

# Violence against pregnant women will remain hidden as long as no direct questions are asked

Kerstin E. Edin and Ulf Högberg

**Objective:** to assess the experience, knowledge, attitudes and routines regarding violence against pregnant women among midwives working at antenatal clinics in the county of Västerbotten, northern Sweden.

**Design:** five qualitative research interviews with midwives were conducted. In addition, questionnaires were sent to all midwives working at the antenatal clinics in the county.

**Findings:** the midwives, although very knowledgeable about and sensitive to pregnant women and their needs, still rarely revealed the occurrence of violence. Symptoms and signals of abuse may vary and are not easily recognised by an outsider. Among pregnant women registered at the antenatal clinic, the midwives roughly estimated that the frequency of known cases of physical and sexual abuse before and during the current pregnancy was 2.3 and 0.6%, respectively for the preceding calendar year. The local programme for antenatal care provided no guidelines regarding response to violence, no instruments for disclosure and no directions about support when confronted with an abused pregnant woman. The midwife did not usually ask any questions if she was merely suspicious but had no strong supporting evidence. In answering the questionnaire however, the midwives were positive towards asking every pregnant woman about abuse in approximately the same way as they asked about other issues already incorporated in the records.

**Conclusion:** most likely the midwives in this study were disclosing only a fraction of the cases of abuse against women. Violence of this kind will probably remain hidden as long as the whole issue of violence is not included in the national recommendations or in the local programme for antenatal care.

**Implications for practice:** there should be specific written recommendations in the national antenatal care programme to guide and support the midwives in questioning *all* pregnant women about violence. To achieve adequate and optimal assessment and intervention at the antenatal clinic, the midwives need to be given education and training and provided with a supportive professional network both for themselves and for the abused women.  
© 2002 Elsevier Science Ltd. All rights reserved.

Kerstin E. Edin  
MPH, RNM,  
Post-graduate student  
Epidemiology,  
Department of Public  
Health and Clinical  
Medicine,  
Umeå University,  
SE 901 85 Umeå, Sweden

Ulf Högberg  
MD, PhD  
Obstetrics & Gynaecology,  
Department of Clinical  
Science,  
Umeå University  
SE-90185 Umeå, Sweden

(Correspondence to: KE,  
E-mail: kerstin.edin@  
epiph.umu.se)

Received 1st March 2001  
Revised 19th June 2001; 26th  
March 2002  
Accepted 7th June 2002

## INTRODUCTION

At least 20% of women worldwide have at some time in their lives been sexually or physically abused by a man and the WHO (1997) has stated that violence against women is a priority issue in the fields of health and human rights. In studies of various designs among pregnant women, the

reported prevalence of physical and sexual violence before pregnancy ranges from 15 to 41% and during pregnancy from 1 to 19% (Helton et al. 1987, Campell et al. 1992, McFarlane et al. 1992, 1996, Parker et al. 1993, Berenson et al. 1994, Gielen et al. 1994, Dye et al. 1995, Norton et al. 1995, Grimstad et al. 1997, Curry et al. 1998, Hedin et al. 1999). In abusive

relationships, the violence is generally not an isolated event but occurs repeatedly (McFarlane et al. 1996). Particularly in serious cases of abuse, the violence typically does not cease when the women become pregnant but can instead escalate (Helton & Snoddgrass 1987, Helton et al. 1987, Campell et al. 1992, Parker et al. 1993, 1994, Curry et al. 1998). In some cases, the abuse starts during the pregnancy, most often during the second or third trimester (Helton et al. 1987, Helton & Snoddgrass 1987, Parker et al. 1993, 1994). Compared to before and during pregnancy, the greatest risk of violence however, appears to be during the first six months after delivery (Gielen et al. 1994).

Abused women experience physical problems related to stress and more often have more medical complications during their pregnancy than other women (Parker et al. 1994, Dye et al. 1995, McFarlane et al. 1996, Curry et al. 1998). Pregnant women in an abusive relationship are often anxious and depressed, unhappy about their pregnancy and more worried about labour, birth and motherhood than are other women (Campell et al. 1992, Dye et al. 1995). The unborn baby is at risk of intrauterine death or premature birth (Dye et al. 1995, Curry et al. 1998, Covington et al. 2001) and is also at risk of being low birth weight (Covington et al. 2001, Murphy et al. 2001).

All reports regarding the physical, psychological and social consequences of violence for the pregnant woman and the resulting risks to the unborn baby indicate that there is a need for action. Antenatal care provides an ideal setting in which to bring up the issue of abuse, because the repeated visits to the midwife allow for the development of trust and confidence on the part of the women (Heise et al. 1999).

### Swedish antenatal care

Midwives working in antenatal clinics in Sweden are responsible for birth education classes and the routine care of the pregnant women who visit her regularly, about ten times during pregnancy and also at least once after delivery. Only if a midwife is made aware of something being out of the ordinary will the pregnant woman be referred to a physician.

The National Board of Health and Welfare in Sweden provides national regulations and recommendations for antenatal care throughout the country. The national guidelines are interpreted at county level and further adapted locally to the antenatal care organisation in each health district.

Violence against women has reached top priority on the Swedish political agenda during the last decade and for this reason several important initiatives have emerged. As regards

health-care professionals special feature issues of medical journals have been published and a variety of educational programmes and study guides about violence against women have been made available. Yet, only two studies on violence and pregnancy have been published in Sweden (Hedin et al. 1999, Stenson et al. 2001). Moreover, the National Board of Health and Welfare in Sweden has not so far provided any national recommendations for the antenatal care programme regarding abuse assessment and intervention. Today, it is up to either the county or health district authority or even each clinic or individual midwife to include or exclude the topic.

### Objectives

The aims of this study were to find out *whether* the issue of violence was addressed in the antenatal care programme in the county of Västerbotten, Sweden and if so, *how*. Further objectives were to assess the knowledge, attitudes and routines among midwives concerning violence, to discover whether they considered abuse to be a rare phenomenon or not and to what extent they had personal experience of meeting abused pregnant women.

### METHODS

The investigation was carried out in the county of Västerbotten, located in the north of Sweden, with a population of 260,000 and comprising one-eighth of the total area of Sweden. Access to undertake the study was given by the midwife manager responsible for antenatal care in the county.

The study was conducted using a combination of qualitative and quantitative methods. Qualitative research interviews seemed to be the best option for making an initial approach to a complex and partly unexplored subject area. The aim of the interviews was to obtain a richer and deeper understanding of the midwives' work and the possibilities and hindrances that existed when they were confronted with women in particularly difficult circumstances. Moreover, it was the plan that the interviews would provide the basis for the quantitative part of the study through selection of important questions for a questionnaire. The idea in using triangulation was to achieve both a deeper and broader understanding (Starrin et al. 1997).

### Interviews

The interviews were conducted by one of the authors (KEE) and carried out as 'semi-structured

open ended interviews' (Lincoln & Guba 1985, Starrin et al. 1997). An interview guide was constructed based on the research questions and comprised the topics to be covered along with written questions. The exact wording and sequence of questions were not the same in all interviews allowing for rewording, elucidation and digression. The interview guide consisted of an initial general part with 15 questions about practical experience in antenatal care and the midwives' routines and observations and regarding health risks in general among pregnant women. The subsequent part of the guide consisted of 16 questions specifically about violence, e.g. if the midwife had suspected abuse in some pregnant women, the signs and signals of such abuse that would be expected, risk categories, consequences of violence and an estimated frequency of known violence. In addition, the second part of the interview manual included questions concerning routines, professional networks, reasons why the midwife would not ask or the woman would not disclose violence, different ways of acting when violence was revealed and whether there was any obligation to document or report violence. The interview manual was finalised after a pilot interview with an experienced midwife at an antenatal care clinic (this interview was not included in the study).

An initial sample of five midwives was considered adequate for accomplishing the purpose of the study, but there was the possibility of enlarging the sample if it became necessary. Midwives chosen for interview had to meet three criteria: (i) they had to have been working as a midwife in antenatal care for the last five years, (ii) the clinic at which they worked had to be located in the health district where the University is located and (iii) they had to be unaware of the specific purpose of the study. Of 24 midwives, 18 were eligible and five were selected by drawing lots. Five substitutes were also picked by lot in case a stand-in should be needed, but this situation did not in fact arise.

The five midwives were initially provided with a description of the purpose of the interview, as being about 'health risks in pregnant women' in general terms. They were all guaranteed anonymity and declared themselves willing to participate. The reason for not revealing the specific purpose of the interview beforehand was to avoid bias and to facilitate a wide perspective regarding attitudes and routines, especially when carrying out the first part of the interviews that focused on health risks in general.

The interviews were completed between September and November 1998. Both data collection and analyses were informed by 'Grounded Theory' developed by Glaser and Strauss (Starrin

et al. 1997). The five interviews were scheduled to allow plenty of time in an undisturbed setting; four at antenatal care clinics and one outside. Each interview lasted 45–60 minutes and was tape-recorded. Some comments from the midwives, reflections about the dialogue and the interview situation were noted immediately after the interviews. The complete recorded interviews were transcribed verbatim (by KEE) within a few weeks after the final interview. Smaller revisions were made in the text to facilitate reading, as well as changes to protect anonymity.

The open coding started with the identification of certain words and expressions in the printouts. These codes were then linked to each separate question on the inquiry form. The codes were marked with a number corresponding to the interview and all subsequent steps towards creating categories (theoretically generated concepts according to 'Grounded Theory') were documented. Two main categories emerged from the analysis, one for each part of the interview (Starrin et al. 1997). To make the presentation of categories easier to grasp, the interviews were retold in parallel in a summarised descriptive text (Edin 1999). Finally, the two main categories were described and interpreted as a social process, inspired by 'symbolic interactionism' which seeks to explain human behaviour in terms of meanings and which has its roots in the work of sociologists such as Cooley, Mead and Blumer (Spradley 1979). This meaning is a perspective that will always limit what one observes and understands because it works as a filter through which everything is interpreted (Charon 1998).

Neither during the analysis process nor after the theoretical coding, where two main categories emerged, was any convincing evidence found for the need to carry out additional interviews. During the interviews no definition of 'abuse of women' was given as the idea was to leave the concept open. Consequently, the exact meaning of the phrase could be different for each midwife but the material does not allow any further elucidation of this matter.

The interviewer may have introduced unwanted bias into the interviews, because she is a midwife and therefore has a pre-understanding of the subject matter. This pre-understanding, however, seemed to facilitate comprehension of what the midwives described. Moreover, the interviewer found it easy to keep an open, curious mind because of her professional experience from a close but different area of care (delivery care at the hospital). The preliminary analysis and results were written in Swedish and presented to the five midwives for comments; none had any objections. Analysis of the interviews was fully completed before the development of the questionnaire was begun in order to avoid any unnecessary, unintentional influence.

### The questionnaire

The research questions together with the result of the interviews formed the basis of the questionnaire design. The form was modified after a pilot test with one midwife (who later also received the definitive version of the questionnaire).

In January–February 1999, the questionnaires were posted to all 51 midwives in all 36 antenatal clinics in the county. The midwives who had been interviewed earlier were included in the 51. The midwives were invited to return the forms in pre-addressed and pre-paid envelopes. Non-responders were sent a reminder within one to two months.

The purpose of the questionnaire was to survey the midwives' knowledge, attitudes, routines and experiences regarding abuse. An accompanying letter stated the objectives of the study, guaranteed anonymity and included a definition of the term 'abuse' as physical/sexual abuse according to the AAS (*Abuse Assessment Screen*, see Parker et al. 1993). The form comprised multiple-choice questions and invited free comments.

The midwives were first asked how many years' experience they had had in antenatal care and about antenatal care organisation in general. The respondents were requested to estimate retrospectively the number of pregnant women they had met who were either abused during their actual pregnancy or had a prior history of abuse. The midwives were then asked about signs of abuse, specifically whether at times they had suspected but were unable to confirm abuse, and if so what signs they considered signified abuse. Finally, the respondents were asked if they received any support regarding dealing with abused pregnant women from their clinic and if they would consider it acceptable to systematically ask every pregnant woman about abuse.

The estimate of the 95% confidence interval for the numbers of women abused before and during current pregnancy (Table 1) was calculated using Poisson approximation (Campbell & Machin 1990). The various free comments to the

questions were typed, linked to the numeric analysis and supplemented with a written content analysis informed by the first steps in 'Grounded Theory' analysis (Starrin et al. 1997). This was done in a simplified way without theoretical coding, using only substantive coding composed of concepts taken from the midwives' comments.

The number of pregnant women enrolled in antenatal clinics during 1998 was based on the estimated numbers provided by the midwives and taken from their personal statistics. If the response rate is taken into consideration and deductions made for miscarriages the number obtained, 2459, agrees fairly well with the official statistic in the county of 2401 births in total during 1998.

All estimations of what had been obvious to the midwives, regarding frequency of abuse, were retrospective and some midwives commented on the problem of remembering and of mixing up pregnant women with other patients. Recall-biases and misclassification might result in both underestimation and overestimation (Hennekens & Buring 1987). This potential unreliability was the reason for including only 1998, and excluding the years before 1998, in the calculations.

### Ethics in interviews and questionnaires

At the time of data collection, it was not necessary to gain approval from a research ethics committee for research involving health-care staff. However, the midwives participating in this study were accorded the dignity and respect required for all research participants. All midwives participated voluntarily in the study and none was in any sense dependent on the person conducting the study (KEE). The midwives who were interviewed did not know beforehand that there would be questions about abuse. These questions might conceivably have come as an unpleasant surprise if any of the midwives had had personal experience of violence. The questions, however, were neither

**Table 1** Retrospective estimates of the number of pregnant women enrolled during 1998, known by their midwife to be physically or sexually abused before and during current pregnancy. Antenatal clinics, Västerbotten, Sweden. CI 95% Poisson approximation

	Estimated number of abused women per midwife	Estimated frequency of abuse among pregnant women	Response rate among the midwives
Pregnant women met during the last year who had been abused at some point during their lifetime	1.4 (range 0–5)	(54/2389) 2.3% (CI 1.69–2.95)	95%
Pregnant women met during the last year who had been abused during the current pregnancy	0.4 (range 0–2)	(14.5/2459) 0.6% (CI 0.34–1.0)	98%

intrusive nor personal in character, but asked specifically about abused pregnant women and accordingly none of the midwives gave any sign of being uncomfortable during the interviews.

The questionnaires included no questions regarding individual patient information and no questions about personal experience of violence. The inquiry examined professional knowledge, attitudes and routines regarding the issue of violence. The form allowed for free written comments from the midwives and many had opinions, but no one expressed a critical view regarding the actual investigation or about being asked.

## FINDINGS

The results of the interviews and questionnaires are presented separately in chronological order. It should be remembered when reading the findings that, when the midwives spoke specifically about abuse, much of what they said seemed to reflect their theoretical knowledge rather than their actual experiences. The numbers of unrecorded cases were unknown, but their own perceptible experience of abused women was limited.

### Interviews

The midwives interviewed had been working in antenatal care clinics for an average of 17 (range 6–28.5) yrs and each had about 95 (range 70–150) pregnant women enrolled annually for regular visits.

In the outline of the presentation below, the two main categories 'The midwife with the sensitive ear' and 'You can't easily tell from the outside' are the headings and the structures for the first and second parts of the interviews. The two main categories are described in the categories and sub-categories from which the main categories were built (see Figs. 1 & 2). The categories are presented in the text as sub-headings in italics, followed by carefully abbreviated editions of the originally retold condensed interview text (Edin 1999). The third heading 'Interpretation as a social process' applies to the two main categories and describes 'the interpretative meeting between the midwife and the pregnant woman' (see Fig. 3).

#### The midwife with the sensitive ear

It was apparent from the first general part of the interview that all midwives were very perceptive towards pregnant women and their needs (see Fig. 1). They tried to understand not just the obvious, but also the underlying meanings of what pregnant women did and said.

#### The midwife with the sensitive ear

*Non-attendance of pregnant women for antenatal care is a point to be noted*

- absent
- point to be noted

*It has become more burdensome to be pregnant*

- increasing demands
- loneliness
- harsh social circumstances

*The midwife tries to create a comprehensive picture of the woman*

- poor standard routine questions
- difficult questions
- good to have questions that you address to everyone

*The midwife tries to conduct a dialogue*

- the midwives must listen and try to understand
- sometimes you do not get the gist of it

*The spouse is invited*

- of course the man should take part
- the man as the controller of the woman

**Fig. 1** The main category followed by categories and sub-categories from the first part of interview, which was mainly focused on health risks, attitudes and routines in general at the antenatal clinic.

#### You cannot easily tell from the outside

*Difficult to disclose*

- hard to interpret
- the woman conceals things
- afraid to lose her only security
- poor protection

*No connection with social class*

- abuse of power
- addiction to alcohol
- psychosomatic and depressive symptoms

*Must get to know her and have strong reasons before asking*

- establish a contact
- go further
- careful choice of words but being straight
- the person who tells

*Support the woman*

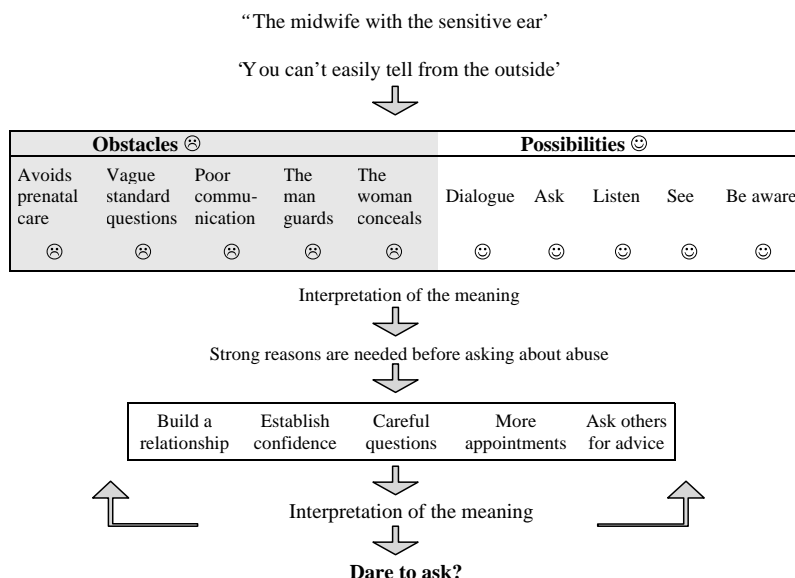
- powerlessness

*The support should be easily accessible*

- there are no joint strategies
- there are no guidelines
- based on the law
- take the side of the law or of the woman

**Fig. 2** The main category followed by categories and sub-categories from the second part of interview, where the emphasis was specifically on abuse and pregnancy.

*Non-attendance of pregnant women at the antenatal care clinic is a point to be noted.* Pregnant women may, of course, have valid reasons for not turning up at the antenatal clinic but the midwives recognised this absence as a potential warning sign. They identified numerous psychosocial motives for its occurrence together with fears concerning the coming delivery or aversion to a gynaecological examination because of previous traumatic experiences.



**Fig. 3** Model of the interpretative meeting between the midwife and the pregnant woman explained as a social process. ‘To beat about the bush’.

*It has become more burdensome to be pregnant.* The midwives recognised that more and more pressure is put on a pregnant woman because her employer, husband, family and social life make heavy demands on her. In families where the husband is unemployed and family finances are strained, the pregnant woman may not be able to afford to stay away from work even if she wants to. Moreover, many women seem to be alone with no other person besides their partner to rely on during pregnancy.

*The midwife tries to create a comprehensive picture of the woman.* The midwives preferred to use pre-printed questions for their records because they provided some sort of quality guarantee, by reducing the risk of missing important areas of inquiry. Standard multiple choice options in the records, such as those concerned with alcohol and smoking, were considered uncontroversial because they are addressed to everyone and nobody is singled out. In contrast, questions about psychological disorders and about previous pregnancies or abortions were still considered somewhat taboo. The midwives noted that many of the pre-printed multiple-choice options in the antenatal care forms left out important issues and they considered them to be poorly designed and in need of reformulation.

*The midwife tries to conduct a dialogue.* The midwives tried to establish reliable contacts with the pregnant women. They saw reticence as a possible sign that the women were hiding something. The midwives scheduled more frequent visits and allocated more time for each visit in the case of pregnant women who were reserved and unwilling to talk. Sometimes the pregnant woman simply did not want the midwife to

interfere and it was not possible to get close to her.

*The spouse is invited.* The midwives agreed that spouses, if they are to relate well to their children, need to be involved early on and already during the pregnancy. By meeting both the woman and her spouse, the midwives obtained a clearer picture of the woman’s situation and it was felt that the woman could benefit from having someone with whom to talk over issues brought up during the consultations.

If a spouse always accompanied the woman to the antenatal clinic, and in particular if he was prone to answer questions actually addressed to her, the midwife grew suspicious and wondered why he needed control. One midwife even mentioned a case where the husband accompanied his wife to every appointment and was extraordinarily well mannered and pleasant during the visits, but later turned out to have been abusing his wife. It is especially complicated with immigrants when the spouse acts as interpreter, because there is no way of knowing whether or not the translation is correct. The spouse may also be unwilling to accept an outside translator. Authorised translators were also seen as expensive and as one midwife put it ‘you know that our boss complains if the translation bills get too high’.

Generally, the midwives welcomed the presence of the spouse during antenatal visits. At the same time, they recognised that pregnant women need to speak openly about sensitive issues without any one else being present.

**You can’t easily tell from the outside**

The second part of the interviews was entirely focused on abuse: how to detect abuse, how to

approach women experiencing abuse and how to provide care for these women (see Fig. 2).

The midwives agreed that abuse was rarely identified and may be more prevalent than is generally believed. Three of the five midwives believed they met one or maybe two abused women every year, the remaining two had met one or a few cases during all their years in the profession (>15 yrs). One of them was very ambiguous about it, but had occasionally observed mental abuse, spouses who were mean, unsympathetic or restricted the independence of the woman.

*Difficult to disclose.* The midwives mentioned that abuse is regarded as taboo, the abused woman feels ashamed, blames herself, thinks that the abuse is her fault and consequently finds it hard to talk about. Abused women could not be expected to reveal their condition to just anyone. The midwives sometimes had a vague feeling that something was wrong in the woman's mood or behaviour but were unable to pinpoint the exact reasons.

The midwives described different ways of interpreting the potential signs and symptoms of abuse but also said how difficult it was to know whether a suspicion was well founded because 'it's not easy to tell from the outside'.

The midwives pointed out the obstacles an abused woman may face if she wants to escape from her spouse. If she has no help from family or friends he may be her only support and anything is better than nothing. If she leaves him, she will never feel secure, because he can show up at any time and beat her and she can never be certain of getting custody of the children.

*No connection with social class.* The midwives did not believe that abuse was linked to specific groups in society although they believed that much abuse was induced by social factors. They also believed that the risk of abuse was higher among some immigrant groups and suggested that conflicts could arise when these groups confronted Swedish culture where women have more freedom than in their own culture.

*Must get to know her and have strong reasons before asking.* The midwives recognised their obligation to ask if they suspected abuse and trusted their intuition to be correct in most cases, but abuse was seen as a very sensitive issue. For this reason, they argued that they needed very strong reasons and good contact with the pregnant woman before they could actually bring up the issue of abuse. Otherwise they might not be told the truth or the woman might not return.

When it was necessary, a midwife could take the opportunity to schedule more frequent appointments and thus try to build up a relationship until it reached the point where she

could simply ask about abuse. To gain the woman's trust, she had to choose her words carefully, but much could be achieved by straight talking. Sometimes the midwives received reports of abuse from relatives, friends or acquaintances of the woman, but sometimes from other professionals whom they could also consult in ambiguous cases.

*Support the woman.* The midwives recognised the importance of establishing confidence and of ensuring that the pregnant woman was guaranteed privacy. It was easy to get emotionally upset on behalf of the woman and abandon one's professional attitude by stepping in and giving her active help. While it was difficult for the midwives to actually protect abused women, they could provide them with information about where to go if something happened.

*The support should be easily accessible.* None of the midwives were aware of any guidelines at the antenatal care clinics that would be helpful in meeting pregnant women exposed to violence. In cases of abuse, the midwives thought the best way would be to get informal support from experienced people connected with the clinic. Someone from the social services ought to be attached to the clinic. The midwives also pointed out that shelters for women were a valuable resource.

The only basic guidance available to midwives was the law, which they considered difficult to interpret. A balance had to be maintained between the woman's welfare and safety on the one hand and the midwives' obligation to follow the law regarding professional confidentiality, documentation and reporting on the other.

### **Interpretation as a social process**

*'To beat about the bush'* (see Fig. 3). The midwife performs physical examinations following certain written guidelines and knows what to do if there are deviations from the norm. To understand and openly disclose what is not obvious, the midwife must use her 'sensitive ear', because no useful standard instruments are available for identifying and solving different kinds of psychological or social problems.

When the midwife suspects abuse (or any other psychosocial problem), she tries to find time to talk to the pregnant woman, to interpret and understand her life situation. The midwife tries to create a dialogue, to listen, to ask questions, to use her intuition and to keep her eyes open. This interpretative process is hindered if the woman is reserved and unwilling to talk freely, conceals her problems, has an accompanying spouse who acts as a guard and hampers the dialogue or if she decides to not keep her appointments at the clinic. There have to be strong reasons for a midwife to ask a woman

intrusive questions. Instead of bringing up the subject of abuse (or any other sensitive question) directly, the midwives try to interpret the situation while establishing closer contact, proposing more frequent appointments or perhaps asking other professionals for advice. As a result, it may be possible for the midwife to encourage confidence and be ready and able to use carefully chosen words to ask the necessary questions, on the other hand she may never reach that point.

### The questionnaire

The response rate to the questionnaire was 82% (42/51 midwives at 31/36 clinics) after one written reminder. The midwives who responded had been working in an antenatal clinic for an average of almost 16 (range 1–34) yrs. During 1998, each midwife met an average of just above 60 (range 10–119) registered pregnant women. The numbers had declined since ‘the baby boom’ of ten years before, when each midwife typically met more than 100 (range 10–246) women in one yr.

The midwives reported that the routines implied that women almost always met the same midwife throughout their pregnancy. The average number of visits was about ten (range 7–14) including a postpartum appointment. According to the midwives, the pregnant women’s needs and preferences determined the number of visits; taking into accounts the midwives’ time and workload.

From the questionnaires, it could be calculated that midwives had met a total of 2459 registered pregnant women during the last year (40 out of 42 midwives answered this question). The midwives were requested to estimate how many of these women they believed had been physically or sexually abused.

Fifteen midwives had met none and nine had met more than two women whom they recognised as having been abused before the current pregnancy. Twenty-nine midwives were not aware of meeting any woman who had been abused during the current pregnancy and none had met more than two such women. From these estimates, the proportion of women known to have been abused at some time before the current pregnancy was 2.3% and the average frequency of abuse during pregnancy was 0.6% (see Table 1). It is important to note that these numbers reflect what the midwives recalled and recognised and not the actual incidence of abuse.

*Recognised signs of abuse.* Most midwives had suspected abuse in cases where it could not be confirmed (32 yes, three no, six unsure). The midwives cited several signs that might imply abuse including external signs such as bruises without any plausible explanations; an intuitive

feeling that ‘something is wrong’ and that a woman tried to maintain the appearance that ‘everything is all right’ when it obviously was not. Others missed visits, were insecure, rejected advances and were always in a hurry. Abuse may be indicated by the attitude of the partner in controlling the woman or signs of difficulties in family relations. The midwives also mentioned women who expressed various fears; fear of physical examinations, the taking of specimens, the coming birth and worries about the well-being of the baby.

*Certain groups or not.* Many midwives believed that there were no reasons to be especially suspicious of abuse within particular groups in society (15 yes, 21 no, four maybe). Conversely, a few midwives declared that certain risk groups do exist but at the same time recognised that abused women can come from any group. People with social difficulties, those addicted to drugs or alcohol were mentioned as being at risk and additional risk groups included immigrants or couples where a Swedish born man has brought or ‘bought’ a wife from a foreign country.

*Guided by circumstances.* All but one midwife were more or less in favour of asking about violence even if no sure sign or signal was present, merely a suspicion (17 yes, one no, 23 maybe). From the comments it seems that most believed that the circumstances decided whether or not they asked questions. Midwives need to have time and it is important to establish a positive relationship with the woman. One way to do this is to make a new appointment allowing plenty of time or to meet more frequently. The presence of a partner or a relative can be a hindrance in this situation.

*To pose the question to everyone.* The idea of asking all pregnant women questions about abuse, as is done with respect to smoking and alcohol, was acceptable to almost all midwives (27 said yes, only four said ‘no’ but of them two mentioned ‘maybe’ in the comments, 11 were unsure). Although different opinions were expressed regarding screening, most midwives suggested the use of straight routine questions, similar to those that are already included in the routine records. Others would prefer the topic to be included as part of an ordinary conversation. The issue could be brought up during the first visit or at a later visit, allowing a reasonable level of contact to be established first.

The midwives’ reasons for asking every pregnant woman registered at their antenatal clinics questions about abuse was that this would play down the issue; no one would need to feel singled out when confronted with a sensitive question. Furthermore, midwives mentioned that such routines would indicate both interest and openness regarding the problem on the part of the

antenatal clinic. It would also provide the midwives with an opportunity to discuss openly the reasons why the questions were included and to hand over some printed information about abuse.

Some midwives were ambivalent about screening, one concern being whether it would be possible to get honest responses. The importance of bringing up questions about abuse in a proper context was mentioned because such questions may pose a threat to the personal integrity of the woman. There might be a problem if the midwife were pressed for time when the woman decided to make personal and sensitive disclosures. One midwife commented:

This is a very difficult problem, we just see the tip of the iceberg. Much more education is needed in this area. It is many years before you dare to ask if a woman has been the victim of violation. If you get a 'yes' what are you going to do then? It is at that point it gets hard.

*Lack of assessment routines and intervention plans.* None of the midwives were aware of any clinical routines aimed at revealing abuse. One midwife stated:

I have certainly missed a lot, but it is simply like that, how can you find them and how do you get them to admit it?

Most midwives (seven aware, 29 unaware, five unsure) did not know if any verbal instructions existed within the organisation of antenatal care regarding interventions once abuse had been confirmed. The seven midwives who knew about such a strategy did not mention a specific plan within antenatal care but it could be understood from their comments that they had been involved in a joint collaboration concerning abuse with the primary health-care facilities. There was no significant difference between those seven midwives and the others concerning estimates of abuse prior to or during pregnancy.

Midwives had occasionally been contacted about abuse, usually by someone connected with the clinic but also by relatives of abused women. If abuse was revealed, the primary contact was a social worker, then a district nurse or a general practitioner but also a psychologist or an obstetrician. More or less the same professionals seemed to provide the support needed by midwives when they had to deal with troublesome situations such as domestic violence. Two midwives declared that they lacked support and one said:

No, I do not know of anyone. When I needed help there was no one there for me! I had to request help. What we need is continual professional guidance.

## DISCUSSION

### Possible weakness and limitations of study

Antenatal care has a homogeneous organisation throughout Sweden but the national recommendations regarding psychosocial care are not very detailed and consequently their application may vary from county to county. This study was carried out in only one county and it is possible that the findings may have been different in other parts of Sweden.

At the end of November 1998, about two months before the questionnaires were sent out, many Swedish newspapers carried startling articles about violence among pregnant women. The reports referred to a study about abuse of pregnant women in Sweden (Hedin et al. 1999). Headlines such as 'Pregnant women are unsafe at home' and 'Men start to beat women when they are expecting a baby' attracted attention and many people, including midwives, reacted with great concern. This might possibly have influenced the response to the questionnaires. The conclusions from the questionnaires did not however seem to contradict those of the interviews (which were completed before these alarming articles appeared).

### Comparisons with international studies

In international studies, the reported prevalence of physical and sexual violence before pregnancy is on average around 25% (Helton et al. 1987, Campell et al. 1992, McFarlane et al. 1992, 1996, Parker et al. 1993, Berenson et al. 1994, Norton et al. 1995, Grimstad et al. 1997, 1998, Curry et al. 1998, Hedin et al. 1999). During pregnancy, the prevalence varies considerably and ranges between 1 and 19%, which may at least partly be explained by different study designs (Helton et al. 1987, Campell et al. 1992, McFarlane et al. 1992, 1996, Parker et al. 1993, Berenson et al. 1994, Gielen et al. 1994, Dye et al. 1995, Norton et al. 1995, Grimstad et al. 1997, 1998, Curry et al. 1998, Hedin et al. 1999). Studies indicate that *asking* about violence is in itself essential, but it is also important *how many times* and *in what way* the questions are asked (Helton et al. 1987, Campell et al. 1992, Parker et al. 1993, Berenson et al. 1994, Gielen et al. 1994, Dye et al. 1995, Norton et al. 1995, McFarlane et al. 1996, Curry et al. 1998, Edin 1999).

Many studies about violence and pregnancy have been carried out in the USA and reveal the highest prevalence when women were asked more than once and when certain standardised inquiry forms were used (Helton et al. 1987, Campell et al. 1992, Parker et al. 1993, Berenson et al. 1994, Gielen et al. 1994, Dye et al. 1995, Norton et al. 1995, McFarlane et al. 1996, Curry

et al. 1998). In one study, all pregnant women were asked about abuse, but the question was put in different ways in two subsequent separate periods. In the first period, questions about abuse were included among other routine questions and the prevalence of abuse during pregnancy was 1%. In the second period, nothing was changed in the routines apart from the use of separate standardised inquiry forms about abuse (AAS) and the prevalence rose to 10% (Norton et al. 1995).

The disclosure of violence against women is greatly facilitated when there is a setting where all possible ethical and safety concerns are taken into consideration (Ellsberg et al. 2001). Privacy and confidentiality must be maintained when health-care professionals try to identify violence (WHO 1997). If communication problems occur in health-care, the use of trained interpreters must be obligatory (Brooks 1992). In our study, reluctance on the part of the spouse could hinder the midwife from providing a translator but so could the unwillingness of the clinic to pay for one. This is contrary to the law which not only states that a non-Swedish-speaking person has this right, but also places an obligation on the health-care authorities to provide a translator when needed.

### Conclusion

The main findings in this study are that, despite the fact that midwives were sensitive to the needs of pregnant women and had considerable theoretical knowledge about signs and symptoms of abuse in women, they rarely identified abuse. The midwives had to have strong reasons before they would ask direct questions about such a sensitive issue and they received no guidance from the antenatal care programme regarding abuse assessment and intervention. The midwives own suggestions were to include routine questions about abuse in the standard antenatal care forms used with all pregnant women, as well as the setting up of a professional network to provide better support for both the abused pregnant women and the midwives.

### Implications for practice

It is known that violence against women remains mostly unrecognised and the suggestion has been made that straight standardised questions should be put to *all* pregnant women during antenatal care to increase the disclosure of violence (Norton et al. 1995). Most women do not appear averse to being asked routinely about violence by their midwife or other health-care personnel (Stenson et al. 2001, Webster et al. 2001, Bradley et al. 2002, Richardson et al. 2002). The role of the midwife needs to be clearly articulated

through guidelines, education and training and clear directions. This will result in their having the confidence to ask about violence and to give support when required (Bewley et al. 1997, Marchant et al. 2001). To obtain an adequate and optimal assessment of violence among pregnant women, the midwives need to learn more about the problem, to investigate their own attitudes and to understand the underlying causal relations to violence (Bewley & Gibbs 1991). Education related to violence is one way of changing attitudes that will make a difference to practical behaviour (Moore et al. 1998, Ellsberg et al. 2001). To achieve joint action with an interdisciplinary approach, the education and training should ideally take place together with other professionals involved in the care of pregnant women (Bewley et al. 1997).

### ACKNOWLEDGEMENTS

We would like to thank the midwives who were willing to participate in the study and the County Council of Västerbotten, Sweden for its financial support.

### REFERENCES

- Berenson AB, Wiemann CM, Wikinson GS et al. 1994 Perinatal morbidity associated with violence experienced by pregnant women. *American Journal of Obstetrics and Gynecology* 170(6): 1760–1769
- Bewley S, Friend J, Mezey G 1997 Violence against women. RCOG Press, London
- Bewley C, Gibbs A 1991 Violence in pregnancy. *Midwifery* 7: 107–112
- Bradley F, Smith M, Long J et al. 2002 Reported frequency of domestic violence: cross sectional survey of women attending general practice. *British Medical Journal* 324: 271–274
- Brooks TR 1992 Pitfalls in communication with Hispanic and African-American patients: do translators help or harm? *Journal of the National Medical Association* 84(11): 941–947
- Campbell JC, Poland ML, Waller JB et al 1992 Correlates of battering during pregnancy. *Research in Nursing and Health* 15: 219–226
- Campbell MJ, Machin D 1990 Medical statistics a common sense approach. Alan R. Liss Inc, New York
- Charon JM 1998 Symbolic interactionism. Prentice-Hall, Englewood Cliffs, N J
- Covington DL, Hage M, Hall T et al. 2001 Preterm delivery and the severity of violence during pregnancy. *The Journal of Reproductive Medicine* 46(12): 1031–1039
- Curry MA, Perrin N, Wall E 1998 Effects of abuse on maternal complications and birth weight in adult and adolescent women. *Obstetrics and Gynecology* 92(4): 530–534
- Dye TD, Tollivert NJ, Lee RV et al. 1995 Violence, pregnancy and birth outcome in Appalachia. *Paediatric and Perinatal Epidemiology* 9(1): 35–47
- Edin KE 1999 It's hard to tell by the outside, abuse of pregnant women and the experience of five midwives working at prenatal clinics in the county of Västerbotten, Unpublished Master Thesis in Public Health, Epidemiology, Department of Public Health and Clinical Medicine, Umeå University, Sweden 21, ISSN 1401–3282 (in Swedish)
- Ellsberg M, Heise L, Pena R et al. 2001 Researching domestic violence against women: methodological

- and ethical considerations. *Studies in Family Planning* 32(1): 1–16
- Gielen AC, O'Campo PJ, Faden RR et al. 1994 Interpersonal conflict and physical violence during the childbearing year. *Social Science & Medicine* 39(6): 781–787
- Grimstad H, Schei B, Backe B et al. 1997 Physical abuse and low birth weight a case-control study. *British Journal of Obstetrics and Gynaecology* 104: 1281–1287
- Grimstad H, Backe B, Jacobsen G et al. 1998 Abuse history and health risk behaviours in pregnancy. *Acta Obstetrica et Gynecologica Scandinavica* 77: 893–897
- Hedin LW, Grimstad H, Möller A et al. 1999 Prevalence of physical and sexual abuse before and during pregnancy among Swedish couples. *Acta Obstetrica et Gynecologica Scandinavica* 78: 310–315
- Heise L, Ellsberg M, Gottmoeller M 1999 Ending violence against women. *Population Reports Series L, Number 11. Population Information Program, Centre for Communication Programs, The John Hopkins School of Public Health, Baltimore, MD, USA*
- Helton AS, Snodgrass FG 1987 Battering during pregnancy: intervention strategies. *Birth* 14(3): 142–147
- Helton AS, McFarlane J, Andersson ET 1987 Battered and pregnant: a prevalence study. *American Journal of Public Health* 77(10): 1337–1339
- Hennekens CH, Buring JE 1987 *Epidemiology in medicine*. Little, Brown and Company, Boston/Toronto
- Lincoln YS, Cuba EG 1985 *Naturalistic inquiry*. Sage Publications, London
- Marchant S, Davidson LL, Garcia J et al. 2001 Addressing domestic violence through maternity services: policy and practice. *Midwifery* 17(3): 164–170
- McFarlane J, Parker B, Soeken K et al 1992 Assessing for abuse during pregnancy: severity and frequency of injuries and associated entry into prenatal care. *The Journal of the American Medical Association* 267(23): 3176–3178
- McFarlane J, Parker B, Soeken K 1996 Abuse during pregnancy: associations with maternal health and infant birth weight. *Nursing Research* 45(1): 37–42
- Moore ML, Zaccaro D, Parsons LH 1998 Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic and Neonatal Nursing* 27(2): 175–182
- Murphy CC, Schei B, Myhr TL et al. 2001 Abuse: a risk factor for low birth weight? A systematic review and meta-analysis. *Canadian Medical Association Journal* 164(11): 11578–11579
- Norton LB, Peipert JF, Zierler S et al. 1995 Battering in pregnancy: an assessment of two screening methods. *Obstetrics and Gynecology* 85(3): 321–325
- Parker B, McFarlane J, Soeken K et al. 1993 Physical and emotional abuse in pregnancy: a comparison of adult and teenage women. *Nursing Research* 42(3): 173–178
- Parker B, McFarlane J, Soeken K 1994 Abuse during pregnancy: effects on maternal complications and birth weight in adult and teenage women. *Obstetrics and Gynecology* 84(3): 323–328
- Richardson J, Coid J, Petruckevitch A et al. 2002 Identifying domestic violence: cross sectional study in primary care. *British Medical Journal* 324: 274–279
- Spradley JP 1979 *The ethnographic interview*. Library of Congress in Publication Data, Washington
- Starrin B, Dahlgren L, Larsson G et al. 1997 *Along the path of discovery*. Studentlitteratur, Lund
- Stenson K, Saarinen H, Heimer G et al. 2001 Women's attitudes to being asked about exposure to violence. *Midwifery* 17(1): 2–10
- Webster J, Stratigos SM, Grimes KM 2001 Women's responses to screening for domestic violence in a health-care setting. *Midwifery* 17(4): 289–294
- WHO 1997 *Women's health and development (WHA 49.25). Family and Reproductive Health*. World Health Organization, Geneva