Domestic violence against women is well recognised as an important health problem worldwide, resulting in injuries and other short and long term health consequences. The most difficult step in the battle against domestic violence is the provision of opportunities for victims to talk about what is happening to them. This difficulty is further aggravated by our traditional Chinese culture that women should not expose the family affairs to non-family members. Pregnancy thus becomes an excellent or even the only opportunity for women to ask for help. Obstetricians / gynecologists and midwives are committed to women’s health at both the physical and psychological levels. Our relationship with patients can usually go beyond the disease model. In other words, there is no reason why we should not be involved in this battle of civilisation.

The first prevalence study

In our clinical practice, we do not routinely ask the pregnant women for any history of domestic violence unless there is strong suspicion such as multiple injuries, which is rare. As a result, the problem is often overlooked. In 1998, we performed the first study on the prevalence of domestic violence in pregnant women in Hong Kong1. This was also the first study in a Chinese community.

631 pregnant women attending their first antenatal clinic in our hospital were interviewed by a designated research nurse. The interview took place in a private setting with the husband or male partner absent. The questionnaire was derived from the Abuse Assessment Screen (AAS)23. This screen assesses past and recent history of domestic violence using five structured and directed questions. 131 women (17.9%) had a history of abuse, 99 of them (15.7%) had been abused in the preceding year, 27 of them (4.3%) had been abused during pregnancy and 59 women (9.4%) had been sexually abused in the preceding year. The husband was the perpetrator in the majority of cases. The nature of abuse during pregnancy was mainly psychological in the form of threats of abuse without any physical injury. Risk factors for domestic violence in pregnancy included unplanned pregnancy and women with husbands or partners who were unemployed or manual workers. Unexpectedly, domestic violence occurred more commonly in permanent local residents than new immigrants from mainland China.

The prevalence of domestic violence in Chinese pregnant women from our study was comparable to those in other nations. The prevalence of abuse during pregnancy was noted to be in a range of 0.9-20.1% (3.9-8.3% in most studies) in a large review of US studies4. The prevalence across countries is similar: 6.4% in the UK (7.8% including threats)5, 6.6% in Canada5, 6.8% in South Africa5, and 11% in Sweden (21% including symbolic violence and threats)6. On the other hand, the nature of abuse was very much different. There was not a single case of physical injury in our abused group.

Does domestic violence affect the pregnancy outcome in Chinese women?

The pregnancy outcome of the above cohort has also been reported6. No difference was found between the abused and non-abused groups in terms of antenatal complications, preterm delivery, mode of delivery, birth weight, birth asphyxia and admission to neonatal intensive care unit. This finding was in contrast to that of Caucasian studies in which domestic violence was associated with an increased risk of miscarriages, preterm labour, foetal distress and low birth weight7-13. However, a strong element of physical abuse was present in the Caucasian studies. We hypothesised that domestic violence against our Chinese pregnant women, in which the nature of violence is almost entirely verbal abuse6, might mainly affect their psychological well-being. In other words, the real impact of domestic violence in pregnancy in Chinese women might not be reflected by the usual pregnancy outcome parameters but rather by other outcome measures such as the incidence of postnatal depression.

Domestic violence and postnatal depression

In 2001, we confirmed this hypothesis by performing another domestic violence study on 838 women after delivery14. There was a screening programme for postnatal
depression in our hospital which started in 2000. It was a three-stage screening. Women after delivery would be asked to complete the Stein's Daily Scoring System (SDSS) and Edinburgh Postnatal Depression Scale (EPDS) questionnaires on Day 2 or 3 post-delivery (Stage 1). They would be asked to complete another set of EPDS one to two days after they went home (Stage 2). At six weeks post-delivery, they would complete the third set of EPDS (Stage 3). SDSS was developed specifically to measure maternity blues in the puerperium\textsuperscript{18,19}. EPDS is a useful screening tool for postnatal depression\textsuperscript{20}. It had been reported that 11 to 17% of Chinese women scored highly on the EPDS six weeks to six months postpartum\textsuperscript{15-20}.

143 women (17.1%) had a history of abuse. 139 of them (16.6%) had been abused in the last year. Abuse occurred during the current pregnancy in 87 women (10.4%). 14 women (1.7%) had been sexually abused in the last year. Husband / boyfriend (27.9%), mother-in-law (26.7%) and employer / colleague (20.9%) were the three most common types of perpetrator of abuse. The nature of abuse was verbal and / or sexual in all the cases. The only risk factor that reached statistical significance was unplanned pregnancy (p=0.002). The incidence of abuse was also found to be higher in permanent residents (those who lived in Hong Kong for more than 7 years), single / divorced women, smokers, drinkers and low income group (< HK$5000 per month), although the difference was not statistically significant. The abused group had significantly higher SDSS and EPDS scores at all stages of screening (p=0.003, p=0.000, p=0.010 and p=0.001 respectively).

As the pregnancy advanced into the puerperium, the mother-in-law and employer / colleague became as important as the husband who was the major perpetrator in our previous study\textsuperscript{1}. There are some possible explanations. Nowadays in Hong Kong, most couples would not live with their parents and parents-in-law. However, during pregnancy and especially after delivery, the parents and in-laws would usually give a lot of advice and comments. Some of these comments or traditional taboos are not compatible with the knowledge that the pregnant women have obtained from their own readings, antenatal talks and information from the obstetricians and midwives. Conflicts may arise as a result and it is not surprising that the mother-in-law comes into the scene of domestic violence. Furthermore, the majority of the pregnant women in Hong Kong are working (only 35% were housewives from our data). As the pregnancy advances, the working pregnant women would have to take more time off work to attend the antenatal clinics and sometimes for hospital admissions. This might result in conflicts with the employers and colleagues.

There are a few possible explanations for the association between domestic violence and postnatal blues / depression. Firstly, domestic violence may lead to psychological trauma and then postnatal depression. Secondly, certain psychological traits or personality problems may lead to relationship problems and domestic violence. These psychological traits or personality problems also might predispose to postnatal depression. Thirdly, the women who subsequently develop postnatal depression may be very sensitive and they may interpret harmless words retrospectively as verbal abuse.

**Routine screening for domestic violence in pregnancy**

According to the World Health Organisation (WHO) criteria for screening\textsuperscript{21}, an important health problem should only be screened when there is a suitable screening test which is acceptable to the population; when there is an effective treatment; when there are adequate facilities for diagnosis and treatment; when the risk of physical and / or psychological harm from screening is less than the potential benefit; and when screening costs are balanced against benefits. It would be interesting to examine how many of these criteria are satisfied by the current understanding of domestic violence in Chinese pregnant women.

The questionnaire which we used to screen for domestic violence in pregnancy was the AAS\textsuperscript{2,3}. This screen assesses past and recent history of domestic violence using five structured and directed questions. The questionnaire is simple, takes only a few minutes to complete and can therefore be used in a busy clinic. Nevertheless, the use of this sort of structured questionnaires can increase the detection rate of domestic violence during pregnancy by up to 7 times\textsuperscript{22}. One drawback of the AAS is that it focuses on physical and sexual abuse rather than psychological or emotional abuse which is the predominant form of abuse in our Chinese population. Moreover, the acceptability of this screening method by Chinese pregnant women has not been formally assessed. In other words, further modification of the AAS to emphasise the psychological element and completion of formal acceptability studies are essential before the AAS can be used for routine screening in Chinese pregnant women.

The second question to answer is whether there is any effective intervention for domestic violence in pregnancy. A systemic review article published in the BMJ\textsuperscript{22} summarised six intervention studies, five from the United States and one from New Zealand. None was a randomised controlled trial. The interventions that took place in antenatal clinics, primary care and emergency departments included advice about services, advocacy and counselling. The results were inconclusive. Apart from increased referral to outside agencies, little evidence existed for changes in important outcomes such as decreased exposure to abuse. No studies measured the quality of life, mental health outcomes or potential harm to women from screening programmes. Furthermore, cultural differences and the difference in the nature of abuse would make the results of these intervention studies difficult to extrapolate to our Chinese population. Local intervention studies are therefore essential.

In addition, we need to study whether there are adequate manpower and resources for screening and intervention; whether there is any psychological and / or physical harm from screening; and the cost-effectiveness of the screening programme. Before all these study results are available, it would be premature to introduce a screening programme for domestic violence in our pregnant population.
The way forward

The Department of Obstetrics and Gynaecology and the Department of Nursing Studies, Faculty of Medicine, University of Hong Kong, have collaborated to form a Domestic Harmony Study Group to study the effects of abuse on pregnant women and to find more effective ways to help them. We have just completed a randomised controlled trial on the effectiveness of an empowerment intervention model specially designed for Chinese abused pregnant women in reducing intimate partner violence and improving women’s health status (paper under review). The intervention model was found to be effective in reducing intimate partner violence and improving the health of the women. Further studies to refine the intervention model are ongoing. In a prevalence study on domestic violence against male partners of pregnant women, 13% of the 100 men studied reported that they had been abused by their female partners (unpublished). We are also currently working on the application of this bi-directional concept of domestic violence in our empowerment intervention model.

Our group has a strong belief that pregnancy is an excellent opportunity for screening the early stage of domestic violence (verbal abuse) and effective intervention at this stage can prevent the progression of the severity of violence or even a major family tragedy such as suicide and homicide. We still have a long way to go not just to prove this hypothesis but also to convince the health policy makers and the public to accept this concept and realise its potential application.

References

7) Local data showed that domestic violence is significantly associated with postnatal depression.
8) The Abuse Assessment Screen (AAS) is originally designed to screen for psychological abuse.
9) Effective intervention model for domestic violence in pregnancy is well established in Caucasian countries.
10) More studies are required before routine screening for domestic violence in pregnancy is justified.

**ANSWER SHEET FOR APRIL 2005**

Please return the completed answer sheet to the Federation Secretariat on or before 30 April 2005 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

**Domestic Violence in Pregnancy - The Scene in Hong Kong**

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**Answers to March 2005 issue**

**Obstructive Sleep Apnoea: Increasing Evidence of Cardiovascular Complications**


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**FMSHK VISA Card**

In celebration of the launch of FMSHK VISA, IBA will reward all new FMSHK cardholders, who submit their applications before April 30, 2005 and accumulate an annual spending of HK$80,000 or above, with a 0.2% cash rebate on their annual spending amount. All new cardholders are also entitled to perpetual fee waiver and can choose one welcome gift from the list below:

- Conair Massager
- Conair Compact Garment Steamer
- VTech DECT Phone
- Panasonic Warm Jar Rice Cooker
- BenQ Joybee 120 MP3 Player
- 18 Speed Foldable Bike

In addition to the cash rebate, FMSHK VISA cardholders will enjoy a full spectrum of unparalleled credit card privileges and benefits offered by IBA. FMSHK VISA cardholders will receive double bonus points if they spend with their cards on Saturdays and Sundays locally or abroad. Cardholders will be given a personalised interest rate of as low as 8% based on their financial standing, compared to the standard interest rate of 24%-36% in the market. Other benefits include “One Family” Octopus Automatic Add-Value service, “Any-can-do Purchase Installment Plan” which allows cardholders to enjoy up to 88 days interest free period for the first installment plus shopping privileges at over 100 desirable merchant outlets in town.

FMSHK members can choose to apply for a classic VISA, a gold VISA or a Platinum VISA, to suit their own financial needs. Exclusive privileges will be extended to Platinum cardholders including VISA Platinum concierge service, air-travel benefits and a 24-hour dedicated Platinum Customer Service Hotline.

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**FMSHK Photography Interest Group**

Monthly Lunch Time Gathering

Monthly lunch time gathering on last Thursday of each month at 萬人迷酒樓 in Mongkok.

Remember to bring along your recent photo work for appreciation.

Members who want to register in the reminder call list please fax your fax number and telephone number to Dr. Bing-man LAI on 2789 3288.

Tel: _______________________    Fax: _________________________     to register for lunch.