.75	.84
Threats of mild violence	.75	.87
Threats of moderate violence	.70	.90
Threats of serious violence	.82	.93
Violence dimension	.92	.96
Mild violence	.79	.80
Minor violence	.76	.86
Moderate violence	.88	.92
Serious violence	.91	.93
Sexual violence	.59	.70
Overall	**.93**	**.96**
SF12	**.72**	**.80**

Prevalence of Domestic Violence

Women in the sample were asked about their experiences of domestic violence before, during the current pregnancy, and after birth.

Domestic violence before pregnancy

Two questions with yes and no responses were used as initial screening questions to elicit the experience of domestic violence in the 12 months prior to conception. Table 4.8 presents the number and percentage of women who answered "yes" to the questions. It can be seen that the initial screening question yielded a very low incidence of domestic violence. Fourteen out of 421 women (3.3%) reported that their partners had threatened them during the twelve months prior to conception while 5.5% (n = 23) reported being hurt by their partner in the same period. Women reporting abuse were then asked how many times abuse had occurred. Abuse in the twelve months prior to pregnancy was reported to occur 7.14 (SD = 10.47, range 1-32) times for threats, and 3.87 (SD = 4.12, range 1-20) times for being hurt by their partners.

Table 4.8: Abuse prior to conception

Questions	Response n (%)	
	Yes	No
In the one-year period before you became pregnant, did your partner threaten to hurt you?	14 (3.3%)	407 (96.7%)
In the one-year period before you became pregnant, did your partner hurt you?	23 (5.5%)	398 (94.5%)

Domestic violence during pregnancy and after birth

Two measures were used to determine the nature of domestic violence during pregnancy and after birth, the Psychological Maltreatment of Women Inventory-short form (PMWI) (Tolman, 1999, n.d) and the Severity of Violence against Women Scale (SVAW) (Marshall, 1992). The nature of domestic violence will be presented in terms of psychological, threats and acts of physical, and sexual violence, reported during Phase 1 and Phase 2. Further questioning of women using the PMWI and SVAW revealed a much higher incidence of violence than the original screening questions.

Frequency of Psychological abuse during pregnancy using the Psychological Maltreatment of Women Inventory (PMWI)

Table 4.9 presents responses to questions related to the frequency of psychological abuse in Phase 1 according to the PMWI. These questions were completed by 421 pregnant women who were 32 weeks pregnant or more.

The data revealed that during pregnancy 14% of women (n = 59) were occasionally told by their partners that their feelings were irrational and crazy, 12.1% (n = 51) were occasionally sworn, yelled or screamed at by their partners, 9.3% (n = 39) were occasionally called names, and 9.5% (n = 40) of women reported their partners occasionally used money or made important financial decisions without consulting them. Women also reported their partners occasionally monitored their time and made them account for their whereabouts (n = 31, 7.4%), blamed them for their

(partner's) problems (n = 26, 6.2%), were jealous or suspicious of the woman's friends (n = 23, 5.5%), treated them as inferior (n = 19, 4.5%), and accused them of having an affair with another man (n = 17, 4%).

Table 4.9: Frequency of psychological abuse during pregnancy using the PMWI

Items	Psychological abuse n (%)				
	Never	Rarely	Occasionally	Frequently	Very frequently
My partner:					
1. called me names	334 (79.3)	40 (9.5)	39 (9.3)	6 (1.4)	2 (0.5)
2. swore at me	322 (76.5)	43(10.2)	51 (12.1)	2 (0.5)	3 (0.7)
3. yelled and screamed at me	313 (74.3)	50(11.9)	51 (12.1)	5 (1.2)	2 (0.5)
4. treated me like an inferior	388 (92.2)	11 (2.6)	19 (4.5)	3 (0.7)	-
5. monitored my time and wanted accounts for my whereabouts	355 (84.3)	21 (5.0)	31 (7.4)	10 (2.4)	4 (1.0)
6. used money or made important financial decisions without talking to me about it	357 (84.8)	18 (4.3)	40 (9.5)	2 (0.5)	4 (1.0)
7. was jealous and suspicious of my friends	377 (89.5)	17 (4.0)	23 (5.5)	4 (1.0)	-
8. accused me of having an affair with another man	385 (91.4)	16 (3.8)	17 (4.0)	2 (0.5)	1 (0.2)
9. interfered in my relationships with other family members	402 (95.5)	7 (1.7)	10 (2.4)	1 (0.2)	1 (0.2)
10. tried to keep me from doing things to help myself	380 (90.3)	20 (4.8)	16 (3.8)	2 (0.5)	3 (0.7)
11. restricted the use of the telephone	402 (95.5)	4 (1.0)	12 (2.9)	1 (0.2)	2 (0.5)
12. told me that my feelings were irrational and crazy	318 (75.5)	33 (7.8)	59 (14.0)	7 (1.7)	4 (1.0)
13. blamed me for his problems	377 (89.5)	15 (3.6)	26 (6.2)	1 (0.2)	2 (0.5)
14. tried to make me crazy	387 (91.9)	9 (2.1)	13 (3.1)	6 (1.4)	6 (1.4)

Frequency of psychological abuse after birth using PMWI

Women were also asked about psychological abuse after birth according to the PMWI. Two hundred and seventy-four women were contacted in Phase 2 (at 6 weeks after birth), and asked to rate how often their partners carried out each behaviour. Their responses are outlined in Table 4.10. The majority of women reported that their partners 'occasionally' told them that their feelings were irrational and crazy (n = 36, 13.1%), their partners were jealous or suspicious of the woman's

friends (n = 32, 11.7%), and partners yelled and screamed at them (n = 31, 11.3%). Women also reported that their partners 'occasionally' called them names or swore at them (n = 23, 8.4%), partners occasionally blamed them for his problems or tried to make them crazy (n = 14, 5.1%). A small proportion of women were accused by their partners of having an affair with another man (2.9% responded "rarely" and 0.4% responded "occasionally" to this question). Small numbers of women reported having their partner interfere in their relationship with other family members (2.9%).

Table 4.10: Frequency of psychological abuse after birth using the PMWI

Items	Psychological abuse n (%)				
	Never	Rarely	Occasionally	Frequently	Very frequently
My partner:					
1. called me names	246 (89.8)	3 (1.1)	23 (8.4)	2 (0.7)	-
2. swore at me	243 (88.7)	6 (2.2)	23 (8.4)	1 (0.4)	1 (0.4)
3. yelled and screamed at me	237 (86.5)	4 (1.5)	31 (11.3)	1 (0.4)	1 (0.4)
4. treated me like an inferior	261 (95.3)	1 (0.4)	12 (4.4)	-	-
5. monitored my time and wanted accounts for my whereabouts	259 (94.5)	1 (0.4)	12 (4.4)	2 (0.7)	-
6. used money or made important financial decisions without talking to me about it	243 (88.7)	2 (0.7)	22 (8.0)	3 (1.1)	4 (1.5)
7. was jealous and suspicious of my friends	237 (86.5)	3 (1.1)	32 (11.7)	2 (0.7)	-
8. accused me of having an affair with another man	265 (96.7)	8 (2.9)	1 (0.4)	-	-
9. interfered in my relationships with other family members	266 (97.1)	1 (0.4)	5 (1.8)	2 (0.7)	-
10. tried to keep me from doing things to help myself	244 (89.1)	25 (9.1)	2 (0.7)	3 (1.1)	-
11. restricted the use of the telephone	255 (93.1)	16 (5.8)	3 (1.1)	-	-
12. told me that my feelings were irrational and crazy	234 (85.4)	2 (0.7)	36 (13.1)	2 (0.7)	-
13. blamed me for his problems	260 (94.9)	-	14 (5.1)	-	-
14. tried to make me crazy	256 (93.4)	2 (0.7)	14 (5.1)	-	2 (0.7)

Frequency and severity of threats of and acts of physical violence during pregnancy using the Severity of Violence against Women Scale (SVAW)

Table 4.11 presents responses to each item of threats and acts of violence during pregnancy according to the SVAW. The following section will describe the prevalence of threats and acts of physical violence during pregnancy from the most to the least common form.

Symbolic violence was the most common form of physical violence identified by women in the study (as shown in Table 4.11). The item "my partner drove dangerously with me in the car" (causing her to feel scared) was the most common form of symbolic violence reported by 14.7% (n = 62) of women, with 9.5% (n = 40) experiencing this form of violence "a few times", and 3.6% (n = 15) "often". Less than two percent of women (n = 7, 1.7%) reported that this happened "once" during the current pregnancy. The second most common form of symbolic violence women experienced during pregnancy was that the partner "kicked a wall, door, or furniture" (10.2% response rate) with over three percent of women reporting in each category of occurrence (3.3% - "once", 3.8% - "a few times", 3.1% - "often"). The next common form of symbolic violence reported by women was that their partners "threw, smashed or broke an object" (9.3% response rate ranging from 1.7%-4.0%). Moreover, 4% of women (n = 17) reported that their partners threw an object at them at least once during their current pregnancy.

The next form identified was threats of mild violence. Over five percent of women (n = 25, 5.9%) reported their partners acted like a bully toward them at least once during current pregnancy, and made threatening gestures at them (n = 22, 5.2%). Women also reported their partners shook their finger at them (n = 20, 4.8%), and shook their fist at them (n = 14, 3.7%). Overall, women in this study tended to experience threats of mild violence "a few times" and "often". Less than one percent of women reported threats "once" during the current pregnancy.

The items partner "threatened to hurt me" (4.4%), "threatened to kill himself" (3.3%), and "threatened to kill me" (3.3%) were identified as the most common forms of serious threats.

Acts of mild violence reported by participants included partner "grabbed me suddenly or forcefully" (4.6%). Similarly, having a partner pushed or shoved them was reported by 3.8% of women. Relatively few women reported they were held down, pinned in place (1.7%), or shaken or roughly handled by their partners (1.6%).

A relatively low incidence of acts of minor violence during pregnancy was identified in this study. However, women experiencing this form of violence were most likely to report that their "partner pulled my hair" (3.6% response rate: 0.5% - once, 1.4% - a few times, 1.7% - often), followed by "my partner twisted my arm" (response rate 2.8%: 0.7% - once and a few times, 1.4% - often).

Very few women experienced acts of moderate violence. Women (n = 6, 1.4% and n = 5, 1.2%) reported being slapped by their partners with the palm of his hand "once" and "often" respectively during the current pregnancy. About two percent of women were slapped around the face and head. One or two women reported that they were slapped with the back of their partner's hand (this act is defined as having increased force and more anger).

Partners "threatened to harm or damage things I cared about" was a form of moderate threat experienced by women (2.9% response rate: 0.5% - "once", 0.7% - "a few times", and 1.7% - "often").

The least common forms of physical violence identified by participants were acts of serious violence. Relatively few women exposed to serious violence during pregnancy, such as being "stomped on" (0.2%), "hit by an object" (0.2%), "punched" (0.5%), "kicked" (1.2%), or being "choked" (1.2%). None of the women were burned with an object, beaten up, had a knife or gun or a club-like object used on her.

Table 4.11: Frequency and severity of threats and acts of physical violence during pregnancy by current partners using the SVAW

Items	During Pregnancy n (%)			
	Never	Once	A few times	Often
Symbolic violence				
Kicked a wall, door or furniture	378 (89.8)	14 (3.3)	16 (3.8)	13 (3.1)
Threw, smashed or broke an object	382 (90.7)	7 (1.7)	15 (3.6)	17 (4)
Drove dangerously with me in the car	359 (85.3)	7 (1.7)	40 (9.5)	15 (3.6)
Threw an object at me	404 (96)	6 (1.4)	5 (1.2)	6 (1.4)
Mild threats				
Shook finger at me	401 (95.2)	2 (0.5)	8 (1.9)	11 (2.6)
Made threatening gestures at me	399 (94.8)	2 (0.5)	8 (1.9)	12 (2.9)
Shook fist at me	407 (96.7)	2 (0.5)	5 (1.2)	8 (1.9)
Acted like a bully toward me	396 (94.1)	3 (0.7)	9 (2.1)	13 (3.1)
Moderate threats				
Destroyed my belongings	415 (98.6)	4 (1)	-	2 (0.5)
Threatened to harm or damage things I cared about	409 (97.1)	2 (0.5)	3 (0.7)	7 (1.7)
Threatened to destroy property	411 (97.6)	2 (0.5)	5 (1.2)	4 (1)
Threatened someone I cared about	411 (97.6)	1 (0.2)	4 (1)	5 (1.2)
Serious threats				
Threatened to hurt me	401 (95.2)	4 (1.0)	9 (2.1)	7 (1.7)
Threatened to kill himself	407 (96.7)	4 (1.0)	2 (0.5)	8 (1.9)
Threatened to kill me	407 (96.7)	4 (1.0)	3 (0.7)	7 (1.7)
Threatened me with a weapon	415 (98.6)	1 (0.2)	-	5 (1.2)
Threatened me with a club-like object	417 (99.0)	-	-	4 (1.0)
Acted like he wanted to kill me	411 (97.6)	-	3 (0.7)	7 (1.7)
Threatened me with a knife or gun	417 (99.0)	1 (0.2)	-	3 (0.7)
Mild violence				
Held me down, pinning me in place	414 (98.3)	1 (0.2)	4 (1)	2 (0.5)
Pushed or shoved me	405 (96.2)	4 (1)	5 (1.2)	7 (1.7)
Grabbed me suddenly or forcefully	402 (95.5)	4 (1)	7 (1.7)	8 (1.9)
Shook or roughly handle me	414 (98.3)	1 (0.2)	1 (0.2)	5 (1.2)

Table 4.11: Frequency and severity of physical and sexual violence during pregnancy by current partners using the SVAW (continued)

Items	During Pregnancy n (%)			
	Never	Once	A few times	Often
Minor violence				
Scratched me	417 (99.0)	-	2 (0.5)	1 (0.2)
Pulled my hair	406 (96.4)	2 (0.5)	6 (1.4)	7 (1.7)
Twisted my arm	409 (97.1)	2 (0.5)	2 (0.5)	6 (1.4)
Spanked me	411 (97.6)	2 (0.5)	2 (0.5)	4 (1.0)
Bit me	419 (99.5)	1 (0.2)	-	1 (0.2)
Moderate violence				
Slapped me with the palm of his hand	409 (97.1)	6 (1.4)	1 (0.2)	5 (1.2)
Slapped me with the back of his hand	417 (99)	1 (0.2)	2 (0.5)	1 (0.2)
Slapped me around the face and head	412 (97.9)	4 (1.0)	1 (0.2)	4 (1.0)
Serious violence				
Hit me with an object	420 (99.8)	-	1 (0.2)	-
Punched me	419 (99.5)	-	-	2 (0.5)
Kicked me	416 (98.8)	2 (0.5)	2 (0.5)	1 (0.2)
Stomped on me	420 (99.8)	-	-	1 (0.2)
Choked me	416 (98.8)	1 (0.2)	2 (0.5)	2 (0.5)
Burned me with something	421 (100.0)	-	-	-
Used a clublike object on me	421 (100.0)	-	-	-
Beat me up	421 (100.0)	-	-	-
Used a knife or gun on me	421 (100.0)	-	-	-

Frequency and severity of threats, and acts of physical violence after birth using the SVAW

The frequency of responses to each item of threats and acts of physical violence after birth are outlined in Table 4.12. The following section will describe threats and acts of physical violence from the most frequent to the least common forms.

Similar to threats and acts of physical violence during pregnancy, women reported experiencing symbolic violence after birth more often than other forms of physical violence. Participants identified that their partners "drove dangerously with me in the car" (4.4%) and "kicked a wall, door or furniture" (3.6%), as the most common

forms of symbolic violence. The next form identified was mild threats in which their partners made threatening gestures at them (3.3%), shook a fist at them (2.9%) and acted like a bully toward them (2.9%).

The items that described partner behaviours as "pushed or shoved me" (3.3%) and "grabbed me suddenly or forcefully" (2.9%) were also identified as the most common acts of mild violence.

Very few women experienced moderate threats. However, 2.9% of women identified that their partners threatened someone they cared about, 1.1% received threats to harm or damage things they cared about, or destroyed their property.

The items partner "threatened to hurt me" (2.2%), "threatened to kill himself" (1.1%), and "threatened me with a club-like object" (1.1%) were identified by women as the most common forms of threatened serious violence.

Acts of minor physical violence reported by participants included partner "spanked me" (2.2%) and "pulled my hair" (1.5%). Slightly less than two percent of women (1.8%, n = 5) reported that their partner slapped them with his palm, as the most common form of moderate actual violence.

Relatively few women experienced any form of acts of serious violence (0.4% - 1.1%). However, the item partner "choked me" was identified by 1.1% of women (n = 3).

Table 4.12: Frequency and severity of threats and acts of physical violence after birth using the SVAW

Items	Responses n (%)			
	Never	Once	A few times	Often
Symbolic violence				
Kicked a wall, door or furniture	264 (96.4)	1 (0.4)	8 (2.9)	1 (0.4)
Threw, smashed or broke an object	268 (97.8)	-	6 (2.2)	-
Drove dangerously with me in the car	262 (95.6)	1 (0.4)	10 (3.6)	1 (0.4)
Threw an object at me	271 (98.9)	-	2 (0.7)	1 (0.4)
Mild threats				
Shook finger at me	268 (97.8)	-	4 (1.5)	2 (0.7)
Made threatening gestures at me	265 (96.7)	2 (0.7)	5 (1.8)	2 (0.7)
Shook fist at me	269 (98.2)	-	4 (1.5)	1 (0.4)
Acted like a bully toward me	269 (98.2)	1 (0.4)	3 (1.1)	1 (0.4)
Moderate threats				
Destroyed my belongings	272 (99.3)	1 (0.4)	1 (0.4)	-
Threatened to harm or damage things I cared about	271 (98.9)	1 (0.4)	2 (0.7)	-
Threatened to destroy property	271 (98.9)	1 (0.4)	2 (0.7)	-
Threatened someone I cared about	269 (98.2)	1 (0.4)	4 (1.5)	-
Serious threats				
Threatened to hurt me	268 (97.8)	2 (0.7)	1.1(3)	1 (0.4)
Threatened to kill himself	271 (98.9)	1 (0.4)	1 (0.4)	1 (0.4)
Threatened to kill me	273 (99.6)	-	1 (0.4)	-
Threatened me with a weapon	272 (99.3)	-	2 (0.7)	-
Threatened me with a clublike object	271 (98.9)	-	3 (1.1)	-
Acted like he wanted to kill me	272 (99.3)	-	2 (0.7)	-
Threatened me with a knife or gun	272 (99.3)	-	2 (0.7)	-
Mild violence				
Held her down, pinning me in place	272 (99.3)	1 (0.4)	1 (0.4)	-
Pushed or shoved me	265 (96.7)	3 (1.1)	6 (2.2)	-
Grabbed me suddenly or forcefully	266 (97.1)	-	8 (2.9)	-
Shook or roughly handle me	271 (98.9)	-	3 (1.1)	-

Table 4.12: Frequency and severity of threats and acts of physical violence after birth using the SVAW (continued)

Items	Responses n (%)			
	Never	Once	A few times	Often
Minor violence				
Scratched me	272 (99.3)	-	2 (0.7)	-
Pulled my hair	270 (98.5)	1 (0.4)	3 (1.1)	-
Twisted my arm	271 (98.9)	-	3 (1.1)	-
Spanked me	268 (97.8)	1 (0.4)	5 (1.8)	-
Bit me	272 (99.3)	-	1 (0.4)	1 (0.4)
Moderate violence				
Slapped me with the palm of his hand	269 (98.2)	1 (0.4)	4 (1.5)	-
Slapped me with the back of his hand	272 (99.3)	-	2 (0.7)	-
Slapped me around the face and head	269 (98.2)	1 (0.4)	4 (1.5)	-
Serious violence				
Hit me with an object	273 (99.6)	-	1 (0.4)	-
Punched me	272 (99.3)	-	2 (0.7)	-
Kicked me	272 (99.3)	-	2 (0.7)	-
Stomped on me	273 (99.6)	-	1 (0.4)	-
Choked me	271 (98.9)	1 (0.4)	2 (0.7)	-
Burned me with something	274 (100.0)	-	-	-
Used a club-like object on me	274 (100.0)		-	-
Beat me up	274 (100.0)		-	-
Used a knife or gun on me	273 (99.6)	-	1 (0.4)	-

Frequency and severity of sexual violence during pregnancy

Sexual violence was assessed using six items on the SVAW (as outlined in Table 4.13). The most commonly reported form of sexual violence experienced by women during their current pregnancy was "partner demanded sex" (18.3%). This occurred "once" (0.7%), "a few times" (11.6%) and "often" (5.9%). The item "partner made me have sexual intercourse against my will" was the second highest form of sexual violence reported by women (9.1% response rate: 1% - happened "once", 5.2% - "a few times", and 2.9% - "often"). Several women reported that their partners made them have anal sex against their will (0.7%, n = 3), used an object on them in a sexual way (0.4%, n = 2) or physically forced them to have sex (0.5%, n = 2).

Table 4.13: Frequency of sexual violence during pregnancy using the SVAW

Items	Responses n (%)			
	Never	Once	A few times	Often
Sexual violence				
Demanded sex	344 (81.7)	3 (0.7)	49 (11.6)	25 (5.9)
Made me have sexual intercourse against my will	383 (91.0)	4 (1.0)	22 (5.2)	12 (2.9)
Physically forced me to have sex	419 (99.5)	-	1 (0.2)	1 (0.2)
Forced me to have oral sex against my will	409 (97.1)	3 (0.7)	4 (1.0)	5 (1.2)
Made me have anal sex against my will	418 (99.3)	1 (0.2)	-	2 (0.5)
Used an object on me in a sexual way	419 (99.5)	-	1 (0.2)	1 (0.2)

Frequency and severity of sexual violence after birth

As shown in Table 4.14, the most common form of sexual violence occurring after birth related to the partner "demanded sex" (10.9%), followed by "partner made me have sexual intercourse against my will" (6.9%). The items partner "forced me to have oral sex against my will" and "physically forced me to have sex", were reported by 1.1% of women. None of the women reported that their partner "used an object on me in a sexual way".

Table 4.14: Frequency of sexual violence after birth using the SVAW

Items	Responses n (%)			
	Never	Once	A few times	Often
Sexual violence				
Demanded sex	244 (89.1)	4 (1.4)	26 (9.5)	-
Made me have sexual intercourse against my will	255 (93.1)	3 (1.1)	16 (5.8)	-
Physically forced me to have sex	271 (98.9)	-	3 (1.1)	-
Forced me to have oral sex against my will	271 (98.9)	-	3 (1.1)	-
Made me have anal sex against my will	272 (99.3)	-	2 (0.7)	-
Used an object on me in a sexual way	274 (100.0)	-	-	-

Overall prevalence of various forms of domestic violence during pregnancy and after birth

Psychological violence

The Psychological Maltreatment of Women Inventory (PMWI)-short form was used to determine the incidence of psychological abuse during pregnancy and after birth. The PMWI consists of 2 subscales: Emotional/verbal and dominance/isolation. Women were categorized into abused and non-abused groups (as outlined in Table 4.15). According to Tolman (n.d) psychological abuse was significant if women had a total score of more than 7, they were categorized as abused. If they had a total score of 7 or below they were categorized into the non-abused group. For overall psychological abuse, the abused group had a total psychological score of greater than 14 while the non-abused group had a total score of 14 or below. Table 4.15 presents the percentage of abused and non-abused women during pregnancy as well as the possible and actual score range, means, and standard deviations.

There were 46.1% of women (n = 194) who were exposed to psychological violence in the emotional/verbal subscale, and 35.6% (n = 150) in the dominance/isolation subscale with 53.7% of women (n = 226) exposed to overall psychological abuse during pregnancy.

Psychological abuse after birth was also investigated. Women were categorized into psychologically abused and non-abused groups using the same cut off scores as used during the pregnancy phase.

It can be seen from Table 4.16 that 25.2% of women (n = 69) were exposed to psychological violence in the emotional/verbal subscale, and 24.8% (n = 68) in the dominance/isolation subscale, with 35.4% of women (n = 97) exposed to overall psychological abuse after birth.

Physical violence

Women were also categorized into physically abused and non-abused groups. The abused group had a total physical score of more than 40 while the non-abused group had the score of 40 or below. There were 26.6% of women (n = 112) who were exposed to physical abuse at least once during pregnancy. A similar cut-off point was also used to categorize women into physically abused and non-abused groups after birth. Table 4.16 presents the percentage, means, standard deviations of violence scores after birth. It can be seen that almost ten percent of women (n = 26 out of 274, 9.5%) reported some form of physical violence following childbirth.

In relation to target sites of injuries, the present study found that during pregnancy most women reported arms and hands were the most targeted sites of injury (n = 40, 9.5%), followed by face and body (n = 25, 5.9%). Abused women also reported being hit around the shoulders (n = 16, 3.8%), head (n = 15, 3.6%), buttock area (n = 8, 1.9%) and neck (n = 5, 1.2%). Participating women did not report the stomach as a target site. Following childbirth, abused women reported the face (n = 14, 5.1%) as the most affected site of injuries followed by arms and hands (n = 13, 4.8%) and body (n = 12, 4.4%). Women also reported the shoulder (n = 9, 3.3%), buttock area (n = 6, 2.2%), head (n = 4, 1.5%) and neck (n = 3, 1.1%).

Sexual violence

Women were categorized into sexually abused and non-abused groups. The total score of sexual violence ranged from 6-18. The sexually abused group had a total score of more than 6 while the non-abused group had a score of 6 or less. As can be seen in Table 4.15, the abused group represented 19.2% of the sample (n = 81) whereas the non-abused group represented 80.8% (n = 340) of women. One out of five women (n = 81 out of 421) were exposed to some form of sexual violence at least once during pregnancy.

Women were also categorized into sexually abused and non-abused groups after birth using the same scores as during pregnancy. Table 4.16 outlines the percentages, the possible and actual score range, means, and standard deviation of sexual abuse after

birth. The majority of women (n = 243, 88.7%) did not identify any form of sexual violence after birth, however over ten percent (n = 31, 11.3%) of women experienced some form of sexual violence following childbirth.

Table 4.15: Violence scores on the PMWI and SVAW during pregnancy

Scales/Subscales	Possible score range	Abused n (%)	Non-abused n (%)	$\bar{x}$	SD	Actual score range
PMWI						
Emotional/verbal	7-35	194 (46.1)	227 (53.9)	9.10	3.56	7-32
Dominance/isolation	7-35	150 (35.6)	271 (64.4)	8.25	2.37	7-22
Total psychological abuse score	**14-70**	**226 (53.7)**	**195 (46.3)**	**17.35**	**5.19**	**14-54**
SVAW						
Threats dimension	19-76	111 (26.4)	310 (73.6)	20.89	5.59	19-65
Symbolic acts	4-16	95 (22.6)	326 (77.4)	4.81	1.97	4-16
Threats of mild violence	4-16	46 (10.9)	375 (89.1)	4.47	1.65	4-16
Threats of moderate violence	4-16	22 (5.2)	399 (94.8)	4.20	1.07	4-13
Threats of serious violence	7-28	37 (8.8)	384 (91.2)	7.41	1.87	7-25
Violence dimension	21-84	31 (7.4)	390 (92.6)	21.69	3.72	21-62
Mild violence	4-16	26 (6.2)	395 (93.8)	4.26	1.25	4-15
Minor violence	5-20	21 (5)	400 (95.0)	5.23	1.19	5-15
Moderate violence	3-12	12 (2.9)	409 (97.1)	3.12	0.82	3-12
Serious violence	9-32	8 (1.9)	413 (98.1)	9.09	0.96	9-24
Total physical abuse score	**40-160**	**112 (26.6)**	**309 (73.4)**	**40.00**	**8.67**	**40-127**
Sexual violence	6-24	81 (19.2)	340 (80.8)	6.72	1.73	6-18
Total SVAW abuse score	**46-184**	**149 (35.4)**	**272 (64.6)**	**49.30**	**9.33**	**46-141**

Table 4.16: Violence scores on the PMWI and SVAW after birth

Scales/Subscales	Possible score range	Abused n (%)	Non-abused n (%)	$\bar{x}$	SD	Actual range
PMWI						
Emotional/verbal	7-35	69 (25.2)	205 (74.8)	8.31	3.01	7-29
Dominance/isolation	7-35	68 (24.8)	206 (75.2)	8.18	2.64	7-25
Total psychological score	**14-70**	**97 (35.4)**	**177 (64.6)**	**16.48**	**4.94**	**14-48**
SVAW						
Threats dimension	19-76	23 (8.4)	251 (91.6)	19.64	3.47	19-58
Symbolic acts	4-16	18 (6.6)	256 (93.4)	4.23	1.12	4-15
Threats of mild violence	4-16	11 (4.0)	263 (96.0)	4.19	1.11	4-14
Threats of moderate violence	4-16	5 (1.9)	269 (98.1)	4.08	0.67	4-12
Threats of serious violence	7-28	7 (2.6)	267 (97.4)	7.14	1.16	7-22
Violence dimension	21-84	13 (4.7)	261 (95.3)	21.42	2.87	21-55
Mild violence	4-16	12 (4.4)	262 (95.6)	4.15	0.83	4-12
Minor violence	5-20	7 (2.6)	267 (97.4)	5.12	0.88	5-15
Moderate violence	3-12	5 (1.9)	269 (98.1)	3.08	0.62	3-9
Serious violence	9-32	3 (1.1)	271 (98.9)	9.07	0.77	9-19
Total physical abuse score	**40-160**	**26 (9.5)**	**248 (90.5)**	**41.06**	**6.12**	**40-113**
Sexual violence	6-24	31 (11.3)	243 (88.7)	6.39	1.26	6-14
Total SVAW abuse score	**46-184**	**48 (17.5)**	**226 (82.5)**	**47.45**	**6.60**	**46-119**

The SVAW scale frequencies for different types of physical and sexual abuse during pregnancy and after birth by current partners are presented in Figure 4.1. It can be seen that violence decreased in the immediate period after birth. The proportion of women exposed to the different types of violence according to the SVAW at some time (once or more) during the current pregnancy are presented as: symbolic violence (n = 95, 22.6%), threats of mild violence (n = 46, 10.9%), threats of moderate violence (n = 22, 5.2%), threats of serious violence (n = 37, 8.8%), mild violence (n = 26, 6.2%), minor violence (n = 21, 5.2%), moderate violence (n = 12, 2.9%), serious violence (n = 8, 1.9%), and sexual violence (n = 81, 19.2%).

In contrast to abuse during pregnancy, lower proportions of women were exposed to the following categories of violence according to the SVAW at least one or more times after birth and are as follows: - symbolic violence (n = 18, 6.6%), threats of mild violence (n = 11, 4%), threats of moderate violence (n = 5, 1.9%), threats of serious violence (n = 7, 2.6%), mild violence (n = 12, 4.4%), minor violence (n = 7,

2.6%), moderate violence (n = 5, 1.9%), serious violence (n = 3, 1.1%), and sexual violence (n = 31, 11.3%).

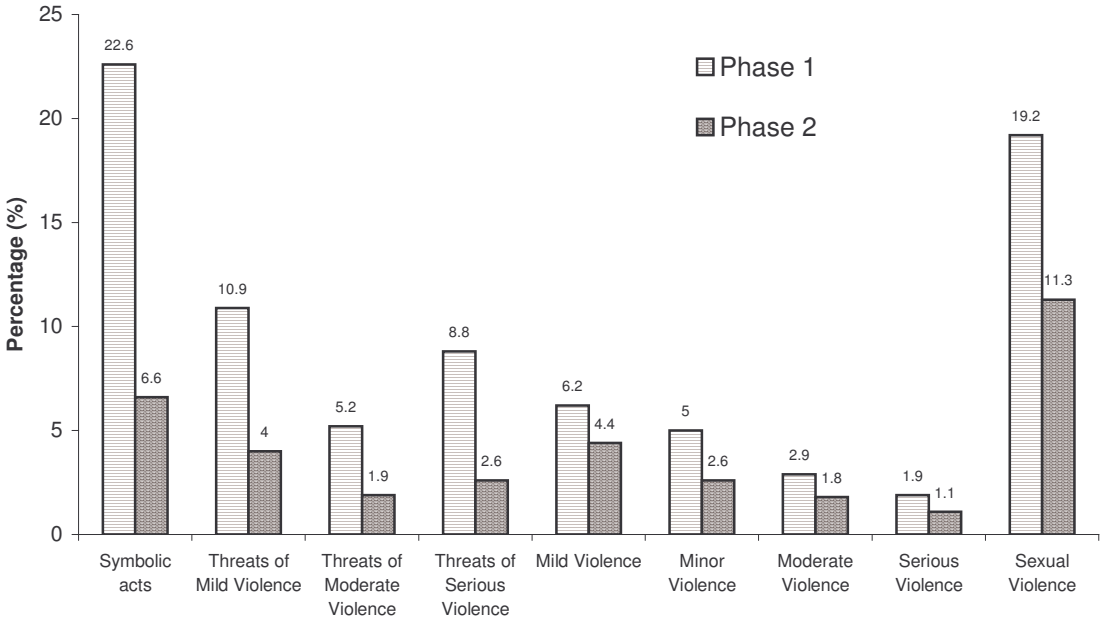

Figure 4.1: Comparison of frequencies of different types of violence according to subscales of the SVAW during pregnancy and after birth

Types of domestic violence

The following section is a summary of overall prevalence of domestic violence for each type of violence. Figure 4.2 presents overall proportions of women who had been abused (according to the three main types of violence: psychological, physical and sexual violence). During pregnancy the majority of women had been exposed, at least once or more, to psychological abuse (53.7%), followed by physical abuse (26.6%) and sexual abuse (19.2%). Similarly, the majority of women had experienced psychological abuse after birth (35.4%) once or more often. Sexual violence (11.3%) was slightly higher after birth than physical abuse (9.5%).

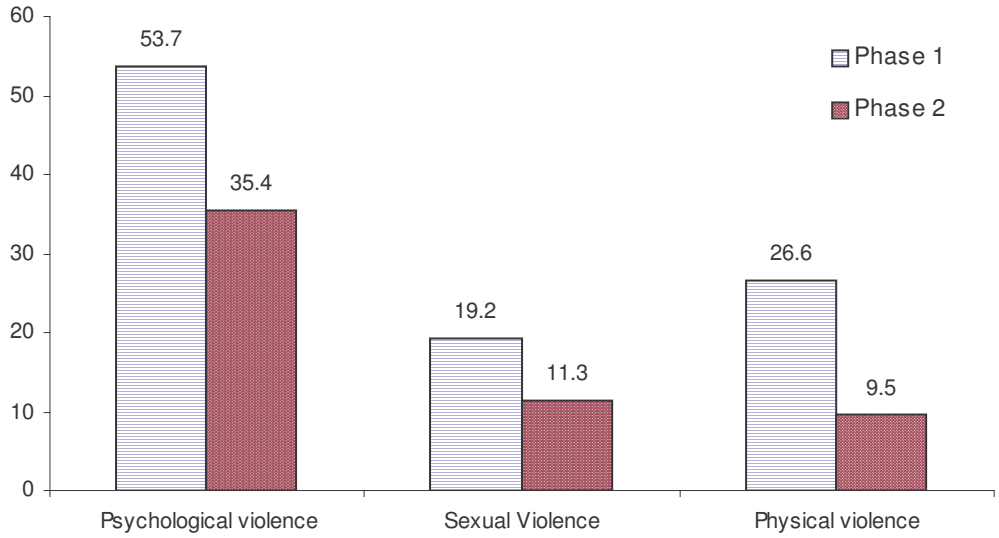

Figure 4.2: Comparison of types of domestic violence during pregnancy and after birth

Prevalence of types of domestic violence

During pregnancy (Phase 1)

More than half of the women (n = 251, 59.6%) experienced some form of abuse at least once during their current pregnancy. Figure 4.3 shows the percentage and number of women who experienced different types of domestic violence. As illustrated in Figure 4.3, 10.2% (n = 43) of women experienced all three types of abuse, 13.8% (n = 58) experienced both physical and psychological abuse, 5.5% (n = 23) experienced both sexual and psychological abuse, 2.4% (n = 10) experienced only physical abuse, 3.3% (n = 14) experienced only sexual abuse, and 24.2% (n = 102) experienced psychological abuse only.

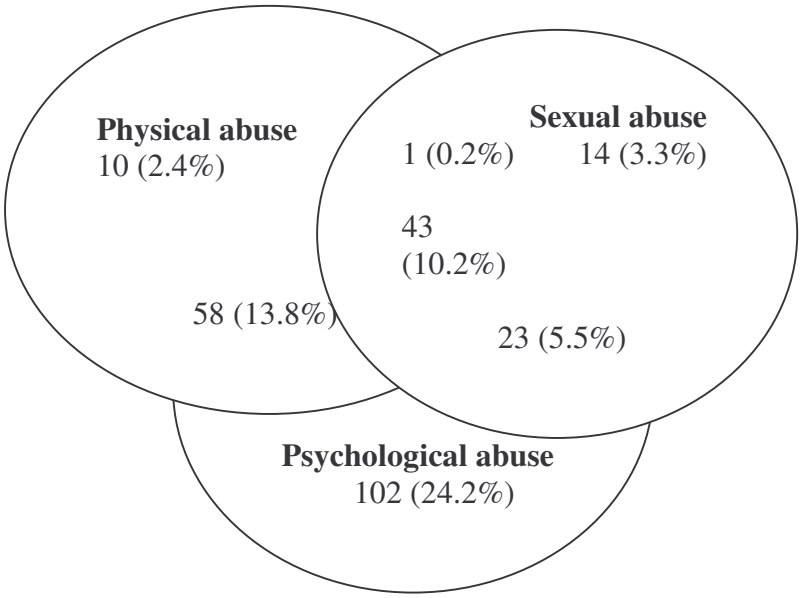

Figure 4.3: Overlap of types of domestic violence during pregnancy

After birth (Phase 2)

Figure 4.4 presents the prevalence of types of domestic violence in Phase 2. Over thirty percent of women (n = 107, 39.1%) were exposed to some form of domestic violence in the six-week period following childbirth. Over three percent of women (n = 9, 3.3%) had experienced all three forms of abuse while a slightly higher proportion experienced both physical and psychological abuse (n = 15, 5.5%), and both sexual and psychological abuse (n = 14, 5.1%). The percentage of women experiencing only sexual abuse was 2.9% (n = 8), and only psychological abuse was 21.5% (n = 59). Two women experienced only physical abuse while no women were exposed to both physical and sexual abuse in Phase 2.

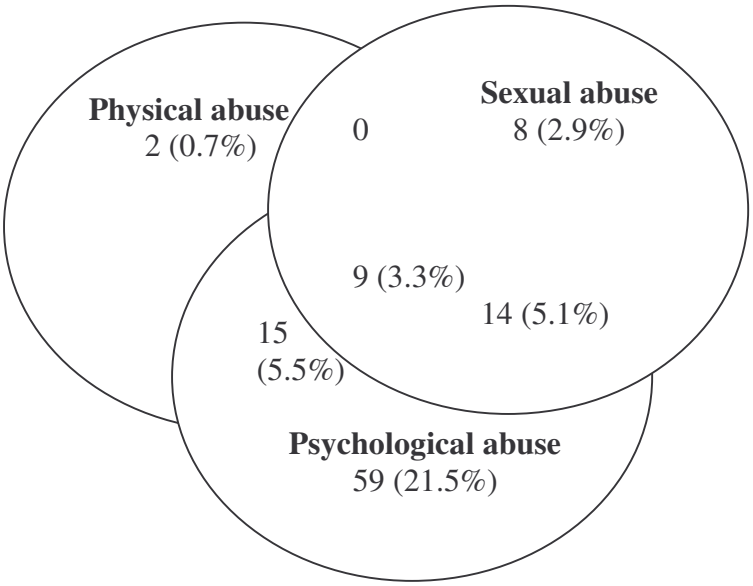

Figure 4.4: Overlap of types of domestic violence after birth

Associations between Women's Demographic Characteristics and Domestic Violence

To determine factors associated with domestic violence analysis was undertaken using independent t-tests, Chi-square tests, One Way Analysis of Variance (ANOVA) and multiple regression. Post-hoc analysis was conducted where appropriate to determine group differences. Demographic characteristics of women included age, marital status, education, occupation, monthly income, length of marriage, number of marriage, parity, type of family, possession of health care card, family debt and negative behaviours, such as, smoking, drinking alcohol, using illicit drugs and gambling.

Age

Younger women were more likely to experience psychological abuse according to the PMWI ($\bar{x}$ = 25.2 years, SD = 5.12 for abused women; $\bar{x}$ = 26.9 years, SD = 5.34 for non-abused women). They were also more likely to experience physical abuse according to the SVAW than older women ($\bar{x}$ = 24.3 years, SD = 4.18 for abused women; $\bar{x}$ = 26.6 years, SD = 5.51 for non-abused women). Sexual violence was

also likely to be reported among younger women ($\bar{x}$ = 25.3 years, SD = 5.48). There was a statistically significant association between women's age and psychological abuse (t (419) = 3.30, p<.005) and physical abuse (t (258) = 4.55, p<.001) but not between age and sexual abuse.

Marital status

Women who were married without marriage certificates (n = 120, 53.1%) were more likely to report psychological abuse than those married with certificates (n = 88, 38.9%) ($\chi^2(4) = 9.37$, p<.05). Relatively few women in a de facto relationship (n = 15, 6.6%) or separated (n = 3, 1.3%) reported experiencing psychological abuse. Similar rates of physical and sexual abuse were observed for all marital status categories. There was a significant association between marital status and physical abuse ($\chi^2(4) = 14.17$, p<.05). However, there was no significant association between marital status and sexual abuse.

ANOVA was used to compare the means of domestic violence scores among women in different marital status groups categorized as married with certificate, married without certificate, separated and de facto. The analysis revealed that the response scores of women who were physically and psychologically abused in each marital status category were significantly different (F (3, 417) = 13, p < .001). Post hoc analysis using Tukey HSD found that separated women ($\bar{x}$ = 71.7) scored significantly higher on physical violence items than women who were married with a certificate ($\bar{x}$ = 42.5), married without a certificate ($\bar{x}$ = 42.1) and de facto ($\bar{x}$ = 44.7).

The scores of psychological violence were also significantly different between women according to their marital status (F (3, 417) = 8.5, p < .001). Post hoc analysis revealed that separated women ($\bar{x}$ = 29.7) scored significantly higher on psychological violence than women who were married with a certificate ($\bar{x}$ = 17), married without a certificate ($\bar{x}$ = 17) and de facto ($\bar{x}$ = 19). There was no significant different between sexual violence scores and each marital status category.

Monthly income

Psychological violence was higher among women who had no monthly income (n = 92, 40.7%) and those with incomes between 1,000-5,000 Baht. Women with higher incomes reported less psychological violence. Scores for physical (n = 46, 41.1%) and sexual violence (n = 33, 40.7%), on the other hand, were slightly higher among women with incomes between 1,000 - 5,000 Baht closely followed by women with no income (for physical n = 45, 40.2%, and sexual violence n = 33, 40.7%). Relatively small proportions of women with higher incomes reported violence. There was a significant statistical difference between income and psychological abuse ($\chi^2(4) = 9.08$, $p<.05$) in that women with low incomes were more likely to report psychological abuse. However, this study found no association between monthly income and physical and sexual violence.

Length of relationship

Length of relationship was also investigated as a factor influencing domestic violence. Women who were in a shorter relationship were more likely to experience domestic violence (psychological violence $\bar{x}$ = 4.6 years, SD = 3.80; physical violence $\bar{x}$ = 4.3 years, SD = 3.65; sexual violence $\bar{x}$ = 4.4 years, SD = 3.62) than women in a longer relationship (psychological $\bar{x}$ = 5.3 years, SD = 4.09; physical $\bar{x}$ = 5.2 years, SD = 4.03; sexual $\bar{x}$ = 5.1 years, SD = 4.01). Independent samples t-test revealed a statistically significant difference between length of relationship (numbers of years in relationship) and physical violence (abuse and non-abused groups) ($t(419) = 1.98$, $p<.05$). Women in shorter relationships were more likely to report physical violence. However, there was no significant difference between length of relationship and psychological or sexual violence.

Past abuse

The relationship between abuse before pregnancy, during pregnancy and after birth was investigated. There was a consistent association between abuse before pregnancy and during pregnancy ($\chi^2(2) = 10.15$, $p<.005$) but not after birth. When comparing abuse during pregnancy and after birth, it was also found that women who

experienced abuse during pregnancy were more likely to experience abuse after birth ($\chi^2(2) = 13.22$, $p<.001$).

Drinking habits

As shown in Table 4.17, only a small number of women drank alcohol and there were low numbers of participants reporting psychological (n = 15, 6.6%), physical (n = 11, 9.8%), and sexual (n = 5, 6.2%) abuse. An adjustment was therefore made to collapse women's responses into drinking and non-drinking groups due to a violation of statistical assumptions, and found that there was a significant difference between alcohol drinking habits and physical abuse ($\chi^2(2) = 5.61$, $p<.05$). However, there was no significant association between alcohol use and psychological and sexual abuse.

An analysis of variance on the reported scores of domestic violence in relation to groupings for alcohol use revealed a significant difference between women who drank alcohol and those who did not ($F(2, 419) = 9.1$, $p < .001$). Post-hoc Turkey HSD showed that women who drank occasionally ($\overline{X} = 24$) scored significantly higher on psychological violence than women who did not drink ($\overline{X} = 17$) or rarely drank alcohol ($\overline{X} = 18.2$). No significant difference was found between drinking habits and scores on physical and sexual violence of women.

Other factors

There were no statistically significant associations between education level, occupation, type of family, level of debt, possession and type of health care card, gambling habits and any type of domestic violence. The relationships between smoking and illicit drug use and violence were unable to be determined in this study due to a small number of women who reported cigarette or illicit drug use.

Table 4.17: Percentage of negative health behaviours of women and different types of abuse

Negative behaviours	Types of abuse Psychological abuse n (%)		Physical abuse n (%)		Sexual abuse n (%)	
Smoking	Yes	No	Yes	No	Yes	No
Yes	5 (2.2)	-	2 (1.8)	3 (1.0)	1 (1.2)	4 (1.2)
No	221 (97.8)	195 (100)	110 (98.2)	306 (99.0)	80 (98.8)	336 (98.8)
Drinking						
Yes	15 (6.6)	8 (4.1)	11 (9.8)	12 (3.9)	5 (6.2)	18 (5.3)
No	211 (93.4)	187 (95.9)	101 (90.2)	297 (96.1)	76 (93.8)	322 (94.7)
Illicit drug use						
Yes	-	-	-	-	-	-
No	226 (53.7)	195 (46.3)	112 (26.6)	309 (73.4)	81 (19.2)	340 (80.8)
Gambling						
Yes	24 (10.6)	12 (6.2)	9 (8.0)	27 (8.7)	7 (8.6)	29 (8.5)
No	202 (89.4)	183 (93.8)	103 (92.0)	282 (91.3)	74 (91.4)	311 (91.5)

Associations between Partner Characteristics and Domestic Violence

Further analysis using independent t-tests for continuous variables and Chi-square analysis for nominal demographic variables was also conducted to test associations between demographic characteristics of partners and domestic violence.

Partner's age

Women, whose partners were younger than the rest of the sample, were more likely to be abused in all three forms of violence ($\bar{x}$ = 28.4 years SD = 5.86 and $\bar{x}$ = 30.4 years SD = 6.04 for psychological abuse and non-abuse, respectively; $\bar{x}$ = 27.6 years SD = 5.38 and $\bar{x}$ = 30 years SD = 6.29 for physical abuse and non-abuse, respectively; $\bar{x}$ = 28.5 years SD = 5.87 and $\bar{x}$ = 29.5 years SD = 6.19 for sexual abuse and non-abuse, respectively). Independent t-tests revealed a statistical relationship between age of partner and psychological ($t(419) = 3.28$, $p < .005$) and physical abuse ($t(419) = 3.5$, $p < .005$) (grouped as abuse and non-abused groups). However, there was no significant relationship between a partner's age and sexual violence.

Smoking habits

Women whose partners were cigarette smokers were more likely to report psychological abuse (n = 161, 71.2%), physical abuse (n = 86, 76.8%), and sexual abuse (n = 56, 69.1%) than women whose partners did not use cigarettes. There was a statistically significant association between partner's smoking and psychological abuse ($\chi^2(2) = 21.32$, $p<.05$), and physical abuse ($\chi^2(2) = 15.90$, $p<.05$). However, a partner's smoking was not significantly associated with sexual abuse.

Drinking habits

Women whose partners occasionally drank alcohol were more likely to report psychological abuse (n = 103, 45.6%). These women were also more likely to report physical (n = 46, 41.1%) and sexual (n = 37, 45.7%) abuse. A statistically significant relationship was found between partner's drinking and psychological abuse ($\chi^2(4) = 11.77$, $p<.05$), and physical abuse ($\chi^2(4) = 25.64$, $p<.05$) but not sexual abuse.

An analysis of variance on the reported scores of domestic violence in relation to alcohol use by partners revealed a significant difference between women whose partners drank alcohol and whose did not ($F(3, 417) = 6.7$, $p <.001$). Post-hoc comparisons using the Tukey HSD test indicated that the mean scores of physical violence for women whose partner drank alcohol frequently ($\bar{X}$ = 48.9) were significantly higher than women whose partner did not drink ($\bar{X}$ = 41.7), rarely drank ($\bar{X}$ = 42.4) and drank alcohol occasionally ($\bar{X}$ = 42). Women whose partners drank frequently also scored higher on psychological violence scale ($F(3, 417) = 5.1$, $p = 0.002$). No significant difference was found between sexual violence scores and drinking habits of partners.

Other factors

There were no statistically significant associations between partner's education level, occupation, monthly income, gambling habits and domestic violence. The relationship between illicit drug use and domestic violence could not be analysed further in this study due to small numbers.

Domestic Violence and Health Outcomes

Maternal outcomes

The SF-12 health survey was administered to women during pregnancy (Phase 1) and at 6 weeks postpartum (Phase 2). A Repeated Measure ANOVA using the General Linear Model Program was used to detect differences in mean scores of each subscale between Phase 1 and Phase 2. Table 4.18 presents means, standard deviations of the eight subscales of the SF-12 for Phase 1 and 2 compared to the 1998 general U.S. population norms (Ware et al., 2002) as no Thai or Asian data are available for comparison.

The first subscale of the SF-12 measured in this study was "general health functioning". The mean general health functioning score of all women during pregnancy ($\bar{X}$ = 48.54, SD = 19.65) was better than women after birth ($\bar{X}$ = 44.07, SD = 17.75) (as shown in Table 4.18). It can be concluded that overall general health of women had declined significantly after birth ($F(1, 273) = 10.98$, $p<.005$). There was also a much lower mean score of general health of women in the study sample during both phases compared with general U.S. population norms ($\bar{X}$ = 72.20, SD = 23.19).

The second subscale of the SF-12 was "physical functioning". The mean score of physical functioning for women during pregnancy was 68.43 (SD = 21.98), which is slightly lower than the U.S. population norm of 81.18 (SD = 29.11). After birth the mean was 86.50 (SD = 19.73) which was similar to the population norm (Ware, 2000). In the present study, women's physical functioning improved significantly after childbirth ($F(1, 273) = 111.31$, $p<.001$).

The third subscale of SF-12 was "role physical". Similar to physical functioning, the mean score of role physical for women during pregnancy was 65.10 (SD = 22.86) and 78.42 (SD = 20.19) after birth. This is slightly lower than the U.S. population norm ($\bar{X}$ = 80.53, SD = 27.14). Comparing the mean scores, it was found that

women's role physical had improved significantly between the two phases with better functioning after birth (F (1, 273) = 68.58, p<.001).

The fourth subscale of the SF-12 explored in this study was "role emotional". At 6 weeks postpartum, the mean role emotional score increased significantly from 78.33 (SD = 21.97) to 92.70 (SD = 15.33) (F (1, 273) = 103.54, p<.001) indicating better emotional health after birth. This increased mean score is slightly higher than the U.S. population norm ($\bar{X}$ = 86.41, SD = 22.36).

"Bodily pain" was another subscale of the SF-12 measured in this study. In contrast to general health, the mean bodily pain score for women after birth ($\bar{X}$ = 75.64, SD = 22.69) was higher than the mean score during pregnancy ($\bar{X}$ = 68.43, SD = 22.09). Compared to the U.S. population norm ($\bar{X}$ = 81.74, SD = 24.53), women in both phases had lower mean scores of bodily pain. After birth, women in the present study had less bodily pain than during pregnancy (F (1, 273) = 17.56, p<.001).

"Vitality" was also measured in this study. The mean vitality score for women during pregnancy was 43.52 (SD = 23.86) and 57.76 (SD = 19.65) at 6 weeks after birth, which is similar to the U.S. population norm of 55.59 (SD = 24.84). After birth women's vitality significantly improved (F (1, 273) = 66.4, p<.001).

The next subscale was "mental health". The mean score of women's mental health had improved significantly from 67.61 (SD = 18.03) in pregnancy to 77.01 (SD = 11.65), (F(1, 273) = 62.81, p<.001) at 6 weeks postpartum. The mean mental health score of the U.S. population norm ($\bar{X}$ = 70.18, SD = 20.51) was slightly higher than the mean score of the study sample in pregnancy, but lower than after birth.

The last subscale of the SF-12 measured in this study was "social functioning". The mean social functioning score for women in Phase 1 ($\bar{X}$ = 80.20, SD = 23.79) was lower than the mean score for women in Phase 2 ($\bar{X}$ = 86.59, SD = 20.86). The mean social functioning score for women in pregnancy was also lower than that for

the U.S. population norm ($\bar{x}$ = 83.74, SD = 24.76). Reported social functioning increased remarkably at 6 weeks after birth (F (1, 273) = 13.63, p<.001).

Overall, there were statistically significant differences in all subscales of the SF-12 between Phase 1 and Phase 2 as illustrated in Figure 4.5.

Table 4.18: Comparison of SF-12 during pregnancy and after birth of the sample

Scales/Subscales	During pregnancy		After birth		Partial Eta Squared	Observed Power	F-value	U.S. Population norms	
	$\bar{x}$	SD	$\bar{x}$	SD				$\bar{x}$	SD
SF12									
General health	48.54	19.65	44.07	17.75	.039	.910	10.98*	72.20	23.19
Physical functioning	68.43	21.98	86.50	19.73	.290	1.000	111.3*	81.18	29.11
Role physical	65.10	22.86	78.42	20.19	.201	1.000	68.58*	80.53	27.14
Role emotional	78.33	21.97	92.70	15.33	.275	1.000	103.54*	86.41	22.36
Bodily pain	68.43	22.09	75.64	22.69	.060	.987	17.56*	81.74	24.53
Vitality	43.52	23.86	57.76	19.65	.196	1.000	66.40*	55.59	24.84
Mental health	67.61	18.03	77.01	11.65	.187	1.000	62.81*	70.18	20.51
Social functioning	80.20	23.79	86.59	20.86	.048	.957	13.63*	83.74	24.76

1998 General U.S. Population Norm based Data (Ware et al., 2002)

*P< .001

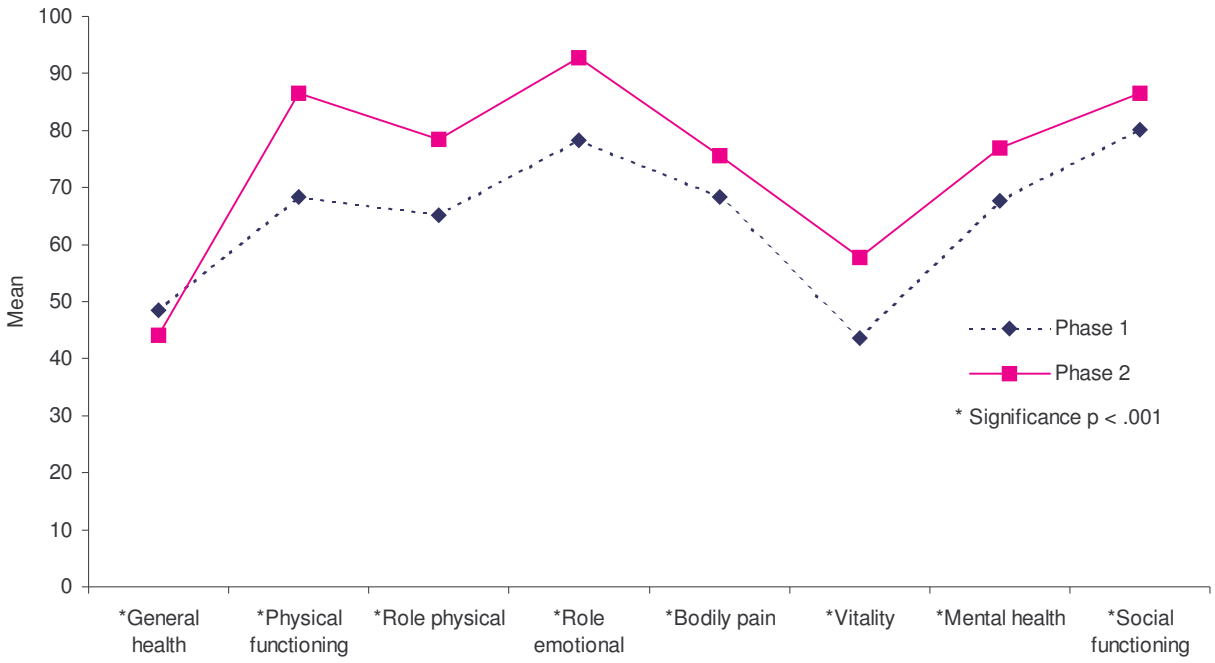

Figure 4.5: Comparison of subscales of SF-12 during pregnancy and after birth

Comparison of SF-12 and abuse during pregnancy

Independent t-tests were used to examine the relationship between the SF-12 and abused and non-abused women. Given that 8 separate independent t-tests were undertaken, alpha levels were set at .006 (.05/8 = .006) as determined by a Bonferroni Adjustment to control for possible Type I error (Pallant, 2005).

Figure 4.6 presents the comparison of mean scores of each subscale of SF-12 between abused and non-abused women in any type of violence. It can be seen that abused women had significantly lower mean scores than non-abused women in role emotional functioning ($t(419) = 3.87$, $p = .001$), bodily pain ($t(419) = 4.64$, $p = .001$), vitality ($t(419) = 3.21$, $p = .001$), and mental health ($t(419) = 3.98$, $p = .001$). There were no significant differences in the remaining subscales

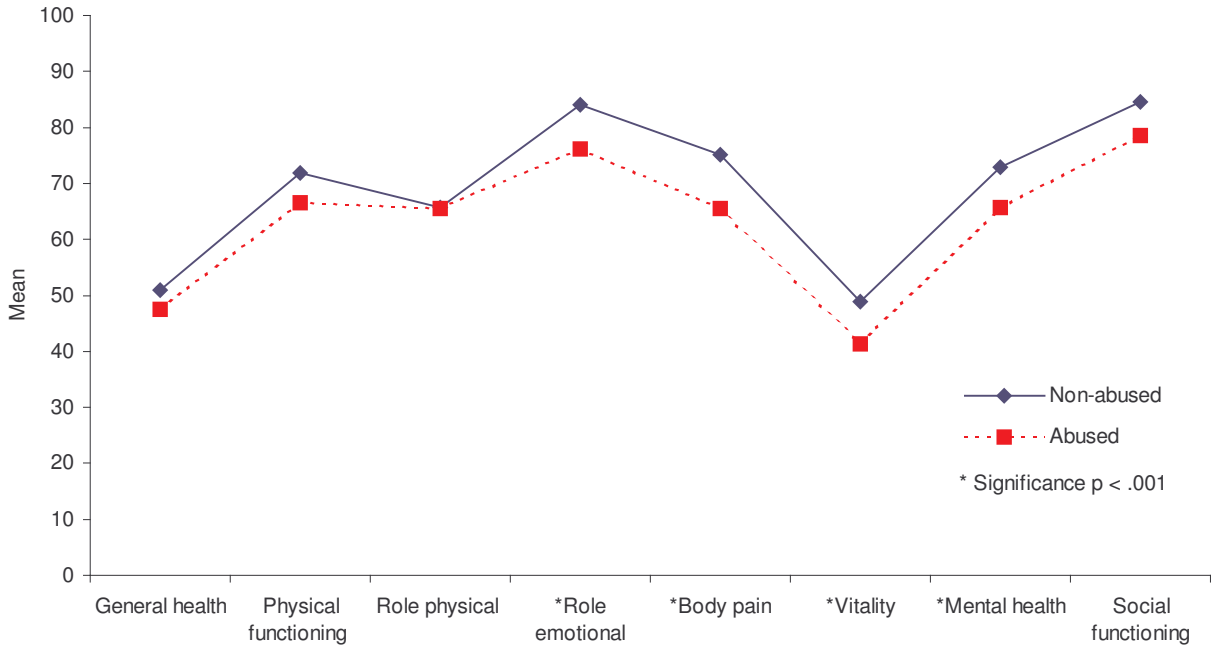

Figure 4.6: Comparison of mean scores of each subscale of SF-12 between abused and non-abused pregnant women in any type of violence

Table 4.19 presents means and standard deviations of the SF-12 in Phase 1 for women who were abused and non-abused in all three forms of violence in Phase 1. From Table 4.19, it can be seen that abused women had lower mean scores in all scales of the SF-12, except for role physical functioning where women who were abused psychologically had higher mean scores than non-abused women (Figure 4.7). Role emotional functioning was significantly lower for women who were abused in all three forms of violence compared to non-abused women (psychological abuse - t (419) = 3.82, p <.001, physical - t (419) = 4.2, p<.001, sexual - t (419) = 5.39, <.001). Similarly, mental health was significantly lower for women who reported all three forms of violence compared to non-abused women (psychological abuse - t (418.76) = 4.87, p <.001, physical - t (164.2) = 4.61, p<.001, sexual – t (106.86) = 3.13, <.005).

Social functioning was significantly lower for women who were abused physically (t (419) = 3.94, p <.001) (Figure 4.8) and sexually (t (419) = 4.09, p <.001) (Figure 4.9). Although the mean score of social functioning for psychologically abused

women was lower than non-abused women, there was, however, no statistically significant difference.

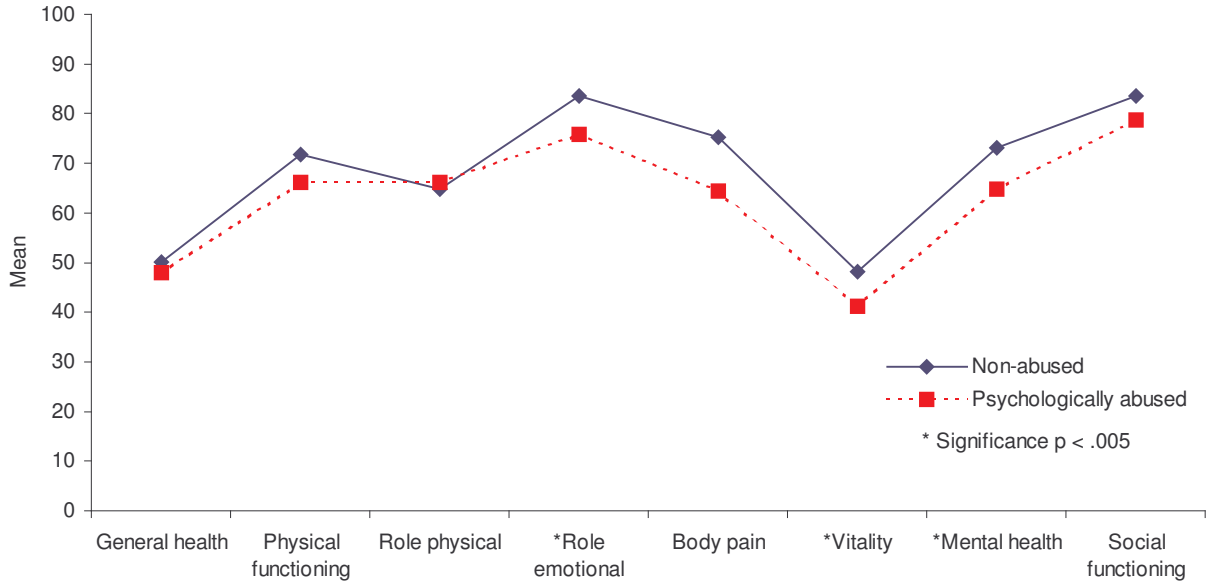

Figure 4.7: Comparison of subscale means of SF-12 between psychologically abused and non-abused women during pregnancy

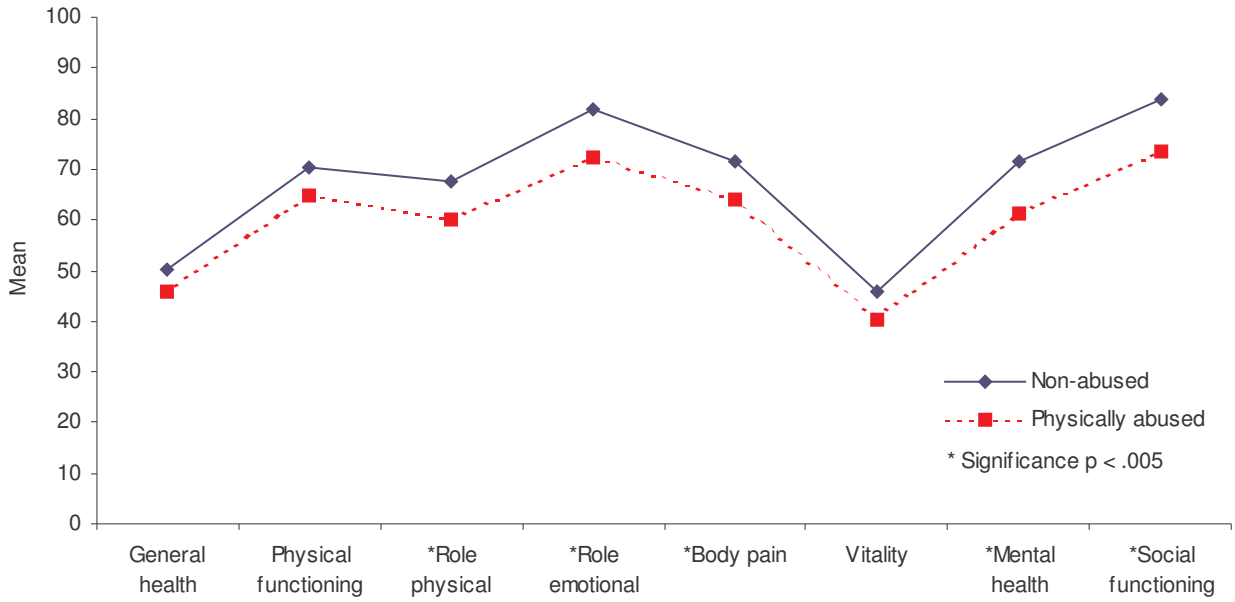

Figure 4.8: Comparison of subscale means of SF-12 between physically abused and non-abused women during pregnancy

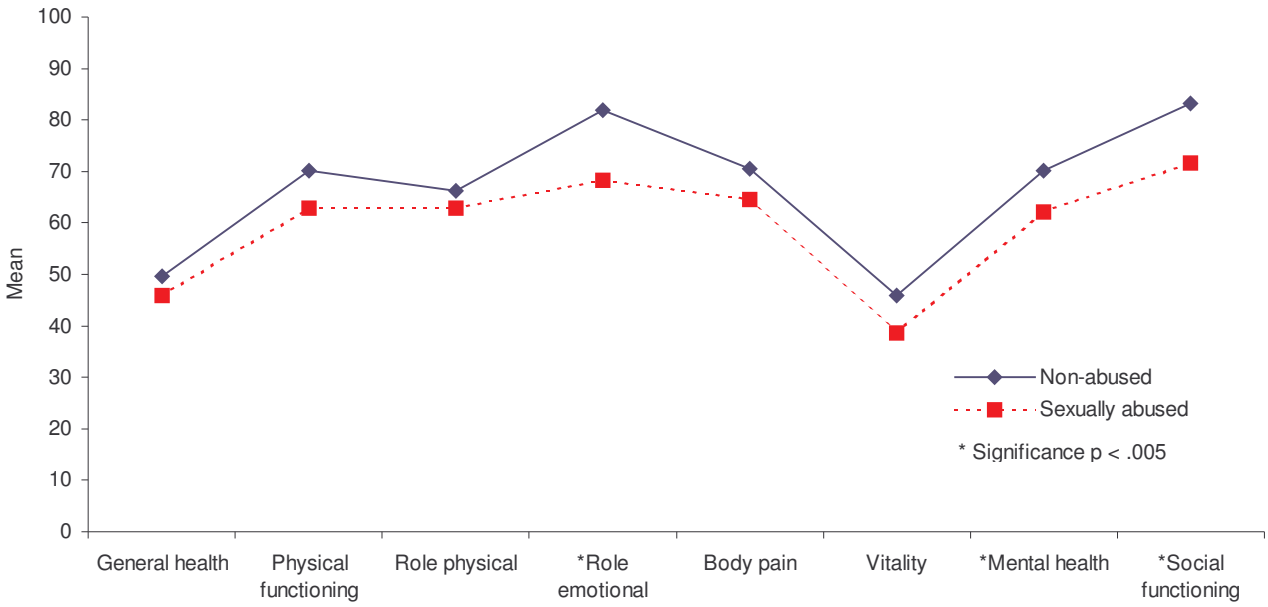

Figure 4.9: Comparison of subscale means of SF-12 between sexually abused and non-abused women during pregnancy

Vitality was significantly lower for women who were abused psychologically (t (419) = 3.01, p = .003) but not physically (t (419) = 2.05, p = .041) or sexually (t (419) = 2.43, p = .016).

Similarly, role physical functioning was found to be significantly lower for women who experienced physical violence (t (419) = 2.80, p = .005) than women who were not. However, role physical functioning scores were not statistically different between women who were abused either psychologically or sexually and women who were not.

Not surprisingly, abused women had lower mean bodily pain scores than non-abused women. It can be concluded that physically abused women had significantly higher bodily pain than non-abused women (t (419) = 3.26, p = .001). However, there was no statistical difference in scores for bodily pain by women who experienced other forms of abuse. In relation to physical functioning, there was also no statistical difference in physical functioning mean scores between abused and non-abused women and any form of violence.

Table 4.19: SF-12 for women during pregnancy

SF-12 scales		Psychological abuse		Physical abuse		Sexual abuse	
		$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
General health	Non abuse	50.15	18.90	50.11	19.00	49.69	19.01
	Abuse	47.92	19.45	45.76	19.48	45.86	19.81
Physical functioning	Non abuse	71.79	20.29	70.23	21.40	70.15	21.78
	Abuse	66.15	22.83	64.73	22.65	62.96	21.33
Role physical functioning	Non abuse	64.87	23.64	67.44	23.01	66.14	23.79
	Abuse	66.10	23.16	**60.27	23.62	62.96	21.42
Role emotional functioning	Non abuse	**83.53	20.23	81.92	20.52	81.99	20.27
	Abuse	75.77	21.23	**72.32	21.19	**68.36	21.11
Body pain	Non abuse	75.26	20.31	71.44	21.21	70.59	21.36
	Abuse	64.38	21.03	**63.84	20.91	64.51	20.87
Vitality	Non abuse	48.21	25.32	45.87	24.37	45.81	24.50
	Abuse	**41.15	22.83	40.40	23.55	38.58	22.38
Mental health	Non abuse	73.21	16.35	71.36	16.73	70.18	17.48
	Abuse	**64.71	19.42	**61.16	21.11	*62.19	21.38
Social functioning	Non abuse	83.59	23.81	83.66	22.52	83.24	22.44
	Abuse	78.76	22.91	**73.66	24.39	**71.61	25.23

*p<.05
**p<.001

Comparison of SF-12 and abuse after birth

The same statistical procedures were used to test relationships between the SF-12 subscale scores and abused and non-abused women in Phase 2.

A comparison of mean scores of each subscale of SF-12 between abused and non-abused women in any type of violence in Phase 2 can be seen in Figure 4.10. Women who experienced abuse after birth reported significantly lower mean scores than non-abused women in two subscales; social functioning ($t(194.5) = 2.98$, $p = .003$), and mental health ($t(272) = 3.13$, $p = .002$). There were no significant differences in any other subscale.

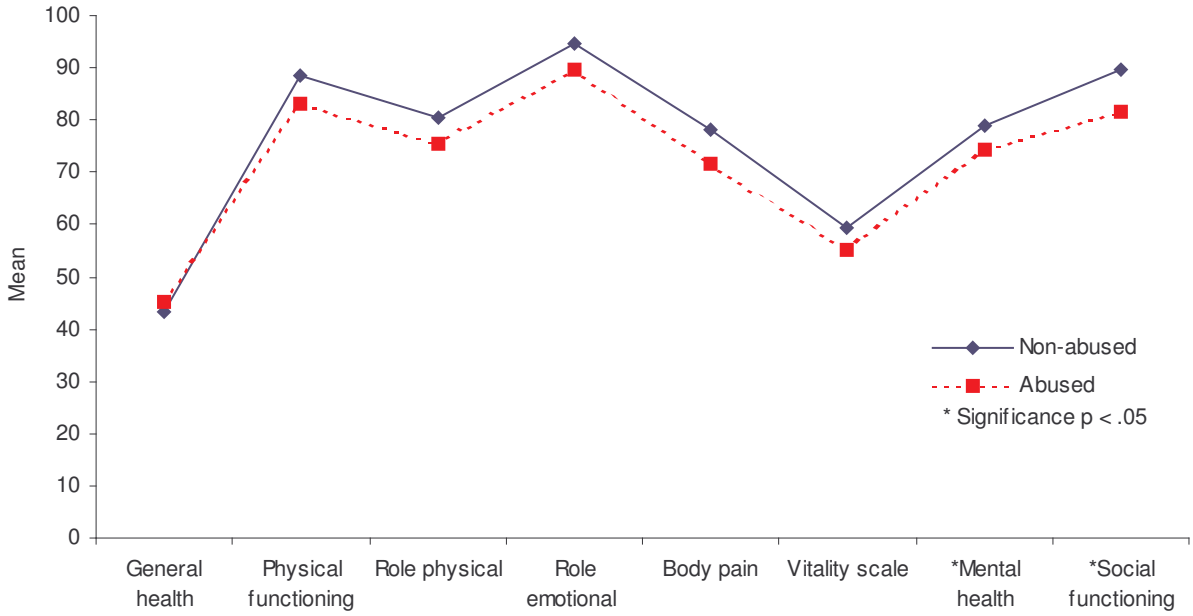

Figure 4.10: Comparison of mean scores of each subscale of SF-12 between abused and non-abused women in any type of violence after birth

A comparison of SF-12 scores and different types of abuse after birth

The following section compared means subscale scores of the SF-12 between women who experienced different types of domestic violence and those who did not. Table 4.20 presents means, standard deviations on the SF-12 for women who were abused and non-abused in all forms of violence in Phase 2. Comparisons of the SF-12 and the three different types of violence are also illustrated in Figures 4.11, 4.12 and 4.13.

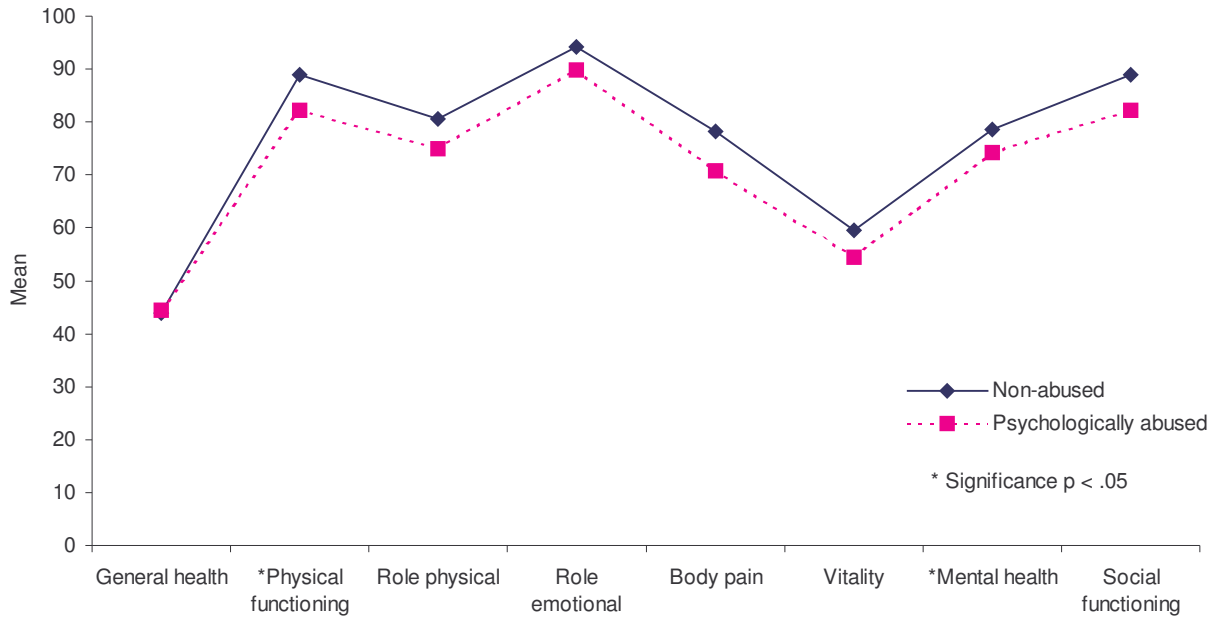

Figure 4.11: Comparison of subscale means of SF-12 between psychologically abused and non-abused women after birth

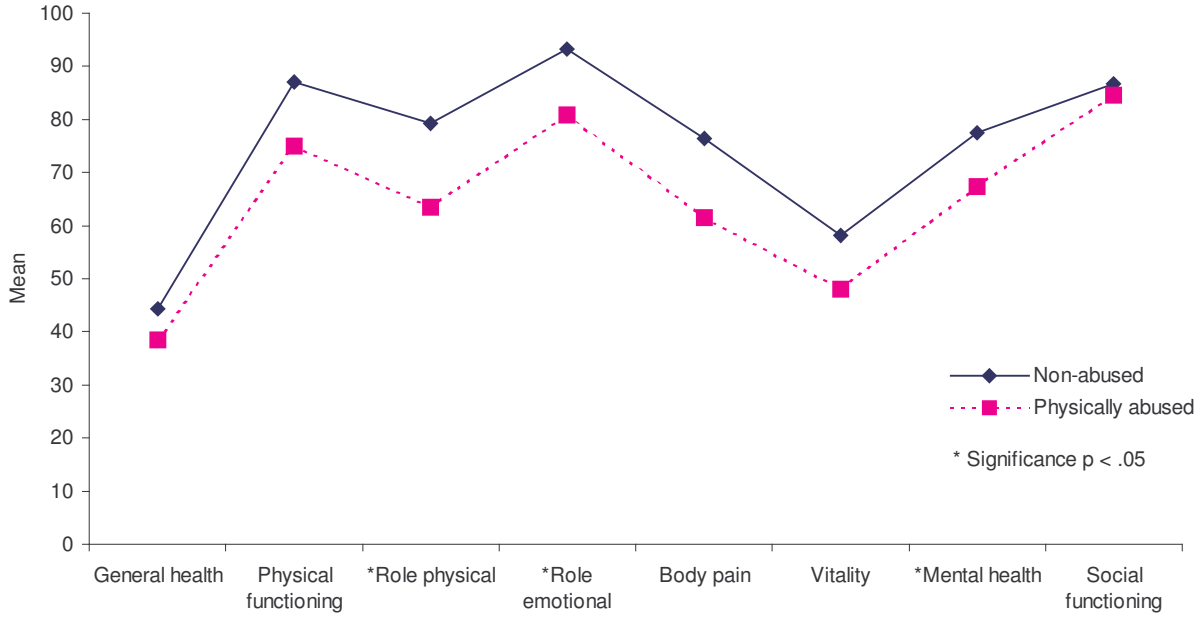

Figure 4.12: Comparison of subscale means of SF-12 between physically abused and non-abused women after birth

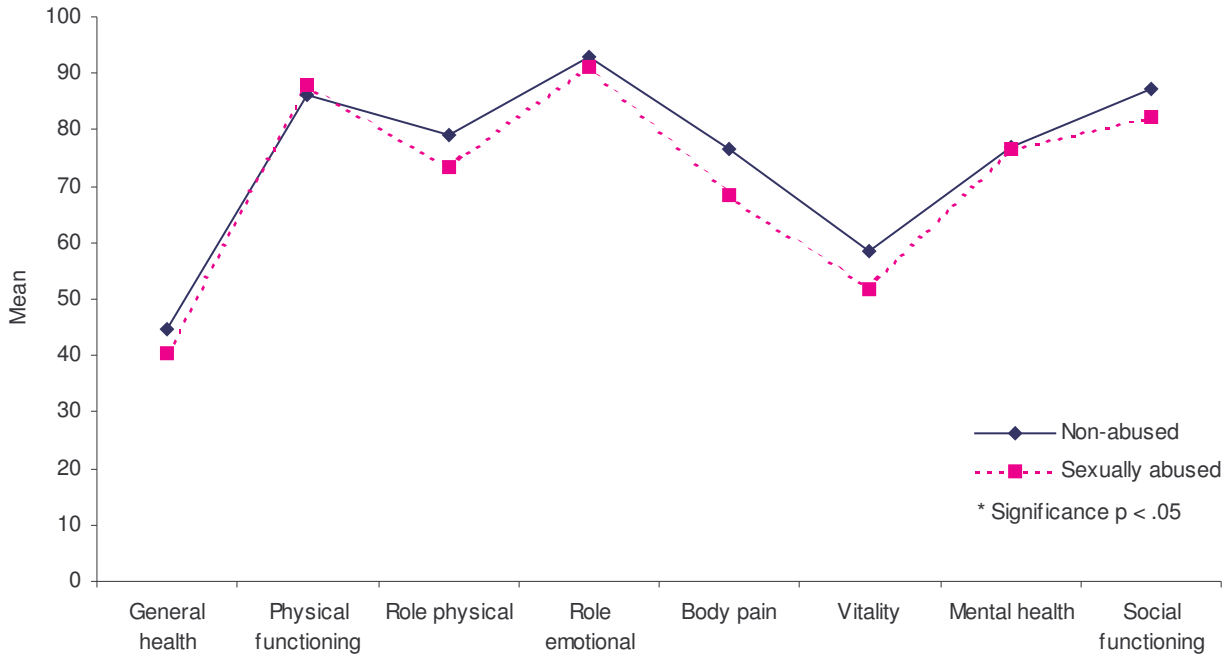

Figure 4.13: Comparison of subscale means of SF-12 between sexually abused and non-abused women after birth

Role physical functioning, role emotional functioning, bodily pain, vitality, social functioning, and mental health mean scores were lower in the presence of all forms of abuse for women as shown in Table 4.20. General health was slightly higher for women who were abused psychologically but not higher for women who were abused physically or sexually, compared to non-abused women. Mean physical functioning scores were also slightly higher for women who were sexually abused but lower for women who were abused psychologically and physically compared to non-abused women. However, there were significant differences in subscale mean scores for role physical functioning and mental health by abused and non-abused women. Mental health mean scores were significantly lower for women who were abused psychologically ($t(271) = 3.02$, $p = .003$) and physically ($t(272) = 3.13$, $p = .002$) but not sexually. Role physical functioning was significantly lower for women who were exposed to physical abuse only ($t(272) = 2.77$, $p = .006$) but not other forms. There was no significant difference in any subscale between sexually and non-sexually abused women after birth.

Table 4.20: SF-12 results for women after birth

SF-12 scales		Psychological abuse		Physical abuse		Sexual abuse	
		$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
General health	Non abuse	43.93	16.91	44.35	17.93	44.55	17.86
	Abuse	44.53	19.26	38.46	12.97	40.32	16.68
Physical functioning	Non abuse	88.98	18.43	87.07	19.06	86.32	20.06
	Abuse	*82.29	21.13	75.00	28.87	87.90	16.92
Role physical functioning	Non abuse	80.65	18.70	79.17	19.52	79.06	19.93
	Abuse	74.87	21.73	*63.46	27.70	73.39	21.83
Role emotional functioning	Non abuse	94.28	13.78	93.30	14.60	92.90	15.11
	Abuse	89.84	17.61	*80.77	23.73	91.13	17.14
Bodily pain	Non abuse	78.25	21.98	76.34	22.43	76.54	21.92
	Abuse	70.83	23.42	61.54	24.19	68.55	27.36
Vitality	Non abuse	59.60	19.21	58.24	19.71	58.54	19.19
	Abuse	54.43	20.19	48.08	16.01	51.61	22.30
Mental health	Non abuse	78.60	10.76	77.49	11.49	77.06	11.63
	Abuse	*74.22	12.67	*67.31	10.87	76.61	11.96
Social functioning	Non abuse	88.98	19.18	86.69	20.74	87.14	20.75
	Abuse	82.29	23.20	84.62	24.02	82.26	21.60

* $p<.05$

Maternal complications and domestic violence

In addition to the SF-12, adverse maternal outcomes during pregnancy (e.g., antepartum haemorrhage, premature rupture of membranes, vaginal infection), and having postnatal complications (e.g., postnatal infection, postnatal haemorrhage) were compared between abused and non-abused women. Chi-square analysis was performed to determine the relationship between domestic violence and complications during pregnancy and after birth. One statistically significant difference was found between physical violence during pregnancy and antepartum haemorrhage ($\chi^2(2) = 8.79$, $p<.05$). There were no significant relationships between other maternal complications either during pregnancy or after birth, and abuse status.

Neonatal outcomes

Neonatal outcomes in terms of low birth weight, having complications after birth and difficulty feeding were also measured in this study. There were 21 women (7.7%) who had given birth to a low birth weight infant (less than 2,500 grams). Of these, 4.4% of women (n = 12) were exposed to psychological abuse, and 2.2% exposed to physical abuse and sexual abuse during pregnancy. There was no statistical

association between low birth weight of infants and domestic violence during pregnancy, but this was difficult to conclude due to the low numbers of women who had low birth weight infants. In relation to feeding difficulties, and complications of infants after birth, there were also no statistical associations between domestic violence and these neonatal problems.

In summary, although the two screening items identified a very low prevalence of violence, other instruments used in this study identified more than half the women (59.6%) experienced some form of violence at least once during the current pregnancy and over thirty percent (39.1%) in the six-week period following childbirth. The prevalence of psychological violence during pregnancy (53.7%) and after birth (35.4%) was the highest among all three forms of domestic violence. Physical violence during pregnancy was reported by 26.6% of women and decreased to 9.5% after birth. Similarly, sexual violence decreased from 19.2% during pregnancy to 11.3% in the postpartum. Factors found to be associated with domestic violence in this study, particularly physical and psychological abuse, included age for both women and partners, marital status (married without a certificate), low income, shorter length of relationship, past history of abuse, and negative health behaviours of partners particularly drinking and smoking.

This study also investigated the impact of violence on women's health and wellbeing, particularly, health status and pregnancy outcomes. The study revealed that the health status of women who reported abuse was worse in seven out of eight subscales of the SF-12 Health Survey in both phases compared with women who did not report abuse. Women who have been exposed to domestic violence during pregnancy had significantly lower health status than non-abused women in terms of bodily pain, vitality, role emotional functioning and mental health. Women who experienced abuse after birth had significantly lower health status in terms of social functioning and mental health. Moreover, women who were abused during pregnancy in particular physical forms of abuse, were more likely to have an antepartum haemorrhage.

In relation to neonatal outcomes, this study found no statistical association between domestic violence and low birth weight of infants, feeding difficulties, and complications of infants after birth, which could be due to small number of women who gave birth to low birth weight infants.

A Statistical Model of Domestic Violence and Women's Health

The present study also sought to extend knowledge in the field of study by investigating women's responses to domestic violence or ways in which women who have been exposed to domestic violence dealt with the violence, their perceived needs and support, as well as barriers inhibiting them from seeking help by using seven open-ended questions. The following section presents a statistical model for domestic violence and women's health followed by several case study extracts that attempt to illustrate women's experience of domestic violence during pregnancy and postpartum period.

Multiple regression analysis was used to explore relationships between domestic violence scores (continuous dependent variable) and a number of independent variables or predictors including age of women, number of live children, number of pregnancies, and number of miscarriages. These variables were selected based on the review of literature identifying associations with domestic violence. The results are outlined in Table 4.21 and Table 4.22.

The analysis indicated that four variables under investigation (age of women, number of live children, number of miscarriages, and number of pregnancies) had a significant impact on the experiences of psychological violence during pregnancy ($F(4, 416) = 3.44$, $p<.05$, $R = .179$, $R^2 = .032$). The model however, explained only a small percent (3.2%) of the variance in psychological violence scores. Of these four variables, age of women made a statistically significant contribution to the experience of psychological violence during pregnancy (β -.19, $p<.05$).

Table 4.21: Regression of women's characteristic variables on psychological violence

Characteristic variables	Standard error	β	*T*	Sig t
Age of women	.050	-.191	-3.44	.001*
Number of live child	.769	-.027	-.248	.804
Number of miscarriages	.838	-.123	-1.549	.122
Number of pregnancies	.719	-.152	1.193	.233

*p< .05

Multiple regression analysis was also performed to determine the relationships between those four variables and sexual violence during pregnancy. The results, as demonstrated in Table 4.22, showed that the model reached statistical significance for sexual violence (F (4, 416) = 2.5, p<.05, R = .153, R^2 = 0.23). However, it would appear that these variables did not make a significant unique contribution to the prediction of sexual violence during pregnancy. It can be concluded that young women with more live children, multiple pregnancies and experiences of miscarriage were more likely to experience sexual violence. The results found no statistical association between those variables (i.e., age of women, number of live child, number of miscarriages, and number of pregnancies) and physical violence. Similarly, no significant associations were found between those variables and any form of domestic violence in the postpartum period.

Table 4.22: Regression of women's characteristic variables on sexual violence

Characteristic variables	Standard error	β	*T*	Sig *t*
Age of women	.018	.07	-1.27	.205
Number of live child	.278	-.14	-1.3	.208
Number of miscarriages	.303	-.14	-1.77	.078
Number of pregnancies	.260	.07	.74	.459

In addition, a regression analysis was undertaken to determine the contribution of domestic violence (psychological, physical and sexual) on the health status of women (as measured by the eight subscales of the SF-12 Health Survey). Table 4.23 demonstrates a significant association between the experience of psychological violence during pregnancy and physical functioning (R^2 = .032, p<.05), bodily pain (R^2 = .06, p<.05), vitality (R^2 = .029, p<.05), social functioning (R^2 = .061, p<.05), role emotional (R^2 = .087, p<.05) and mental health (R^2 = .132, p<.001) of pregnant women. A significant association was also found between sexual violence during pregnancy and social functioning (R^2 = .061, p<.05) and mental health (R^2 = .087, p<.001) of pregnant women. There was no significant association between physical violence during pregnancy and women's health status.

Table 4.23: Regression of domestic violence during pregnancy on pregnant women's health measuring by SF-12 Health Survey

Independent variables	Dependent variables	B	Beta	T	Sig t	R	R^2
Psychological violence	Physical functioning	-.58	-.13	-.198	.048*	.178	.032
	Body pain	-.949	-.214	-3.362	.001*	.246	.06
	Vitality	-.722	-.143	-2.219	.027*	.169	.029
	Social functioning	-.936	-.192	-3.028	.003*	.248	.061
	Role emotional	-.870	-.199	-3.168	.002*	.296	.087
	Mental health	-1.033	-.268	-4.392	.000**	.363	.132
Sexual violence	Social functioning	-1.862	-.138	-2.697	.007*	.248	.061
	Role emotional	-2.197	-.180	-3.580	.000**	.296	.087

* p<.05
** p <.001

Multiple regression was also performed to determine the contribution of the experience of domestic violence during pregnancy in the health status of women after childbirth. As outlined in Table 4.24, psychological violence during pregnancy had a significant impact on physical functioning (R^2 = .024, p<.05), social functioning (R^2 = .056, p<.05), and role emotional (R^2 = .115, p<.05) of women after

childbirth. Physical violence during pregnancy was also found to be significantly associated with role emotional functioning (R^2 = .115, p<.05) and mental health (R^2 = .052, p<.05) of women after childbirth. There was no significant association between sexual violence during pregnancy and women's health in the postpartum period.

Table 4.24: Regression of domestic violence during pregnancy on women's postpartum health

Independent variables	Dependent variables	B	Beta	T	Sig t	R	R^2
Psychological violence	Physical functioning	-.735	-.167	-2.226	.027*	.154	.024
	Social functioning	-.788	-.169	-2.296	.022*	.238	.056
	Role emotional	-.521	-.152	-2.133	.034*	.339	.115
Physical violence	Role emotional	-.370	-.201	-2.762	.006*	.339	.115
	Mental health	-.225	-.161	-2.138	.033*	.229	.052

* p < .05

Table 4.25 demonstrates a significant association between the experience of different forms of domestic violence after childbirth and women's health in the postpartum period. All forms of violence adversely affected the wellbeing of participating women.

Table 4.25: Regression of domestic violence after birth on women's postpartum health

Independent variables	Dependent variables	B	Beta	T	Sig t	R	R^2
Psychological violence	Physical functioning	-1.181	-.298	-3.944	.000**	.235	.055
	Role physical	-1.077	-.267	-3.528	.000**	.223	.050
	Social functioning	-1.729	-4.10	-5.579	.000**	.324	.105
	Role emotional	-.801	-.258	-3.490	.001*	.302	.091
	Mental health	-.704	-.300	-4.030	.000**	.287	.082
Physical violence	Physical functioning	.577	.177	2.414	.016*	.235	.055
	Social functioning	.747	.216	3.021	.003*	.324	.105
Sexual violence	Mental health	1.206	.131	2.073	.039*	.287	.082

* p<.05
** p<.001

Women's Needs and Support

The present study also aimed to investigate women's needs and support. Table 4.26 outlines types of support services required by women who experienced intimate partner violence both during pregnancy and following childbirth. There were 251 women who experienced at least one type of intimate partner violence in Phase 1 and 107 in Phase 2. Out of 251 women, 100 women (39.8%) reported that their problem was not serious enough, they did not have any physical injuries requiring any medical help and therefore they did not require any support from other people. Whereas those who stated that the problem was serious, reported receiving help from families, friends, and relatives (n = 20, 8%), support from health care professionals (n = 8, 3.2%), alcohol and gambling cessation program (n = 6, 2.4%), shelters/crisis homes and domestic violence resources (n = 5, 2%), and family counselling (n = 3, 1.2%). In Phase 2, abused women identified that alcohol and gambling cessation programs (n = 6, 5.6%), family counselling (n = 6, 5.6%), local and legal authority involvement (n = 4, 3.7%) and anger management program (n = 4, 3.7%) were needed more than other services.

Table 4.26: Needs and support identified by abused women

Needs and support required	Phase 1 n (%)	Phase 2 n (%)
Not serious enough	100 (39.8%)	47 (43.9%)
Private issue and needed to solve problem by themselves	98 (39%)	26 (24.3%)
Support from families, friends and relatives	20 (8%)	2 (1.9%)
Support from health care professionals	8 (3.2%)	2 (1.9%)
Alcohol and gambling cessation programs	6 (2.4%)	6 (5.6%)
Mediator	5 (2.0%)	3 (2.8%)
Shelter, crisis homes or domestic violence support services	5 (2.0%)	2 (1.9%)
Family counselling	3 (1.2%)	6 (5.6%)
Village headman and police involvement	2 (0.8%)	4 (3.7%)
Strict law on women's rights	2 (0.8%)	1 (0.9%)
Domestic violence education to change public perception	2 (0.8%)	1 (0.9%)
Anger management program	2 (0.8%)	4 (3.7%)
Telephone counselling	2 (0.8%)	1 (0.9%)
Sex education	1 (0.4%)	1 (0.9%)
Less involvement from parents-in-law	1 (0.4%)	1 (0.9%)

The present study also aimed to investigate barriers inhibited women from disclosing violence and from seeking help. The results are presented in Table 4.27 and 4.28. As shown in Table 4.27, there were 71 women who were victims of intimate partner violence in Phase 1 (during pregnancy) but did not disclose the violence to others. The reasons included intimate partner violence was a private issue or a family problem (n = 43, 60.5%), the problem was not serious enough (n = 20, 28.2%), shame (n = 5, 7.0%) and lack of support persons (n = 3, 4.2%). In Phase 2 (after birth) there were 45 women who reported that they did not tell anyone about the abuse. The reasons were mainly because they felt that violence was not serious enough (n = 24, 53.3%) and was a family matter (n = 21, 46.7%).

Table 4.27: Barriers to violence disclosure

Barriers to violence disclosure	Phase 1 n (%)	Phase 2 n (%)
Family affair/private matter	43 (60.5%)	21 (46.7%)
Not serious enough	20 (28.2%)	24 (53.3%)
Shame	5 (7.0%)	1 (2.2%)
Lack of support person	3 (4.2%)	1 (2.2%)

In addition, barriers to women's help seeking were explored (as outlined in Table 4.28). In Phase 1, there were 135 women who reported that they did not seek help from others when the violence occurred. The majority of women (n = 98, 72.6%) reported the problem was a private issue. Over 7 percent reported that they felt shame to ask for help from others while 6.7% (n = 9) felt that no-one could help them with the problem. There were 77 women in Phase 2 who reported that they did not seek help from others. Similar results were found in Phase 2.

Table 4.28: Barriers to women's help seeking

Barriers to women's help seeking	Phase 1 n (%)	Phase 2 n (%)
Private issue	98 (72.6%)	57 (74%)
Shame	10 (7.4%)	5 (6.5%)
Feeling that no-one could help	9 (6.7%)	6 (7.8%)
Lack of support network	5 (3.7%)	2 (2.6%)
Lack of knowledge on domestic violence services	5 (3.7%)	2 (2.6%)
Negative experiences with local and legal authorities	4 (3.0%)	3 (3.9%)
Believing that husbands/partners would change	4 (3.0%)	2 (2.6%)

Case Studies

The following section presents the case studies of abused women. All women who gave responses other than "never" to any question of the PMWI and SVAW were asked about how they dealt with domestic violence, in other words what they did when abuse occurred, any reasons they perceived contributed to violence, and barriers that inhibited them from seeking help. They were also asked about their needs and types of support they would find helpful in dealing with domestic violence. The following case examples are used to illustrate the experience of pregnant women who are victims of domestic violence, barriers to seeking help, and strategies they used in dealing with domestic violence. Pseudonyms are used to protect the identities of the women.

The case of Nong

Nong is a 23-year old woman in a de facto relationship and has one son aged 2 years old with her de facto. She has been living with her de facto for 3 years. Nong finished her diploma in accounting two years ago but is now doing home duties and is dependent on her partner for an income. She does not drink alcohol, use illicit drugs or gamble. Her partner aged 30 years old, completed a high school level of education. He works as a laborer for a building company and earns approximately 9,000 Baht per month (approximately AUD $310). He smokes approximately 20 cigarettes per day, drinks occasionally but does not gamble or use any illicit drugs. They live in their own house in a village of a district in Kalasin Province, which is approximately one hour by bus to Khon Kaen Hospital. Nong and her partner are

30,000 Baht (about AUD $1,035) in debt to a private loan dealer in her village, for a motorbike and daily use. Nong was 33 weeks pregnant on the day of the interview.

Nong reported that her partner started to abuse her after the birth of her first son who is now 2 years old. She was "physically hurt" on at least 5 occasions in the last twelve months before this pregnancy. She recalled one occasion when she was physically abused while living in Bangkok with her partner (they moved to Bangkok for a few months) but no one helped because it was viewed as a private issue. The rest of the abuse occurred in her hometown in the Northeastern Thailand, where people tended to help, even though they thought it was a private matter.

Nong stated she was abused again during pregnancy and following childbirth on "many occasions". Nong scored 93 out of 160 on threats and acts of physical subscale of the SVAW, 12 out of 24 for sexual subscale of the SVAW, and 25 out of 70 on the PMWI. Nong reported her partner often abused her physically, verbally and sexually. During this pregnancy Nong stated that her partner threatened to hurt her, shook a fist at her, pushed and grabbed her forcefully, pulled her hair, twisted her arms and slapped her face. He also physically forced her to have sex with him. After the birth of their son (who weighed 2,300 grams at birth) her partner did not physically hurt her but threatened to hurt her, and made threatening gestures at her. He also continued to physically force her to have sexual intercourse against her will.

Nong often felt downhearted and depressed. When the violence occurred Nong stated she mostly kept quiet, tried to be as calm as she could and not to fight back as she was afraid that the violence would escalate. Nong recalled one time when she was abused during her current pregnancy she reported it to the police but the police did not help. The police told her that it was a private problem and that sooner or later Nong and her partner would be good to each other so they recommended that she compromise and reconcile with her partner, and not to press charges against him. As a consequence Nong said she did not report the abuse to the police or ask for help from anyone. She sometimes told her cousins and close friends about the abuse and at other times her mother and a Buddhist priest as a means of ventilation. Nong

believed there were many reasons that led to quarrels and subsequent physical abuse. Nong thought that the causes of the violence were economic problems, her partner's expectation of her as a mother and wife, sexual jealousy, and her partner not wanting her to tell other people about their family life.

Nong further elaborated about her needs and support that would be helpful to her in dealing with violence. From her personal experience she identified several strategies to meet the needs of women who experienced domestic violence. Nong believed that strategies such as providing a mediator to facilitate resolution of problems, charging perpetrators or courts requiring perpetrators to seek treatment would be useful.

Moreover, Nong stated that the police should have more understanding of domestic violence and the importance of helping women who were abused. Nong said that when she reported the abuse, the police said it was a "husband and wife issue", "you would sleep together anyway" so they asked her to go home. They did not take the case seriously, pay attention to it, or charge her partner. Similarly, Nong reported that a village headman, who played an important role in helping villagers to solve any problems before the issue reached the police, should have an understanding about domestic violence and know how to help abused women. She felt that the village headman did not want to intervene in cases of domestic abuse.

Nong also raised important points about the public's perception of domestic violence and the associated stigma as illustrated below:

> *About Thai culture, if we are separated, women are always the ones who are blamed and stigmatized as "Mae Haang" or "Mae Mai" (means a widow). This stigma makes us like a bad person. Also, some people in the community perceive that domestic violence is a husband and wife matter so they do not bother or help, but at the same time these people say that it the woman who chooses so can't help. If women don't choose to leave the husband they have to be patient for the sake of the family and children.*

Shelters or crisis homes for abused women situated in the Northeast region of Thailand was another support strategy that Nong identified. She stated that a shelter or crisis home would be very helpful for abused women, particularly, those who did not have elder family members to help them when the abuse occurred and when it was not safe for them to stay home.

The case of Jeab

Jeab is a 22-year old housewife who married after finishing grade 9 at school. She has been with her husband for almost 7 years and they have a son aged 3 years and 8 months. Jeab was having her second child and was 32 weeks pregnant at the time of the interview. She does not smoke, drink alcohol or use illicit drugs.

Jeab's husband is 27 years old and works as a soldier. He earns approximately 8,000 Baht per month (AUD $276). He does not gamble but smokes heavily and drinks occasionally. Jeab lives with her husband and son in government accommodation in a district half an hour drive from the Health Promotion Centre Region 6. The family has a 20,000 Baht debt from a private loan dealer (often a private source of debt has a very high interest rate). Jeab scored 54 out of 70 for psychological abuse according to the PMWI ("often" category), and 122 out of 160 for physical abuse according to the SVAW (occurred "many times"). There was no sexual abuse in Jeab's case.

Jeab reported that the abuse began during her first pregnancy when she was "*kicked*" and "*slapped around the face*", and as a result, she left her husband. She returned after he went to see her mother asking where she was and vowing that he would not abuse her again, however a few months later he started to abuse her again. In the twelve- month period prior to this current pregnancy Jeab reported that her husband abused her more than 30 times both verbally and physically. The abuse continues however and during the first four months of this pregnancy, Jeab experienced psychological abuse only. The first episode of physical abuse during pregnancy occurred when Jeab was 5 month pregnant. Jeab reported that her husband " *kicked, hit, punched, and choked"* her. Jeab also reported, *"he twisted my arms, stomped on*

me, used a knife on me and whatever he can do". Jeab was "*badly injured*" around her head, face and body and she was admitted to a hospital in her district for one day. This time Jeab's mother suggested that she should try to put up with the violence until she gave birth, and if her husband abused her again she should leave him and not return, and she would not tell of her whereabouts under any circumstances. Jeab stated that she continued to experience similar forms of psychological and physical abuse during this pregnancy.

Jeab could not really pinpoint why her husband used violence on her although she stated, "*sometimes I thought he has a mental problem but he said I am the cause of violence*". Jeab said that her husband wanted her to fulfil domestic responsibilities such as cooking, cleaning, keeping house tidy, looking after the son and serving him when he was at home. If she did not meet his expectations he abused her and in this way he blamed her for his violence. He also did not want Jeab to go out of the house or talk to other people. Jeab said "*he is a jealous type of man*". Jeab further said that her husband would be more violent when he came home drunk. When drunk he would verbally and physically abuse her, but when sober he would threaten and verbally abuse her.

Jeab felt stressed, worried and confused about the abuse. She did not know what to do except cry when the abuse occurred. Jeab stated that if she kept quiet or did not challenge him, he would say "*why did you not say anything*", and if she walked away he would be more angry and the violence escalated, and if she spoke up the violence also got worse. Jeab felt so hopeless as it seemed that there was "*no way out or no solution*" to the continued abuse. Her feelings of hopelessness led her to try drastic measures.

> *I tried everything, I used to overdose, hang myself and wanted to commit suicide. I wanted to go as far as I can. Some other times I felt like if I had a gun I would shoot him.*

Jeab never reported the abuse to the police because of feelings of shame and she was afraid that her husband would hurt her mother, as he had previously rampaged and threatened her mother indicating that he would throw a grenade into their house and burn it. Jeab also said that she never told her friends about the abuse because of the shame and fear. Although she wanted to do so, she was "*not brave enough*". Jeab expressed her feeling of hopelessness as "*overwhelming and tight in the chest…it is more than enough. I cry inside*". Jeab stated that only her mother and father in-law knew about the abuse but they were unable to help.

Jeab further expressed her concerns regarding her son who witnessed the abuse and was abused as well. Jeab said that her son has started to rage and behave violently. A week before this antenatal visit, Jeab moved her son to live with her father in-law who is a retired government employee living in a municipal area of Khon Kaen Province. At first her husband did not allow the move, but after Jeab told him that she wanted her son to attend school her husband allowed her to move the boy.

From Jeab's experience, she identified several interventions that would assist her to deal with domestic violence. These included an education program to help women develop a safety plan, strategies to help deal with abusive and violent husbands, and the provision of resources including organizations to support abused women. Jeab said that she wanted to leave the relationship but did not know where to go. Jeab did not know what services were available for abused women, where to get help, what to do if she chooses to leave him, and who would take custody of her son. A requirement of a marriage certificate is that women have to change their surname to their husband's surname and this was of concern to Jeab. Because she was required to use her husband's name it was very difficult for her to leave and get a job as she was required to inform her husband and get his permission. Jeab felt that it was a restriction for abused women who tried to find a job and work to support themselves. Jeab suggested that there should be some flexibility for abused, married women to work without a husband's consent or permission. Non-judgmental and compassionate care from health care professionals was another support that Jeab

identified as an important aspect particularly when abused women were admitted to the hospital.

At the end of the interview, Jeab said that she would definitely leave her husband if the abuse continues because her son is now with her father in-law and her mother will not tell of her whereabouts despite her husband's threats. Jeab felt sad when thinking that she has been abused from a very young age. Jeab thanked the researcher and said that she was very happy that there was such research into domestic violence as other women may benefit from this study. Jeab was unable to be contacted after birth.

The case of Daeng

Daeng has been married (without certificate) for 3 years and is having her first child. She is 26 years old. She works at a Doll factory and earns approximately 5,000 Baht (AUD $172) per month. Daeng travelled about forty- five minutes by car from her home to Khon Kaen hospital where she had her antenatal check up. Daeng's husband is 43 years old. He is a barber and has his own barbershop. Her husband smokes half a pack of cigarettes per day, he occasionally drinks alcohol and gambles. After they married, Daeng moved to live with her husband in a village about 100 kilometres away from her parent's home. On the day of the interview, Daeng's husband drove her to the hospital. She was 32 weeks pregnant. Daeng scored 73 out of 160 on threats and acts of physical subscale of the SVAW, 12 out of 24 for sexual subscale of the SVAW, and 26 out of 70 on the PMWI.

Daeng reported that her husband started to verbally abuse a year after they married, swearing and yelling at her and denigrating her as a person. Soon after, he also started to threaten to hurt her many times prior to the current pregnancy. During her pregnancy Daeng frequently suffered a range of emotional, physical and sexual abuse. Daeng further stated that her husband used controlling behaviours, particularly, interfering with her relationships with other family members and isolating her from family, relatives and friends as well as monitoring her movements. In addition, her husband threw objects at her, used threatening gestures at her,

threatened to damage her belongings and property, and threatened to hurt her parents or relatives. He also threatened to hurt her and kill her. Added to this, Daeng reported that she has been sexually abused. Her husband demanded she have sex with him and forced her to have oral sex against her will.

During the interview, Daeng looked down only, had no eye contact with the researcher and seemed to have low self-esteem. Daeng said that when her husband abused her, she kept quiet and sometimes left the house and stayed with her mother in-law who lives about 200 metres from her house. Daeng stated that she did not know who could help her with this problem and she felt too ashamed to tell people although her mother-in-law knew about the abuse but she had no influence on his behaviour. Daeng said that she plans to go back to her mother who lives in another district, 100 kilometres from her husband's house. She felt that at least she has support from her mother. Daeng could not identify why her husband abused her. However, Daeng stated "*he controls me in everything…He always says I am stupid, not smart, and ugly*". Daeng gave birth at Khon Kaen Hospital to a baby boy but she did not attend her follow up appointment after birth, and she had no telephone. It is possible that Daeng may have moved to her mother's house as planned.

The case of Bee

Bee is 20 years of age and having her second child. She has been married to her husband since finishing grade 9. She works in a shoe factory in the municipal area of Khon Kaen province and earns approximately 9,000 Baht (AUD $310) per month. Her family has a 10,000 Baht (AUD $345) debt to a private source. Normally, Bee lives in a rented house in Khon Kaen municipal area with her husband, her two-year old son and her elder sister but at the time of the interview Bee had separated from her husband for a week because of his abuse, and was currently staying at her parents' house in a district approximately 150 kilometres from Khon Kaen municipal area. Bee was 36-weeks pregnant on the day of interview.

Bee's husband is 24 years old. He works in a fishing net factory in the same area as Bee, and has a monthly income of 5,000 Baht (AUD $172). He smokes and drinks

alcohol heavily everyday. Bee stated that her husband started to "*threaten and physically abuse"* her during her first pregnancy when he started to "*get drunk almost everyday*". After the birth of her first child, Bee said that her husband physically hurt her and threatened to hurt her at least once a month. During the current pregnancy Bee was also exposed to the abuse. She was hit on the head, face, body, arms and legs. Bee scored 127 out of 160 on threats and acts of physical subscale of the SVAW, 14 out of 24 for sexual subscale of the SVAW, and 42 out of 70 on the PMWI. Bee reported that her husband threatened to hurt and kill not only her but also her parents and relatives with a knife and a gun. In addition, Bee stated *"he pushed, kicked, slapped my face and choked me. That was not enough he hit me with anything that he could grab and beat me up".* He also used a knife on her. Bee reported her husband abused her many times during this pregnancy. Moreover, he sexually abused her by physically forcing her to have sex, and forcing her to have oral sex against her will.

Bee further told the researcher about the abuse on the day she was admitted to hospital to give birth. Bee said that at approximately 2200 hrs, her husband drove a motorbike to the hospital with her son while he was drunk and had an accident on the way to the hospital. When Bee asked him why he came this late, he started to pull her hair and kick her body. The hospital staff then called hospital security personnel to take him away. Bee had bruises on her body from this attack.

Bee believed that the cause of violence related to his alcohol problem. He came home drunk every night and spent all his money on alcohol. Bee said that when he got drunk, he couldn't control his mind and behaviour. He was "hot tempered" and never took responsibility for his actions or behaviours. Bee did not know what to do in order to stop the violence. She cried and tried to help herself when being abused. *"I fought back sometimes."* Sometimes she tried to escape the abuse by going to her parent's house. Bee reported she had separated from him many times and each time he asked her to come back and promised that he would not do it again, but the abuse continued. Bee said that she puts up with the violence because of her son, if they are separated her husband will take her son with him.

In relation to the sexual violence, Bee stated that she verbalized her unwillingness but her husband did not listen to her. She sometimes used different strategies, for example, telling him she was menstruating, had a stomachache or pretended to be asleep. Bee stated these strategies worked at times. Bee found her neighbours to be supportive and very helpful, and they had tried to stop him from physically abusing her. She also said that her parents, brother, sister and relatives are sources of support for her. Bee identified family support as well as an alcohol cessation program as important support strategies in helping couples experiencing domestic violence and alcohol addiction. Bee stated that husbands must also change their behaviours.

Six weeks after birth Bee came to the hospital for follow up. She said that she now lives with her husband because he went to her parent's house a week after she was discharged from the hospital. He begged her to come home for the sake of their children and he promised that he would not abuse her again. Bee reported that after birth her husband had not physically abused her but was always complaining. Bee said that when he was drunk she tried not to talk to him and kept quiet so he did not physically abuse her. Bee plans to definitely leave him and not return if he physically hurts her again this time.

In summary, women in this study reported physical, psychological and sexual abuse. The patterns of violence are similar in two case studies where the abuse first occurred after the birth of their first child (Nong and Bee) and continued into the current pregnancy and after birth. In another case (Jeab) the abuse started to occur during the first pregnancy and continued to the current pregnancy. Daeng, who was having her first child, experienced abuse a year after marriage and the abuse continued into the current pregnancy. The latter two cases were unable to be contacted after birth therefore the abuse following childbirth was unidentified. The women reported that these traumatic experiences of domestic violence had pervasive consequences on their health and wellbeing which often led to significant adverse health problems such as low self esteem, helplessness, fear, social withdrawal, suicidal ideation, and physical injuries. The causes and contributing factors of domestic violence as reported by the women in this case studies included partner's

controlling behaviours and narrow expectations of women as a wife and a mother, economic problems, and husband's alcohol abuse. The case studies clearly showed that domestic violence in Thai culture is about the power of men who exert control over women. This can be seen from the case studies where the women's partner/husband controlled their lives through rigid expectations about their role as a wife. Women in this study were expected to rear children, care for the elderly and family members, and manage the household as well as other duties. The perpetrators used violence as a tool to achieve power and control over their partners and children.

In relation to the women's responses to domestic violence, they identified that crying, keeping quiet and trying to minimize active resistance were helpful for them. Some women even fought back, and temporarily left the house to stay with parents or their parents-in-law. In relation to sexual violence, some women reported they did nothing while others tried to verbalize their unwillingness, for example telling their husband that they did not want it, pretending to be sleeping, or saying that they were having a period or stomach ache. These strategies sometimes worked or at least helped to lessen the severity of the violence while at other times not. It is also noted in these case studies that abused women continued living in abusive relationships. This is because of the stigma and blame attached to women in domestic violence situations and this seems to be acute in Thai culture. Other reasons for continuing in the relationship included their concern about their children, lack of knowledge about domestic violence resources, believing that the husband's behaviours might change, feeling powerless to change, negative experiences with legal authorities, and financial problems.

Resources and support that abused women identified as supportive and hoped to be established in helping women in abusive relationships were education programs on domestic violence including programs on helping women to develop a safety plan, provision and availability of domestic violence resources in the Northeast region of Thailand, such as shelters, crisis homes, as well as support from family members, friends, relatives and neighbours. Other support required to deal with domestic violence also included alcohol cessation programs for abusive husbands and support

from legal authorities such as police and village headmen who need to discourage tolerance of domestic violence and how they can help women who are victims of violence. These issues are significant and indicate a dire need for legal reform directed at protecting women and the introduction of education to prevent violence and health services to address the negative health outcomes of domestic violence in Thailand.

Chapter 5 : Discussion

The present study, informed by principles of feminist research, aimed to investigate the prevalence of domestic violence perpetrated by current intimate male partners among Thai pregnant women who attended antenatal clinics in Khon Kaen Province, Northeastern Thailand. The study also investigated women's health issues related to domestic violence, strategies used by women in dealing with domestic violence, required needs and support as well as the barriers inhibiting them from seeking help.

The present study is the first investigation into the prevalence of domestic violence during pregnancy and following childbirth in the Northeastern Thailand. The strength of this research is an investigation of domestic violence that included not only physical violence but also psychological and sexual violence, since all forms of violence can be used to control female partners. Moreover, the study conducted a follow up of the same group of women using the same research tools [the Psychological Maltreatment against Women Inventory (PMWI) and the Severity of Violence against Women scale (SVAW)]. This approach enabled a better understanding of domestic violence for childbearing women over time.

In the following sections, the results of the study are discussed and the possible explanations for domestic violence in pregnancy and following childbirth are provided. In the first instance, the prevalence of domestic violence is discussed, followed by factors contributing to domestic violence. Health outcomes related to domestic violence, perceived causes and women's responses to domestic violence are then explored. Women's needs and support, barriers to disclosing violence, and barriers inhibiting women from seeking help are also discussed. Finally, contribution to the emerging theory on domestic violence, limitations of the study and recommendations for future research are presented.

Prevalence of Domestic Violence

The first purpose of this study was to determine the prevalence of domestic violence during pregnancy and following childbirth. This section will firstly discuss the findings in relation to prevalence of domestic violence during pregnancy, followed by the prevalence after childbirth. Four hundred and twenty one women participated in Phase 1 of the study (during pregnancy) and 274 women in Phase 2 (after birth). This represents a 65% response rate. Although just over one-third of women who were lost to follow up had a mobile phone, they were still unable to be contacted in Phase 2. This may be because of changes in mobile phone providers in the region, no telephone signal due to poor service coverage, loss of the mobile phone, or women moving to other city after birth.

Prevalence of violence during pregnancy

Overall, at least 53% of participating women experienced psychological abuse during pregnancy according to the PMWI. When focusing on each subscale of the PMWI, this study found that 46.1% experienced emotional/verbal abuse and 35.6% reported experiencing dominance/isolation. This high incidence indicated that Thai men exert their power and control over their wives through the use of emotional/verbal abuse, dominance and isolation. Although psychological violence does not cause physical injuries to women, it causes a great deal of emotional distress that can negatively impact on women's psychological health and wellbeing. Importantly, women experiencing psychological violence may appear to function well, but the effect of this violence on their health status and health behaviours may be substantial and long lasting (Wagner & Mongan, 1998).

The prevalence of psychological violence from the present study, especially in dominance/isolation subscale, was much lower than that found in a Swedish study (Hedin, 2000) but similar results were found in scores on the emotional/verbal subscale. Hedin (2000) found that 44.4% of women experienced emotional/verbal abuse according to the PMWI, and 89.4% experienced dominance/isolation. The difference in prevalence between the present study and the Swedish study may be related to cultural variations. Swedish women may live more socially isolated lives,

particularly in the winter months, than Thai women. However, reasons for this difference may be multifaceted and are speculative at this point.

In relation to threats, acts of physical violence and sexual violence, the present study found that 26.4% of women experienced threats of physical violence, 7.4% experienced actual acts of physical violence, and 19.2% experienced sexual violence during pregnancy. The findings of the present study are similar to other studies using the same research tools. For example, a Swedish study found 24.5% of women experienced threats and/or acts of violence during the preceding year of pregnancy (Hedin, 2000).

Similarly, another study found that the prevalence of physical abuse before pregnancy was 6.9% compared with 6.1% during pregnancy and 3.2% during a mean postpartum period of 3.6 months (Martin et al., 2001). Commonly, perpetrators were their current or former husbands/partners. The present study clearly demonstrates that a substantial number of pregnant Thai women are exposed to psychological, physical and sexual violence.

Previous studies suggest that physical violence in intimate relationships is not a separate event, and is often accompanied by psychological and sexual violence (Guo et al., 2004; Parker et al., 1994; Parker et al., 1993). The present study found that over twenty-nine percent of women experienced at least two types of domestic violence during pregnancy, in which at least 10% (n = 43) experienced all three forms of violence. These findings are consistent with other studies (Guo et al., 2004; Yoshihama & Sorenson, 1994). For example, a study conducted in China found a strong association between emotional, sexual and physical violence (Guo et al., 2004). It was also found that almost one-third of women experienced more than one type of violence.

Prevalence of domestic violence in the postpartum period

The majority of studies on domestic violence have focused on the period before and during pregnancy, and few have examined postpartum violence. Previous studies also focused mainly on physical violence. The second aim of the present study was therefore to investigate the prevalence of domestic violence in the immediate postpartum period. The study was the first to be conducted in Thailand that explored the prevalence of domestic violence in the postpartum period. Women who participated in Phase 1 were contacted 6 weeks after childbirth. The findings of the current study confirmed that women who were abused during pregnancy were more likely to be abused after birth as well. The results of this study showed that 39.1% of women (n = 107) experienced some form of domestic violence at least once following childbirth.

Amongst the abused, 35.4% of women reported psychological violence according to the PMWI with 25.2% experiencing emotional/verbal violence, and 24.8% experiencing dominance/isolation. In addition, 8.4% experienced threats of physical violence, 4.7% acts of physical violence, and 11.3% of women experienced sexual violence. Similar to pregnancy, some women experienced more than one type of domestic violence. The present study found that over three percent of women (3.3%, n = 9) have been subjected to all forms of domestic violence, 5.5% experienced both physical and psychological violence, and 5.1% experienced both sexual and psychological violence.

Another study measuring postpartum abuse using the SVAW found that 32 out of 132 women (24.2%) reported threats, physical or sexual abuse during the 8-week postpartum (Hedin, 2000). Of these 32, the majority of abused women (n = 20) experienced symbolic violence, followed by threats of mild violence (n = 17), and acts of mild violence (n = 7). Relatively few women experienced acts of minor to serious violence in the postpartum period (n = 2 in each subscale). Sexual violence was reported by one woman. Although the period of violence monitoring was longer in Hedin's study than the present study, the prevalence estimates were not higher.

The findings from the present study showed that 48 out of 274 women (17.5%) reported threats, acts of physical and/or sexual violence. However, the present study revealed that sexual violence was experienced by the majority of Thai postpartum women (11.3%, n = 31) who reported abuse, followed by symbolic violence (6.6%, n = 18), acts of mild violence (4.4%, n = 12), and threats of mild violence (4%, n = 11). The prevalence of sexual violence is interesting. One possible explanation may be related to the issue of sexual inequality which, under Thai law, husbands/partners have the right to sexual intercourse with their wives. The 1997 Constitution section 276 of Criminal Law Code, states that a man will be charged as committing a crime only when he sexually abuses a woman other than his wife (Pekanan & Wongsurawat, 2001). This implies that marital rape is not recognized as a crime by Thai law, and as such men can sexually abuse their wives. The inadequacy of Thai law may contribute to the high prevalence of sexual violence among childbearing Thai women. In addition, this high rate of domestic violence, in particular sexual violence, may be due to the view of women as sexual objects and a lack of respect for women's bodies (Thajeen, 2002) as well as the perception of some Thai men that rape or sexual assault is acceptable behaviour (Archavanitkul, 2001). Archavanitkul (2001) asserts that the root of domestic violence in Thailand originates from the Thai patriarchal culture. This patriarchal culture allows Thai men to dominate women within marriage by exerting their power over their wife not only through such means as violence, and sexual abuse but also sanctioning the belief that these are acceptable means.

Another interesting finding was that 9.5% of women (n = 26) reported that abuse started soon after birth. The appearance of new cases of women abused following childbirth may indicate that the overall incidence of domestic violence among Thai women is increasing. Even though the postpartum period should be a joyful period with the birth of a baby, it is by no means safe for some women. It is likely that violence that occurred following childbirth among these women could continue at any time in their reproductive lives. The findings of this study indicate that past abuse was a major risk factor for continued domestic violence, and this is consistent with previous studies (Hillard, 1985; Martin et al., 2001; McFarlane et al., 1992).

The design of previous studies on domestic violence that included different perpetrators, domestic violence questions, and time periods has resulted in variable prevalence rates of domestic violence following childbirth. For example, a study conducted with a representative sample of 32 communities in China found higher prevalence rates (8.9%) of domestic violence after birth (Guo et al., 2004). However, this Chinese study was different from the present study in various ways. For example, the longer postpartum period studied (mean 11 months), may have resulted in recall bias as participants had a child aged 6 to 18 months and were reporting retrospectively.

A longer period of examination is not always associated with a higher incidence of domestic violence following childbirth. A study conducted in the U.S. found that 3.2% of women were physically abused during a mean postpartum period of 3.6 months (Martin et al., 2001) while the current study found slightly higher incidence estimates in physical violence at 6 weeks after birth. This difference may be due to different domestic violence assessment tools used, and the establishment of a trusting relationship between the researcher and women to facilitate disclosure.

In relation to when the violence started, 9.5% of women (n = 26) reported that violence began in the postpartum period while 32.8% (n = 90) experienced domestic violence during the current pregnancy but not after birth, and 29.6% of women (n = 81) reported experiencing domestic violence both during pregnancy and after childbirth. These findings clearly support the notion that women who were abused during pregnancy were more likely to be abused after birth. Previous research indicated that during pregnancy women maybe at risk of domestic violence since pregnancy is a time of stress in anticipation of the financial and emotional burden of a new child in the couple relationship. It is also a time of increased risk of domestic violence because of possible ambivalent feelings about the pregnancy, increased vulnerability of women, emergent economic pressure and decreased sexual availability (Lent, 1991 cited in Yang et al., 2005).

Factors Contributing to Domestic Violence

Factors associated with domestic violence were explored in this study including demographic factors of both women and partners, such as, age, marital status, length of relationship, education, occupation, income, type of family, family debt, negative health behaviours and women's parity. Since previous Thai studies were conducted in urban areas, the present study makes a unique contribution by investigating the experiences of women in a poorer area of the country, and the sample was representative of the region. Overall, women who participated in this study were aged between 18 and 40 years with the mean age of 26 years (SD = 5.3). The majority of women (83.1%) were low-income earners with a monthly income of 5,000 Baht (approximately AUD$172) or lower. In 2005, minimum wage for labour work in Khon Kaen Province is 140 Baht (AUD$ 4.7) per day whereas in other provinces in the Northeast region of Thailand the minimum daily wage rates are between 137-139 Baht (AUD$ 4.6 - 4.7) (Ministry of Labour, 2005). The present sample therefore reflects a high number of low-income earners, and non-government employees. The findings of this current study suggest that poor, rural women are also at risk of domestic violence.

The present study found that women who identified psychological abuse were more likely to be young ($\overline{X}$ = 25.2 years), married without a marriage certificate, and have low monthly incomes. Similarly, women who experienced physical abuse were young ($\overline{X}$ = 24.3 years), married without a certificate, had shorter lengths of relationship ($\overline{X}$ = 4.3 years), drank alcohol, and had previous abusive experiences. A possible explanation as to why younger pregnant women are more likely to experience domestic violence than older women may relate to their vulnerability and inexperience with interpersonal relationships (Wiemann et al., 2000). Moreover, younger women may lack experience in life that could forewarn of the difficulties associated with becoming involved with males who have a history of dangerous or violent behaviours (Wiemann et al., 2000).

In relation to partner characteristics, age (partners who were younger), as well as smoking and drinking habits were significantly associated to psychological and

physical abuse. Other demographic factors of partners were not found to be associated with either psychological or physical violence.

The present study found that women who had a low monthly income were more likely to experience psychological and physical violence. This finding supports the view that although domestic violence occurs in all socio-economic groups, low income women or those living in poverty are more likely to be affected when compared to women in high-income groups (Hedin et al., 1999; Martin et al., 2001; Stewart & Cecutti, 1993). Although acknowledging social and demographic characteristics that define risk groups for domestic violence, Jewkes (2002) pointed out "poverty is the exception and increases risk through effects on conflict, women's power, and male identity" (p. 1423). Levinson (1989) also stated that domestic violence against wives occurs more frequently in societies in which men hold economic and decision-making power in the household, where women do not have easy access to divorce, and where violence is routinely used to resolve the conflicts. Having a stable source of social support and economic independence from husbands and families offers a woman some protection from domestic violence (Levinson, 1989).

Findings from the present study also support the view that substance abuse, in particular alcohol abuse, is a major risk factor contributing to domestic violence. The majority of women's partners drank alcohol occasionally. In particular, women whose partners used alcohol were more likely to experience physical and psychological violence during pregnancy and following childbirth. Similar results were found in several studies (e.g., Donath, 2002; Hedin & Janson, 2000; Muhajarine & D'Arcy, 1999). Donath (2002) asserted that although alcohol is not necessarily the direct cause of domestic violence, women who live with heavy drinkers are at far greater risk of partner violence. These women are also at risk of suffering more severe injuries, as men who have been drinking inflict more serious violence at the time of an assault (Donath, 2002).

The present study also demonstrated that previous abuse was a strong risk factor for subsequent abuse including abuse in the postpartum period. Almost 30 percent of women (n = 81) reported the continuation of violence. This finding is consistent with a statewide study conducted in North Carolina (Martin et al., 2001). It is important that midwives and related health care professionals be aware of this risk factor in order to improve the detection rate and optimise intervention after discovering the abuse (Stewart, 1994).

In relation to sexual violence, the present study found that young women with more live children, multiple pregnancies and had experiences of miscarriages were at risk of sexual violence. The findings from the current study however, were inconsistent with a Chinese study which found that the common factors associated with sexual violence included alcohol abuse by women or where partners had a history of illicit drug abuse (Guo et al., 2004). In regards to illicit drug abuse, it is noteworthy that in the present study none of the women reported use of illicit drugs and only one partner was a drug abuser. This relatively low number may reflect hesitancy on the part of women to report drug abuse or the lack of drug abuse in the region. At the time of data collection Thailand had strong campaigns on combating and eliminating drug abuse using such slogans as "War on Drugs". This may have led women to not disclose substance abuse to others due to fear of authorities and punishment.

Health Outcomes related to Domestic Violence

Pregnancy is a vulnerable time for women physically, psychologically and emotionally. During pregnancy many changes occur and much energy goes into preparation for the next stage of life (Spietz & Kelly, 2002), to take on the role of "mother" and integrate a child into the life of the woman and family. Pregnant women often encounter underestimated and yet unprecedented changes in their lives, relationships, and bodies as they move toward motherhood (Spietz & Kelly, 2002). These changes can be challenging enough in a 'normal" pregnancy and even more so in the face of domestic violence, depression, unresolved grief or loss, isolation, and other mental health issues (Spietz & Kelly, 2002).

The present study aimed to investigate the health status of Thai women both during pregnancy and after birth by using the SF-12 Health Survey. Health status of women who experienced domestic violence was compared to those who did not. The findings showed that during pregnancy women reported mean scores on the eight subscales of between 43.5 and 80.2 while after birth women reported mean scores of between 44.1 and 92.7. When comparing to the 1998 general U.S. population norms (a basis for meaningful comparisons across scales), it was found that women in both phases had significantly lower mean scores in all eight subscales of the SF-12. However, it is expected that the Thai population in general would have a lower SF-12 scores than the general U.S. population due to several factors such as living conditions and health support from the government. The general U.S. population norms (Ware et al., 2002) were used due to the lack of Thai or any other Asian population norms. The SF-12 Health Survey was used for the first time in Thailand during this study. Findings suggest that pregnant Thai women have poorer health and quality of life during pregnancy than after birth and an even poorer level of functional status than people in developed countries. These results are consistent with other studies. For example, a U.S. study of 125 white women found that pregnant women reported more bodily pain, poorer physical functioning, and more functional limitations resulting from physical health problems (Hueston & Kasik-Miller, 1998). Similarly, another study found that women in late pregnancy had poorer social functioning and lower vitality than the community sample (Otchet, Carey, & Adam, 1999).

There are some possible explanations to the improvement in women's health after birth. Otchet et al. (1999) pointed out that, after successful delivery, women have a more positive perception of their overall health, despite their reported social, and emotional limitations. Secondly, Kaewsarn, Moyle and Creedy (2003) found that Thai women were likely to have considerable family support networks around the time of birth. It is possible that during the postpartum period, Thai women, particularly those who live in an extended family, have support from family, friends and respected elders in the community. In some villages, elders in the family will also teach women how to care for their child. Kaewsarn et al. (2003) reported that

women living in an extended family structure were assisted with housework by their mothers, female relatives, husband and children, whereas women from nuclear families with no close relatives relied on their husband for assistance. The support received may have contributed to a significant increase in their health especially mental health.

Pregnant women may have functional limitations caused by the pregnancy, and result in lower health status scores. Hueston and Kasik-Miller (1998, p. 209) stated "pregnancy is a time of intense physical change, and is associated with a great deal of emotional upheaval in many women". This period of physical and emotional stress can have a significant impact on the wellbeing of an expectant mother.

The only subscale of the SF-12 found to be higher in pregnancy than after birth in this study was general health where questions focus mainly on the perceptions of the individual's overall health status. It was noted that during the interview, women reported that their episiotomy wound was not properly healed. Although the wound did not affect their functioning and social activities, they felt that their general health was not good. This can be interpreted that Thai women appear to view and perceive their health separately, not in a holistic way, or that Thai women may try to push themselves to be physically and emotionally active despite decreased general health. Another study also found that during pregnancy women had higher social functioning than in the puerperium period (Otchet et al., 1999). The authors asserted that the significant decrease in social functioning after delivery and significant lower scores in the puerperium for functional limitations resulting from emotional distress might indicate additional demands that newborn infants place on mothers or couples.

When comparing abused and non-abused women, it was found that women who experienced domestic violence during pregnancy reported significantly lower health status than those who did not on at least four subscales of the SF-12, namely vitality, bodily pain, role emotional functioning and mental health. Women who were abused after birth also reported lower mean scores in social functioning and mental health although the remaining were not significantly different. Domestic violence produces

differences in the health status of women. Domestic violence has substantial psychological effects that can have long-term health care implications. Similar results were reported in another study that found women who experienced emotional violence scored significantly lower for functional status than non-abused women on 7 of the 8 subscales (Wagner & Mongan, 1998). These 7 subscales were physical role functioning, emotional role functioning, sexual functioning, bodily pain, mental health, vitality, and general health perceptions.

Another study suggested that women who were victims of violence, experienced adverse mental health and decreased ability to function socially and emotionally, in addition to impaired physical performance, vitality, general health, and reports of bodily pain (McFarlane, Willson, Malecha, & Lemmey, 2000). Overall, it can be said that the violence affects the quality of life for abused women (McFarlane et al., 2000). Furthermore, abuse during pregnancy is a major threat to the health and survival of the pregnant woman (McFarlane et al., 1999).

When comparing the effect of different types of violence on women's health status as measured by the SF-12, the present study found that during pregnancy, women who were physically and sexually abused had lower mean scores in all subscales whereas women who were psychologically abused had lower mean scores in all but role physical functioning. Mental health, bodily pain, and role emotional subscales were found to be statistically significant between abused and non-abused women in all three forms of abuse. Social functioning was found to be significant lower in women who were physically and/or sexually abused than who were not. Role physical and vitality were found to be significantly lower in women who experienced physical and psychological abuse, respectively.

In relation to abuse after birth, it was found that women who experienced physical abuse had significantly lower mean scores than women who did not on 3 of the 8 subscales: role physical, role emotional and mental health. Psychologically abused women reported significantly poorer mental health than non-abused women. There were no statistical differences in any subscale of the SF-12 between women who

experienced sexual abuse and those who did not. Although, not all subscales were significantly different between the two groups of women, at least 7 subscales were lower in women who were abused in all three forms. This study clearly showed that domestic violence not only affected women's physical health that limited their physical functioning in daily lives, but also affected their mental health.

Maternal complications

There is some agreement in the literature regarding the impact of violence on women's health. Most frequently cited are: somatic complaints, depression, anxiety, post traumatic stress disorder (PTSD), substance abuse, suicide attempts and gynaecological complaints (Amaro et al., 1990; Mazza et al., 1996; McCauley et al., 1995). The present study however did not directly explore these negative impacts. The study afforded a different focus on the health of women who have been subjected to domestic violence by using the SF-12 Health Survey and extended to the investigation on the association between maternal complications such as premature rupture of the membranes, infection, miscarriage, postnatal haemorrhage, and domestic violence. In relation to maternal complications, the present study found that antepartum haemorrhage was significantly associated with physical violence during pregnancy, although other maternal complications showed no association. Sammons (1981 cited in Newberger et al., 1992) postulated that physical or sexual abuse involving abdominal trauma during pregnancy was significantly associated with antepartum haemorrhage, foetal fracture, rupture of the uterus, and liver, spleen, or pelvic fractures. Although the target sites of injuries of abused women in this study were mainly their limbs, over five percent of abused women reported the abuse was also directed toward the face and the body albeit not specific to the abdomen.

Neonatal outcomes

Domestic violence during pregnancy has a pervasive effect not only on maternal health and wellbeing but also infant outcomes. Some studies showed that domestic violence is linked to low birth weight of infants (Bullock & McFarlane, 1989; Parker et al., 1994). The present study did not support these findings although some variables such as age, income level, and family structure were controlled. These may

be because of the low numbers of mothers who had low birth weight infants (n = 21, 7.7%) compared to 11% of women who had low birth weight infants in 2001 in Khon Kaen Hospital (Khon Kaen Hospital, 2001). Further, social support and other protective factors, such as, antenatal education/programs which were not measured in this study, may have influenced this trend. The lack of effect of domestic violence on low birth weight has been found in several studies (Cokkinides et al., 1999; Grimstad et al., 1999; O'Campo et al., 1995; Quinlivan & Evans, 2001; Shiono, Rauh, Park, Lederman, & Zuskar, 1997).

Although a study conducted by Quinlivan and Evans (2001) suggested that women who experienced abuse were likely to have an infant with poor weight gain, feeding difficulties and jaundice, the present study found no association between abuse and these neonatal problems. In relation to other adverse neonatal outcomes such as foetal injuries, stillbirth, neonatal death, and other complications after birth which have been described in previous studies (Petersen et al., 1997), the findings of the present study indicated only two women had stillbirth and no other adverse outcomes were identified making it difficult to determine the relationship between domestic violence and these neonatal problems.

Perceived Causes of Domestic Violence

A feminist orientation that views domestic violence as the result of patriarchal dominance and rigid social structures seems to fit with these research findings for several reasons. The perceived causes of domestic violence as described by women in this study were related to the Thai patriarchal family structure, and power inequalities between women and their partners, as seen from the rigid expectations of women as wife and mother, partner's controlling behaviours, and economic dependence and lack of status in the socio-legal system.

Research has indicated that abusers often used violence as a tool to achieve power and control over their female partners and children (Dobash & Dobash, 1979). Several researchers assert that the abusers use violence to gain power and control because they believe that they are entitled to the obedience, services, loyalty, and the

exclusive intimacy of their female partners (Dobash & Dobash, 1979; Rich, 1979 cited in Hart, 1995-2005). Perpetrators often learn that they will not be seen to be responsible for or suffer adverse consequences if they utilize violence as a tactic to achieve or sustain power over their partners (Dobash & Dobash, 1979). Furthermore, it is asserted that where a wife disagrees with her violent husband or fails to defer to his preferences, she risks retaliatory violence (Dobash & Dobash, 1979).

Economic inequality has been associated with the incidence of domestic violence (Levinson, 1989). In the current study, the majority of both women and their partners had monthly incomes of between 1,000 – 5,000 Baht (AUD $35-172); almost 40 percent of women were housewives; and 2.6% had partners who had no income. It can be seen that these women were reliant on their partners/husbands or someone else for financial support. In Thailand only women who are government employees, or employed in a private company and have a social security card are entitled to receive their monthly income from employers while on maternity leave. The dependency of some women on their husbands' financial/economic support may limit their ability to seek help, obtain services and assistance they need in dealing with domestic violence, and or leave abusive relationships in order to protect themselves and their children from further abuse. To accommodate this, effective support services that assist women in being self-sufficient need to put into place. However, the findings in the present study suggest that economic inequality alone does not account for the incidence of domestic violence in Thai society, as several women in the study reported husbands/partners' controlling behaviours and alcohol consumption at times of violence as perceived causes.

Heavy alcohol consumption was another reason that abused women in the present study cited as a cause of domestic violence. This is consistent with the survey data that showed significant associations between partners' drinking habits and domestic violence particularly, physical and psychological violence. The majority of abused women reported that the violent incidents occurred following their husband's alcohol consumption especially when he was unable to control his behaviours or make clear

judgments. Some women reported confronting their husbands and disagreeing with their excessive drinking and as a result experienced anger and abuse. These abused women therefore believed that drinking caused domestic violence, although alcohol is an indirect cause of domestic violence (Donath, 2002). This can be explained from some responses where women said that their partners spent wages on alcohol and socializing with friends but never helped them to take care of the family. This led to arguments and subsequent abuse when the husband returned home intoxicated. This finding supports a Thai study that found alcohol was associated with domestic violence although the direct cause of domestic violence was inconclusive and complex (Thanaudom, 1996). Inconclusive in that some women also reported experiencing abuse while their husbands were not drunk.

According to Jewkes (2002), "alcohol is thought to reduce inhibitions, cloud judgment, and impair ability to interpret social cues. However, biological links between alcohol and domestic violence are complex" (p. 1425). Some researchers have noted that alcohol may act as a cultural "time out" for men with antisocial behaviours (Gelles, 1974 cited in Jewkes, 2002). Alcohol is also seen as an excuse for a husband/partner to abuse his wife (Magar, 2003). Gelles (1974 cited in Jewkes, 2002) stated that men were likely to act violently when drunk because they believed they would not be held accountable for their behaviours or actions. In addition, in some communities, men have described using alcohol in a premeditated manner to enable them to beat their wives because violence is accepted as a social norm (Jewkes, 2002).

The perceived causes of domestic violence identified by women in the current study are consistent with those identified in a Lebanese study by Keenan, El-Hadad and Balian (1998) who conducted a qualitative content analysis of descriptive narratives of 60 low-income Lebanese women. Three main categories of causes for spousal physical violence emerged and included unmet marital role expectations, conflicts with in-laws, and husband's substance abuse. Examples of unmet role expectations included the failure of a wife to fulfil basic household tasks such as cooking, cleaning, and taking care of a child, and husband/partner's expectations of their

wife's appearance outside the family. The study also identified conflicts with families of husbands, which included demands for obedience and demonstration of allegiance to the husband and respect for his family (Keenan et al., 1998). In relation to substance abuse, particularly alcohol, this Lebanese study found that women experienced domestic violence when their husbands were drunk and abuse occurred following a challenge or confrontation to a husband's authority by the woman's disapproving actions or words. Emotional, financial and work stresses were also identified as family factors associated to domestic violence (Keenan et al., 1998).

Husband jealousy of male friends was another reason reported by women in the current study as prompting violence. The PMWI survey identified that 10.5% (n = 44) of pregnant women reported that their husband was jealous or suspicious of their friends and this was more remarkable after childbirth (13.5%). These findings are consistent with a previous study that identified sexual jealousy and suspicion of adultery as causes of domestic violence perpetrated by male partners (Levinson, 1989). Sexual jealousy can be used by a husband to control and isolate his wife from her friends and social networks in the belief that he owns or possesses her (Campbell, 1992; McGregor, 1990).

Understanding the reasons women perceive to be causes of domestic violence as well as the mechanisms through which many associated factors contributed to domestic violence will help to clarify interventions and strategies needed for primary prevention of the problem (Jewkes, 2002). These primary interventions will help to address the societal underpinnings of domestic violence in Thailand.

Responses to Domestic Violence

This study also explored women's responses to domestic violence. Women who had been subjected to domestic violence identified a range of responses when violence occurred. Consistent with previous studies, most abused women were not passive victims but rather adopted and employed different active strategies in dealing with violence to maximize their safety and that of their children. The majority of women in the present study claimed that during violent incidents they kept silent or tried to

minimise active resistance to their husband/partner's violence to avoid its escalation. They believed that if they challenged their partners' control over them, the risk of violent incidents would increase. This finding is similar to another study that found confrontation often led to more serious violence (Keenan et al., 1998).

Some women stated they cried because they did not know what else they could do in order to stop the violence. It is possible that abused women in the present study felt helpless and hopeless in dealing with the violence. Walker (1979) suggested that women who had many ultimately unsuccessful attempts to stop violence in their relationships would eventually develop learned helplessness, and subsequently they stopped their attempts to engage in strategies they used before. Learned helplessness is a psychological consequence of living in an abusive relationship (Walker, 1993). Seligman (1975 cited in Walker, 1993, p. 135) described learned helplessness as "the process by which organisms learn that they cannot predict whether what they do will result in a particular outcome". Walker (1993) argued that this does not mean that abused women learn to behave in a hopeless way, instead they lose their belief that they can predict that a particular response will bring about their safety. Walker (1993) further argued that abused women who developed learned helplessness, did not respond with total helplessness or passivity, rather they narrowed their choices of responses in order to gain the highest predicted successful outcomes.

Avoidance was another strategy used by abused women in this study as a way of dealing with domestic violence. Some women reported they temporarily went out of the house to stay with their parents or mother-in law while others temporarily separated from husbands. These women would return when they felt that their violent partners had calmed down or were begged to return by the contrite partner. This strategy may limit opportunities for men to behave violently although it does not prevent violence (Idrus & Bennett, 2003). Going to a temple to see a Buddhist priest was also used by some women as a means of support. This can be linked to a cultural belief that the temple and Buddhist priests are sources of mental/emotional support for many people in Thailand.

Previous studies conducted in other Asian countries have identified similar strategies used by abused women (Chaisetsampun, 2000; Idrus & Bennett, 2003; Sen, 1998). For example, a study conducted in Calcutta, India, using semi-structure interviews with 47 women explored the ways in which women deal with intimate partner violence and found that 11% of women who were abused did "nothing" because they felt that the man was too big or too strong to tackle, 29% cried and responded in ways that did not challenge the man (Sen, 1998). In addition, it was found that a small number of women used retaliation to resist the violence by grabbing the man's hands to stop him or tearing his clothes as a mean of frustration or anger (Sen, 1998). Similarly, a study conducted in central Thailand found that women who were abused both physically and sexually also used retaliation as a response to partner abuse while at least 30 percent of women did not fight back (Archavanitkul et al., 2003). The reason for not using retaliation and confrontation by some women was that it often resulted in the escalation and increased severity of violence. It is also possible that some abused women in the present study did not confront their violent husbands/partners because they were emotionally or physically fearful or frightened of their violent partners.

The present study found that some women who have been subjected to domestic violence also reported telling others particularly friends, family members and neighbours about it and asking for assistance from their relatives particularly after incidents. They sometimes also notified the abuse to local authorities, such as, a village headman and/or police seeking help to intervene as they felt that they could be protected at that moment. However, many women found that notifying local or legal authorities did not necessarily mean that they would be safe or their husbands would be charged. Often when the abuse was repeated, women were reluctant to report the matter to local authorities. Abused women also learnt that they would be in a more dangerous situation when returning home if no effective interventions were implemented by legal authorities. Walker (1984) stated that repeated abuse leads to passivity and decreased cognitive ability to perceive the possibility of success by victims. After repeated abuse, women no longer believe that they have total control over their bodies and lives and feel powerless to change or seek assistance. The

findings of the present study are consistent with the study conducted in the North region of Thailand (Chaisetsampun, 2000).

As expected, not all women in the current study disclosed abuse nor sought help from others. The reasons given in this study included: viewing domestic violence as a private problem; feeling ashamed; being afraid that they would be blamed for the violence; believing that the abuse was her responsibility; and believing that no-one could help. There are many well-documented barriers to women disclosing domestic violence. These barriers include shame and/or embarrassment, fear of the perpetrators, fear of judgmental attitudes, belief or hope the abusers will change behaviours as soon as the baby is born, belief that the abuse is normal and common among couples, feeling of self-blame, and concern over confidentiality (Archavanitkul et al., 2003; Hegarty et al., 2000; Hegarty & Roberts, 1998; Hegarty & Taft, 2001). Further, an Australian study by Coumarelos and Allen (1999) suggested several possible explanations for the low rates of disclosure including the victims believing that violence in general or certain types of violence were acceptable and should be tolerated, incorrectly believing that their needs could not be met by the present criminal justice system and their needs could not be met by available services.

In regards to women's responses to sexual violence, the majority of sexually abused women in the present study reported that they did nothing while others tried to verbalize their unwillingness, such as, telling their partners/husbands that they did not want sex, pretending to sleep, or making excuses such as menstruation or having a stomach ache. Women reported that these strategies sometimes helped while at other times they did not. It appears that women in the present study had no or less power in negotiating their sexual preference with their partners.

Women's Needs and Support

Another main purpose of this study was to examine the needs and support women would find helpful in dealing with domestic violence. Abused women in this study identified various needs and support mechanisms. The main issues, as illustrated in

the case studies can be grouped as socio-legal assistance, emotional support, and community health promotion.

One of the most important support services identified by abused women in the present study was socio-legal assistance. Women reported that police and local authorities lacked understanding on domestic violence. Abused women stated they reported the abuse to the police and village headmen to enable them to press charges against their abusive husbands. However, instead of arresting or charging the abusive husbands, the police only worked toward mediation in an attempt to have the couple reconcile. Participants reported that police did not file their complaints against the abusers because they viewed it as a family matter, and lacked understanding about the legal rights of victims of domestic violence. Similarly, women also found that the village headmen did not want to implement any measures or intervene in a domestic dispute. Women in this study further suggested that police and local authorities should be knowledgeable and confident enough to deal with issues of domestic violence more effectively. These findings are consistent with other Thai studies (Archavanitkul et al., 2003; Chaisetsampun, 2000).

These negative experiences with police and local authorities subsequently led to a decrease in the use of services and unreported violent incidents by many abused women. According to Waldrop and Resick (2004) "women's use of particular coping strategies is reflective of context and personal factors as well as the outcomes that they expect from their strategies" (p. 297). They suggested that the choice of help abused women would use in the future were based on the degree to which their expectations were met in the past. They further stated that the responses of potential support sources, such as, police, have sometimes been problematic (Waldrop & Resick, 2004). Many abused women have lost their faith in police and social justice institutions such as courts and children's services due to their negative experiences, and report frustration, disappointment, anger, and rage (Renker, 2002). Situations related to failure to arrest, being arrested, and having their children placed into custody when they reported violence to authorities were also often cited by abused women as problems faced when dealing with legal authorities (Renker, 2002).

Although several legal mechanisms as well as the establishment of organizations helping women experiencing domestic violence are available in Thailand, it is clear that victims have little protection against the problem. It is noted that women in the present study reported the need for crisis centres and shelters to be established and access to health professionals who specialise in violence against women in the districts and/or provinces in the Northeast region of Thailand. The establishment of crisis centres or accommodation in this area would provide for safe containment and support to women who are not safe or cannot stay home especially at a times of extreme danger. It would also facilitate women's access to services, as currently domestic violence services are located in Bangkok or other provinces in central Thailand. Travelling to such services is extremely difficult for most women given the distance and cost. In addition, some women indicated a lack of knowledge or awareness about support services, not knowing where to access help, or to whom they could turn for assistance. These findings suggest that more needs to be done to publicise the availability of services, so that women who have experienced domestic violence know where to turn for assistance. More needs to be done to provide better information to women about existing social and legal remedies to violence and the network of support services. The needs identified in the present study largely reflect that services available for abused women and children should be well integrated in order to support women in remote areas of Thailand.

This proposition supports the findings of an Australian study (Coumarelos & Allen, 1999) that found 2.6% of women who experienced physical assaults claimed that the main reason they did not use crisis, legal and financial services was because they did not know of such services. In addition to not knowing about the existence of services, it is possible that some women are not aware of the ways in which the existing criminal justice system and victims services could help them deal with victimization. The extent to which the Thai criminal justice system responds to the needs of victims of domestic violence is largely unknown and requires further investigation. Reports from women in the present study indicate, however, that the justice system is failing many abused women.

In developed countries, women's crisis centres and shelters have been the cornerstone of programmes for women who have been exposed to domestic violence (World Health Organization, 2000). These support services provide emergency shelter in addition to emotional, legal, and material support to abused women and their children (World Health Organization, 2000). These centres also provide support groups and individual counselling, job training, programs for children, assistance in dealing with social and legal services, and referrals for treatment for drug and alcohol abuse. Most shelters and crisis centres were originally established by women activists, and many are now run by professionals and receive government funding (World Health Organization, 2000).

In many developing countries, shelters and crisis centres for women have been established since the early 1980s (World Health Organization, 2000). Most countries have at least some non-government organizations offering specialized services for victims of violence. Some countries have hundreds of such organizations (World Health Organization, 2000). Since maintaining shelters is expensive, many developing countries have established telephone hotlines or non-residential crisis centres that provide some of the services provided by residential programs. Where the establishment of a formal shelter is not possible, women have often found other ways to deal with emergencies related to domestic abuse. World Health Organization (2000) suggested that setting up an informal network of "safe homes", where women in distress can seek temporary shelter in the homes of neighbours is an alternative approach. Further, some communities have designated their local place of worship such as a temple or church, as a place where women can stay with their children overnight to escape drunken or abusive partners (World Health Organization, 2000). In Thailand one of the most effective services that provide assistance to women and children who are victims of violence is "Praveenaa Hongsakul Foundation for Children and Women" established in 1999 in Bangkok. This foundation is a non-profit organization established by Praveenaa Hongsakul who is a member of the Thai parliament. This service is becoming more well-known all over Thailand, however, accessing this service can be difficult for many women

particularly those who live in the Northeast region of Thailand due to financial problems and distance to the service.

Emotional support services were another helpful resource identified by abused women in this study. This support included counselling services and care by health care professionals. The counselling services should include family counselling, drug and alcohol cessation programs, development of safety plans for women experiencing domestic violence, and counselling on how to live in harmony in the homes. A mediator (or someone who could help stop the violence or counsel abusive husbands to not use violent behaviours) was also required by abused women especially those who had no family members or close relatives. Not all women in the present study wanted to leave their relationships. Women reported trying different strategies to end the violence and keep their families intact. Women who were in an abusive relationship noted that the couples needed to work together and with the help from these services, the violence may be stopped and that their marriage could be saved. They also hoped that their partners/husbands would change for the better in order to keep their families intact. Some women identified the development of a safety plan to help those who chose to continue in the relationship. Such supports are critical resources for women attempting to end and/or manage the violence in their relationships. Such strategies may operate directly to protect abused women against future violence, or indirectly by enabling women to utilize resources and strategies more effectively (Goodman, Dutton, Vankos, & Weinfurt, 2005). Women in the present study also identified the need for counselling services on health related stress since domestic violence has a pervasive effect on women's health and wellbeing. In the present study, some abused women reported taking drastic measures such as suicide attempts and overdosing, in addition to feeling stressed, worried, hopeless, and depressed. Such services would help minimise the likelihood of problems getting worse.

In relation to support from health care providers, abused women reported empathy and compassionate care were important particularly for women who have been exposed to domestic violence and received injuries and required hospitalisation or

medical attention. Women in the present study found health care professionals to be judgmental. This finding is consistent with another study which found that some women were disappointed with health care providers who tended to be prejudiced, underrate the violence or reluctant to tackle abuse (Flinck, Paavilainen, & Astedt-Kurki, 2005). These women hoped that health caregivers had the courage to ask about the violence without blaming and condemning (Flinck et al., 2005).

Helping abused women is seen as a difficult and demanding task for nursing staff and other health care providers because they have to face their own attitudes, fears, distress, helplessness and insecurity (Frost, 1999). They may also feel frustration, and powerlessness when caring for domestic violence victims (Sugg & Inui, 1992). Education may help prepare nurses and other health care providers to assess and intervene in domestic violence cases (Espinosa & Osborne, 2002). Waldrop and Resick (2004) suggested that it is often necessary for health care providers not only to broaden women's options on how to manage the violence but also assist women in decreasing the psychological symptoms that result from victimization. It is also important particularly for health providers to assist abused women to increase their social supports, job skills and access to social services such as legal assistance and court orders of protection (Sullivan, Basta, Tan, & Davidson, 1992).

Another support service identified by abused women in this study was community health promotion. This included education on domestic violence and programs to help raise the general public's awareness of domestic violence and also to change public perceptions regarding violence in the home. Some women reported that domestic violence continued to be seen as a family matter, or a husband and wife problem. Providing domestic violence education to the government could increase awareness and change public attitudes toward domestic violence, which in turn may increase public knowledge and understanding (Costa & Matzner, 2002).

The findings of the present study are consistent with two other Thai studies. One study conducted in Bangkok and a province in central Thailand using focus group interviews with women identified a number of preventive measures that included law

and policy reform on wife rape, police involvement such as arresting an abusive husband, raising public awareness of domestic violence, promotion and establishment of hotlines by local organizations in different areas, and employment support (Archavanitkul et al., 2003). Another study reported that the needs of and support for abused women in Northern Thailand included safety or security, sympathy and moral support, financial independence, legal assistance, and consultation on health related violence (Chaisetsampan, 2000).

In the United States, one study followed-up domestic violence survivors 6 months after exiting a shelter. The authors found that immediately upon exiting the domestic violence shelter, women identified various needs. These needs consisted of health care, education, social and financial support, transportation, obtaining employment and legal assistance (Allen et al., 2004). By instigating a collaborative approach, recognizing these support and care needs, health care professionals and other related services can respond appropriately and effectively to meet the needs of women who have been exposed to domestic violence.

Barriers to Disclosing Violence

Midwives and other health care professionals are in a key position to identify pregnant women currently in an abusive relationship or at risk of being abused. Clinicians need to assess for domestic violence early in the course of antenatal care to potentially assist pregnant women to avoid negative consequences of domestic violence (McFarlane, Soeken, & Wiist, 2000). Pregnancy and the early postpartum period are times when healthy women have frequent, scheduled visits with health care providers. This is because pregnant women are often motivated to protect their unborn child from harm. Therefore, pregnant women and mothers are motivated to attend antenatal and postnatal clinics as a mean of receiving health care and protecting their unborn or newborn baby, and thus providing opportunities for midwives and nurses to assess and identify women who have been subjected to domestic violence, and to provide early interventions to these women (Wiemann et al., 2000). At the first antenatal visit pregnant women may not trust their health care providers, and they may be reluctant to disclose the abuse perpetrated by their

partners. However, research has shown that many women would talk openly if given a chance and rapport has been established (Rodriguez, Sheldon, Bauer, & Perez-Stable, 2001).

The present study found several reasons why women did not report or disclose domestic violence to others. Firstly, the view of domestic violence as a family affair or a private matter was one of the most common barriers that inhibited women from disclosing abuse and even seeking help. Many women felt that they needed to solve the problem by themselves and needed to endure the violence in order to keep the family together. Costa and Matzner (2002) asserted that this perception of personal responsibility and self-blame make it virtually impossible for women to address the problem publicly, further driving it underground. The perception of domestic violence as a family matter is also perpetuated by police and even local officials and contributes to their reluctance to get involved. The view of domestic violence as a family issue is reinforced in the Thai proverb "The inside should not be taken out, the outside should not be brought in (fai nai mai hai nam o'k, fai n'ok mai hai nam khao)" (Costa & Matzner, 2002, no page number). This Thai proverb suggests that family matters should remain within the family. Exposing such family problems may result in 'loss of face' and should be avoided at all costs (Costa & Matzner, 2002).

Secondly, women in the current study reported a lack of support persons or did not know who could help them with this problem. For example, some women reported they wanted to talk to someone but did not have anyone available with whom to discuss the violence. This finding is in line with the conclusion of Fugate et al. (2005) that the most common reason for women not talking to someone about the abuse was related to barriers and isolation. Whilst some women gave privacy reasons, such as, the domestic violence incidents or the relationship are 'too personal' and are 'nobody else's business', many women expressed shame, embarrassment, or fear of being judged or criticized if they talked to someone (Fugate et al., 2005). Similarly, many domestic violence victims feel humiliated and give up reporting incidences to avoid the shame and guilt inflicted upon them

(Pekanan & Wongsurawat, 2001). These reasons may reflect a common tactic of control used by perpetrators of isolating as well as shaming the woman, which is a common psychological dynamic in domestic violence (Fugate et al., 2005).

According to Seng et al. (2002), some women may not be aware of how their history of trauma from domestic violence may affect their pregnancy and general health, and thus not disclose the abuse history. Women may not disclose this history to health care providers for a variety of reasons including fear, shame, and concerns about confidentiality, trauma amnesia, or lack of trust (Seng, Sparbel, Low, & Killion, 2002). Abused women prefer to disclose only when they see visual cues such as support group posters, domestic violence shelter posters, or when responding to screening questions or therapeutic interpersonal openness from care providers that demonstrate competence and respect (Seng et al., 2002). Furthermore, women who are abused and also using illicit drugs during pregnancy are likely to only disclose if they believe there are resources to address their trauma-related needs (Seng et al., 2002). While the reasons for not reporting domestic violence or seeking assistance are varied, one study found that almost half of the women who did not report violent incidents thought that it was too minor to involve the police or judicial authorities although these women indicated that they had spoken to someone else, usually a friend or neighbour about what had happened to them (Mouzos & Makkai, 2004).

Barriers Inhibiting Women from Seeking Help

Domestic violence is a pervasive social and public health issue requiring a comprehensive response from all related agencies and communities across Thailand. Previous studies have indicated that women who are victims of domestic violence do seek help from a wide variety of domestic violence services and resources (Allen et al., 2004; Fugate et al., 2005), however, there are barriers that inhibit many women from seeking help. The fourth aim of the present study was to identify barriers inhibiting women from seeking help. The findings of the present study, as illustrated in the case studies, identified the lack of support networks and/or lack of knowledge on domestic violence resources, feeling powerless and hopeless, believing that the

partner/husband would change, and negative experiences with legal and local authorities.

Having no support networks especially family support has left many pregnant women and mothers to face domestic violence alone. Many women in the present study reported that they would try to solve the problem by themselves. But for those who had family members or relatives, they would seek help from these people if the violence did not stop. Muhajarine and D'Arcy (1999) stated that women who were abused during pregnancy were less likely to have a wide network of friends with whom they could talk or get together compared to those who were not abused. Good social support and networks can be a source of power for women and may be protective against domestic violence (Counts, Brown, & Campbell, 1992).

Feeling that no-one could help with domestic violence was another barrier from seeking assistance reported by women in the present study. This suggests that abused women may feel helpless with their situation. In addition, women did not seek assistance simply because they were not aware or did not know what services and resources were available for them. This finding is consistent with a previous study that found a large number of women lacked knowledge of resources (Fugate et al., 2005). This included women who did not know of any agencies, who to contact, where to go, or how to contact an agency or counsellor. Another study found that lack of childcare or transportation as reasons for barriers to seeking medical care (Gielen, O'Campo, Faden, Kass, & Xue, 1994). Moreover, some women considered that the situation was not serious enough to seek medical care or that medical care was not considered useful (Fugate et al., 2005). Further some women did not go to an agency because they were not going to leave their partners (Fugate et al., 2005). It appears that these women may believe that to seek help from an agency or counsellor would result in the end of their relationship.

Negative experiences in the past with local and legal authorities could also inhibit abused women from seeking help or contacting police when the violence reoccurred. For example, one woman in the current study indicated that she did not ask for help

when the violence was repeated because on a previous occasion the village headman had not filed a report of the incident, and when she reported the violence to police, she was advised to reconcile with her husband. This resulted in an escalation of violence and retaliation when returning home since no protection was given to her and the police did not charge or arrest her abusive husband. These negative legal experiences are similar to those in other countries. Heise et al. (1994) stated that "universally police are reluctant to intervene in cases of domestic violence, and too often, protection orders become meaningless because police and judicial officers refuse to enforce penalties for non-compliance" (p. 1171). In Thailand although there are several female police officers in Bangkok, Songkla (Southern Thailand), and Chiangmai Province (Northern Thailand) to support and encourage female victims of abuse to come forward, their presence has not increased the rate of prosecution because the justice and legal systems have yet to be reformed. According to Heise et al. (1994) the effectiveness of legal reforms is highly dependent on the extent that they are accessed, implemented and enforced. This is particularly apparent where women are unaware of their rights and where laws go against accepted customs.

Seeking help can be complicated by social and religious expectations of women (Flinck et al., 2005). Flinck et al. (2005) explained that abused women pondered their own guilt or they were afraid that their partners would prevent them from talking about the violence or that seeking help would lead to more violence. These barriers enhanced the likelihood of women not seeking assistance and remaining in an abusive relationship.

Many abused women in the current study reported that they continued to stay in an abusive relationship although they wanted to leave or had even attempted to leave several times. There were several reasons for continuing in such relationships. Firstly, they hoped or believed that the situation would change for the better as soon as the baby was born, or that their partners might change their behaviour. The next reason for continuing in a relationship was concern about their children and financial dependence on partners which made it even harder for them to leave. Moreover, the

parents of some women felt that the problem could be resolved without divorcing or separating. This may be due to the Thai traditional belief that divorce leads to sin and the woman would be stigmatised and blamed for the failure of the marriage. Further, Thai women are taught to endure and be patient in relationships in order to keep the family and for the sake of their child (Archavanitkul et al., 2003). This finding supports previous studies that concluded family and social role expectations were barriers encountered by women experiencing domestic violence (Anderson et al., 2003). Anderson et al. (2003) stated that female socialization in a patriarchal society relegates women to the role of primary caretakers of their relationships and families. The role of domestic violence victims as caretakers squarely puts the blame on them for the failure of the relationship. This serves to amplify the burden of blame women often experience by their abuser. Consequently, abused women often perceive that they have no alternative than to remain in the relationship and place a high value on the promises of change or apologies given by the abusive partner (Anderson et al., 2003). Further, Walker (1984) argued that women experiencing repeated abuse often become passive and are less likely to perceive the possibility of success from leaving a violent relationship. After repeated abuse, women no longer believe that they have control over their lives and they feel powerless to change, as a consequence of entrapment (Walker, 1984).

External factors may also play a major part in preventing victims from escaping violent relationships. Anderson et al. (2003) argued that weak and unavailable community resources as well as inadequate assistance could contribute to women remaining in the relationship and not seeking assistance. Abused women may perceive that their safety is more at risk if they try to leave. Furthermore, women are given messages by the unavailability of resources that their safety is not important and that they would not be protected from the abuse. In the absence of real protection, it is rational for abused women to put more faith in the promises and apologies of their abusive partners. This situation encourages women to be compliant and use conciliatory strategies (Bailey et al., 1997).

To escape domestic violence, resources are needed such as money, a place to go, support from police and courts, support from family and friends, and/or professionals (Anderson et al., 2003). In the absence of these resources, escape from domestic violence is impossible for many women. Even in those communities with available resources, the perception of domestic violence victims may be that such resources are unavailable. Linking victims with adequate and appropriate resources of necessities and support is vital (Anderson et al., 2003). In addition, abused women may sometimes require not only a service to help recover from the violence but also assistance in resolving problems with partners or in finding the courage to leave the abusive relationship (Coumarelos & Allen, 1999).

Leaving a violent relationship may involve a particular danger to life. The findings of the present study showed that some women left their relationship several times, but returned because their abusive partners threatened to harm not only them but also their love ones such as parents or relatives. In addition, some women returned to the abusive relationships because of their partners' vows to change. By returning to the relationship, abused women entered the cycle of domestic violence as suggested by Walker (1984). Added to this, Landenburger (1998) asserted that leaving an abusive relationship is a process which includes periods of denial, self-blame and suffering before women come to recognize the reality of domestic violence and identify with other women in similar situations. At this point, disengagement and recovery from the abusive relationship begins. Recognizing that this process exists can help nurses and other health care providers to be more understanding and less judgmental about women who return to abusive situations (Landenburger, 1998). Importantly, to effectively help abused women to deal with domestic violence problems, support services need to be established in this region of Thailand to assist women.

Contribution to the Emerging Theory on Domestic Violence

Given the lack of statistics and limited studies in relation to domestic violence among Thai pregnant women, the current study attempted to determine the prevalence of domestic violence during pregnancy and following childbirth, and identify possible contributing factors, perceived causes and support mechanisms. The current study

did not aim to test any existing theories and conceptualizations about domestic violence. Feminist perspectives however were used to inform the study and were used to make sense of the study findings. The contribution of the current study to these perspectives is discussed below.

1. Women in the present study reported that they were controlled, isolated from family and friends, and blamed for the marital problems. The results of this study strengthen the feminist perspective that men use violence as a means to exert their power and control over their wives who hold the subordinate position in the home and family (Dobash & Dobash, 1979; Yllo, 1993, 2005). Furthermore, the Thai traditional belief that by means of marriage, husbands have the right to control wives through whatever means including the use of violence perpetuates violence in Thai society. While Thai men believe that they "own" their wives, violence will continue against innocent women.

2. The findings of the present study also support the perception that gender roles perpetuate inequalities between men and women in Thai society. The present study found that the rigid role expectations of Thai women held by their husbands contributed to domestic violence. This is based on the notion that a husband is viewed as the household head, and a wife as a caretaker and mother. This perception contributes to men's beliefs that as the head of the family they are dominant in a marital relationship. Men believe that they can resort to violence if their wives do not meet their expectations. Women on the other hand are subordinate to men and will be blamed for an unsuccessful marriage, and for not fulfilling their roles as good wives and mothers. In these social contexts, domestic violence is invisible and accepted by women themselves, the couple, their families, and their community in order to maintain the values, commitment to patriarchal gender roles and social stability.

3. Although violence occurs in all socio-economic groups, the results of this study supported previous research that women with low income or those who were financially dependent on their husbands were more likely to be abused

than those who did not. This finding supported the notion that violence against women becomes a method used by men to maintain social control and power over women through economic dominance. The effects of economic inequality are mediated through women's inability to leave the violent relationships or to live independently. The lack of economic power of women also hinders their self-confidence and ability to use information and access domestic violence resources available in society.

4. Alcohol consumption was found to be associated with domestic violence, and was perceived by women in this study to be a cause of domestic violence. However, to break the silence of domestic violence, alcohol should be seen as a contributing factor to domestic violence rather than a cause of it. If alcohol is believed to be a cause of domestic violence, men are likely to act violently when drunk and believe they are not responsible or held accountable for their behaviours. Thus, alcohol can be used as an excuse to abuse women.

5. A changing economy in Thailand, and a shift from an agricultural to industrialized society has resulted in living pattern changes for some people in this area. Prior to this economic change, people in this region relied on agriculture mainly rice production and tended to be self-sustaining. Recently more people depend on daily wages and materials, and as a consequence may need to move to other catchments for jobs which remove them from their extended support networks. Coupled with this, workers are exposed to alcohol and are more pressured to generate income for daily living. Financial stress may contribute to domestic violence especially for childbearing Thai women who are financially or economically dependent on their husbands/partners.

6. Because Thai women live in a strong patriarchal society, their rights often go unrecognised by the broader community and are more hidden in rural and remote areas due to adherence to traditional values, limited resources, and less access to education and job opportunities. Therefore more research needs to be done with women, not to or for women. By doing so, the findings

of such research will serve women's best interests, help to address their concerns and experiences, and lead to improvements in the conditions of women's lives. Most importantly, women will be better empowered and receive advocacy.

Limitations of the Study

There are several limitations of this study. Firstly, due to the low literacy levels of some participants, the researcher needed to do face-to-face interviewing to complete surveys. This may have resulted in the likelihood of women providing responses that they felt were socially desirable. Since domestic violence is still perceived as a private or personal issue in Thai society, it is possible that women who are victims of domestic violence did not want to disclose the violence because of shame and the social embarrassment they may have felt in particular in Phase 1 where the participants first met the researcher and rapport had not been established. The women's responses may have also been driven by their ongoing fear of their husbands/partners' violence. Secondly, since domestic violence is a sensitive issue, some women may have been concerned that they would miss their turn to see a midwife when their names were being called for their antenatal check up, although they were reassured about this by the researcher, this factor may have led to underreporting the problem in order to end the interview quickly. Thirdly, the study included only women who were contactable by telephone (which could be their own telephone or a relative), or those who attended their 6-week postpartum follow up at the selected hospitals. This data collection approach may have resulted in the exclusion of women in the violent relationships because of an inability to follow-up. However, the researcher found that telephone interview was appropriate in Phase 2 especially where the researcher had met the participants in Phase 1 and a trusting relationship had been developed. It would be hard to employ other strategies such as travelling to the participants' homes or a health centre where they attended their postnatal follow up. This would require additional resources such as more time and financial support to enable travel to participants who were often from different and distant villages and districts. Fourthly, the differences in time frames for collection on domestic violence data made it difficult to compare the prevalence of violence

between the two periods (pregnancy and after childbirth). Fifthly, the study only used two screening questions to determine the incidence of domestic violence before pregnancy. It would be more comparable if the same questions were used to elicit domestic violence before and during as well as after birth. Finally, this study looked at domestic violence from women's perspectives and was underpinned by feminist principles, it may be necessary to gain male perspectives to understand their attitudes towards violent behaviours.

Recommendations for Future Research

The present study not only enhances knowledge and understanding of the nature of domestic violence in Thai culture but also broadens the concept of domestic violence in nursing research in Thailand. Based on the findings of this research, recommendations for future research are made. It is recommended that:

1. This study should be replicated in other regions of Thailand to enhance comparisons that may provide useful insights into the prevalence, factors associated on domestic violence, maternal and neonatal health as well as needs and supports of abused women. More studies on domestic violence in Thailand will help to improve services and raise awareness of a possible endemic problem. Further studies will also help to extend the emerging evidence that domestic violence in Thailand is a problem that requires urgent attention.
2. Further exploration on domestic violence in different groups of Thai women from different settings may add to the general knowledge and understanding of the phenomena across the culture. This would also provide the possibility of generalizing findings and further the development of programs for women who experience domestic violence.
3. Studies with professionals such as mental health nurses, midwives, legal authorities, and other related care providers would provide insight into their knowledge, attitudes, practical skills, experiences and service needs in assisting pregnant women who are victims of domestic violence. Such research would be useful in identifying areas that need further attention such

as education, continuing professional education and models of services delivery.

4. Further research using a longitudinal approach is needed to determine the pattern of abuse over a longer period after childbirth as well as determine any variation in Thai women's responses overtime. For example, some of the influences might be related to a change in social situations and circumstance such as economic factors.
5. Further research using action research or interventions may be useful as a means to inform programs that aim to reduce and prevent domestic violence.
6. Further research to ascertain domestic violence from a male perspective is also needed to understand violent behaviour and design effective intervention strategies.

Summary

This chapter has discussed the findings in relation to the literature. The findings suggest that domestic violence in pregnant women is a problem in Thailand that requires urgent attention from government, related organizations, and communities to work together toward prevention and implement early interventions to reduce risks and harm associated with this type of violence. Factors found to be associated with domestic violence among Thai pregnant women are similar to previous studies. In addition, from the women's perspective, it was identified that the causes of domestic violence are mainly related to power and control embedded in the patriarchal structure of Thai society. Helpful resources and required support identified by women in the current study are similar to studies conducted in other parts of Thailand. However, these needs are different from those found in previous studies conducted in developed countries particularly in regards to responses from the justice system. This investigation suggests the need for increased public awareness of the problem to enable societal structural changes in Thailand. More services for domestic violence victims need to be developed in the Northeast region of Thailand since most domestic violence services and resources operate in Bangkok. The paucity of resources in rural areas makes it more difficult for abused women to

access services and can be a major barrier that inhibits abused women from seeking assistance.

Chapter 6 : Conclusions and Implications

Introduction

Although there have been many calls for more investigations of the relationship between culture, nationality and different forms of domestic violence against women (Campbell, Garcia-Moreno, & Sharps, 2004), very little research has been conducted to examine the prevalence and incidence of domestic violence during pregnancy and after birth in different ethnic groups or in developing countries especially Thailand.

The purposes of this study were to examine the prevalence of domestic violence (perpetrated by current male partners/husbands) during pregnancy and following childbirth in a cohort of women from the Northeast region of Thailand. It also aimed to investigate possible adverse maternal and neonatal outcomes associated with domestic violence, ways in which women dealt with domestic violence and barriers that inhibited women from seeking help, as well as helpful resources and support. The research consisted of two phases with a cohort of pregnant women attending antenatal care at two large tertiary hospitals in Khon Kaen Province. In Phase 1, 421 women were recruited, of these, 274 women could be contacted again in Phase 2. The overall response rate was 65%, which is adequate for community-based studies.

In order to enhance the comparability of results with previous studies and future replication studies, data were collected using standardized questionnaires (the Psychological Maltreatment of Women Inventory, the Severity of Violence against Women Scale, and the SF-12 Health Survey) and seven open-ended questions developed by the researcher based on a review of literature. These measures were translated into Thai using a set protocol. As such the study has contributed to the availability of measures for Thai health professionals interested in determining the prevalence and consequences of domestic violence on childbearing women.

Four case studies were also used to illustrate ways in which abused women dealt with domestic violence, perceived causes of domestic violence, barriers inhibiting them from seeking help, as well as identifying needs and support mechanisms

women would find helpful in dealing with violence in their own homes. This qualitative data collection strategy was useful in identifying the contextual experience of domestic violence for women that is not necessarily revealed in survey responses. The following section highlights the major conclusions drawn from this work and presents implications of the study.

Major Conclusions

High rates of domestic violence during pregnancy and the postpartum

This particular study is unique in its investigation of domestic violence prevalence in Thailand. It comprehensively assessed violence in all three forms - psychological, physical and sexual. The inclusion of psychological and sexual violence is relatively uncommon in the literature as the majority of previous studies have focused on physical violence. The inclusion of the three areas of violence has contributed to a broader understanding of the types and incidence of violence childbearing women experience.

The current study clearly demonstrated that the periods of pregnancy and early motherhood, which are highly regarded in most societies, are not protective against domestic violence, instead many women reported that violence began during these periods. The prevalence of domestic violence during pregnancy was high with 53.7% of women experiencing psychological violence, 26.6% experiencing threats and acts of physical violence, and 19.2% being sexually abused. The prevalence of domestic violence in pregnant women in this study is similar to one other study that used the same tools to assess violence (Hedin, 2000), but is higher than other studies using different tools that did not comprehensively assess all forms of violence.

In relation to the prevalence of domestic violence after childbirth, the present study found that the incidence of domestic violence at 6 weeks following child birth was lower than in pregnancy but still high with 35.4% of women experiencing psychological violence, 9.5% of participants reporting threats and acts of physical violence, and 11.3% reporting sexual violence. This study also found that nearly a

third of women experienced domestic violence during pregnancy and this continued after birth, one third experienced domestic violence during pregnancy only but not after birth, while around ten percent of women experienced domestic violence which began following childbirth. These findings strongly suggest that violence during pregnancy is sufficiently common to warrant development of violence–related interventions for antenatal and postnatal care in Thailand.

Gender-based violence

Although previous studies have indicated that domestic violence occurs across all age groups, cultures and socio-economic groups, the findings of the present study suggest that women who were young, of low socio-economic status, in shorter relationships, had experience of past abuse, and whose partners were alcohol users were at greatest risk. Abused women in this study also identified partners' controlling behaviours and rigid role expectations as reasons for abuse.

The study provides evidence that domestic violence in Thai culture is about the power of men who attempt to exert control over women, not only control over their lives through rigid expectations about women's roles as wife and mother but also through economic dependency. This finding is supported by previous research, which identified that perpetrators use violence as a tool to achieve power and control over their partners and children (e.g., Dobash & Dobash, 1979). The findings from the current study also support the general assertion that gender inequalities in relationships are important factors linked to domestic violence.

It can be concluded that the dynamics of violence are similar to those in other developing countries but the patriarchal dominance in Thai society serves to further oppress women. This was evidenced by "headmen" in the village not referring acts of violence to the authorities, police hesitancy to become involved in "private" matters, social norms that martial happiness is the responsibility of women and that in some way they "deserve" to be abused because they are not a "good" wife and are to blame. These factors are major social barriers that hinder women's ability to effectively cope with the problem and access to violence support services. Women

therefore need to be empowered to shed the "secrecy" and "privacy" surrounding domestic violence in order to give a public face to domestic matters (Pande, 2002) and confront and expose perpetrators although they are intimate partners (Amoakohene, 2004).

Poor health outcomes associated with domestic violence

Domestic violence against women during pregnancy has serious health consequences. The findings of the present study strongly support the conclusion that domestic violence has significant negative health effects on women's physical and emotional well-being. Abused pregnant women reported significantly poorer health status in terms of emotional functioning, vitality, bodily pain, mental health and social functioning compared to those who were not abused. In addition, women who experienced domestic violence in the postpartum period reported significantly lower mean scores on mental health and social functioning than women who did not. As supported by case study data, women reported drastic measures such as attempted suicide, self-harm, and drug overdose in response to continued domestic violence. The present study also found that domestic violence in pregnancy was linked to antepartum haemorrhage although no statistical association was found between domestic violence and other adverse maternal outcomes. This study confirms that domestic violence is a key health risk factor among Thai women.

In regards to neonatal outcomes, although previous studies reported that adverse infant outcomes such as low birth weight, miscarriage, fetal distress and fetal death were associated with abuse during pregnancy, the present study found no significant difference between abuse status and these adverse neonatal outcomes.

For women, abuse during pregnancy and following childbirth limits their functional ability and contributed to psychological distress that may place them at increased risk of developing pronounced mental health problems. Consequently, limited functional ability and adverse psychological effects of domestic violence on women may have indirect harm on their unborn or newborn baby. Abuse during pregnancy and after birth may also hinder women's ability to obtain proper antenatal and postnatal care

and ability to provide quality care to the newborn baby. Longitudinal studies are required to investigate effects on the psychological development of the child.

Urgent need for formal support systems

Although there are measures available to assist women and children who are victims of violence in Thailand, women in the present study identified a variety of support services that ranged from informal to formal service systems. Abused women in particular those who had no family members or those who lived alone with husbands identified informal support systems such as family, friends and neighbours as vital in providing refuge at times when violence occurred, and as a result would assist to lessen the severity of the incident or at least help to some degree at times of critical danger. However, urgently needed are more direct formal support systems for abused women in the form of emergency homes, crisis shelters, and professional services such as medical care, legal representations, and counselling. The findings of the present study clearly demonstrate that there is much to be done in this region of Thailand in order to efficiently assist women who are victims of domestic violence. This was evidenced by abused women feeling unsupported by the legal system. This relates to police inaction, no case filed, no convictions and cases of death due to extreme violence. There continues to be poor socio-legal structures in this region of Thailand. Police and village headmen will continue to not intervene in domestic violence unless there are a social changes and no tolerance for violence in the community. The present study also found limited resources for victims in the Northeast region of Thailand, therefore there is an urgent need for major reform and the provision of infrastructure in the community. The findings also emphasize the need for the development of domestic violence services in the Northeast region of Thailand. The availability of the services and resources is important in assisting women who are victims of domestic violence to move on with their life, and help deal with violence in their own homes, and ensure their safety.

Implications of the Study

This study provides a basis to expand our understanding of the nature and experience of domestic violence during pregnancy and after birth among Thai women living in the poorest region of Thailand. Findings demonstrated that pregnancy and the immediate postpartum periods are times when women are at increased risk of domestic violence. Many women in the present study lacked knowledge about domestic violence services, and had limited family and social support networks. These factors as well as the perceptions of domestic violence as a private matter have contributed to many women remaining in abusive relationships and often these factors have left many of them facing the problems alone. The findings of the present study have important implications for practice, education, and social policy development.

Implications for practice

Domestic violence against pregnant women is a specific social and health problem that demands more attention since two lives are involved: the woman and her unborn child. The findings from this study have important implications for practice in order to assist women who have been abused and help make social and structural changes in Thailand. These findings will also help to inform health care providers and health related personnel organizations to develop strategies for identification and early intervention with pregnant and postpartum abused women that are culturally appropriate. The following target areas could be prioritised and established.

First, domestic violence services available for abused women in Thailand should be developed and decentralized to a provincial and/or district level with a full range of appropriate services. There should also be an increase in non-government organizational (NGO) involvement in providing services. These services could include family counselling, relationship counselling services, emergency services for women who have injuries from domestic violence, psychological support services, legal assistance, crisis/emergency home assistance, and information centres in all districts of the provinces. Nurses and other health care professionals should also have a good coordination system for confidential referrals.

Second, nurses and other health care providers should be familiar with domestic violence information in order to advocate for victims of domestic violence. To facilitate this, all hospitals including health centres in Thailand should develop and have domestic violence guidelines or written protocols and policies. The guidelines may include definitions of domestic violence, facts and myths about domestic violence, common indicators of different types of domestic violence, culturally sensitive assessment questions and techniques, medical record documentation, reviews of safety issues for women and staff, advocacy with police and court system, available community services as well as referral systems. These procedures and protocols will help nurses and other health care professionals to properly and effectively intervene and refer women who have been exposed to domestic violence.

Third, each hospital should have a mental health nurse or a midwife who specializes in helping victims of violence to provide psychological support to abused women as well as work collaboratively with other health care providers to help abused women and their children.

Fourth, rehabilitation and treatment services for perpetrators should also be established at least in a major hospital of each province since the majority of women's partners in the present study had a substance abuse problem. This is particularly important given that the partner's drinking behaviour was found to be a significant associated risk factor for domestic violence.

Fifth, each hospital, health centre and community should have posters, signs, booklets and other media to promote a broad coverage of domestic violence issues central to pregnant women and to women in general that promote recognition of domestic violence and increase public awareness of this problem. These advertising campaigns should emphasize that domestic violence in Thai culture is a crime and not to be tolerated in any community. Information on services and contact details should be included. Both women and their partners should be provided with written material about domestic violence at antenatal clinics or any hospital wards. These

approaches are both a prevention-based intervention and a way of reducing isolation faced by abused women.

Finally, provincial and/or district hospitals should implement routine screening for domestic violence of all women both during pregnancy and in the early postpartum period since these periods are one of the few times that healthy women have frequent, scheduled visits with health care professionals (McFarlane et al., 1992). These times also represent the periods when women are often motivated to protect their unborn or newborn child from harm (Wiemann et al., 2000). Most importantly, when the data of the present study were collected, some women thanked the researcher and stated that they were very happy that there was research into this topic. They felt that they were cared for and that findings would benefit women in need. Routine screening may assist in identifying women at risk thereby enhancing early interventions and the effective management of domestic violence risk to prevent its dangerous consequences. However, support systems for abused women must be available to accommodate women's needs if screening takes place. It would be disempowering for women if they disclosed violence but then received no support to enact change in their lives.

Implications for education

Results of this study indicated that domestic violence continues to be viewed as a private issue in Thailand, many women lacked knowledge about domestic violence services, and support available for abused women was limited. Therefore, education on domestic violence is important in breaking the silence of domestic violence and raising public awareness. The message that domestic violence is unacceptable and must not be tolerated in Thai society can also be disseminated through education.

Education on domestic violence must target both women and those who are involved such as families, friends, nurses, other health personnel, police, village headmen and other legal authorities as well as citizens. Women must be empowered and informed about their rights, educated about gender equality and informed about available support. By providing education, women will be more empowered to seek help.

Domestic violence education can be provided via the use of mediums, such as advertising campaigns through television and radio networks, posters and signboards. Each village should also have preventive measures and public campaigns to increase community awareness of domestic violence problems. This will help to reinforce the importance and prevalence of the problem, and help to decrease the isolation that victims of domestic violence face (Espinosa & Osborne, 2002). This will also enable family and friends to respond appropriately and supportively. Friends and neighbours must also be encouraged to report domestic violence or intervene with the victim or perpetrator.

In addition, education on domestic violence must target nursing/midwifery students since they are the professional groups, who in the future will come into contact with women who have experienced domestic violence and will have the opportunity to assess, educate and refer these women to appropriate supports and social services. Domestic violence should therefore be included in curricula in order to raise student awareness, increase knowledge and promote positive understanding about domestic violence. By doing so nursing and midwifery students and future health personnel will be better-prepared to meet the needs of, and to provide effective care to, women who have been exposed to domestic violence.

In addition to nursing/midwifery students, other health personnel should also be targeted such as trainees and clinicians. Information on professional obligations and their roles in combating violence against pregnant women should also be emphasized in training sessions. This approach to education would ensure that clinicians are equipped to discuss abuse routinely with their patients, colleagues, and students, as well as lobby at the local, national and even global level for funding for research, treatment and prevention, and socio-legal changes in Thailand to protect victims and to improve the status of women.

Finally, education about human rights in particular women's rights and gender equality and education on how to build and promote healthy relationships, and marriage preparation can assist young people and future couples. Education should

also be provided to Thai families on raising and teaching children to respect women as equal in the family.

Implications for social policy development

Domestic violence is a significant social and public health problem, which relates to women's rights and inequality in Thai society. These findings therefore have important implications for both government and non-government organizations in terms of pursuing social and policy changes in Thailand in order to reduce and prevent domestic violence. The need for social and policy changes must be addressed at all levels in Thailand. Government and related agencies need to work collaboratively to overcome this problem. Consideration needs to be given to redressing social and structural inequalities inherent within Thai society, the oppressive nature of domestic violence to prevent the incidence of domestic violence. Thai people have the right to protection from violence which was guaranteed in the 1997 Thai constitution, Article 53 which states "Children, youth, and family members shall have the right to be protected by the State against violence and unfair treatment" (Pekanan & Wongsurawat, 2001, p. 78). However, the findings of the present study highlighted the need for more attention from all levels in Thai society and more public campaigns to increase community awareness of the problems faced by pregnant women. This will help change social attitudes toward domestic violence in Thailand and break the silence of domestic violence not only in this remote area of Thailand but also the country as a whole.

In addition, the findings suggest an urgent need for improvements to law enforcement and reform in Thailand and state and local involvement in eliminating domestic violence. For example, all related parties need to work together to make amendments to Thai Criminal Law Code especially Section 276 which is ambivalent in regard to marital rape or sexual violence perpetrated by the husbands against their wives. This gap has contributed to the high prevalence of sexual violence as indicated in the current study. Domestic and family violence legislation in Thailand should be reviewed and reformed to improve the policies and prosecution of domestic violence, increase collaboration between legal and social/welfare agencies,

develop specialist knowledge, and develop a better criminal justice system for women who are victims of domestic violence.

Other intervention strategies should include political activism in areas such as welfare reform and child custody legislation, as well as political efforts to end discrimination directed toward domestic violence victims. Efforts to decrease all forms of violence, the promotion of healthy images of women in the media, and increased stronger penalties for perpetrators should be reinforced (Espinosa & Osborne, 2002).

The findings from the current study also indicated that abused women often faced difficulties when seeking help from police and other authorities due to their lack of understanding on domestic violence. These findings suggest that changes need to be made in the legal system. It is important that a strict policy for legal authorities be adhered to when helping victims of domestic violence. The policy must emphasize that domestic violence is recognized and responded to as a crime. Education and training emphasizing issues on domestic violence, women's rights and gender equality should also be provided to police and legal authorities including village headmen. This will provide them a better understanding and knowing how to respond in cases of domestic violence.

References

Abbott, J., Johnson, R., Koziol-McLain, J., & Lowenstein, S. R. (1995). Domestic violence against women: Incidence and prevalence in an emergency department population. *Journal of the American Medical Association (JAMA), 273*(22), 1763-1767.

ACOG. (1995). Domestic violence. *ACOG Technical Bulletin, Number 209 - August*.

Allen, N. E., Bybee, D. I., & Sullivan, C. M. (2004). Battered women's multitude of needs: Evidence supporting the need for comprehensive advocacy. *Violence Against Women, 10*(9), 1015-1035.

Alston, M. (1997). Violence against women in a rural context. *Australian Social Work, 50*(1), 15-21.

Amaro, H., Fried, L. E., Cabral, H., & Zuckerman, B. (1990). Violence during pregnancy and substance use. *American Journal of Public Health, 80*(5), 575-579.

Amoakohene, M. I. (2004). Violence against women in Ghana: a look at women's perceptions and review of policy and social responses. *Social Science & Medicine, 59*, 2373-2385.

Anderson, M. A., Gillig, P. M., Sitaker, M., McCloskey, K., Malloy, K., & Grigsby, N. (2003). "Why doesn't she just leave?": A descriptive study of victim reported impediments to her safety. *Journal of Family Violence, 18*(3), 151-155.

Archavanitkul, K. (2001). **ความรุนแรงต่อผู้หญิง: ภัยเงียบ ภัยมืดและภัยสว่าง บนทุกเส้นทางชีวิตผู้หญิง** (Violence against women: Danger in the silence, dark, light and every aspect of women's lives). In K. Archavanitkul & P. Boonmongkon (Eds.), *Reconstructing the Concept of Women and Health* (pp. 487-544). Bangkok.

Archavanitkul, K., Karnjanajitra, C., Im-Em, W., & Lertsrisantad, U. (2003). **ความรุนแรงในชีวิตคู่กับสุขภาพผู้หญิง** (*Women's health and intimate partner violence*). Nakorn Pratom, Thailand: Social and Population Research Institute, Mahidol University.

Australian Bureau of Statistics. (1996). *Women's Safety Australia*. Canberra: Commonwealth of Australia.

Australian Medical Association. (1998). *Position statement on domestic violence*. Canberra: AMA.

Bacchus, L., Mezey, G., & Bewley, S. (2002). Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service. *British Journal of Obstetrics and Gynecology, 109*, 9-16.

Bailey, J. E., Kellermann, A. L., Somes, G. W., Banton, J. G., Rivara, F. P., & Rushforth, N. P. (1997). Risk factors for violence death of women in the home. *Archives of Internal Medicine, 157*(7), 777-782.

Ballard, T. J., Saltzman, L. E., Gazmararian, J. A., Spitz, A. M., Lazorick, S., & Marks, J. S. (1998). Violence during pregnancy: Measurement issues. *American Journal of Public Health, 88*(2), 274-276.

Barriball, L. (1999). Non-response in survey research: a methodological discussion and development of an explanatory model. *Jounrnal of Advanced Nursing, 30*(3), 677-686.

Bhumiprabhas, S. (2001, 9 August). Fight for rights. *The Nation*.

Bograd, M. (1988). Feminist perspectives on wife abuse: An introduction. In K. Yllo & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 11-28). Newbury park, CA: Sage.

Bowen, E., Heron, J., Waylen, A., Wolke, D., & the ALSPAC study team. (2005). Domestic violence risk during and after pregnancy: Findings from a British longitudinal study. *BJOG: An International Journal of Obstetrics and Gynecology, 112*, 1083-1089.

Bowker, L. H., & Maurer, L. (1987). The medical treatment of battered wives. *Women & Health, 12*(1), 25-45.

Bradley, F., Smith, M., Long, J., & O'Dowd. (2002). Reported frequency of domestic violence: cross sectional survey of women attending general practice. *BMJ, 324*, 1-5.

Brink, P. J., & Wood, M. J. (1998). Descriptive designs. In P. J. Brink & M. J. Wood (Eds.), *Advanced design in nursing research* (2 ed., pp. 287-307). Thousand Oaks, California: Sage.

Brown, T., Frederico, M., Hewitt, L., & Sheehan, R. (2000). Revealing the existence of child abuse in the context of marital breakdown and custody and access disputes. *Child Abuse & Neglect, 24*(6), 849-859.

Browne, K., & Herbert, M. (1997). *Preventing family violence*. Chichester: John Wiley & Sons.

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

Burns, N., & Grove, S. K. (1997). *The practice of nursing research: Conduct, critique, and utilization* (3rd ed.). Pennsylvania: W.B. Saunders.

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

Campbell, J. C. (1992). Wife-battering: Cultural contexts versus Western social sciences. In D. A. Counts, J. K. Brown & J. C. Campbell (Eds.), *Sanctions & sanctuary: Cultural perspectives on the beating of wives* (pp. 229-249). Boulder, Colorado: Westview Press.

Campbell, J. C., Poland, M. L., Walker, J. B., & Ager, J. (1992). Correlates of battering during pregnancy. *Res Nurs Health, 15*, 219-226.

Campbell, J. C., Poland, M. L., Waller, J. B., & Ager, J. (1992). Correlates of battering during pregnancy. *Research in Nursing & Health, 15*, 219-226.

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.

Chaisetsampun, W. (2000). *Experiences of abuse and the need for assistance of abused wives.* Unpublished master's thesis, Chiang Mai University, Chiang Mai, Thailand.

Chocksawat, O. (2003). *Marital power and physical violence against wives.* Unpublished master's thesis, Chiang Mai University, Chiang Mai, Thailand.

Clongphayaban, B. (1999). *Family violence: The factors associated with wives violence in Muang District, Srakaew Province.* Unpublished master's thesis, Mahidol University, Bangkok, Thailand.

Coker, A. L., Smith, P. H., Mckeown, R. E., & King, M. J. (2000). Frequency and correlates of intimate partner violence by type: Physical, sexual and psychological battering. *American Journal of Public Health, 90*(4), 553-559.

Cokkinides, V., Coker, A. L., Sanderson, M., Addy, C., & Bethea, L. (1999). Physical violence during pregnancy: Maternal complications and birth outcomes. *Obstetrics & Gynecology, 93*(5), 661-666.

Cokkinides, V. E., & Coker, A. L. (1998). Experiencing physical violence during pregnancy: prevalence and correlates. *Family and Community Health, 20*(4), 19-37.

Costa, L. M., & Matzner, A. (2002). *Abusing images: Domestic violence in Thai cartoon books*. Retrieved 26 April, 2005, from http://wwwsshe.murdoch.edu.au/intersections/issue8/costa.html#t63

Coumarelos, C., & Allen, J. (1999). *Predicting women's responses to violence: The 1996 Women's Safety Survey*. Retrieved 10 March, 2003, from http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/cjb47.pdf/$file/cjb47.pdf

Counts, D. A., Brown, J. K., & Campbell, J. C. (1992). *Sanctions and sanctuary: Cultural perspectives on the beating of wives*. Boulder: Westview Press.

Covington, D. L., Dalton, V. K., Diehl, S. J., Wright, B. D., & Piner, M. H. (1997). Improving detection of violence among pregnant adolescents. *Journal of Adolescent Health, 21*(1), 18-24.

Covington, D. L., Justason, B. J., & Wright, L. N. (2001). Severity, manifestations, and consequences of violence among pregnant adolescents. *Journal of Adolescent Health, 28*(1), 55-61.

Davies, M. (Ed.). (1994). *Women and violence*. London: Zed Books.

DeNeui, G. (1991). *The making of a sodality in Northeastern Thailand*. Retrieved 30 January, 2003, from http://www.thaicov.org/resources/documents/sodality.html

Deoisres, W. (2004). *Prevalence and determinants of abuse during pregnancy in Eastern region of Thailand.* Paper presented at the 15th International Nursing Research Congress, Sigma Theta Tau International, Dublin, Ireland.

Desai, S., & Saltzman, L. E. (2001). Measurement issues for violence against women. In C. M. Renzetti, J. L. Edleson & R. K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 35-55). Thousand Oaks: Sage.

Dietz, P. M., Gazmararian, J. A., Goodwin, M. M., Bruce, F. C., Johnson, C. H., & Rochat, W. (1997). Delayed entry into prenatal care: Effect of physical violence. *Obstetrics & Gynecology, 90*(2), 221-224.

Dobash, R. E., & Dobash, R. (1979). *Violence against wives: A case against the patriarchy*. New York: The Free Press.

Donath, S. (2002). Alcohol abuse and the risks of violence. *Australian and New Zealand Journal of Public Health, 26*(5), 411.

Duffy, M. (1985). A critique of research: A feminist perspective. *Health Care Women International, 6*, 341-352.

Dutton, D. G., & Bodnarchuk, M. (2005). Through a psychological lens: Personality disorder and spouse assault. In D. R. Loseke, R. J. Gelles & M. M. Cavanaugh (Eds.), *Current Controversies on Family Violence* (2 ed.). Thousand Oaks: Sage.

Dye, T. D., Tollivert, N. J., Lee, R. V., & Kenny, C. J. (1995). Violence, pregnancy and birth outcome in Appalachia. *Paediatric and Perinatal Epidemiology, 9*, 35-47.

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

Fernandez, F. M., & Krueger, P. M. (1999). Domestic violence: Effect on pregnancy outcome. *JAOA, 99*(5), 254-256.

Field, A. (2000). *One-way repeated measures ANOVA using SPSS*. Retrieved 20 November, 2003, from http://www.sussex.ac.uk/Users/andyf/teaching/rm2/onewayrmspss.pdf

Flinck, A., Paavilainen, E., & Astedt-Kurki, P. (2005). Survival of intimate partner violence as experienced by women. *Women and Children, 14*, 383-393.

Flitcraft, A. H., Hadley, S. M., Hendericks-Matthews, M. K., McLeer, S. V., & Warshaw, C. (1992). American Medical Association diagnostic and treatment guidelines on domestic violence. *Archives of Family Medicine, 1*, 39-47.

Frost, M. (1999). Health visitors' perceptions of domestic violence: the private nature of the problem. *Journal of Advanced Nursing, 30*(3), 589-596.

Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help seeking. *Violence Against Women, 11*(3), 291-310.

Gazmararian, J. A., Lazorick, S., Spitz, A. M., Ballard, T. J., Saltzman, L. E., & Marks, J. S. (1996). Prevalence of violence against pregnant women. *The Journal of the American Medical Association, 275*(24), 1915-1920.

Gelles, R. J. (1993). Through a sociological lens: Social structure and family violence. In R. J. Gelles & D. R. Loseke (Eds.), *Current controversies on family violence*. Newbury Park: Sage.

Gelles, R. J., & Cornell, C. P. (1990). *Intimate violence in families*. Newbury Park: Sage.

Gelles, R. J., & Loseke, D. R. (Eds.). (1993). *Current controversies on family violence*. Newbury Park: SAGE Publications.

Gerbert, B., Abercrombie, P., Caspers, N., Love, C., & Bronstone, A. (1999). How health care providers help battered women: The survivor's perspective. *Women & Health, 29*(3), 115-135.

Gielen, A. C., O'Campo, P. J., Faden, R. R., Kass, N. E., &, & Xue, X. (1994). Interpersonal conflict and physical violence during the childbearing year. *Soc Sci Med, 39*, 781-787.

Goodman, L., Dutton, M. A., Vankos, N., & Weinfurt, K. (2005). Women's resources and use of strategies as risk and protective factors for reabuse over time. *Violence Against Women, 11*(3), 311-336.

Gordon, M. (2000). Definitional issues in violence against women: Surveillance and research from a violence research perspective. *Violence Against Women, 6*(7), 747-783.

Gray, A., & Punpuing, S. (1999). *Gender, sexuality and reproductive health in Thailand*. Nakhon Pathom: Institute for Population and Social Research, Mahidol University.

Grew, C. A. (1991). The domestic violence advocacy service-an innovative legal service for women. In R. Batten, W. Weeks & J. Wilson (Eds.), *Issues Facing Australian Families: Human Services Respond* (pp. 194-203). Melbourne: Longman Cheshire.

Grimstad, H., Schel, B., Backe, B., & Jacobsen, G. (1999). Anxiety, physical abuse, and low birth weight. *Scandinavian Journal of Public Health, 27*, 296-300.

Guo, S. F., Wu, J. L., Qu, C. Y., & Yan, R. Y. (2004). *Domestic violence in China before, during, and after pregnancy*. Retrieved 12 January, 2005, from http://www.cmj.org/information/full.asp?id=1523

Hall, J. M., & Stevens, P. E. (1991). Rigor in feminist research. *Advances in Nursing Science, 13*, 16-29.

Hart, B. J. (1995-2005, 14 March 2005). *Barbara J. Hart's Collected Writings*. Retrieved 29 March, 2005, from http://www.mincava.umn.edu/documents/hart/hart.html

Healey, K. (Ed.). (1998). *Violence in the family* (Vol. 99). Balmain: The Spinney Press.

Hedin, L., & Janson, P. (1999). The invisible wounds: The occurrence of psychological abuse and anxiety compared with previous experience of physical abuse during the childbearing year. *Journal of Psychosomatic Obstetrics and Gynecology, 20*, 136-144.

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

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

Hedin, L. W., & Janson, P. O. (2000). Domestic violence during pregnancy: The prevalence of physical injuries, substance use, abortions and miscarriages. *Acta Obstetricia et Gynecologica Scandinavica, 79*, 625-630.

Hegarty, K., Hinsmarsh, E. D., & Gilles, M. T. (2000). Domestic violence in Australia: Definition, prevalence and nature of presentation in clinical practice. *MJA, 173*, 363-367.

Hegarty, K., & Roberts, G. (1998). How common is domestic violence against women? The definition of partner abuse in prevalence studies. *Australian and New Zealand Journal of Public Health, 22*(1), 49-54.

Hegarty, K. L., & Taft, A. J. (2001). Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Australian and New Zealand Journal of Public Health, 25*(5), 433-437.

Heise, L. (1993). Violence against women: The hidden health burden. *World Health Statistics Quarter, 46*, 78-85.

Heise, L. L. (1995). Violence against women. In G. Reardon (Ed.), *Power and process: A report from the women linking for change conference, Thailand, 1994*. Oxford: Oxfam.

Heise, L. L., Raikes, A., Watts, C. H., & Zwi, A. B. (1994). Violence against women: A neglected public health issue in less developed countries. *Social Science Medicine, 39*(9), 1165-1179.

Helton, A. S., McFarlane, J., & Anderson, E. T. (1987). Battered and pregnant: A prevalence study. *American Journal of Public Health, 77*(10), 1337-1339.

Hillard, P. J. (1985). Physical abuse in pregnancy. *Obstetrics & Gynecology, 66*(2), 185-190.

Horsfall, J. (1991). *The presence of the past: Male violence in the family*. Sydney: Allen & Unwin.

Hudson, W. W., & McIntosh, S. R. (1981). The assessment of spouse abuse: two quantifiable dimensions. *Journal of Marriage and the Family, 43*, 873-885.

Hueston, W. J., & Kasik-Miller, S. (1998). Changes in functional health status during normal pregnancy. *Journal of Family Practice, 47*(3), 209-212.

Idrus, N. I., & Bennett, L. R. (2003). Presumed consent: Marital violence in Bugis society. In L. Manderson & L. R. Bennett (Eds.), *Violence against women in Asian societies* (pp. 41-60). London: RoutledgeCurzon.

Im, E. (2000). A feminist critique of research on women's work and health. *Health Care for Women International, 21*, 105-119.

Institute for Population and Social Research. (2002). *Mahidol Population Gazette*. Retrieved 15 January, 2003, from http://www.mahidol.ac.th/mahidol/pr/gazette.htm

Irion, O., Boulvain, M., Straccia, A., & Bonnet, J. (2000). Emotional, physical and sexual violence against women before or during pregnancy. *British Journal of Obstetrics and Gynaecology, 107*, 1306-1308.

Irwin, J., & Thorpe, R. (1996). Women, violence and social change. In R. Thorpe & J. Irwin (Eds.), *Women and Violence: Working for Change* (pp. 1-18). Sydney: Hale & Iremonger.

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

Jasinski, J. L. (2001). Theoretical explanations for violence against women. In C. M. Renzetti, J. L. Edleson & R. K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 5-21). Thousand Oaks: Sage.

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

Johnson, J. K., Haider, F., Ellis, K., Hay, D. M., & Lindow, S. W. (2003). The prevalence of domestic violence in pregnant women. *BJOG: An International Journal of Obstetrics and Gynecology, 110*, 272-275.

Jones, G., Havanon, N., & Mehta, S. (1997). *Draft report of the UNFPA programme support mission to Thailand* (Unpublished report for UNFPA (English)).

Jones, P. S., Lee, J. W., Phillips, L., Zhang, X., & Jaceldo, K. (2001). An adaptation of Brislin's translation model for cross-cultural research. *Nursing Research, 50*, 300-304.

Keawsarn, P., Moyle, W., & Creedy, D. (2003). Traditional postpartum practices among Thai women. *Journal of Advanced Nursing, 41*(4), 358-366.

Keenan, C. K., El-Hadad, A., & Balian, S. A. (1998). Factors associated with domestic violence in low-income Lebanese families. *Journal of Nursing Scholarship, 30*(4), 357-362.

Khon Kaen Hospital. (2001). *Department of Obstetrics and Family Planning*. Retrieved 11 October, 2002, from http://www.kkh.go.th/dep/obstetrics/index.html

Khon Kaen Hospital. (2001, 14 August 2005). *Department of Obstetrics and Family Planning*. Retrieved 15 December, 2002, from www.kkh.go.th/dep/obstetrics/index.html

Koss, M. P., Goodman, L. A., Browne, A., Fitzgerald, L. F., Keita, G. P., & Russo, N. F. (1994). *Male violence against women at home, at work, and in the community*. Washington: American Psychological Association.

Koss, M. P., & Heslet, L. (1992). Somatic consequences of violence against women. *Archives of Family Medicine, 1*, 53-59.

Kyriacou, D. N., Anglin, D., Taliaferro, E., Stone, S., Tubb, T., Linden, J. A., et al. (1999). Risk factors for injury to women from domestic violence. *The New England Journal of Medicine, 341*(25), 18921897.

Landenburger, K. M. (1998). The dynamics of leaving and recovering from an abusive relationship. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 27*, 700-706.

Lau, Y. (2005). Does pregnancy provide immunity from intimate partner abuse among Hong Kong Chinese women. *Social Science & Medicine, 61*, 365-377.

Lertsrisantad, U. (2002). *The Problem of Domestic Violence*. Retrieved 21 January, 2003, from http://thaiwomen.net/tncwa/html/html_texten_forum/vio_3.htm

Letourneau, E. J., Holmes, M., & Chasedunn-Roark, J. (1999). Gynecologic health consequences to victims of interpersonal violence. *Women's Health Issues, 9*(2), 115-120.

Leung, W. C., Leung, T. W., Lam, Y. Y. J., & Ho, P. C. (1999). The prevalence of domestic violence against pregnant women in a Chinese community. *International Journal of Gynecology & Obstetrics, 66*, 23-30.

Levinson, D. (1989). *Family violence in cross-cultural perspective*. Thousand Oaks: Sage.

Magar, V. (2003). Empowerment approaches to gender-based violence- Women's court in Delhi slums. *Women's Studies International Forum, 26*(6), 509-523.

Marshall, L. L. (1992). Development of the Severity of Violence Against Women Scales. *Journal of Family Violence, 7*(2), 103-121.

Martin, S. L., English, K. T., Clark, K. A., Cilenti, D., & Kupper, L. L. (1996). Violence and substance use among North Carolina pregnant women. *American Journal of Public Health, 86*(7), 991-998.

Martin, S. L., Mackie, L., Kupper, L. L., Buescher, P. A., & Moracco, K. E. (2001). Physical abuse of women before, during, and after pregnancy. *JAMA, 285*(12), 1581-1630.

Mazza, D., Dennerstein, L., & Ryan, V. (1996). Physical, sexual and emotional violence against women: A general practice-based prevalence study. *Medical Journal of Australia, 164*, 14-17.

McCauley, J., Kern, D. E., Kolodner, K., Dill, L., Schroeder, A., DeChant, H. K., et al. (1995). The "Battering Syndrome": Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Annals of Internal Medicine, 123*(10), 737-746.

McFarlane, J. (1991). Violence during teen pregnancy: Health consequences for mother and child. In B. Levy (Ed.), *Dating violence: Young women in danger* (pp. 136-141). Seattle: Seal Press.

McFarlane, J. (1993). Abuse during pregnancy: The horror and the hope. *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing, 4*(3), 350-362.

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

McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. *JAMA, 267*(23), 3176-3179.

McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reed, S. (1999). Severity of abuse before and during pregnancy for African American, Hispanic, and Anglo women. *Journal of Nurse-Midwifery, 44*(2), 139-144.

McFarlane, J., Soeken, K., & Wiist, W. (2000). An evaluation of interventions to decrease intimate partner violence to pregnant women. *Public Health Nursing, 17*, 443-451.

McFarlane, J., Willson, P., Malecha, A., & Lemmey, D. (2000). Intimate partner violence: A gender comparison. *Journal of Interpersonal Violence, 15*(2), 158-169.

McGregor, H. (1990). *Domestic violence: Alcohol and other distractions- a grassroots perspective*. Retrieved 30 December, 2002, from www.aic.gov.au/publications/proceedings/01/McGregor.html

Mezey, G. C., & Bewley, S. (1997). Domestic violence and pregnancy. *British Medical Journal, 314*(7090), 1295-1296.

Ministry of Labour, T. (2005). *Minimum wage rates increased for 2005*. Retrieved 22 April, 2005, from http://www.labour.go.th/en/wage.html#1

Mouzos, J., & Makkai, T. (2004). *Australian Domestic and Family Violence Clearinghouse Newsletter: Legislation and Policies*. Sydney: The University of New South Wales.

Muhajarine, N., & D'Arcy, C. (1999). Physical abuse during pregnancy: Prevalence and risk factors. *Canadian Medical Association Journal, 160*(7), 1007-1011.

Mulder, N. (1996). *Inside Southeast Asia: Religion, everyday life, cultural change*. Amsterdam: The Pepin Press.

Newberger, E. H., Barkan, S. E., Lieberman, E. S., McCormick, M. C., Yllo, K., Gary, L. T., et al. (1992). Abuse of pregnant women and adverse birth outcome: Current knowledge and implications for practice. *JAMA, 267*(17), 2370-2376.

O'Campo, P., Gielen, A. C., Faden, R. R., & Kass, N. (1994). Verbal abuse and physical violence among a cohort of low-income pregnant women. *Womens Health Issues, 4*(1), 29-37.

O'Campo, P., Gielen, A. C., Faden, R. R., Zue, Z., Kass, N., & Want, M. C. (1995). Violence by male partners against women during childbearing year: A contextual analysis. *American Journal of Public Health, 85*, 1092-1097.

Office of the National Commission on Women's Affairs. (2000). *Out of the silence: Fighting violence against women in Thailand*. Retrieved 21 March, 2005, from http://web.worldbank.org

Office of Women's Affairs and Family Development. (n.d). *A life free of violence: It's our right. Thailand country profile*. Retrieved 14 February 2004, 2004, from http://www.unifem-eseasia.org/resources/others/domesticviolence/PDF/Thailand.pdf

O'Leary, K. D. (1993). Through a psychological lens: Personal traits, personality disorders, and levels of violence. In R. J. Gelles & D. R. Loseke (Eds.), *Current Controversies on Family Violence*. Newbury Park: Sage.

Otchet, F., Carey, M. S., & Adam, L. (1999). General health and psychological symptoms status in pregnancy and the puerperium: what is normal? *Obstetric & Gynecology, 94*(6), 935-941.

Pagelow, M. D. (1984). *Family violence*. New York: Praeger.

Pallant, J. (2005). *SPSS survival manual: A step by step guide to data analysis using SPSS for Windows (Version 12)*. Crows Nest, NSW: Allen & Unwin.

Pande, R. (2002). The public face of a private domestic violence. *International Feminist Journal of Politics, 4*(3), 342-367.

Parker, B., & McFarlane, J. (1991a). Feminist theory and nursing: An empowerment model for research. *Advances Nursing Science, 13*(3), 59-67.

Parker, B., & McFarlane, J. (1991b). Nursing assessment of the battered pregnant women. *MCN: Journal of Maternal Child Nursing, 16*, 161-164.

Parker, B., McFarlane, J., & Soeken, K. (1994). Abuse during pregnancy: Effects on maternal complications and birth weight in adult and teenage women. *Obstetric & 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.

Peckover, S. (2003). 'I could have just done with a little more help': an analysis of women's help seeking from health visitors in the context of domestic violence. *Health and Social Care in the Community, 11*(3), 277-282.

Peedicayil, A., Sadowski, L. S., Jeyaseelan, L., Shankar, V., Jain, D., Suresh, S., et al. (2004). Spousal physical violence against women during pregnancy. *BJOG: An International Journal of Obstetrics and Gynecology, 111*, 682-687.

Pekanan, M., & Wongsurawat, K. (2001). *The Planned Parenthood Association of Thailand: Prevention of domestic violence against women and children in Thailand through the promotion of reproductive health*. Retrieved 6 January, 2005, from www.icomp.org.my/Publish/Volume9-3.pdf

Petersen, R., Gazmararian, J. A., Spitz, A. M., Rowley, D. L., Goodwin, M. M., Saltzman, E. L., et al. (1997). Violence and adverse pregnancy outcomes: A review of the literature and directions for future research. *American Journal of Preventive Medicine, 13*(5), 366-373.

Petersen, R., Saltzman, L. E., Goodwin, M., & Spitz, A. (1998). *Key scientific issues for research on violence around the time of pregnancy*. Atlanta, GA: Centers for Disease Control and Prevention.

Polit, D. F., & Hungler, B. P. (1999). *Nursing research: Principles and Methods*. Philadelphia: J.B. Lippincott.

Poonyarat, C. (2002). *In Thailand, domestic violence is a community affair*. Retrieved 21 January, 2003, from http://www.cyberdyaryo.com/features/f2002_0823_06.htm

Public Health Agency of Canada (PHAC). (2002, 31 July 2002). *A guide to HIV/AIDS epidemiological and surveillance terms*. Retrieved 14 February 2004, 2004, from http://www.phac-aspc.gc.ca/publicat/haest-tesvs/p_e.html

Queensland Health. (2000). *Initiative to combat the health impact of domestic violence against women: Stage 1 Evaluation Report*. Brisbane: Queensland Health.

Quicker, J. C. (2002). Thailand. In R. W. Summers & A. M. Hoffman (Eds.), *Domestic Violence: A Global View* (pp. 156-166). Westport, Connecticut: Greenwood Press.

Quinlivan, J. A., & Evans, S. F. (2001). A prospective cohort study of the impact of domestic violence on young teenage pregnancy outcomes. *Journal of Pediatric and Adolescent Gynecology, 14*, 17-23.

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

Ramsay, J., Richardson, J., Carter, Y. H., Davidson, L. L., & Feder, G. (2002). Should health professionals screen women for domestic violence? Systematic review. *BMJ, 325*, 1-13.

Renker, P. R. (2002). Keep a blank face. I need to tell you what has been happening to me. *MCN, 27*(2), 109-116.

Roberts, G. L., O'Toole, B. I., Lawrence, J. M., & Raphael, B. (1993). Domestic violence victims in a hospital emergency department. *Medical Journal of Australia, 159*, 307-310.

Roberts, K., & Taylor, B. (1998). *Nursing research processes: An Australian perspective*. Melbourne: An International Thompson Publishing Company.

Rodriguez, M. A., Bauer, H. M., & McLoughlin, E. e. a. (1999). Screening and intervention for intimate partner abuse: Practices and attitudes of primary care physicians. *JAMA, 282*(5), 468-474.

Rodriguez, M. A., Sheldon, W. R., Bauer, H. M., & Perez-Stable, E. J. (2001). The factors associated with disclosures of intimate partner abuse to clinicians. *Journal of Family Practice, 50*, 338-344.

Safeguard women, say two groups. (2002, 7 August). *The Nation*.

Savona-Ventura, C., Savona-Ventura, M., Drengsted-Nielsen, S., & Johansen, K. S. (2001). Domestic abuse in a central Mediterranean pregnant population. *European Journal of Obstetrics & Gynecology and Reproductive Biology, 98*(1), 3-8.

Schneider, Z., Elliott, D., LoBiondo-Wood, G., & Haber, J. (2003). *Nursing research: Methods, critical appraisal and utilisation* (2 ed.). Sydney: Mosby.

Scutt, J. (1991). Criminal assault at home: Policy directions and implications for the future. In W. Weeks & J. Wilson (Eds.), *Issues facing Australia Families: Human Services Respond* (2 ed., pp. 183-193). Melbourne: Longman Cheshire.

Sen, P. (1998). Violence in intimate relationships: A research project in India. In H. Afshar (Ed.), *Women and empowerment: Illustrations from the Third World* (pp. 134-154). London: Macmillan.

Seng, J. S., Sparbel, K. J. H., Low, L. K., & Killion, C. (2002). Abuse-related posttraumatic stress and desired maternity care practices: Women's perspectives. *Journal of Midwifery & Women's Health, 47*(5), 360-370.

Shiono, P. H., Rauh, V. A., Park, M., Lederman, S. A., & Zuskar, D. (1997). Ethnic differences in birthweight: The rol of lifestyle and other factors. *American Journal of Public Health, 87*(5), 787-793.

Showstack, J. A., Budetti, P. P., & Minkler, D. (1984). Factors associated with birthweight: An exploratory of the roles of prenatal care and length of gestation. *AJPH, 74*(9), 1003-1008.

Shuaytong, P., Phijaisanit, P., Isaranurug, S., & Weerawatthanodom, N. (1998). Violence against women: Characteristics and associated factors. *Chulalongkorn Medical Journal, 42*(5), 395-412.

Smith, P. H., Tessaro, I., & Earp, J. A. (1995). Women's experiences with battering: A conceptualisation from qualitative research. *Women's Health Issues, 5*(4), 173-182.

Somsin, B. (2002, 23 July). Wife-killer ruling: women urge mass protest. *The Nation*.

Spietz, A., & Kelly, J. (2002). The importance of maternal mental health during pregnancy: Theory, practice, and intervention. *Public Health Nursing, 19*(3), 153-155.

Stewart, D. (1994). Incidence of postpartum abuse in women with a history of abuse during pregnancy. *Canadian Medical Association Journal, 151*, 1601-1604.

Stewart, D. E., & Cecutti, A. (1993). Physical abuse in pregnancy. *Canadian Medical Association Journal, 149*(9), 1257-1263.

Straus, M. (2005). Women's violence toward men is a serious social problem. In D. R. Loseke, R. J. Gelles & M. M. Cavanaugh (Eds.), *Current Controversies on Family Violence* (2 ed.). Thousand Oaks: Sage.

Sugg, N. K., & Inui, T. (1992). Primary care physicians' response to domestic violence. *Journal of American Medical Association, 267*(3157-3160).

Sullivan, C. M., Basta, J., Tan, C., & Davidson, W. S. (1992). After the crisis: A needs assessment of women leaving a domestic violence shelter. *Violence Victims, 7*, 269-275.

Sushma, K. (2000). *Domestic violence against women and girls*. Retrieved 15 December, 2002, from http://www.unicep-icdc.org/publications

Thajeen, T. (2002). *Campaigning to solve the problem of violence against women: Cooperation between the government and private organizations*. Retrieved 15 December, 2002, from http://thaiwomen.net/tncwa/html/html_texten_forum/vio_2.htm

Thanaudom, D. (1996). *Family violence: A study in pregnant women.* Unpublished master's thesis, Mahidol University, Bangkok, Thailand.

Tollestrup, K., Sklar, D., Frost, F. J., Olson, L., Weybright, J., Sandvig, J., et al. (1999). Health indicators and intimate partner violence among women who are members of a managed care organization. *Preventive Medicine, 29*, 431-440.

Tolman, R. M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence Victims, 4*, 159-177.

Tolman, R. M. (1999). The validation of the Psychological Maltreatment of Women Inventory. *Violence and Victims, 14*(1), 25-35.

Tolman, R. M. (n.d). *Psychological Maltreatment of Women Inventory*. Retrieved 27 July 2003, 2003, from http://sitemaker.umich.edu/pmwi

U.S. Department of Health and Human Services. (1990). *Healthy people 2000: National Health promotion and disease prevention objectives*. Washington (DC): Public Health Service.

U.S. Department of Health and Human Services. (1998). Rural health-care providers' attitudes, practices, and training experience regarding intimate partner violence-West Virginia, March 1997. *Morbidity and Mortality Weekly Report, 47*(32), 670-673.

UNIFEM. (2000). *Gender and development in Thailand*. Retrieved 21 January, 2005, from http://www.unifem-eseasia.org/resources/others/gendev/sectionb3.htm

UNIFEM. (2005). *Pathway to gender equality*. Retrieved 10 May, 2006, from www.eldis.org/static/DOC17734.htm

United Nations. (1995). *Population change, development and women's role and status in Thailand*. New York: Asian Population Studies Series No. 135.

United Nations. (2000). *Women's health and development: Country profile, Thailand*. Retrieved 23 January, 2003, from http://www.journ.freeserve.co.uk/thai/thai1.html

Wagner, P. J., & Mongan, P. F. (1998). Validating the concept of abuse. *Arch Fam Med, 7*(Jan/Feb), 25-29.

Waldrop, A. E., & Resick, P. A. (2004). Coping among adult female victims of domestic violence. *Journal of Family Violence, 19*(5), 291-302.

Walker, L. (1979). *The battered women*. New York: Harper & Row.

Walker, L. E. (1984). *The battered women syndrome*. New York: Springer.

Walker, L. E. (1993). The battered woman syndrome is a psychological consequence of abuse. In R. J. Gelles & D. R. Loseke (Eds.), *Current Controversies on Family Violence* (pp. 133-153). Newbury Park: Sage.

Ware, J. E., Kosinski, M., & Keller, S. D. (1996). A 12-item Short Form Health Survey: Construction of scales and preliminary tests of reliability and validity. *Medical Care, 34*(3), 220-233.

Ware, J. E., Kosinski, M., Turner-Bowker, D. M., & Gandek, B. (2002). *How to score version 2 of the SF-12 health survey*: QualityMetric Incorperated Lincoln, Rhode Island and Health Assessment Lab Boston, Massachusetts.

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

Webster, J., Stratigos, S. M., & Grimes, K. M. (2001). Women's responses to screening for domestic violence in a health-care setting. *Midwifery, 17*, 289-294.

Webster, J., Sweett, S., & Stolz, T. (1994). Domestic violence in pregnancy: A prevalence study. *The Medical Journal of Australia, 161*, 466-470.

Weinbaum, Z., Stratton, T. L., Chavez, G., Mothlewski-Link, C., Barrera, N., & Courtney, J. G. (2001). Female victims of intimate partner physical domestic violence (IPP-DV), California 1998. *American Journal Preventative Medicine, 21*(4), 313-319.

Whitehead, A., & Fanslow, J. (2005). Prevalence of family violence amongst women attending an abortion clinic in New Zealand. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 45*, 321-324.

Wiemann, C. M., Agurcia, C. A., Berenson, A. B., Volk, R. J., & Rickert, V. I. (2000). Pregnant adolescents: Experiences and behaviors associated with physical assault by an intimate partner. *Maternal and Child Health Journal, 4*(2), 93-101.

Wiist, W. H., & McFarlane, J. (1998). Severity of spousal and intimate partner abuse to pregnant Hispanic women. *Journal of Health Care for the Poor and Underserved, 9*(3), 248-261.

World Health Organization. (1999). *Putting women's safety first: ethical and safety recommendations for research on domestic violence against women*. Geneva: Global programme on Evidence for Health Policy.

World Health Organization. (2000). *Chapter 4: Violence by intimate partners*. Retrieved 11 March, 2005, from http://www.who.int/violence_injury_prevention/violence/world_report/chapters/en/

World Health Organization. (2005). *The World Health Report 2005: Make every mother and child count*. Retrieved 10 May, 2006, from www.who.int/whr/2005/whr2005_en.pdf

Yang, M. S., Yang, M. J., Chou, F. H., Yang, H. M., Wei, S. L., & Lin, J. R. (2005). Physical abuse against pregnant aborigines in Taiwan: Prevalence and risk factors. *International Journal of Nursing Studies, 43*(1), 21-27.

Yllo, K., & Bograd, M. (Eds.). (1988). *Feminist perspectives on wife abuse*. Newbury Park: Sage.

Yllo, K., & Straus, M. A. (1990). Patriarchy and violence against wives: The impact of structural and normative factors. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp. 383-399). New Brunswick, NJ: Transaction.

Yllo, K. A. (1993). Through a feminist lens: Gender, power, and violence. In R. J. Gelles & D. R. Loseke (Eds.), *Current controversies on family violence* (pp. 47-62). Newbury Park, CA: Sage.

Yllo, K. A. (2005). Through a feminist lens. In D. R. Loseke, R. J. Gelles & M. M. Cavanaugh (Eds.), *Current Controversies on Family Violence* (2 ed.). Thousand Oaks: Sage.

Yoshihama, M., & Sorenson, S. B. (1994). Physical and sexual and emotional abuse by male intimates: Experiences of women in Japan. *Violence Victims, 9*, 63-77.

Appendix A: Help Card Given to Women

บัตรข้อมูล (Help Card)

โรงพยาบาลขอนแก่น เลขที่ 56 ถ. ศรีจันทร์ อ.เมือง จ.ขอนแก่น โทร 043-336 789
แผนกฝากครรภ์ ต่อ 1306
แผนกวางแผนครอบครัว ต่อ 1168
แผนกการให้คำปรึกษา ต่อ 1140
ศูนย์อนามัยที่ 6 ขอนแก่น เลขที่ 195 ถ. ศรีจันทร์ อ.เมือง จ.ขอนแก่น 40000 โทร 043-243 210, 043-242 041 แผนกฝากครรภ์ต่อ 157

มูลนิธิผู้หญิง 02-435 1246, 02- 433 5149
มูลนิธิเพื่อนหญิง 02-513 1001
มูลนิธิศูนย์ฮอทไลน์ 02-277 7699
บ้านพักฉุกเฉิน 02-929 2222
มูลนิธิปวีณา หงสกุลเพื่อเด็กและสตรี 02-972 5490

Appendix B: Antenatal Questionnaire

Antenatal Questionnaire

To be completed by researcher	**Code:……..……**
	Date:……..
	Hospital:……

Part 1: Background Information

Please answer every question by filling in the space provided or by selecting the answer as indicated.
Personal details

1. Name…….
2. Address…….
3. Your age…….years
4. What is your highest education level?
   - □ Completed year 6 and below
   - □ Completed year 12
   - □ Diploma/certificate
   - □ Bachelor degree
   - □ Postgraduate
   - □ Did not attend school
5. What is your occupation?
   - □ Laborer
   - □ Employed in co-operate
   - □ Professional career, technician
   - □ Small business, trading
   - □ Agriculturer
   - □ Unemployed
   - □ Government officer
   - □ Other, please specify……
   - □ Home duties
6. What is your monthly income?
   - □ Less than 1,000 Baht
   - □ 9,001-20,000 Baht
   - □ 1,000-5,000 Baht
   - □ More than 20,000 Baht
   - □ 5,001-9,000 Baht
7. What is your marital status?
   - □ Married with marriage certificate
   - □ Married without marriage certificate
   - □ Separated/other (e.g., divorced, widowed)
   - □ De facto relationship
8. Your expected date of delivery: ……
9. Previous pregnancies
   - □ None □ 1 □ 2 □ 3 □ 4 or more

Questions 10-14 are to be answered only women who indicate at least one previous pregnancy in Question 9. The rest go to Question 15.

10. Number of previous pregnancies resulting in live births?…….

11. How old is your youngest child?……years

12. Have you ever had a miscarriage?
    - □ No
    - □ Yes, When……. How many times?…….. ……

13. Have you ever had an abortion?
    - □ No
    - □ Yes, When……. How many times?……..

14. Number of previous pregnancies resulting in stillbirth?……

    When……

15. When was your first antenatal visit in this pregnancy?
    - □ Before 12 weeks
    - □ 21-28 weeks
    - □ 37-40 weeks
    - □13-20 weeks
    - □ 29-36 weeks

16. Do you have a health care card or health insurance?
    - □ Yes, please specify type of health care card……
    - □ No

17. Do you have any health problem?
    - □ Yes, please specify……
    - □ No

18. Do you smoke a cigarette?
    - □ Yes ……cigarettes per day.
    - □ No

19. Do you drink alcohol?
    - □ Yes, very rarely (about once a month)
    - □ Yes, occasionally (about once a fortnight)
    - □ Yes, frequently (at least once in a week)
    - □ No

20. Do you use illicit drugs?
    - □ Yes, please specify type……
    - □ No

21. Do you gamble?
    - □ Yes, please specify type of gambling……..
      How often do you gamble?……
      How much money did you spend on gambling each time?……Baht
    - □ No

Husband details

1. Your husband/partner's age …….. years

2. What is his highest education level?
    - □ Completed year 6 and below
    - □ Completed year 12
    - □ Diploma/certificate
    - □ Bachelor degree
    - □ Postgraduate
    - □ Did not attend school

3. What is your husband's occupation?
    - □ Laborer
    - □ Employed in co-operate
    - □ Professional career, technician
    - □ Small business, trading
    - □ Agriculturer
    - □ Unemployed
    - □ Government officer
    - □ Other, please specify……
    - □ Home duties

4. What is your husband salary or income per month?
    - □ No income
    - □ 9,001-20,000 Baht
    - □ 1,000-5,000 Baht
    - □ More than 20,000 Baht
    - □ 5,001-9,000 Baht

5. Does your husband/partner smoke a cigarette?
    - □ Yes, ……..cigarettes/day
    - □ No

6. Does he drink alcohol? How many glasses per day? When did he start drinking?
    - □ Yes, very rarely (about once a month)
    - □ Yes, occasionally (about once a fortnight)
    - □ Yes, frequently (at least once in a week)
    - □ No

7. Does he use illicit drugs?
    - □ Yes, please specify type…….
    - □ No

8. Does he gamble?
    - □Yes, please specify type of gambling……
      How often do you gamble?……
      How much money did you spend on gambling each time?……Baht
    - □ No

Family details

1. Type of dwelling living in now?
   □ Owned house/townhouse □ Rented house/townhouse
   □ Owned condominium/flat □ Temporary dwelling (such as squatter house)
   □ Rented apartment/flat □ Other, please specify…….
   □ Rented room

2. Number of family members living with you……
   (Please state their relationship e.g. 1 husband, 1 grandmother, 1 grandfather, 2 daughters etc.)……
   …….
   …….
3. How many children do you have with this husband/partner?……..
4. How long have you been in the relationship?……years
5. Does your family have any debt?
   □ Yes, approximately …….Baht
   Please state source of debts……..
   □ No

Part 2: General Health Questionnaire

We are interested in your general health and how well you are able to do what you normally do. Please tick (√) your response in the appropriate box.

1. In general, would you say your health is:

□ Excellent □ Very good □ Good □ Fair □ Poor

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
A. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
B. Climbing several flights of stairs			

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A. Accomplished less than you would like					
B. Were limited in the kind of work or other activities					

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A. Accomplished less than you would like					
B. Did work or other activities less carefully than usual					

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

□ Not at all □ A little bit □ Moderately

□ Quite a bit □ Extremely

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks…

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
A. Have you felt calm and peaceful?						
B. Did you have a lot of energy?						
C. Have you felt downhearted and depressed?						

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

□ All of the time □ Most of the time □ Some of the time

□ A little of the time □ None of the time

Part 3: Women's safety

We are also concerned about your health and safety, the following questions will be asked how you have been treated by your husband/partner. Please tick (√) the response that most accurately describes how your husband/partner acted toward you both before and during your current pregnancy

1. In the last year before you became pregnant, did your husband/partner ever threaten to hurt you?
   - □ Yes…….times
   - □ No

1. In the last year before becoming pregnant, did your husband/partner ever hurt you or use violence against you?
   - □ Yes…….times
   - □ No

Psychological Maltreatment of Women Inventory

Please tick (√) the response that most accurately describes how your husband/partner acted toward you since this pregnancy began

Your partner/husband's behaviours	Never	Rarely	Occasionally	Frequently	Very Frequently
1. My partner called me names					
2. My partner swore at me					
3. My partner yelled and screamed at me					
4. My partner treated me like an inferior					
5. My partner monitored my time and made me account for where I was					
6. My partner used our money or made important financial decisions without talking to me about it					
7. My partner was jealous or suspicious of my friends					
8. My partner accused me of having an affair with another man					
9. My partner interfered in my relationships with other family members					
10. My partner tried to keep me from doing things to help myself					
11. My partner restricted my use of the telephone					
12. My partner told me that my feelings were irrational or crazy					
13. My partner blamed me for his problems					
14. My partner tried to make me feel crazy					

Severity of Violence Against Women Scale

During the past year, you and your partner have probably experienced anger or conflict. Below is a list of behaviours your partner may have done during this pregnancy. Describe how often your partner has done each behaviour by tick (√) at the appropriate box.

My partner behaviours:	Never	Once	A few times	Many times
1) Kicked a wall, door, or furniture				
2) Threw, smashed, or broke an object				
3) Drove dangerously with me in the car				
4) Threw an object at me				
5) Shook finger at me				
6) Made threatening gestures at me				
7) Shook fist at me				
8) Acted like a bully toward me				
9) Destroyed something belonging to me				
10) Threatened to harm or damage things I cared about				
11) Threatened to destroyed property				
12) Threatened someone I care about				
13) Threatened to hurt me				
14) Threatened to kill himself				
15) Threatened to kill me				
16) Threatened me with a weapon				
17) Threatened me with a club-like object				
18) Acted like he wanted to kill me				
19) Threatened me with a knife or gun				
20) Held me down, pinning me in place				
21) Pushed or shoved me				
22) Grabbed me suddenly or forcefully				

Below is a list of behaviours your partner may have done during this pregnancy. Describe how often your partner has done each behaviour by tick (√) at the appropriate box.

My partner's behaviours:	Never	Once	A few times	Many times
23) Shook or roughly handled me				
24) Scratched me				
25) Pulled my hair				
26) Twisted my arm				
27) Spanked me				
28) Bit me				
29) Slapped me with the palm of his hand				
30) Slapped me with the back of his hand				
31) Slapped me around the face and head				
32) Hit me with an object				
33) Punched me				
34) Kicked me				
35) Stomped on me				
36) Choked me				
37) Burned me with something				
38) Used a clublike object on me				
39) Beat me up				
40) Used a knife or gun on me				
41) Demanded sex whether I wanted to or not				
42) Made me have oral sex against my will				
43) Made me have sexual intercourse against my will				
44) Physically forced me to have sex				
45) Made me have anal sex against my will				
46) Used an object on me in a sexual way				

Part 4: Helpful resources and barriers to seek help (Ask only women who identify abuse in Part 3)

Please answer every question by filling in space provided below

1. How did you deal with the violence?

……

……

……

……

2. If possible, what would you like to do to solve the problem (husband's violence) at that time?

……

……

……

3. What do you think was the cause of your husband's violence toward you?

……

……

……

……

……

4. Did you tell anyone about the abuse?

( ) Yes, who……

…..……

……

……

( ) No, why not ……..

……

……

……

……

Part 4: Helpful resources and barriers to seek help (Continued)

5. Did you ask for help from anyone?

( ) Yes, who……

……

……

( ) No, why not……...

……

……

6. What support or helps would you like to have in order to solve the problem?

……

……

……

……

……

7. What is your plan if your husband acts violently toward you again?

……

……

……

……

Thank you for completing this survey

แบบสอบถามในระยะก่อนคลอด

สำหรับนักวิจัย
รหัส.....
วันที่.....
โรงพยาบาล.....

แบบสอบถามนี้เป็นแบบสอบถามที่สำรวจความคิดเห็นเกี่ยวกับความรุนแรงในครอบครัวและภาวะสุขภาพในระยะก่อนคลอดของท่าน

ส่วนที่ 1 ข้อมูลทั่วไป

โปรดตอบคำถามทุกคำถามโดยการเติมคำในช่องว่างหรือกาเครื่องหมายถูก [√] ตามความเหมาะสม

ข้อมูลส่วนบุคคล

ชื่อ.....

ที่อยู่.....

.....

หมายเลขโทรศัพท์ .....

1. ปัจจุบันท่านอายุ.....ปี
2. การศึกษาสูงสุดของท่าน
   - □ ระดับประถม □ ระดับมัธยม □ ระดับปวส./ปวช.
   - □ ระดับปริญญาตรี □ สูงกว่าปริญญาตรี □ ไม่ได้เรียนหนังสือ
   - □ อื่นๆ โปรดระบุ.....
3. อาชีพของท่าน
   - □ คนงาน รับจ้าง □ รับราชการ □ รัฐวิสาหกิจ
   - □ เกษตรกรรม □ ค้าขาย □ ธุรกิจส่วนตัว
   - □ วิชาชีพเฉพาะทาง/ช่าง□ อื่นๆ โปรดระบุ.....
4. รายได้ของท่านต่อเดือน
   - □ ไม่มีรายได้ □ 1,000-5,000 บาท
   - □ 5,001-9,000 บาท □ 9,001-20,000 บาท
   - □ มากกว่า 20,000 บาท
5. สถานภาพการสมรส
   - □ แต่งงานและจดทะเบียน □ แต่งงานแต่ไม่จดทะเบียน
   - □ แยกกันอยู่/หย่า/เป็นหม้าย □ อยู่ด้วยกัน
6. อายุครรภ์ของท่าน ณ วันนี้.....สัปดาห์
7. กำหนดวันคลอด.....
8. จำนวนครั้งของการตั้งครรภ์ (รวมครั้งนี้ด้วย).....ครั้ง

9. บุตรคนสุดท้องอายุ.....ปี

10. ท่านเคยแท้งลูกหรือไม่
□ ไม่เคย
□ เคย จำนวน.....ครั้ง

11. ท่านเคยทำแท้งหรือไม่
□ ไม่เคย
□ เคย จำนวน.....ครั้ง
เมื่อใด.....

12. จำนวนครั้งที่ทารกตายในครรภ์.....ครั้ง
เมื่อใด.....

13. ท่านมารับการตรวจครรภ์ครั้งแรกเมื่ออายุครรภ์กี่สัปดาห์
□ ก่อน 12 สัปดาห์ □ 21-28 สัปดาห์
□ 13-20 สัปดาห์ □ 29-32 สัปดาห์
□ 33-40 สัปดาห์

14. ท่านมีบัตรประกันสุขภาพหรือไม่
□ ไม่มี
□ มี โปรดระบุประเภทของบัตรประกันสุขภาพ.....

15. ท่านมีโรคประจำตัวหรือไม่
□ ไม่มี
□ มี โปรดระบุ.....

16. ท่านสูบบุหรี่หรือไม่
□ ไม่สูบ
□ สูบ จำนวนประมาณ.....มวนต่อวัน

17. ท่านดื่มสุราหรือไม่
□ ไม่ดื่ม □ ดื่มแต่นานๆครั้ง
□ ดื่มเป็นบางครั้ง □ ดื่มเป็นประจำ

18. ท่านใช้สารเสพติดหรือไม่
□ ไม่ใช้
□ ใช้ โปรดระบุชนิด.....

19. ท่านเล่นการพนันหรือไม่
□ ไม่เล่น
□ เล่น เริ่มเล่นการพนันเมื่อ.....

ข้อมูลเกี่ยวกับสามี/คู่ครอง

1. อายุของสามีท่าน.....ปี

2. การศึกษาสูงสุดของสามีของท่าน

□ ไม่ได้เรียนหนังสือ □ ระดับประถม □ ระดับมัธยม

□ ระดับปวส./ปวช. □ ระดับปริญญาตรี □ สูงกว่าปริญญาตรี

□ อื่นๆ โปรดระบุ.....

3. อาชีพของสามีของท่าน

□ คนงาน รับจ้าง □ ค้าขาย □ รับราชการ

□ เกษตรกรรม □ รัฐวิสาหกิจ □ ธุรกิจส่วนตัว

□ วิชาชีพเฉพาะทาง/ช่าง □ อื่นๆ โปรดระบุ.....

4. รายได้ของสามีต่อเดือน

□ ไม่มีรายได้ □ 1,000-5,000 บาท □ 5,001-9,000 บาท

□ 9,001-20,000 บาท □ มากกว่า 20,000 บาท

5. สามีของท่านสูบบุหรี่หรือไม่

□ ไม่สูบ

□ สูบ จำนวนประมาณ.....มวนต่อวัน

6. สามีของท่านดื่มสุราหรือไม่

□ ไม่ดื่ม □ ดื่มแต่นานๆครั้ง

□ ดื่มเป็นบางครั้ง □ ดื่มเป็นประจำ

7. สามีของท่านใช้สารเสพติดหรือไม่

□ ไม่ใช้

□ ใช้ โปรดระบุชนิด.....

8. สามีของท่านเล่นการพนันหรือไม่

□ ไม่เล่น

□ เล่น

ข้อมูลเกี่ยวกับครอบครัว

1. จำนวนสมาชิกที่อาศัยอยู่กับท่านในปัจจุบัน (รวมท่านด้วย).....คน มีใครบ้าง (โปรดระบุรายละเอียด เช่น ปู่ 1 คน ย่า 1 คน ลูกชาย 1 คน ลูกสาว 2 คน) .....
.....

2. ลักษณะบ้านที่คุณอาศัยอยู่

□ บ้าน แฟลต หรือคอนโดมิเนียมของตนเอง □ ห้องเช่า

□ แฟลตหรืออพาร์ทเมนท์เช่า □ บ้านเช่า/ห้องแถวเช่า

□ บ้านพักชั่วคราว □ อื่นๆ โปรดระบุ.....

3. ท่านมีบุตรกับสามีคนนี้.....คน

4. ท่านแต่งงานหรืออยู่กินด้วยกันกับสามีของท่าน.....ปี

5. ครอบครัวของท่านมีหนี้สิน.....บาทประกอบด้วย □ หนี้ ธกส. .....บาท

□ หนี้สหกรณ์. .....บาท

□ หนี้กลุ่มในชุมชน .....บาท

□ หนี้อื่นๆ. .....บาท

ส่วนที่ 2 แบบสำรวจสุขภาพ SF 12

คำถามต่อไปนี้เป็นคำถามเกี่ยวกับความคิดเห็นเกี่ยวกับสุขภาพของท่านเอง ซึ่งจะเป็นคำถามเกี่ยวกับสุขภาพและความสามารถในการทำกิจกรรมโดยทั่วๆไป

<u>โปรดตอบคำถามทุกคำถาม</u>โดยการกาเครื่องหมายถูก [√] ตัวเลือกในแต่ละข้อ ถ้าหากท่านไม่แน่ใจให้เลือกคำตอบที่ท่านคิดว่าใกล้เคียงที่สุด

1. โดยทั่วไปท่านคิดว่าสุขภาพของท่านเป็นอย่างไร

□ ดีเลิศ □ ดีมาก □ ดี □ พอใช้ □ ไม่ดี

2. คำถามต่อไปนี้เป็นคำถามเกี่ยวกับกิจกรรมที่ท่านปฏิบัติในแต่ละวัน ท่านคิดว่า<u>สุขภาพของท่านทำให้ท่านมีปัญหา</u>ในการทำกิจกรรมเหล่านี้หรือไม่ ถ้ามี มีมากหรือน้อยเพียงใด

<u>กิจกรรม</u>	มีปัญหามาก	มีปัญหาเล็กน้อย	ไม่มีปัญหาเลย
ก. กิจกรรมที่ต้องใช้แรงปานกลาง เช่น เลื่อนโต๊ะ รดน้ำต้นไม้ ขี่จักรยาน 100 เมตร ซักผ้าด้วยตนเอง 8-10 ชิ้น			
ข. เดินขึ้นบันไดหลายชั้นติดต่อกัน			

3. <u>ในระยะหนึ่งเดือนที่ผ่านมา สุขภาพกายของท่านทำให้ท่านมีปัญหาเหล่านี้</u>เวลาทำงานหรือทำกิจกรรมประจำวันหรือไม่?

<u>กิจกรรม</u>	ตลอดเวลา	เกือบตลอดเวลา	บางครั้ง	นานๆครั้ง	ไม่มีเลย
ก. ทำงานได้น้อยกว่าที่ต้องการ					
ข.ไม่สามารถทำงานหรือกิจกรรมบางอย่างได้					

4. <u>ในระยะหนึ่งเดือนที่ผ่านมาปัญหาทางอารมณ์</u> (เช่น รู้สึกหดหู่หรือวิตกกังวล) <u>ทำให้ท่านมีปัญหาเหล่านี้</u>เวลาทำงาน หรือทำกิจกรรมประจำวันหรือไม่?

<u>กิจกรรม</u>	ตลอดเวลา	เกือบตลอดเวลา	บางครั้ง	นานๆครั้ง	ไม่มีเลย
ก. ทำงานได้น้อยกว่าที่ต้องการ					
ข. มีความระมัดระวังในการทำงานหรือกิจวัตรประจำวันน้อยกว่าเดิม					

5. ในระยะหนึ่งเดือนที่ผ่านมา อาการปวดเมื่อยร่างกายของท่านมีผลกระทบต่อการทำงานปกติ ทั้งงานนอกบ้านและงานในบ้าน มากน้อยแค่ไหน?

□ ไม่เลย □ เล็กน้อย □ ปานกลาง
□ ค่อนข้างมาก □ มากที่สุด

6. ในระยะหนึ่งเดือนที่ผ่านมา ท่านมีความรู้สึกต่อไปนี้บ่อยครั้งเพียงใด

	ตลอดเวลา	เกือบตลอดเวลา	บ่อยๆ	บางครั้ง	นานๆ ครั้ง	ไม่มีเลย
ก. ท่านรู้สึกใจเย็นและสงบ						
ข. ท่านรู้สึกว่าตัวเองมีพลังมาก						
ค. ท่านรู้สึกหดหู่ใจ เศร้าใจ						

7. ในระยะหนึ่งเดือนที่ผ่านมา ปัญหาสุขภาพร่างกายหรือปัญหาทางอารมณ์ของท่านมีผลกระทบต่อ กิจกรรมทางสังคมที่ท่านทำตามปกติกับครอบครัวหรือเพื่อนฝูงหรือเพื่อนบ้านหรือกลุ่มคน บ่อยครั้งแค่ไหน?

□ ตลอดเวลา □ เกือบตลอดเวลา □ บางครั้ง
□ นานๆ ครั้ง □ ไม่มีเลย

ส่วนที่ 3 ประสบการณ์เกี่ยวกับความรุนแรงในครอบครัวในระยะก่อนและระหว่างการตั้งครรภ์

1. ในช่วงหนึ่งปีก่อนที่ท่านตั้งครรภ์ สามีของท่านเคยทำร้ายท่านหรือไม่

□ เคย จำนวนครั้ง.....
□ ไม่เคย

2. ในช่วงหนึ่งปีก่อนที่ท่านตั้งครรภ์ สามีของท่านเคยข่มขู่ว่าจะทำร้ายหรือทำให้ท่านได้รับความเจ็บปวดหรือไม่

□ เคย จำนวนครั้ง.....
□ ไม่เคย

แบบสอบถามเกี่ยวกับการถูกกระทำความรุนแรงทางจิตใจ

โปรดตอบคำถามทุกคำถามโดยการกาเครื่องหมายถูก [√] ในช่องที่กำหนดให้ในแต่ละข้อที่ใกล้เคียงกับพฤติกรรมที่สามี/คู่ครองของท่านกระทำต่อท่านในช่วงตั้งแต่ท่านเริ่มตั้งครรภ์นี้จนถึงวันนี้

พฤติกรรมของสามี/คู่ครองของท่าน	ไม่เคย	นานๆครั้ง (หนึ่งครั้งใน 6 เดือน)	เป็นครั้งคราว (หนึ่งครั้งใน 1 เดือน)	บ่อยๆ (หนึ่งครั้งใน 1 สัปดาห์)	เป็นประจำ (มากกว่า1 ครั้ง ใน1 สัปดาห์)
1. สามีของท่านเรียกชื่อท่านโดยใช้สรรพนามที่ทำให้ท่านไม่พอใจ					
2. สามีของท่านพูดคำหยาบใส่ท่าน					
3. สามีของท่านร้องด่า ตะคอก ตะโกนใส่ท่าน					
4. สามีของท่านทำราวกับว่าท่านด้อยกว่าเขา					
5. สามีของท่านคอยติดตามท่านและท่านต้องรายงานว่าท่านทำอะไร อยู่ที่ไหน					
6. สามีของท่านใช้เงินหรือตัดสินใจเกี่ยวกับเรื่องการเงินที่สำคัญโดยไม่ปรึกษาท่าน					
7. สามีของท่านอิจฉาหรือระแวงเพื่อนฝูงของท่าน					
8. สามีของท่านกล่าวหาว่าท่านมีชู้					
9. สามีของท่านเข้ามาแทรกหรือรบกวนในความสัมพันธ์ของท่านกับญาติพี่น้องของท่าน					
10. สามีของท่านกีดกันไม่ให้ท่านทำงานช่วยเหลือตัวเอง					
11. สามีของท่านจำกัดการใช้โทรศัพท์ของท่าน					
12. สามีของท่านบอกท่านว่าความคิดของท่านไม่มีเหตุผลหรือเป็นเรื่องที่โง่เง่า					
13. สามีของท่านโยนความผิดให้ท่านเมื่อเขามีปัญหา					
14. สามีของท่านพยายามทำให้ท่านเป็นประสาท					

แบบสอบถามเกี่ยวกับการถูกกระทำความรุนแรงทางร่างกาย
พฤติกรรมต่อไปนี้อาจเป็นพฤติกรรมที่สามีของท่านกระทำต่อคุณในระหว่างที่คุณตั้งครรภ์ โปรดกา เครื่องหมายถูก [√] ในช่องที่ตรงกับพฤติกรรมในแต่ละข้อโดยกำหนดระยะเวลาที่เกิดพฤติกรรม ดังกล่าว ตั้งแต่วันที่ท่านตั้งครรภ์นี้จนถึงวันนี้

บ่อยแค่ไหนที่สามีของท่านแสดงพฤติกรรมเหล่านี้	ไม่เคย	ครั้งเดียว	2-3 ครั้ง	หลายๆ ครั้ง
1. เตะผนังบ้าน ประตู หรือเครื่องใช้ในบ้าน				
2. ขว้างปาหรือทำลายสิ่งของ				
3. ขับรถอย่างอันตรายน่าหวาดเสียวในขณะที่ท่านอยู่ด้วย				
4. ขว้างปาสิ่งของใส่ท่าน				
5. ชี้นิ้วด่าใส่ท่าน				
6. แสดงท่าทีข่มขู่ใส่ท่าน				
7. สะบัดกำปั้นใส่ท่าน				
8. แสดงท่าทางเหมือนวัวบ้าใส่ท่าน				
9. ทำลายสิ่งของส่วนตัวของท่าน				
10. ขู่จะทำร้ายหรือทำลายสิ่งของที่ท่านหวง				
11. ขู่จะทำลายทรัพย์สมบัติของท่าน				
12. ขู่จะทำร้ายคนที่ท่านรัก นับถือ เคารพบูชา				
13. ขู่จะทำให้ท่านได้รับความเจ็บปวด				
14. ขู่จะฆ่าตัวตาย				
15. ขู่จะฆ่าท่าน				
16. ขู่จะทำร้ายท่านด้วยอาวุธ				
17. ขู่จะทำร้ายท่านด้วยไม้หรือของแข็ง				
18. ทำท่าเหมือนต้องการที่จะฆ่าท่าน				
19. ขู่จะแทงท่านด้วยมีดหรือยิงด้วยปืน				
20. จับตรึงท่านไว้กับที				
21. ผลักท่านอย่างรุนแรง				
22. ดึงหรือกระชากแขนท่านอย่างแรง				
23. เขย่าหรือกระแทกท่านอย่างแรง				
24. ขุดข่วนท่าน				

แบบสอบถามเกี่ยวกับการถูกกระทำความรุนแรงทางร่างกาย (ต่อ)
พฤติกรรมต่อไปนี้อาจเป็นพฤติกรรมที่สามีของท่านกระทำต่อคุณในระหว่างที่คุณตั้งครรภ์ โปรดกา เครื่องหมายถูก [√] ในช่องที่ตรงกับพฤติกรรมในแต่ละข้อโดยกำหนดระยะเวลาที่เกิดพฤติกรรม ดังกล่าวตั้งแต่วันที่ท่านตั้งครรภ์นี้จนถึงวันนี้

บ่อยแค่ไหนที่สามีของท่านแสดงพฤติกรรมเหล่านี้	ไม่เคย	ครั้งเดียว	2-3 ครั้ง	หลายๆ ครั้ง
25. กระชากหรือดึงผมท่าน				
26. บิดแขนท่าน				
27. ตบตีท่าน				
28. กัดท่าน				
29. ตบท่านด้วยฝ่ามือ				
30. ตบท่านด้วยหลังมือ				
31. ตบบริเวณใบหน้าและศีรษะของท่าน				
32. ตีท่านด้วยของแข็ง				
33. ชกต่อยท่าน				
34. เตะท่าน				
35. กระทืบท่าน				
36. บีบคอท่าน				
37. ใช้ของร้อนจี้ท่าน				
38. ทุบตีท่านด้วยไม้ที่มีลักษณะเหมือนไม้กระบองหรือไม้ตีกอล์ฟ				
39. เฆี่ยนตีท่าน				
40. ใช้มีดหรือปืนจี้ท่าน				
41.ต้องการมีเพศสัมพันธ์กับท่านด้วยโดยไม่สนใจว่าท่านต้องการหรือไม่				
42. บังคับให้ท่านมีเพศสัมพันธ์ทางปากโดยที่ท่านไม่ต้องการ				
43. บังคับให้ท่านมีเพศสัมพันธ์ในขณะที่คุณไม่ต้องการ				
44. ใช้กำลังบังคับให้ท่านมีเพศสัมพันธ์ด้วย				
45. บังคับให้คุณมีเพศสัมพันธ์ทางทวารหนักด้วยโดยที่ ท่านไม่ต้องการ				
46. ใช้วัตถุบางสิ่งบางอย่างกับท่านแทนการร่วมเพศ				

47. ในกรณีที่ท่านถูกสามีทำร้ายด้านร่างกายในระหว่างตั้งครรภ์ บริเวณที่ท่านถูกทำร้ายเป็นบริเวณใด? (ตอบได้หลายข้อ)

□ ศีรษะ □ ใบหน้า □ ลำตัว □ แขน □ ขา □ ท้อง
□ เต้านม □ อวัยวะเพศ □ หลัง □ อื่นๆ โปรดระบุ.....

ส่วนที่ 4 คำถามเกี่ยวกับแหล่งความช่วยเหลือและวิธีการเผชิญปัญหาความรุนแรง (ถามเฉพาะหญิงตั้งครรภ์ที่ถูกกระทำความรุนแรง)

โปรดตอบคำถามต่อไปนี้ ในช่องว่างที่กำหนดให้ หรือทำเครื่องหมายถูก √ ในวงเล็บที่กำหนดให้ตามความเหมาะสมพร้อมทั้งอธิบายเหตุผล

1. เมื่อสามีของท่านกระทำความรุนแรงต่อท่าน ท่านมีวิธีจัดการหรือแก้ไขปัญหาอย่างไร?

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2. ถ้าเป็นไปได้ท่านคิดว่าท่านควรแก้ปัญหาขณะนั้นอย่างไร?

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3. ท่านคิดว่าสาเหตุที่สามีของท่านกระทำความรุนแรงต่อท่านคืออะไร

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ส่วนที่ 4 คำถามเกี่ยวกับแหล่งความช่วยเหลือและวิธีการเผชิญปัญหาความรุนแรง (ต่อ)

4 . เมื่อท่านถูกสามีกระทำความรุนแรงต่อท่าน ท่านเคยเล่าให้ใครหรือไม่?

( ) เล่า ท่านเล่าให้ใครฟัง? เพราะอะไร? .....

.....

.....

.....

( ) ไม่เล่า เพราะเหตุใด? .....

.....

.....

5. เมื่อท่านถูกสามีกระทำความรุนแรงต่อท่าน ท่านเคยขอความช่วยเหลือจากใครหรือไม่?

( ) ขอความช่วยเหลือ จากใคร เพราะอะไร? ....

.....

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( ) ไม่ขอความช่วยเหลือ เพราะอะไร?

.....

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6. ท่านอยากได้รับความช่วยเหลืออะไรบ้างเพื่อแก้ปัญหานี้?

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7. ถ้าหากสามีของท่านกระทำความรุนแรงต่อท่านอีก ท่านจะมีแผนในการจัดการกับปัญหาความรุนแรงอย่างไร?

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ขอขอบคุณที่ท่านได้กรุณาตอบแบบสอบถามนี้

Appendix C: Postnatal Questionnaire

Postnatal Questionnaire

To be completed by researcher	**Code:……..……**
	Date:……..
	Hospital:……

General Instructions: Please answer every question by indicating by checkmark (√) the answer which best describes your situation or by filling in the space provided when appropriate.

Personal and obstetric history

1. Your name……
2. Date of delivery……
3. Your weight and height
   On delivery date…….kg.
   Before getting pregnant……..kg.
   Height……cm.

4. How many antenatal check-ups did you have when you were pregnant?
   - □ One- two
   - □ Three- four
   - □ Five- six
   - □ More than six times
   - □ None

5. Did you have any complications when you were pregnant? (Can be answered more than one)
   - □ Yes, antepartum hemorrhage
   - □ Yes, sexual transmitted disease
   - □ Yes, infection
   - □ Yes, premature labour (before 37 weeks of gestation)
   - □ Yes, fetal death
   - □ Yes, high blood pressure, diabetes, thalassemia or goiter
   - □ Other please specify……
   - □ No

6. How did you give birth?
   - □ Normal vaginal delivery
   - □ Vacuum delivery
   - □ Forceps delivery
   - □ Caesarean delivery, reason for Caesarean delivery……

7. During the delivery of your baby did you have any complications?
   - □ Yes, Abruption of placenta
   - □ Yes, Placenta previa
   - □ Yes, Premature rupture of membranes
   - □ Others please specify……
   - □ No

8. Did you have any complications after you gave birth? (Can be answered more than one answer)
   - □ Yes, infection
   - □ Yes, postpartum hemorrhage (blood loss more than 500 cc. after giving birth)
   - □ Yes, high blood pressure
   - □ Yes, still birth
   - □ Others, please specify……
   - □ No

9. How long did you stay at the hospital? …….days

10. Baby's sex □ Boy
    □ Girl

11. Weight of your baby
    At birth …….grams
    At the day of interview……..grams

12. Did the baby have any complications?
    - □ Yes, please specify…….
    - □ No

13. After being discharged home did your baby have to see a doctor as a result of a sickness?
    - □ Yes
    - □ No

14. Were you breastfed?
    - □ Yes
    - □ No

15. Is your baby difficult to feed?
    - □ Yes
    - □ No

16. Do you smoke a cigarette?
    - □ Yes ……cigarettes per day.
    - □ No

17. Do you drink alcohol?
    - □ Yes, very rarely (about once a month)
    - □ Yes, occasionally (about once a fortnight)
    - □ Yes, frequently (at least once in a week)
    - □ No

18. Do you use illicit drugs?
    - □ Yes, please specify type……
    - □ No

19. Do you gamble?
    - □ Yes, please specify type of gambling……
      How often do you gamble?……..
      How much money did you spend on gambling each time?……..…Baht
    - □ No

Husband details

7. Does your husband/partner smoke a cigarette?
    - □ Yes, ……..cigarettes/day
    - □ No
8. Does your husband/partner drink alcohol?
    - □ Yes, very rarely (about once a month)
    - □ Yes, occasionally (about once a fortnight)
    - □ Yes, frequently (at least once in a week)
    - □ No

9. Does your husband/partner use illicit drugs?
    - □ Yes, please specify type……
    - □ No

10. Does your husband/partner gamble?
    - □ Yes, please specify type of gambling……
      How often do you gamble?……..
      How much money did you spend on gambling each time? …….Baht
    - □ No

Part 2: General Health Questionnaire

We are interested in your general health and how well you are able to do what you normally do. Please tick (√) your response in the appropriate box.

1. In general, would you say your health is:
   □ Excellent □ Very good □ Good □ Fair □ Poor

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
A. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
B. Climbing several flights of stairs			

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A. Accomplished less than you would like					
B. Were limited in the kind of work or other activities					

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A. Accomplished less than you would like					
B. Did work or other activities less carefully than usual					

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

□ Not at all □ A little bit □ Moderately
□ Quite a bit □ Extremely

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks…

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
A. Have you felt calm and peaceful?						
B. Did you have a lot of energy?						
C. Have you felt downhearted and depressed?						

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

□ All of the time □ Most of the time □ Some of the time
□ A little of the time □ None of the time

Part 3: Psychological Maltreatment of Women Inventory

We are also concerned about your health and safety, the following questions will be asked how you have been treated by your husband/partner. Please tick (√) the response that most accurately describes how your husband/partner acted toward you both during your pregnancy and after birth (since the day of giving birth until now)

1 = Never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Very Frequently

How often has your partner:	**During pregnancy**					**After birth**				
	1	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
1. My partner called me names										
2. My partner swore at me										
3. My partner yelled and screamed at me										
4. My partner treated me like an inferior										
5. My partner monitored my time and made me account for where I was										
6. My partner used our money or made important financial decisions without talking to me about it										
7. My partner was jealous or suspicious of my friends										
8. My partner accused me of having an affair with another man										
9. My partner interfered in my relationships with other family members										
10. My partner tried to keep me from doing things to help myself										
11. My partner restricted my use of the telephone										
12. My partner told me that my feelings were irrational or crazy										
13. My partner blamed me for his problems										
14. My partner tried to make me feel crazy										

The Severity of Violence Against Women Scale

During the past year, you and your partner have probably experienced anger or conflict. Below is a list of behaviours your partner may have done during this pregnancy and after birth. Describe how often your partner has done each behaviour by tick (√) at the appropriate box of both periods.

My partner's behaviours:	During pregnancy				After birth			
	Never	Once	A few times	Many times	Never	Once	A few times	Many times
1. Kicked a wall, door, or furniture								
2. Threw, smashed, or broke an object								
3. Drove dangerously with me in the car								
4. Threw an object at me								
5. Shook finger at me								
6. Made threatening gestures at me								
7. Shook fist at me								
8. Acted like a bully toward me								
9. Destroyed something belonging to me								
10. Threatened to harm or damage things I cared about								
11. Threatened to destroyed property								
12. Threatened someone I cared about								
13. Threatened to hurt me								
14. Threatened to kill himself								
15. Threatened to kill me								

Below is a list of behaviours your partner may have done during this pregnancy and after birth. Describe how often your partner has done each behaviour by tick (√) at the appropriate box.

My partner's behaviours:	During pregnancy				After birth			
	Never	Once	A few times	Many times	Never	Once	A few times	Many times
16. Threatened me with a weapon								
17. Threatened me with a club-like object								
18. Acted like he wanted to kill me								
19. Threatened me with a knife or gun								
20. Hold me down, pinning me in place								
21. Pushed or shoved me								
22. Grabbed me suddenly or forcefully								
23.Shook or roughly handled me								
24.Scratched me								
25.Pulled my hair								
26.Twisted my arm								
27.Spanked me								
28.Bit me								
29.Slapped me with the palm of his hand								
30.Slapped me with the back of his hand								
31.Slapped me around the face and head								
32.Hit me with an object								

Below is a list of behaviours your partner may have done during this pregnancy and after birth. Describe how often your partner has done each behaviour by tick (√) at the appropriate box.

My partner's behaviours:	During pregnancy				After birth			
	Never	Once	A few times	Many times	Never	Once	A few times	Many times
33. Punched me								
34. Kicked me								
35. Stomped on me								
36 Choked me								
37. Burned me with something								
38.Used a clublike object on me								
39.Beat me up								
40.Used a knife or gun on me								
41.Demanded sex whether I wanted to or not								
42.Made me have oral sex against my will								
43.Made me have sexual intercourse my will								
44.Physically forced me to have sex								
45.Made me have anal sex against my will								
46.Used an object on me in a sexual way								

The following questions are only for women who have experienced abuse.

47. If abuse occurred during pregnancy, what was the target site of injury you were abused by your husband/partner? (please indicate target areas by using numbers)

_____Head	_____Back	_____Hands
_____Face	_____Stomach	_____Legs
_____Body	_____Breast	_____Others, please specify…….

48. If abuse occurred after birth, what was the target site of injury you were abused by your husband/ partner? (please indicate target areas by using numbers)

_____Head	_____Back	_____Hands
_____Face	_____Stomach	_____Legs
_____Body	_____Breast	_____Others, please specify……

49. When you were abused by your husband/partner, have you ever solved the problem by drinking alcohol?

□ Yes
□ No

50. When you were abused by your husband/partner, have you ever solved the problem by taking illicit drug?

□ Yes
□ No

51. When you were abused by your husband/partner, have you ever solved the problem by smoking cigarettes?

□ Yes
□ No

52. When you were abused by your husband/partner, have you ever solved the problem by doing gambling?

□ Yes
□ No

Part 4: Helpful resources and barriers to seek help

(only for women who identify abuse in Part 3)

Please answer every question by filling in space provided below

1. How did you deal with the violence?

……

……

……

……

2. If possible, what would you like to do to solve the problem (husband's violence) at that time?

……

……

……

3. What do you think was the cause of your husband's violence toward you?

……

……

……

4. Did you tell anyone about the abuse?

( ) Yes, who……..

…..……

……

( ) No, why not ……

……

……

Part 4: Helpful resources and barriers to seek help (continued)

5. Did you ask for help from anyone?

( ) Yes, who……..……

…….

…..……

( ) No, why not……

……

……

6. What support or helps would you like to have in order to solve the problem?

……

……

……

……

……

7. What is your plan if your husband acts violently toward you again?

……

……

……

……

……

Thank you for completing this survey

แบบสอบถามในระยะหลังคลอด

สำหรับนักวิจัย
รหัส.....
วันที่.....
โรงพยาบาล.....

แบบสอบถามนี้เป็นแบบสอบถามที่สำรวจความคิดเห็นเกี่ยวกับความรุนแรงในครอบครัวและภาวะสุขภาพในระยะหลังคลอดของท่าน

ส่วนที่ 1 ข้อมูลทั่วไป

โปรดตอบคำถามทุกคำถามโดยการเติมคำในช่องว่างหรือกาเครื่องหมายถูก [√] ตามความเหมาะสม

ข้อมูลส่วนบุคคล

1. ชื่อ.....

2. วันคลอด.....

3. ท่านคลอดโดยวิธีใด?

- □ คลอดปกติ
- □ คลอดโดยใช้เครื่องดูดสุญญากาศ
- □ คลอดโดยใช้คีมดึง
- □ คลอดโดยการผ่าตัด โปรดระบุสาเหตุที่ต้องผ่าตัด.....
  .....

4. ท่านมีความผิดปกติระหว่างตั้งครรภ์หรือไม่? (ถ้ามี ตอบได้หลายข้อ)

- □ ไม่เคยมีความผิดปกติ
- □ มีน้ำเดินก่อนกำหนด/ ถุงน้ำคร่ำแตกก่อนกำหนด
- □ มีเลือดออกทางช่องคลอด
- □ เจ็บครรภ์คลอดก่อนกำหนด
- □ มี เป็นโรคติดต่อทางเพศสัมพันธ์
- □ มีการอักเสบของอวัยวะสืบพันธ์
- □ มี ทารกตายในครรภ์
- □ อื่นๆ โปรดระบุ.....

5. ท่านมีภาวะแทรกซ้อนหรือความผิดปกติระหว่างคลอดหรือไม่?

- □ ไม่มี
- □ มี โปรดระบุ.....

6. ท่านมีภาวะแทรกซ้อนหรือความผิดปกติหลังคลอดหรือไม่? (ถ้ามีความผิดปกติตอบได้มากกว่าหนึ่งข้อ)

□ ไม่มี

□ มี ตกเลือดหลังคลอด

□ มี การติดเชื้อหลังคลอด โปรดระบุ.....

□ มี รกลอกตัวก่อนกำหนด

□ มี ทารกตายทันทีหลังคลอด หรือทารกเมื่อคลอดแล้วไม่มีอาการแสดงของการมีชีวิต

□ อื่นๆ โปรดระบุ.....

7. ระยะเวลาที่ท่านอยู่โรงพยาบาลหลังคลอด.....วัน

8. เพศของบุตร

□ หญิง □ ชาย

9. น้ำหนักของทารกแรกเกิด.....กรัม

10. น้ำหนักปัจจุบันของทารก.....กรัม

11. บุตรของท่านมีภาวะแทรกซ้อนหลังคลอดหรือไม่

□ ไม่มี

□ มี โปรดระบุ.....

12. ท่านมารับการตรวจครรภ์กี่ครั้ง

□ 1 ครั้ง □ 2 ครั้ง □ 3 ครั้ง

□ 4 ครั้ง หรือมากกว่า □ ไม่เคย

13. ท่านสูบบุหรี่หรือไม่

□ ไม่สูบ

□ สูบ จำนวนประมาณ.....มวนต่อวัน

14. ท่านดื่มสุราหรือไม่

□ ไม่ดื่ม □ ดื่มนานๆ ครั้ง

□ ดื่มเป็นบางครั้ง □ ดื่มเป็นประจำ

15. ท่านใช้สารเสพติดหรือไม่

□ ไม่ใช้

□ ใช้ โปรดระบุชนิด.....

16. ท่านเล่นการพนันหรือไม่

□ ไม่เล่น

□ เล่น

ข้อมูลเกี่ยวกับสามี/คู่ครอง

17. สามีของท่านสูบบุหรี่หรือไม่

□ ไม่สูบ

□ สูบ จำนวนประมาณ.....มวนต่อวัน

18. สามีของท่านดื่มสุราหรือไม่

□ ไม่ดื่ม □ ดื่มนานๆ ครั้ง

□ ดื่มเป็นครั้งคราว □ ดื่มเป็นประจำ

19. สามีของท่านใช้สารเสพติดหรือไม่

□ ไม่ใช้

□ ใช้ โปรดระบุชนิด.....

20. สามีของท่านเล่นการพนันหรือไม่

□ ไม่เล่น

□ เล่น

ส่วนที่ 2 แบบสำรวจสุขภาพ SF 12

คำถามต่อไปนี้เป็นคำถามเกี่ยวกับความคิดเห็นเกี่ยวกับสุขภาพของท่านเอง ซึ่งจะเป็นคำถามเกี่ยวกับสุขภาพและความสามารถในการทำกิจกรรมโดยทั่วๆไป

<u>โปรดตอบคำถามทุกคำถาม</u>โดยการกาเครื่องหมายถูก [√] ตัวเลือกในแต่ละข้อ ถ้าหากท่านไม่แน่ใจให้เลือกคำตอบที่ท่านคิดว่าใกล้เคียงที่สุด

1. โดยทั่วไปท่านคิดว่าสุขภาพของท่านเป็นอย่างไร

□ ดีเลิศ □ ดีมาก □ ดี □ พอใช้ □ ไม่ดี

2. คำถามต่อไปนี้เป็นคำถามเกี่ยวกับกิจกรรมที่ท่านปฏิบัติในแต่ละวัน ท่านคิดว่า<u>สุขภาพของท่านทำให้ท่านมีปัญหา</u>ในการทำกิจกรรมเหล่านี้หรือไม่ ถ้ามี มีมากหรือน้อยเพียงใด

<u>กิจกรรม</u>	มีปัญหามาก	มีปัญหาเล็กน้อย	ไม่มีปัญหาเลย
ก. กิจกรรมที่ต้องใช้แรงปานกลาง เช่น เลื่อนโต๊ะ รดน้ำต้นไม้ ขี่จักรยาน 100 เมตร ซักผ้าด้วยตนเอง 8-10 ชิ้น			
ข. เดินขึ้นบันไดหลายชั้นติดต่อกัน			

3. <u>ในระยะหนึ่งเดือนที่ผ่านมา สุขภาพกายของท่านทำให้ท่านมีปัญหาเหล่านี้</u>เวลาทำงานหรือทำกิจกรรมประจำวันหรือไม่?

<u>กิจกรรม</u>	ตลอดเวลา	เกือบตลอดเวลา	บางครั้ง	นานๆครั้ง	ไม่มีเลย
ก. ทำงานได้น้อยกว่าที่ต้องการ					
ข.ไม่สามารถทำงานหรือกิจกรรมบางอย่างได้					

4. <u>ในระยะหนึ่งเดือนที่ผ่านมาปัญหาทางอารมณ์</u> (เช่น รู้สึกหดหู่หรือวิตกกังวล) <u>ทำให้ท่านมีปัญหาเหล่านี้</u>เวลาทำงาน หรือทำกิจกรรมประจำวันหรือไม่?

<u>กิจกรรม</u>	ตลอดเวลา	เกือบตลอดเวลา	บางครั้ง	นานๆครั้ง	ไม่มีเลย
ก. ทำงานได้น้อยกว่าที่ต้องการ					
ข. มีความระมัดระวังในการทำงานหรือกิจวัตรประจำวันน้อยกว่าเดิม					

5. ในระยะหนึ่งเดือนที่ผ่านมา อาการปวดเมื่อยร่างกายของท่านมีผลกระทบต่อการทำงานปกติทั้งงานนอกบ้านและงานในบ้าน มากน้อยแค่ไหน?

□ ไม่เลย □ เล็กน้อย □ ปานกลาง
□ ค่อนข้างมาก □ มากที่สุด

6. ในระยะหนึ่งเดือนที่ผ่านมา ท่านมีความรู้สึกต่อไปนี้บ่อยครั้งเพียงใด

	ตลอดเวลา	เกือบตลอดเวลา	บ่อยๆ	บางครั้ง	นานๆ ครั้ง	ไม่มีเลย
ก. ท่านรู้สึกใจเย็นและสงบ						
ข. ท่านรู้สึกว่าตัวเองมีพลังมาก						
ค. ท่านรู้สึกหดหู่ใจ เศร้าใจ						

7. ในระยะหนึ่งเดือนที่ผ่านมา ปัญหาสุขภาพร่างกายหรือปัญหาทางอารมณ์ของท่านมีผลกระทบต่อ กิจกรรมทางสังคมที่ท่านทำตามปกติกับครอบครัวหรือเพื่อนฝูงหรือเพื่อนบ้านหรือกลุ่มคน บ่อยครั้งแค่ไหน?

□ ตลอดเวลา □ เกือบตลอดเวลา □ บางครั้ง
□ นานๆ ครั้ง □ ไม่มีเลย

ส่วนที่ 3 แบบสอบถามเกี่ยวกับการถูกกระทำความรุนแรงทางจิตใจ

คำถามต่อไปนี้เป็นคำถามเกี่ยวกับพฤติกรรมของสามีท่าน โปรดตอบคำถามทุกคำถามโดยการกาเครื่องหมายถูก [√] ในช่องที่กำหนดให้ในแต่ละข้อที่ใกล้เคียงกับพฤติกรรมที่สามี/คู่ครองของท่านกระทำต่อท่านในช่วงหลังการสัมภาษณ์ครั้งแรกจนถึงวันนี้ กรุณาตอบทั้งสองช่วง

กำหนดให้ 1 = ไม่เคย 2 = นานๆ ครั้ง 3 = เป็นครั้งคราว 4 = บ่อยๆ 5 = เป็นประจำ

พฤติกรรมของสามี/คู่ครองของท่าน	ระหว่างตั้งครรภ์ (ในช่วงหลังการสัมภาษณ์ครั้ง แรกจนถึงวันคลอด)					หลังคลอด (ในช่วงจากวันคลอดจนถึงวันนี้)				
	1	2	3	4	5	1	2	3	4	5
1. สามีของท่านเรียกชื่อท่านโดยใช้สรรพนามที่ทำให้ท่านไม่พอใจ										
2. สามีของท่านพูดคำหยาบใส่ท่าน										
3. สามีของท่านร้องด่า ตะคอก ตะโกนใส่ท่าน										
4. สามีของท่านทำให้ท่านรู้สึกว่าท่านด้อยกว่าเขา เช่นดูถูก ไม่ให้เกียรติท่าน										
5. สามีของท่านคอยติดตามหรือตรวจสอบว่าท่านทำอะไร อยู่ที่ไหน และไปนานเท่าไร (จำกัดเวลา สถานที่)										
6. สามีของท่านใช้เงินหรือตัดสินใจเกี่ยวกับเรื่องการเงินที่สำคัญโดยไม่ปรึกษาท่าน										
7. สามีของท่านอิจฉาหรือระแวงเพื่อนฝูงของท่าน										
8. สามีของท่านกล่าวหาว่าท่านมีชู้										
9. สามีของท่านเข้ามาแทรกหรือรบกวนในความสัมพันธ์ของท่านและเครือญาติของท่าน										
10. สามีของท่านกีดกันไม่ให้ท่านทำงานช่วยเหลือตัวเอง										
11. สามีของท่านจำกัดการใช้โทรศัพท์ของท่าน										
12. สามีของท่านบอกท่านว่าความคิดของท่านไม่มีเหตุผลหรือเป็นเรื่องที่โง่เง่า										
13. สามีของท่านโยนความผิดให้ท่านเมื่อเขาเกิดปัญหา										
14. สามีของท่านพยายามทำให้ท่านเป็นประสาท										

แบบสอบถามเกี่ยวกับการถูกกระทำความรุนแรงทางร่างกาย
โปรดตอบคำถามทุกคำถามโดยการกาเครื่องหมายถูก [√] ในแต่ละข้อที่ตรงกับพฤติกรรมที่สามีคุณกระทำต่อคุณในช่วงหลังการสัมภาษณ์ครั้งแรกจนถึงวันนี้ กรุณาตอบทั้งสองช่วง

กำหนดให้ 1 = ไม่เคย 2 = ครั้งเดียว 3 = สองสามครั้ง 4 = หลายๆ ครั้ง

บ่อยแค่ไหนที่สามีของท่านแสดงพฤตกรรมเหล่านี้	**ระหว่างตั้งครรภ์** (ในช่วงหลังการสัมภาษณ์ครั้งแรกจนถึงวันคลอด)				**หลังคลอด** (ในช่วงจากวันคลอดจนถึงวันนี้)			
	1	2	3	4	1	2	3	4
1. เตะผนังบ้าน ประตู หรือเครื่องใช้ในบ้าน								
2. ขว้างปาหรือทำลายสิ่งของ								
3. ขับรถอย่างอันตรายน่าหวาดเสียวเมื่อท่านอยู่ด้วย								
4. ขว้างปาสิ่งของใส่ท่าน								
5. ชี้นิ้วด่าใส่ท่าน								
6. แสดงท่าทีข่มขู่ใส่ท่าน								
7. สะบัดกำปั้นใส่ท่าน								
8. แสดงท่าทางเหมือนวัวบ้าใส่ท่าน								
9. ทำลายสิ่งของส่วนตัวของท่าน								
10. ขู่จะทำร้ายหรือทำลายสิ่งของที่ท่านหวง								
11. ขู่จะทำลายทรัพย์สมบัติของท่าน								
12. ขู่จะทำร้ายคนที่ท่านรัก นับถือ เคารพบูชา								
13. ขู่จะทำให้ท่านได้รับความเจ็บปวด								
14. ขู่จะฆ่าตัวตาย								
15. ขู่จะฆ่าท่าน								
16. ขู่จะทำร้ายท่านด้วยอาวุธ เช่น ระเบิด ไม้ ฆ้อน								
17. ขู่จะทำร้ายท่านด้วยไม้ที่มีลักษณะเหมือนไม้ตีกอล์ฟ								
18. ทำท่าเหมือนต้องการที่จะฆ่าท่าน								
19. ขู่จะแทงท่านด้วยมีดหรือยิงด้วยปืน								
20. จับตรึงท่านไว้กับที่								
21. ผลักท่าน								
22. ดึงหรือกระชากแขนท่านอย่างแรง								

แบบสอบถามเกี่ยวกับการถูกกระทำความรุนแรงทางร่างกาย (ต่อ)
<u>โปรดตอบคำถามทุกคำถาม</u>โดยการกาเครื่องหมายถูก [√] ในแต่ละข้อที่ตรงกับพฤติกรรมที่สามีคุณกระทำต่อคุณในช่วงหลังการสัมภาษณ์ครั้งแรกจนถึงวันนี้ กรุณาตอบทั้งสองช่วง

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	1	2	3	4	1	2	3	4
23. เขย่าหรือกระแทกท่านอย่างแรง								
24. ขูดข่วนท่าน								
25. กระชากหรือดึงผมท่าน								
26. บิดแขนท่าน								
27. ตบตีท่าน								
28. กัดท่าน								
29. ตบท่านด้วยฝ่ามือ								
30. ตบท่านด้วยหลังมือ								
31. ตบบริเวณใบหน้าและศีรษะของท่าน								
32. ตีท่านด้วยของแข็ง เช่นหม้อ ไห ก้อนหิน อิฐ								
33. ชกต่อยท่าน								
34. เตะท่าน								
35. กระทืบท่าน								
36. บีบคอท่าน								
37. ใช้ของร้อนจี้ท่าน								
38. ทุบตีท่านด้วยไม้ที่มีลักษณะเหมือนไม้กระบองหรือไม้ตีกอล์ฟ								
39. เฆี่ยนตีท่าน								
40. ใช้มีดหรือปืนจี้ท่าน								
41. ต้องการให้มีเพศสัมพันธ์ด้วยโดยไม่สนใจว่าท่านต้องการหรือไม่								
42. บังคับให้ท่านมีเพศสัมพันธ์ทางปากโดยที่ท่านไม่ยินยอม								
43. บังคับให้ท่านมีเพศสัมพันธ์ในขณะที่ท่านไม่ยินยอม								
44. ใช้กำลังบังคับให้ท่านมีเพศสัมพันธ์ด้วย								
45. บังคับให้คุณมีเพศสัมพันธ์ทางทวารหนักด้วยโดยที่ท่านไม่ยินยอม								
46. ใช้วัตถุสิ่งของกับท่านแทนการร่วมเพศ								

47. ในกรณีที่ท่านถูกสามีทำร้ายด้านร่างกายในระหว่างตั้งครรภ์ บริเวณที่ท่านถูกทำร้ายเป็นบริเวณใด? (ตอบได้หลายข้อ)

□ ศีรษะ □ ใบหน้า □ ลำตัว □ แขน
□ ขา □ ท้อง □ เต้านม □ อวัยวะเพศ
□ หลัง □ อื่นๆ โปรดระบุ.....

48. ในกรณีที่ท่านถูกสามีทำร้ายด้านร่างกายในระหว่างหลังคลอด บริเวณที่ท่านถูกทำร้ายเป็นบริเวณใด? (ตอบได้หลายข้อ)

□ ศีรษะ □ ใบหน้า □ ลำตัว □ แขน
□ ขา □ ท้อง □ เต้านม □ อวัยวะเพศ
□ หลัง □ อื่นๆ โปรดระบุ.....

ส่วนที่ 4 คำถามเกี่ยวกับแหล่งความช่วยเหลือและวิธีการเผชิญปัญหาความรุนแรง (ถามเฉพาะหญิงตั้งครรภ์ที่ถูกกระทำความรุนแรง)

โปรดตอบคำถามต่อไปนี้ ในช่องว่างที่กำหนดให้ หรือทำเครื่องหมายถูก [√] ในวงเล็บที่กำหนดให้ตามความเหมาะสมพร้อมทั้งอธิบายเหตุผล

1. เมื่อสามีของท่านกระทำความรุนแรงต่อท่าน ท่านมีวิธีจัดการหรือแก้ไขปัญหาอย่างไร?

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2. ถ้าเป็นไปได้ท่านคิดว่าท่านควรแก้ปัญหาขณะนั้นอย่างไร?

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3. ท่านคิดว่าสาเหตุที่สามีของท่านกระทำความรุนแรงต่อท่านคืออะไร

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ส่วนที่ 4 คำถามเกี่ยวกับแหล่งความช่วยเหลือและวิธีการเผชิญปัญหาความรุนแรง (ต่อ)

4. เมื่อท่านถูกสามีกระทำความรุนแรงต่อท่าน ท่านเคยเล่าให้ใครหรือไม่?

( ) เล่า ท่านเล่าให้ใครฟัง? เพราะอะไร?

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( ) ไม่เล่า เพราะเหตุใด?

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5. เมื่อท่านถูกสามีกระทำความรุนแรงต่อท่าน ท่านเคยขอความช่วยเหลือจากใครหรือไม่?

( ) ขอความช่วยเหลือ จากใคร เพราะอะไร?

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( ) ไม่ขอความช่วยเหลือ เพราะอะไร?

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6. ท่านอยากได้รับความช่วยเหลืออะไรบ้างเพื่อแก้ปัญหานี้?

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7. ถ้าหากสามีของท่านกระทำความรุนแรงต่อท่านอีก ท่านจะมีแผนในการจัดการกับปัญหาความรุนแรงอย่างไร?

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ขอขอบคุณที่ท่านได้กรุณาตอบแบบสอบถามนี้

Appendix D: Permission to Collect Data in Thailand

Letter to Dean of the Faculty of Nursing,
Khon Kaen University, Thailand

622 Kessels Road
Macgregor, QLD 4109
Australia
Tel. +61 7 3875 5356
E-mail: amornrat.sricamsuk@student.gu.edu.au

22 กรกฎาคม 2546

เรื่อง ขออนุญาตเก็บข้อมูล
เรียน คณบดีคณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น
สิ่งที่ส่งมาด้วย 1. เค้าโครงวิทยานิพนธ์ฉบับย่อ เรื่อง ความรุนแรงในครอบครัว: การศึกษาในกลุ่มหญิงตั้งครรภ์

ข้าพเจ้า นางสาวอมรรัตน์ ศรีคำสุข อาจารย์ระดับ 4 สังกัดภาควิชาการพยาบาลจิตเวชศาสตร์ คณะพยาบาลศาสตร์มหาวิทยาลัยขอนแก่น ขณะนี้กำลังศึกษาในระดับปริญญาเอกสาขาการพยาบาลศาสตร์ ณ มหาวิทยาลัยกริฟฟิท เมืองบริสเบน ประเทศออสเตรเลีย ในหัวข้อวิทยานิพนธ์เรื่อง ความรุนแรงในครอบครัว: การศึกษาในกลุ่มหญิงไทยที่ตั้งครรภ์ ซึ่งในการศึกษาครั้งนี้มีกลุ่มตัวอย่างคือ หญิงตั้งครรภ์ อายุ 18-45 ปีที่มีอายุครรภ์ตั้งแต่ 6 เดือนขึ้นไป ที่มารับบริการที่แผนกฝากครรภ์ โรงพยาบาลศรีนครินทร์ โรงพยาบาลขอนแก่นและศูนย์อนามัยที่ 6 จังหวัดขอนแก่น มีความประสงค์ใคร่ขอความอนุเคราะห์จากท่านในการติดต่อผู้อำนวยการของโรงพยาบาลดังกล่าวเพื่อขออนุญาตในการเก็บข้อมูล การวิจัยดังกล่าวในระหว่างเดือนสิงหาคม 2546 ถึง เดือนกุมภาพันธ์ 2547

จึงเรียนมาเพื่อโปรดพิจารณาให้ความอนุเคราะห์ จักเป็นพระคุณยิ่ง

ขอแสดงความนับถือ

(นางสาวอมรรัตน์ ศรีคำสุข)

Permission Letter from Health Promotion Centre Region 6

Attention : Prof. Debra Creedy

เลขที่รับ 6257
วันที่ 31 ก.ค. 2546
เวลา 8.30

ที่ ศธ 0514.6/ 3483

คณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น
อำเภอเมือง จังหวัดขอนแก่น 40002

30 กรกฎาคม 2546

เรื่อง ขออนุญาตให้อาจารย์เข้าเก็บข้อมูล

เรียน ผู้อำนวยการศูนย์อนามัยที่ 6

สิ่งที่ส่งมาด้วย เค้าโครงวิทยานิพนธ์ฉบับย่อ จำนวน 1 ชุด

ด้วย นางสาวอมรรัตน์ ศรีคำสุข อาจารย์ประจำคณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น ซึ่งขณะนี้กำลังศึกษาในระดับปริญญาเอก สาขาการพยาบาลศาสตร์ ณ มหาวิทยาลัยกริฟฟิท เมืองบริสเบน ประเทศออสเตรเลีย ในหัวข้อวิทยานิพนธ์ เรื่อง **ความรุนแรงในครอบครัว: การศึกษาในกลุ่มหญิงไทยที่ตั้งครรภ์** เพื่อให้การศึกษาดังกล่าวสำเร็จตามวัตถุประสงค์ จึงใคร่ขออนุญาตให้อาจารย์เข้าเก็บข้อมูลกับหญิงตั้งครรภ์ อายุตั้งแต่ 18-45 ปีที่มีอายุครรภ์ตั้งแต่ 6 เดือนขึ้นไป ที่แผนกฝากครรภ์ ศูนย์อนามัยที่ 6 ในระหว่างเดือนสิงหาคม 2546 ถึงเดือนกุมภาพันธ์ 2547 ดังรายละเอียดเค้าโครงวิทยานิพนธ์ฉบับย่อแนบมาพร้อมนี้

จึงเรียนมาเพื่อโปรดพิจารณาด้วย จักเป็นพระคุณยิ่ง

ขอแสดงความนับถือ

(ผู้ช่วยศาสตราจารย์ ดร.วรรณภา ศรีธัญรัตน์)
คณบดีคณะพยาบาลศาสตร์

(นางปราณี เตียสวัสดิ์)
รักษาการแทนหัวหน้าฝ่ายบริหารงานทั่วไป

(นางอวยพร แก้วสุข)
ตำแหน่ง นายแพทย์ ๙ ๑ ก ผ.อ.ศูนย์

1 ส.ค. 2546

สำนักงานคณบดี
โทรศัพท์/ โทรสาร 0-4323-7606, 0-4336- 2012, 0-4334-8301

Permission Letter from Khon Kaen Hospital

Attention : Prof. Debra Creedy
Khon Kaen Hospital – Permission letter

ที่ ศธ 0514.6/ 3484

คณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น
อำเภอเมือง จังหวัดขอนแก่น 40002

30 กรกฎาคม 2546

เรื่อง ขออนุญาตให้คาจารย์เข้าเก็บข้อมูล

เรียน ผู้อำนวยการโรงพยาบาลขอนแก่น

สิ่งที่ส่งมาด้วย เค้าโครงวิทยานิพนธ์ฉบับย่อ จำนวน 1 ชุด

ด้วย นางสาวอมรรัตน์ ศรีคำสุข อาจารย์ประจำคณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น ซึ่งขณะนี้กำลังศึกษาในระดับปริญญาเอก สาขาการพยาบาลศาสตร์ มหาวิทยาลัยคริสเตียน ประเทศฟิลิปปินส์ ในหัวข้อวิทยานิพนธ์เรื่อง ความรุนแรงในครอบครัว: การสืบค้นในกลุ่มผู้ป่วยหญิงตั้งครรภ์ เพื่อใช้การศึกษาดังกล่าวสำเร็จตามวัตถุประสงค์ จึงใคร่ขออนุญาตให้ [illegible] ผู้ป่วยหญิงตั้งครรภ์ อายุตั้งแต่ 18-45 ปีที่มีอายุครรภ์ตั้งแต่ 6 เดือนขึ้นไป ที่แผนกฝากครรภ์ โรงพยาบาลขอนแก่น ในระหว่างเดือนสิงหาคม 2546 ถึงเดือนกุมภาพันธ์ 2547 ดังรายละเอียดเค้าโครงวิทยานิพนธ์ฉบับย่อมาพร้อมนี้

จึงเรียนมาเพื่อโปรดพิจารณาด้วย จักเป็นพระคุณยิ่ง

(นางสุดาพร กุมพล)
หัวหน้าพยาบาล
1 ส.ค. 2546

(ผู้ช่วยศาสตราจารย์ [illegible])
คณบดีคณะพยาบาลศาสตร์

โทรศัพท์ โทรสาร 0-4323 7606, 0-4336-2012, 0-4334-8301

Appendix E: Information Sheet for Thai Women

School of Nursing and Midwifery
Nathan Campus, Brisbane
QLD 4111 Australia
Telephone +61 (0)7 3875 5406

Information Sheet

Title: Domestic violence against pregnant women: A Thai perspective

Chief Investigators: Professor Debra Creedy, Professor Wendy Chaboyer, Dr Marie Cooke
Assistant Investigator: Amornrat Sricamsuk (Doctoral Candidate)
Contact address: School of Nursing and Midwifery, Faculty of Nursing and Health,
Griffith University, Nathan, QLD 4111, AUSTRALIA.
Telephone +61 7 3875 5356.
Contact address in Thailand: Department of Psychiatric Nursing,
Faculty of Nursing, Khon Kaen University,
Muang, Khon Kaen, 40002
Telephone (043) 237 606

I am a registered mental health nurse and a Royal Thai Government Scholarship student. As part of my doctoral degree at the School of Nursing, Griffith University, Australia, I am studying pregnancy and postpartum experiences and the impact of these experiences on health. Pregnancy can be a stressful time for some couples. Sometimes there may be threatened or actual violence that involves being yelled at, slapped, or hit. Violence during pregnancy can have bad effects on the mother and the baby. It is important to find out how many women experience violence, and what has been helpful to them, so that health services can be improved and staff better educated on these issues. This study is interested in the experiences of all women, whether or not they are in or have been in a domestic violent situation.

If you agree to participate in this study you will be asked to complete a set of questions during this visit and again during 6 weeks after the birth of your baby. The questionnaire will take about 30 minutes to complete. Your consent and willingness to participate will be sought each time.

All information will be strictly confidential and no names will be used. You will be asked to provide personal details on a separate information sheet. You will be given a code number for the study. All questionnaires will be identified only by this code number.

School of Nursing and Midwifery
Nathan Campus, Brisbane
QLD 4111 Australia

We hope to publish the results of this study in academic journals. Only group data, from which no individual can be identified, will be published. These steps are to ensure that your privacy is protected. The questionnaires and the personal details sheet will be kept separately in a secure place. On completion of the study I will send participants a brief report on the findings.

I would like to assure that you participation is voluntary and you can withdraw at any time without any consequences. Your decision to participate or not to participate in the study will not affect the care given by staff at the hospital.

Care will be taken to ensure that any information collected from you will not be accessed by anyone other than my supervisors and I. Your information will be securely locked and stored in a filing cabinet in a locked office for five years. After this time period, all information will be destroyed. It is not anticipated that you will be upset by the questionnaire. However, if this happens, I can arrange for you to speak with the counseling service in the hospital.

I would be pleased to answer any questions you may have. If you have any queries or concerns regarding this study you can also contact my supervisors: Professor Debra Creedy (Tel +61 7 555 28788), Professor Wendy Chaboyer (Tel +61 7 555 28518) or Dr. Marie Cooke (Tel +61 7 387 57985) for further information.

I also would like to inform you that if you have any complaints concerning the manner in which the research project is conducted, you can send them to the researcher at the above address, or if an independent person is preferred, you may send them to either:

The University's Research Ethics Officer
Office for Research, Bray Centre
Griffith University, Kessels Road, Nathan, QLD 4111
AUSTRALIA
Telephone +61 7 3875 6618

Or
The Pro Vice-Chancellor (Administration)
Bray Centre
Griffith University, Kessels Road, Nathan, QLD 4111
AUSTRALIA
Telephone +61 7 3875 7343

School of Nursing and Midwifery
Nathan Campus, Brisbane
QLD 4111 Australia

Thank you very much for your assistance with this research study. If you are willing to participate in the study, please complete the attached consent form.

Amornrat Sricamsuk
(PhD. Student)

School of Nursing and Midwifery
Nathan Campus, Brisbane
QLD 4111 Australia

คำชี้แจงงานวิจัย

ชื่อโครงการวิจัย: ความรุนแรงในครอบครัว: การศึกษาในกลุ่มหญิงไทยที่ตั้งครรภ์

ทีมวิจัย
1. ศาสตราจารย์ เดบบรา ครีดี (Professor Debra Creedy)
2. ศาสตราจารย์ เวนดี้ ชาโบเยอร์ (Professor Wendy Chaboyer)
3. ดร. มารี คูค (Dr. Marie Cooke)
4. นางสาวอมรรัตน์ ศรีคำสุข

ที่อยู่ในประเทศไทย
ภาควิชาการพยาบาลจิตเวชศาสตร์
คณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น
อ. เมือง จ. ขอนแก่น 40002
โทร (043) 202 407

ข้าพเจ้า นางสาวอมรรัตน์ ศรีคำสุข อาจารย์ระดับ 4 สังกัดภาควิชาการพยาบาลจิตเวชศาสตร์ คณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น ขณะนี้กำลังศึกษาในระดับปริญญาเอก สาขาการพยาบาลศาสตร์ ณ มหาวิทยาลัยกริฟฟิท เมืองบริสเบน ประเทศออสเตรเลีย มีความสนใจที่จะศึกษาเกี่ยวกับประสบการณ์ของท่านในระหว่างตั้งครรภ์และหลังคลอด และผลกระทบของประสบการณ์ดังกล่าว ต่อสุขภาพของท่าน

การตั้งครรภ์อาจเป็นช่วงเวลาที่ทำให้เกิดความเครียดสำหรับคู่ครองบางคู่ครอง และบางครั้งการกระทำความรุนแรง เช่น การข่มขู่ การถูกตบตี อาจเกิดขึ้นได้ ปัญหาความรุนแรงในระหว่างตั้งครรภ์มีผลกระทบอย่างรุนแรงต่อทั้งมารดาและทารก ผู้วิจัยตระหนักถึงความสำคัญของปัญหาดังกล่าว จึงมีความสนใจเป็นอย่างยิ่งที่จะศึกษาถึงประสบการณ์การถูกกระทำความรุนแรงในครอบครัวและแหล่งความช่วยเหลือที่น่าจะเป็นประโยชน์ต่อหญิงที่ถูกทำร้าย ผลการศึกษาในครั้งนี้จะช่วยในการปรับปรุงและพัฒนาการบริการเกี่ยวกับปัญหาดังกล่าว ในการศึกษาครั้งนี้ผู้วิจัยมีความสนใจในประสบการณ์ ของหญิงตั้งครรภ์ทุกคนโดยไม่จำเป็นว่าท่านถูกทำร้ายหรือไม่ก็ตาม

ถ้าท่านยินดีที่จะให้ความร่วมมือในการศึกษานี้ ผู้วิจัยจะขอให้ท่านตอบแบบสอบถาม 2 ครั้ง คือในวันนี้และอีกครั้งในช่วง 6 สัปดาห์หลังคลอด แบบสอบถามจะใช้เวลาประมาณ 30 นาที ข้อมูลที่เก็บรวบรวมได้ในการศึกษานี้จะเก็บเป็นความลับและจะไม่ระบุชื่อของท่าน ข้อมูลส่วนตัวของท่านจะถูกเก็บแยกไว้ต่างหากและจะใช้รหัสแทนเท่านั้น นอกจากนี้ข้อมูลที่เก็บรวบรวมได้จะถูกเก็บไว้ในตู้ที่ปิดมิดชิดและปลอดภัยเป็นเวลา 5 ปี จากนั้นข้อมูลก็จะถูกทำลายเฉพาะผู้วิจัยและอาจารย์ที่ปรึกษาวิจัยเท่านั้นที่จะสามารถดูข้อมูลเหล่านี้ได้

ข้าพเจ้าขอยืนยันว่าความร่วมมือในการศึกษาครั้งนี้เป็นความสมัครใจของท่านและท่านสามารถถอนตัวในการศึกษาเมื่อใดก็ได้โดยจะไม่มีผลกระทบใดๆ ต่อท่านทั้งสิ้นถ้าท่านมีข้อสงสัยหรือคำถามเกี่ยวกับ

School of Nursing and Midwifery
Nathan Campus, Brisbane
QLD 4111 Australia

การศึกษานี้ทานสามารถติดต่อเพิ่มเติมที่อาจารย์ที่ปรึกษาได้ที่ ศาสตราจารย์ เดบบรา ครีดี (Prof. Debra Creedy) โทร +61 7 555 28788 ศาสตราจารย์ เวนดี้ ชาโบเยอร์ (Prof. Wendy Chaboyer) โทร +61 7 555 28518 หรือ ดร. มารี คูค (Dr. Marie Cooke) โทร +61 7 3875 57985 นอกจากนี้ถ้าท่านต้องการยื่นคำร้องเกี่ยวกับการดำเนินการศึกษาครั้งนี้ ท่านสามารถยื่นได้ที่ผู้วิจัยดัง ที่อยู่ข้างต้นหรือท่านสามารถยื่นได้ที่

The University's Research Ethics Officer
Office for Research, Bray Centre
Griffith University, Kessels Rd., Nathan, QLD 4111
AUSTRALIA โทร +61 7 3875 6618

หรือ

The Pro Vice-Chancellor (Administration)
Bray Centre, Griffith University, Kessels Rd.,
Nathan, QLD 4111
AUSTRALIA โทร +61 7 3875 7343

ข้าพเจ้าขอขอบพระคุณท่านเป็นอย่างยิ่งในความร่วมมือในการตอบแบบสอบถามครั้งนี้
ถ้าท่านยินดีที่จะให้ความร่วมมือในการศึกษาครั้งนี้กรุณากรอกหนังสือยินยอมในการศึกษา

ขอแสดงความนับถือ

(นางสาวอมรรัตน์ ศรีคำสุข)

Appendix F: Consent Form

Consent Form

I have read the information sheet and the consent form. I agree to participate in the research study named "Domestic Violence against Pregnant Women: A Thai Perspective" and give my consent freely. I understand that the study will be carried out as described in the information statement, a copy of which I have retained. I realise that whether or not I decide to participate is my decision and will not affect the care given by staff at the hospital. I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction. I understand that my name or any identifying information will not be used in this study or in any written description of it.

I understand that if I wish to participate in this study I will be asked to complete a set of questions at around my third trimester and again at 6 weeks after the birth of my baby. The questionnaire will take around 30 minutes to complete. My consent and willingness to participate will be sought at each stage of this study.

I understand that any information collected is for the purposes of research and will be strictly treated as confidential. I have any concerns regarding this study I can contact either (1) Miss Amornrat Sricamsuk, researcher, Tel (043) 237606, Professor Debra Creedy, supervisor, Tel +61 7 555 28788, Professor Wendy Chaboyer, supervisor, Tel +61 7 555 28518, or Dr. Marie Cooke, supervisor, Tel +61 7 387 57985 for further information.

Signatures:

…… ……

Participant Date

…… ……

Investigator(s) Date

หนังสือยินยอม

ข้าพเจ้าได้อ่านคำชี้แจงเกี่ยวกับการศึกษาและคำยินยอมในการศึกษาแล้วข้าพเจ้ายินดีที่จะให้ความร่วมมืออย่างสมัครใจในการศึกษานี้ในหัวข้อเรื่องความรุนแรงในครอบครัว: การศึกษาในกลุ่มหญิงไทยที่ตั้งครรภ์ ข้าพเจ้าเข้าใจว่าการศึกษาครั้งนี้จะดำเนินไป ตามที่ได้อธิบายไว้ในคำชี้แจงงานวิจัย ซึ่งสำเนาของคำชี้แจงดังกล่าวข้าพเจ้าได้เก็บไว้เป็นหลักฐาน นอกจากนี้การร่วมมือในการศึกษา ครั้งนี้จะไม่มีผลกระทบต่อข้าพเจ้าในการรับบริการในโรงพยาบาลและถ้าข้าพเจ้าต้องการที่จะถอนตัวในการศึกษา ข้าพเจ้าสามารถกระทำเมื่อใดก็ได้โดยไม่จำเป็นต้องอธิบาย เหตุผลและจะไม่มีผลกระทบ ใดๆ ทั้งสิ้น

ถ้าข้าพเจ้าให้ความร่วมมือในการศึกษาครั้งนี้ ข้าพเจ้าจะตอบแบบสอบถาม 2 ครั้ง คือในวันนี้และอีกครั้งหลังจากที่ข้าพเจ้าคลอดได้ 6 สัปดาห์หลังคลอด แบบสอบถามจะใช้เวลาประมาณ 30 นาที และในแต่ละขั้นตอนผู้วิจัยจะขอความยินยอมในการตอบแบบสอบถามจากข้าพเจ้าทุกครั้ง

ข้าพเจ้าเข้าใจว่าข้อมูลที่ได้รับในครั้งนี้จะใช้ในวัตถุประสงค์ของการวิจัยเท่านั้น โดยจะไม่ระบุชื่อของข้าพเจ้า ถ้าข้าพเจ้ามีความสงสัยหรือกังวลเกี่ยวกับการศึกษานี้ ข้าพเจ้าสามารถติดต่อสอบถามข้อมูลเพิ่มเติมได้ที่

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