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WOMEN, PREGNANCY, AND DOMESTIC VIOLENCE IN SPAIN

ITZIAR LUZARRAGA MONASTERIO

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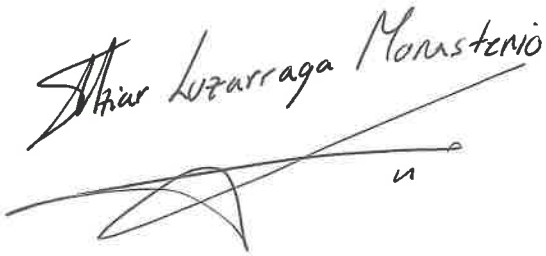
WOMEN, PREGNANCY AND DOMESTIC VIOLENCE IN SPAIN

Dissertation Presented by Itziar Luzarraga Monasterio

Directed by: John M. Gottman, Ph.D. and José Cáceres Carrasco, Ph.D.

Directors

Graduate Student



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Professor at the Complutense University of Madrid

Itziar Luzarraga Monasterio
Visiting Scientist, University of Washington (Seattle, US) 2003-2007
Basque Government Research Scholar

Program for Training Research Personnel in Application Centers Abroad
Department of Education, Universities, and Research, Scientific Policy and Universities of the Basque Government (Vitoria-Gasteiz)

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WOMEN, PREGNANCY AND DOMESTIC VIOLENCE IN SPAIN

Itziar Luzarraga Monasterio

Dissertation Directors:

John. M Gottman, Ph.D. and José Cáceres Carrasco, Ph.D.

University of Deusto

Abstract

Women, Pregnancy and Domestic Violence in Spain

Itziar Luzarraga Monasterio

Chairs of Supervisory Committee

Emeritus Professor at the University of Washington, John M. Gottman

Associate Professor at the University of Deusto, José Cáceres Carrasco

Department of Psychology

Intimate partner violence (IPV) during pregnancy is a widespread global social and health problem. Perpetrators of IPV violate women's human rights and their unborn children. While a large amount of research has been conducted aimed at increasing our understanding of IPV, the majority of this research has taken place in the United States (U.S.). Our understanding of IPV, and particularly IPV that takes place during pregnancy, is more limited in places outside of the U.S., such as in Spain. Several major gaps exist within the literature in this area. Currently, it seems that the prevalence rates of IPV during pregnancy in women from Spain are unknown. In addition, little work has been done to address whether pregnancy and other negative IPV-related risk factors may put women at increased risk of experiencing IPV (Jasinski, 2004). By studying these unknown gaps, protocols and programs to prevent and overcome this problem may be enhanced. Pregnancy is considered a stressful life event, especially with the first child. The transition to parenthood is associated with marital difficulties that may be part of the cascade toward divorce

(Shapiro & Gottman, 2005). Marital quality decreases for up to 67% of couples in the first year of the infant's life (Shapiro, Gottman, & Carrère, 2000). Thus, the stress of this transition may put women at higher risk of experiencing IPV during pregnancy.

The proposed dissertation aimed to expand the research in this field by evaluating how a variety of risk factors that have been commonly related to IPV and the first pregnancy are associated with Spanish women's reports of IPV in their current relationships. One hundred and fifty-five pregnant and 77 non-pregnant women voluntarily participated in an anonymous survey at service centres located in the greater Bilbao area of Spain. Women completed a battery of questionnaires that asked them to self-report on the following constructs: women's experience of being victims of IPV in the last 12 months and a variety of risk factors associated with IPV.

As expected, higher levels of reported IPV were associated with two specific risk factors: history of sexual abuse and alcohol consumption. Results also showed that higher levels of IPV were associated with lower levels of dyadic commitment (couple engagement). Additionally, pregnant women were less likely to experience IPV and risk factors commonly associated with IPV compared to non-pregnant women. Results also showed a significant interaction between pregnancy status and risk factors in predicting the frequency of IPV. Non-pregnant women who were younger and reported more exposure to violence in their past were more likely to experience IPV. However, pregnant women experienced more IPV when they reported more drug use by their partners, lower dyadic adjustment (couple satisfaction), and lower dyadic commitment. Unexpectedly, pregnant women experienced lower IPV when they reported more physical violence in the past, whereas the opposite was found for non-pregnant women.

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DEDICATION

To the victims of domestic violence and the persons dedicated to its prevention and intervention.

1. INTRODUCTION

1.1. Intimate Partner Violence (IPV) Toward Women

Domestic violence (DV) typically refers to all types of violence that occur between couples and among family members, such as child and elder abuse (Dahlberg & Krug, 2002). A specific type of DV, called intimate partner violence (IPV), is defined as "the use of physical assault, sexual coercion, and/or psychological aggression, usually, but not exclusively, taking place in the home, that can lead to injuries and/or death between intimate partners or ex-partners" (Dahlberg & Krug, 2002). The focus of this study is on IPV against heterosexual women because the highest rate of victimization of IPV is among women. IPV against women is considered a major public health issue for two main reasons. First, there is a high prevalence of IPV in most societies (Heise & Garcia-Moreno, 2002; Saltzman, Green, Marks, & Thacker, 2000; Watts & Zimmerman, 2002) with IPV often characterized by male perpetrators (World Health Organization [WHO], 1996) and female victims (Tjaden & Thoennes, 2000), with one out of every three women around the world being abused at least once during their lifetime (Heise, Ellsberg, & Gottemoeller, 1999). Second, IPV against women is associated with many negative outcomes related to women's health and overall adjustment, such as posttraumatic stress disorder, depression, anxiety, and taking substance abuse (Heise & García-Moreno, 2002; Saltzman et al., 2000; Watts & Zimmerman, 2002).

Since IPV against women is a major health problem, advances have been made in the field of IPV against women around the world. Thousands of programs and studies have been developed and conducted through criminal justice systems, human services, and health care systems in order to address this issue. Primarily, these advances have taken place in the United States (U.S.), although research in this area

has been done all around the world, including in the European countries, such as Spain.

Numerous studies have focused on prevention and intervention of IPV against women. For example, some studies have analyzed batterer typologies related to specific relationship interaction patterns (Berns, Jacobson, & Gottman, 1999; Cáceres, 1999; Coan, Gottman, Babcock, & Jacobson, 1998; Echeburúa, 1994; Gottman, Jacobson, Rushe, Shortt, & Babcock, 1995; Jacobson & Gottman, 1998; Jacobson et al., 1994), violence associated with certain characteristics of the couple (Babcock, Jacobson, Gottman, & Yerington, 2000; Cáceres, 2002, 2004, 2007; Cáceres & Cáceres, 2006; Painter & Farrington, 1998; Swahnberg et al., 2004), or women's responses to victimization as a result of IPV (Jacobson & Gottman, 1998; Jacobson, Gottman, Gortner, Berns, & Shortt, 1996; Ruiz-Pérez, Mata-Pariente, & Plazaola-Castaño, 2006; Ruiz-Pérez, Plazaola-Castaño, & del Rio-Lozano, 2006) and intervention programs for victims (Echeburúa & de Corral, 1998; Echeburua, de Corral, Sarasua, & Zubizarreta, 1996; Labrador & Alonso, 2005/2006; Labrador, Fernández-Velasco, & Rincón, 2006; Roberts, 2007).

Although many research studies have been conducted in a variety of countries through out the world, the main focus has been on achieving two goals. One goal has focused on analyzing the overall magnitude of this problem by describing the prevalence rates and negative outcomes associated with IPV. The second goal has focused on prevention of IPV through identification of risk factors that may predict IPV and put women at risk for experiencing IPV. Literature within each of these areas will now be reviewed.

1.1.1. Prevalence of IPV Toward Women

Despite all of the advancements made in prevention and intervention of IPV, violence against women is still prevalent and occurs in all socio-economic classes, religions, and cultures (WHO, 1996). Some data suggest that 3% to 52% of women experienced physical assault in the last 12 months (Heise & García-Moreno, 2002). Other research on prevalence rates of violence against women suggests that worldwide a third of women have been abused at least once during their lifetime (Heise et al., 1999).

Violence against women can also result in death. Studies from Australia, Canada, and South Africa have shown that more than 50% of women murdered over a one-year period were killed by their partners as a result of IPV (Gilbert, 1996; Tremblay, 1999). In both the U.S. and Spain, these statistics have shown that the rate of women murdered by their partners has increased. According to the Bureau of Justice, from 2003 to 2005, the percentage of women in the U.S. murdered by their partners increased 2.00% (Bureau of Justice, 2003/2005a); the Centro de Reina Sofía (Queen Sofía Centre) showed that from 2003 to 2007 there was an increase of 2.86% in Spain and 1.39% in Biscay, a province of the Basque Country region located in North Spain, where the current study was conducted (Centro Reina Sofía, 2003/2007). The most recent data from 2007 showed that, of all women 14 years or older, 3.66% were murdered by their partners in Spain and 1.92% in Biscay. The prevalence of women murdered by their partners around the world is high and continues to increase in the U.S. and even more in Spain.

In 2005, the WHO Multi-country Study on Women's Health and Domestic Violence Against Women (DVAW) studied 24,000 women from 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia, Montenegro,

Thailand, and the United Republic of Tanzania). The study reported that 15% to 71% of women experienced violence by their partners in their lifetime, and a range of 20% to 75% of women experienced emotional abuse, most within the past 12 months (WHO, 2005). Data on physical assault that was gathered from 48 population-based surveys around the world suggested that 10% to 69% of women reported being physically assaulted by their partners at some point in their lives (Heise & García-Moreno, 2002). Looking at European countries, a meta-analysis of 10 prevalence studies of DV against women showed concurrence between the studies, reporting that about 25% of women experienced IPV in their lifetime and 6% to 10% of women suffered from IPV in a single year (Council of Europe, 2002).

In Spain, 17.8% women from three regional councils from Spain reported being a victim during a one-year period (Ruiz-Pérez, Plazaola-Castaño, Blanco-Prieto, et al., 2006). The first national representative survey conducted in Spain on physical assaults against women by their partners disclosed that 4.89% of women were the victims of minor physical assault and 8.05% of women were the victims of severe physical assault (Medina-Ariza & Barberet, 2003), which is defined as violence that could cause bodily harm (Straus & Gelles, 1990). In a study conducted in Biscay, the prevalence of physical assault was 16.2% minor and 6.6% severe (Calvete, Corral, & Estévez, 2007). These results indicate that physical assault is as prevalent and serious in Spain as it is in Canada, Germany, and the U.S. (Medina-Ariza & Barberet, 2003).

The prevalence of women murdered by their partners around the world is high and it is increasing in the U.S. and more in Spain. However, the prevalence of women's victimization varies among countries, with a generally lower prevalence of IPV in Europe. There is a huge range when reporting prevalence, which may be due to the definition of violence, the evaluative methodology used, sample diversity (e.g.,

clinical vs. community), or the timeframe of data collection. However, the majority of researchers agreed that the prevalence rates of victimization and murder were greater than what has been reported in the past (Cáceres & Cáceres, 2006).

However, it is interesting to note that in recent years in the U.S., victimization of women has been decreasing while it has been increasing in Spain. Data from the U.S. indicate that the number of victimization cases reported by women (age 12 or older) of non-fatal violent acts by their partners decreased: 4.3 per 1,000 in 2003, while in 2005 there were 3.6 per 1,000 (Bureau of Justice Statistics, 2003/2005b), or 18% of women (Bureau of Justice Statistics, 2005). However, in Spain, the number of cases reported of women's victimization of IPV from the Spaniard National Police has been increasing: 43,313 cases were reported in 2002 and 62,170 cases in 2006. Of this data, the Basque Country region accounted for 22 cases in 2002 and 116 cases in 2006 (Instituto de la Mujer (Women´s Institute, 2002/2006)).

Moreover, there is evidence that the majority of the cases, especially in Spain, are not reported, suggesting that prevalence may be higher than what studies conclude. It is important to note that research worldwide, including Europe indicates that many, if not most, cases of IPV against women are never reported to legal authorities (American Psychological Association, 1996; Lejoyeux, Fichelle, & Saliou, 2007), leading to skewed prevalence rates. For example, in Spain, only between 3% and 8% of cases are reported (Instituto de la Mujer, 2004). Due to this reporter bias, the prevalence described above may represent much lower rates than what is occurring in reality.

While the percentage of victimization has decreased in the United States the number of women killed by their partners is still increasing. In Spain, some advances have been made toward lowering rates of IPV. However, both the number of women

killed and victimized by their partners is still on the rise and since many people do not report IPV, the rates are probably higher. Therefore, it is important to make further progress in studies focused on the prevalence of IPV and associated negative outcomes to know the real magnitude of this issue in Spain.

1.1.2. Negative Outcomes Associated With IPV Toward Women

IPV against women is considered to be a worldwide concern and is a public health issue that can result in both short and long-term mental and physical health problems (Campbell, 2002; Dahlberg & Krug, 2002; Keeling & Van Wormer, 2007; Lown & Vega, 2001; Marchiori, Rossi, & Colombo, 2004). The negative outcomes associated with IPV are often psychological, emotional, and physical health problems.

There are many negative psychological and emotional outcomes that female victims of IPV may experience. However, the main problems revealed specially by the research done in the U.S. and European countries such as in Spain are posttraumatic stress disorder (PTSD) (Amor, Echeburúa, de Corral, Zubizarreta, & Sarasua, 2002; Astin, Ogland-Hand, Foy, & Coleman, 1995; Pico-Alfonso et al., 2006; Rincón, Labrador, Arinero, & Crespo, 2004), depression (Amor et al., 2002; Astin et al., 1995; Baldry, 2003; Calvete, Estévez, & Corral, 2007; Garcia-Linares, Sanchez-Lorente, Coe, & Martinez, 2004; Pico-Alfonso et al., 2006; Rincón et al., 2004), and anxiety disorders (Amor et al., 2002; Astin et al., 1995; Baldry, 2003; Garcia-Linares et al., 2004; Pico-Alfonso et al., 2006). Other psychological problems are posttraumatic stress syndrome (PTS) (Rincón et al., 2004), psychological distress (Gelles & Harrop, 1989), sexual dysfunction (Labrador & Alonso, 2005/2006), eating disorders, and obsessive-compulsive disorder (Heise & García-Moreno, 2002). Other problems that relate to emotional dysfunction may include low self-esteem (Amor et

al., 2002; Baldry, 2003), feelings of shame and guilt (Heise & García-Moreno, 2002), fear, non-productive feelings, doubts concerning one's self and the world, and distrust in others. Although there are wide array of psychological and emotional problems related to being a victims of IPV, the most prevalent are posttraumatic stress disorder (PTSD), depression, and anxiety disorder.

Female victims of IPV around the world and in Spain also suffer from many physical health problems, such as suffering from external and internal injuries, chronic pain, permanent disabilities, and partial loss of audio and visual function (Labrador & Alonso, 2005/2006). Other direct results of being in a violent relationship are irritable bowel syndrome and gastro-intestinal disorders (Labrador & Alonso, 2005/2006). There are also other possible symptoms related to the reproductive organs, such as gynaecological problems, STDs including HIV, infertility, pelvic inflammatory disease, and chronic pelvic pain (Heise & García-Moreno, 2002). Women who are victims of IPV also engage in self-injurious behaviours, such as participation in unprotected sex (Heise & García-Moreno, 2002) and the use of illicit drugs and alcohol (Heise & García-Moreno, 2002; Ruiz-Pérez & Plazaola-Castaño, 2005). Overall, there are many negative physical outcomes associated with IPV; some are the direct result of physical violence and others are the result of the stress of being in an abusive relationship. Each of these negative outcomes affects the women's well-being and couple puts the women's life at risk.

While some women who are the victims of IPV suffer from physical and psychological problems in both the short and the long-term due to the physical and emotional violence, others are not as fortunate. There are also potentially lethal outcomes associated with being the victim of violence such as contracting HIV/AIDS from experiences of sexual abuse (Heise & García-Moreno, 2002) or suicidal thoughts

and behaviours (Belfrage & Rying, 2004; Bergman & Brismar, 1991; Pico-Alfonso et al., 2006). Although not everybody that thinks about or attempts to commit suicide succeeds in the end, some do go through with it. Lorente (2001) reported that approximately 20% to 40% of women who committed suicide had suffered from IPV in Spain.

Studies on prevalence and negative outcomes are difficult to compare due to the widely divergent methodologies used across studies, such as the use of samples recruited from different locations (e.g., abused women's shelters vs. non-shelter community samples), as well as the lack of longitudinal studies (Garcia-Linares et al., 2005) and problems with reporter bias. Therefore, the true magnitude of IPV against women is still unknown. The annual prevalence of IPV against women in the U.S. differs based on the sample; one national study reported IPV prevalence rates of 1.8%, whereas 14.4% was reported among emergency department patients (Dearwater et al., 1998; Tjaden & Thoennes, 2000).

It is unknown whether negative outcomes, such as depression are the consequences of IPV or whether they increase the risk of experiencing IPV (i.e., the direction of effects can not be determined) (Ruiz-Pérez & Plazaola-Castaño, 2005). Therefore, there is a need to do further research on the prevalence of both IPV and the negative outcomes associates with IPV against women. Additionally, risk factors associated with IPV against women are also important to study because this will contribute to our ability to develop effective prevention and intervention programs addressing IPV.

1.2. Risk Factors Associated With IPV Toward Women

Over the last twenty years, around the world and especially in the U.S., research has been conducted focusing on identifying risk factors associated with IPV

(Baldry & Winkel, 2008; Helmut, Oberhfell-Fuchs, & Woessner, 2004; Riggs, Caulfield, & Street, 2000).

This wealth of data has uncovered several characteristics of women and their partners and specific aspects of their relationships that may put women at risk of IPV (Black, Heyman, & Slep, 2001; Riggs et al., 2000; Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001; Schumacher, Slep, & Heyman, 2001; Stith, Smith, Penn, Ward, & Tritt, 2004). Researchers and policy-makers in Spain and worldwide have noted that there is a strong need to stop and prevent IPV from occurring against women. Hence, most work in this area has focused on the identification of factors that may help to prevent women from experiencing violence in their relationships and intervention efforts (Loewenberg, 2005). Although some research on IPV has been conducted in Spanish samples (Ruiz-Pérez, Blanco-Prieto, & Vives-Cases, 2004; Ruiz-Pérez, Plazola-Castaño, Álvarez-Kindelán, et al., 2006), the prevalence of IPV and correlates associated with IPV in Spain are still widely unknown (Instituto de la Mujer, 1999; Raya-Ortega et al., 2004; Vives, Alvarez-Dardet, & Caballero, 2003). Therefore, identifying risk factors is necessary in order to prompt recognition of elements that may lead to an increased likelihood of experiencing IPV. This creates opportunities for prevention of IPV, which is needed (Loewenberg, 2005; Riggs et al., 2000).

Some currently identified risk factors associated with IPV that are specifically related to women's characteristics include age, education, unemployment, history of violence, alcohol consumption, drug use, depression, anxiety, and social support. Characteristics related to women's partners include partner's age, education, unemployment, alcohol consumption, and drug use. Finally, risk factors that are associated with characteristics of the relationship include household income, dyadic adjustment (couple satisfaction), jealousy, dyadic commitment (couple engagement),

and history of violence in the current relationship. Even though several different classifications of risk factors associated with IPV have been identified, there are still some disagreements in the literature over which specific factors are related to IPV, as some studies provide discrepant conclusions based on their findings. This may be due to the fact that different methodologies, such as samples from different settings, are often used when exploring IPV (Riggs et al., 2000) and associated risk factors. Hence, more research is needed to help further identify which risk factors may be consistently associated with IPV (Stith et al., 2004), especially in Spain where there is some research on women characteristics and even less research on partner and relationship characteristics.

The following are risk factors that research has shown are associated with IPV that pertain to characteristics about women and are included in this study: women's age, education, unemployment, history of violence, alcohol consumption, drug use, stress, depression, anxiety, and social support.

1.2.1. Women's Risk Factors

1.2.1.1. Women's Age

Studies analyzing the relationship between women's age and IPV show mixed results. The few studies that have explored this relation have concluded that there is no association between age and IPV when focused specifically on physical aggression (Jewkes, Levin, & Penn-Kekana, 2002; Painter & Farrington, 1998), and that abuse is more likely to occur among younger and older women than middle-aged women (Finkelhor & Yllö, 1985). However, in a study conducted by the WHO in 2005, women between the ages of 15 and 19 were reportedly at highest risk of experiencing IPV (WHO, 2005). Additionally, the majority of the research supports that younger

age is associated with more IPV (Astin et al., 1995; Jacobson et al., 1994; Lown & Vega, 2001; Swahnberg et al., 2004).

In Spain, similar results have been found, suggesting that as women become older, they were less likely to experience physical and emotional abuse (Ruiz-Pérez, Plazaola-Castaño, Álvarez-Kindelan, et al., 2006). These findings are comparable to other studies from Spain. For example, Escribà-Agüir, Barona-Vilar, Calvo-Mas, Carpio-Gesta, and Fullana-Montoro (2006) analyzed the medical reports of adults over the age of 18 for 500 cases of domestic violence and the highest numbers of cases were for women between 20 and 39 years old.

In general, women's age has been identified as being a risk factor associated with IPV, although this relation has not been found consistently across studies (Schumacher, Feldbau-Kohn, et al., 2001); hence, age will also be explored as a risk factor in the present study.

1.2.1.2. Women's Education

There are also some mixed results primarily from studies done in the U.S. regarding the exact relationship between the amount of education a woman has completed and IPV. A majority of the studies consistently support the association between lower education and greater experiences with IPV (e.g., Breiding, Black, & Ryan, 2008). Low level of education has been associated with IPV toward women within cross-cultural studies (WHO, 2005) and in a number of other studies that differ demographically, such as those from different states in the U.S. and in Sweden (Campbell, Jones, et al., 2002; Jewkes et al., 2002; Lown & Vega, 2001; Swahnberg et al., 2004). For example, some studies have concluded that there is a relation between education and IPV, where less education was associated with a higher

likelihood of being a victim of IPV (Finkelhor & Yllö, 1985; Schumacher, Feldbau-Kohn, et al., 2001).

In Spain, the Instituto de la Mujer performed a study with 2,090,767 women and found that women who had been victimized frequently had a lower level of education compared to those who had not been victimized (Blanco, Ruiz-Jarabo, Garcia de Vinuesa, & Martín-Garcia, 2004). Similarly, Ruiz-Pérez, Plazaola-Castaño, Álvarez-Kindelán, et al. (2006) reported that education was negatively associated with IPV.

Overall, the research suggests that women around the world with less education are at higher risk of victimization than women with greater education, although not all studies found such an association. Thus, education will also be explored as a risk factor in the present study.

1.2.1.3. Women's Unemployment

Only a small number of studies have looked at the relationship between women's unemployment and victimization of IPV. However, studies that have been done, primarily in the U.S. generally deduced that unemployed women are at greater risk for experiencing IPV compared to employed women (e.g., Vest, Catlin, Chen, & Brownson, 2002).

Unemployed women report experiencing more abuse by their partners than employed women (Astin et al., 1995; Finkelhor & Yllö, 1985; Magdol et al., 1997). Similarly, in Spain, the majority of female victims of IPV appeared to be unemployed (Amor et al., 2002), although almost no studies have been done in Spain to address this issue directly.

Although women's unemployment has been identified as a risk factor in the U.S., additional research needs to be done across different cultures such as in Spain,

to determine whether these findings can be generalized. Hence, unemployment will be considered as a risk factor within the current study.

1.2.1.4. Women's History of Violence

Women's past experiences of violence have been identified as a potential risk factor for women to experience IPV later in life. Research has been conducted analyzing women's history of violence and women's victimization of IPV in current relationships. There are some global studies that have not found an association between having a history of experiencing violence and current experiences of IPV (e.g., Astin et al., 1995) while other work in this area has identified past experiences of violence as a potential risk factor associated with IPV.

Several studies have evaluated the impact that witnessing violence between parents during childhood may have on current experiences of IPV; the results are conflict. For example, some research has shown that being exposed to violence between parents at a young age was not associated with women currently experiencing IPV (Astin et al., 1995; Russell, Lipov, Phillips, & White, 1989), while others reported that growing up in a household where parents were violent towards one another was related to a higher risk of experiencing IPV in current relationships (Henning, Leitenberg, Coffey, Turner, & Bennett, 1996; Kantor & Straus, 1989). Overall research, however, tends to identify women's witnessing of interparental violence during childhood as a risk factor for IPV (Bensley, Van Eenwyk, & Simmons, 2003).

Similarly, there are contradictory findings in some studies of women who experienced abuse during childhood and adulthood. Some research has concluded that women who reported IPV were no more likely to have a history of abuse as a child than women who not reported IPV (Astin et al., 1995; Bensley et al., 2003; Cascardi,

O'Leary, Lawrence, & Schlee, 1995). In contrast, some researchers have found that 53% of abused women experienced physical and/or sexual abuse during childhood (Silva, McFarlane, Soeken, Parker, & Reel, 1997), while others have reported even higher frequencies. The majority of research conducted in the U.S and in a few European countries tends to identify with the latter finding, which recognizes that experiencing physical or sexual childhood abuse put women at an increased risk of IPV (Bensley et al., 2003; Coid et al., 2001; Desai, Arias, Thompson, & Basile, 2002; Romito, Crisma, & Saurel-Cubizolles, 2003).

Similar discrepancies between studies focused on women's experiences of abuse during adulthood (prior to current relationships) also exist. A few studies found that abuse by prior partners was not related to IPV in the current relationship (Astin et al., 1995; Russell et al., 1989). However, Painter and Farrington (1998) found that women with a history of sexual abuse during adulthood were four times more likely to experience IPV than women who had not experienced sexual abuse previously. Others have agreed that having been the victim of sexual abuse in the past is a strong risk factor for IPV in current relationships. In addition, researchers have concluded that violent men showed higher levels of violence in previous relationships than non-violent men (Black et al., 2001; Russell et al., 1989), and that women who reported more IPV showed greater violence in previous relationships than women who reported less IPV (Coker, Smith, McKeown, & King, 2000). Despite limited research examining the association between past and current experiences of violence within romantic relationships, a majority of the research highlights previous IPV as a potential red flag for current IPV (Riggs et al., 2000; Thompson et al., 2006).

In Spain, research strongly supports that a history of violence as a potential risk factor for IPV, especially when women have been abused in past relationships. In

a sample of victimized women, 50% had a history of involvement in violence. The majority of this violence was perpetrated by parents (40%), previous partners (5%), or both (5%) (Labrador & Alonso, 2005/2006). Spanish women who were victims of IPV also reported experiencing a greater range of different kinds of violence during their lives, including witnessing more violence between their parents during childhood, more exposure to childhood abuse, and more exposure to violence either by a previous partner or by other perpetrators, compared to non-abused women (Garcia-Linares et al., 2005; Pico-Alfonso et al., 2006). Although it seems that childhood abuse places women at risk for IPV (Garcia-Linares et al., 2004), it seems that adulthood abuse might put women at even greater risk for IPV than childhood abuse (Echeburúa & de Corral, 1998). Ruiz-Pérez, Plazaola-Castaño, Blanco-Prieto, et al. (2006) found that women who had been abused in previous relationships were at a greater risk of being abused in new relationships.

Most research seems to suggest that women who experienced violence in past relationships (either romantic or familial) were at risk for being the victim of IPV in current romantic relationships. However, it seems that results from some studies, primarily from the U.S., show some inconsistencies. Therefore, history of violence, including exposure and involvement during childhood and involvement during adulthood, will be explored as a risk factor in the present study.

1.2.1.5. Women's Alcohol Consumption

Studies that have analyzed the relation between women's alcohol consumption and victimization of IPV provide differing results. While a few studies found no differences between alcohol consumption in abused versus non-abused women (Russell et al., 1989), the majority of studies indicate that women who use alcohol are at an increased risk for IPV victimization (Coker, Davis, et al., 2002; Kantor &

Straus, 1989; Magdol et al., 1997). In a comprehensive meta-analysis, Stith et al. (2004) considered alcohol consumption a minor risk factor for victimization.

In Spain, a study conducted by Rincón et al. (2004) focused on the psychological consequences of IPV with results indicating that women who experienced IPV showed no signs of alcohol issues. However, most studies have shown a relationship between women's alcohol use and IPV. For example, Labrador, Rincón, de Luis, and Fernández-Velasco (2004) showed that alcohol dependency is frequently reported among abused women. Additionally, Ruiz-Pérez, and Plazaola-Castaño (2005) inferred that women's alcohol use was significantly positively correlated with women's abuse.

Most research seems to support that women's alcohol use is associated with IPV victimization. However, there are some inconsistencies in the research literature potentially as a function of variations in measurements of alcohol use between the studies (Schumacher, Feldbau-Kohn, et al., 2001). More information is needed in order to confirm whether women's alcohol use relates to the victimization of IPV. This is especially important to explore in Spain, where alcohol use is progressively more integrated into the norms of social interaction (Ruiz-Pérez & Plazaola-Castaño, 2005). Therefore, in the current study, women's alcohol consumption will be analyzed as a risk factor.

1.2.1.6. Women's Drug Use

A few studies have found no association between women's drug use and victimization of IPV (e.g., Coker, Davis, et al., 2002) and have also shown that female substance abusers were not at increased risk for experiencing IPV (Kantor & Straus, 1989).

However, women's drug use has more commonly been associated with IPV (e.g., Magdol et al., 1997). In fact, positive relations between women's drug use and IPV victimization have been well supported in several studies (e.g., Danielson, Moffitt, Caspi, & Silva, 1998; Magdol et al., 1997; Pan, Neidig, & O'Leary, 1994).

The research literature from Spain has also shown mixed results regarding the relation between drug use and IPV. In a study conducted by Rincón et al. (2004) that focused on psychological consequences of IPV, female victims showed no signs of drug issues. On the other hand, Labrador et al. (2004) found that drug use was frequent among abused women. Other studies have also shown that illicit drug use by women was positively correlated with more abuse (Ruiz-Pérez & Plazaola-Castaño, 2005), which supports the premise that drugs are frequently used as a way to manage the stress related with IPV (Ramos-Lira, Saltijeral-Méndez, Romero-Mendoza, Caballero-Gutierrez, & Martinez-Velez, 2001).

Research seems to indicate that drug use among women is often associated with IPV. Nonetheless, there are some inconsistencies. Thus, additional work needs to be done to clarify whether or not drug use is associated with IPV (Stith et al., 2004). Consequently, the current study will explore drug use as a potential risk factor associated with IPV among women.

1.2.1.7. Women's Depression

Depression has been generally found to be associated with IPV in a number of different countries (e.g., Coid et al., 2003). Women's victimization as a result of IPV has been consistently associated with increased levels of depression in the U.S. and in Spain (Coid et al., 2003; Coker, Davis, et al., 2002; Stein & Kennedy, 2001). A meta-analysis conducted by Stith et al. (2004) showed that depression is a moderate risk factor for victimization of IPV in the U.S.

Research in the U.S. and in Spain concluded that depression may be one of the most prevalent women's mental health issues associated with IPV (Campbell, 2002; Labrador et al., 2004). Indeed, Spanish female victims of IPV reportedly had a higher incidence and severity of depressive symptoms than women who had not been abused (Garcia-Linares et al., 2004; Pico-Alfonso et al., 2006). In other studies in Spain, female victims reported higher levels of depression than those who had not been victimized (Amor et al., 2002; Garcia-Linares et al., 2004). Rincón et al. (2004) reported that 84.2% of victims had symptoms of depression.

Women's depression will be analyzed as a risk factor in the current study based on the wealth of research that has almost exclusively identified depression as a secondary effect of IPV.

1.2.1.8. Women's Anxiety

Another risk factor that research has consistently found to be associated with IPV is anxiety (Tolman & Rosen, 2001). Studies on abused women have described increased anxiety levels compared to non-abused women (Coid et al., 2003; Coker, Davis, et al., 2002). Studies in the U.S. have repeatedly shown that women who experience more severe violence are more likely to report greater anxiety compared to those who had experience less violence (Williams & Mickelson, 2004) with similar findings in Spain (Labrador et al., 2004). Additionally abused women also report greater frequency and severity of anxiety symptoms than non-abused women (Garcia-Linares et al., 2004; Pico-Alfonso et al., 2006).

Research clearly shows that anxiety is a negative outcome of IPV. Therefore, it is important to be able to replicate these findings and provide further support that anxiety may be a potential risk factor related to IPV.

1.2.1.9. Women's Social Support

In the U.S., some researchers have reported no association between social support and IPV against women (e.g., Zlotnick, Kohn, Peterson, & Pearlstein, 1998), while the majority of the researchers have found a negative relationship between social support and IPV (e.g., Coker, Smith, et al., 2002). For example, social support has been identified as a protective factor in the face of IPV, where researchers speculate that having social support available might help woman be less likely to experience IPV (Coker, Smith, et al., 2002). On the contrary, women with little social support available to them may be more likely to experience IPV (Coker, Watkins, Smith, & Brandt, 2003). In Spain, similar results were found, where women who reported having a lack of social support were more likely to be abused (Ruiz-Pérez, Plazaola-Castaño, Álvarez-Kindelán, et al., 2006). Also within a Spanish sample, 15% of abused women reported that they had social support available to them and 30% had family support (Labrador & Alonso, 2005/2006). This link between social support and women's victimization is further supported by research showing that abused women tend to be socially isolated (Neilsen, Russell, & Ellington, 1992).

Most of the research shows that social support is related to women's experiences of IPV. However, there are still some inconsistencies between studies. Therefore, women´s satisfaction with their level of social support will be explored in the current study because more research needs to be carried out in order to determine whether low social support is associated with women victimization (Stith et al., 2004).

1.2.2. Women's Partner Risk Factors

1.2.2.1. Partner's Age

The research on relations between partner's age and IPV against women has shown diverse results. Jewkes et al. (2002) reported no strong association between

these variables. However, previous studies have shown an association between women's partner's age and IPV meaning that the older the partner's age then less IPV (Jacobson et al., 1994).

The majority of research shows that younger men are more likely to be violent towards their partners (Kantor, Jasinski, & Aldarondo, 1994; Pan et al., 1994). Indeed, Riggs et al. (2000) concluded that partner's age should be considered as a potential risk factor for IPV. Therefore, information about partner's age will be collected and analyzed in this study.

1.2.2.2. Partner's Education

In contrast to the other risk factors presented thusfar, the relationship between partner's education and IPV is even more unclear (Breiding et al., 2008; Coker, Davis, et al., 2002). A number of studies have found no association between partner's education and women's experiences of IPV (e.g., Jewkes et al., 2002). However, the majority of studies done in this area have found that low levels of education were negatively associated with IPV. For example, Jewkes et al. (2002) concluded that low partner education was a risk factor for the IPV. Additionally, a meta-analysis conducted by Schumacher, Feldbau-Kohn, et al. (2001) suggested that men who have lower education are more abusive toward their partners. Overall, research conducted in different countries all over the world has demonstrated that partners with low education may be more likely to perpetrate violence against women (Jewkes et al., 2002; Kyriacou et al., 1999; Lown & Vega, 2001; Swahnberg et al., 2004). In Spain, Blanco et al. (2004) found that violent men had lower education levels than non-violent men.

Research has commonly identified men with less education as being at greater risk of being perpetrators of IPV than men with more education. However, some

research has not demonstrated a clear, direct association between these two factors. Thus, further research needs to be done to establish if men's education makes it more likely that they will perpetrate IPV toward their female partners.

1.2.2.3. Partner's Unemployment

Studies that have looked at the relation between partner's unemployment and IPV have reported that unemployment may be linked to increased victimization (e.g., Kantor et al., 1994; Kyriacou et al., 1999). For example, Kyriacou and colleagues (1999) reported that intermittent or recent unemployment was associated with increased IPV toward women. In another more recent study done by Tsui, Chan, So, and Kam (2006), unemployment was reported as a significant risk factor for IPV in Hong Kong. Additionally, Riggs et al. (2000) identified partner's unemployment as a potential risk factor for the perpetration of IPV against women. Research consistently indicates that men's unemployment tends be associated with women victimization. Thus, this factor will be analyzed in the present study.

1.2.2.4. Partner's Alcohol Consumption

Research has consistently shown an association between men's alcohol use and perpetration of IPV against women (Heyman, O'Leary, & Jouriles, 1995; McKenry, Julian, & Gavazzi, 1995; Pan et al., 1994; Rosenbaum & O'Leary, 1981; Russell et al., 1989; Telch & Lindquist, 1984). For example, Kyriacou et al. (1999) reported that women were at greater risk of IPV when their partners used alcohol. Additionally, a meta-analysis conducted by Schumacher, Feldbau-Kohn, et al. (2001) also found evidence to support this association. In a meta-analysis by Stith and colleagues (2004) suggest that men's alcohol use may be a moderate risk factor for abuse towards women. Alcohol use has also been consistently associated with higher frequency and severity of IPV around the world and in Spain (Cerezo, 2000; Heise &

García-Moreno, 2002; Lorente, 2001; Medina, 2002). In Spain, it has been speculated that men's violence towards women typically involves alcohol (Corsi, 1995; Fernández-Montalvo & Echeburúa, 1997). In a study with 2,090,767 women, it was reported that 37% of victims admitted that their partners were drinking too much at the time of the violent incident or in the past (Blanco et al., 2004). Research in the U.S. and Spain has also suggested that perhaps women's partners' alcohol use is significantly associated with abuse, because male partners may use alcohol as an excuse for the abuse. For example, women may assume that violence is occurring due to their partner's level of intoxication, when, in fact, the violence is pre-meditated (Jacobson & Gottman, 1998; Lorente & Lorente, 1998; Villavicencio & Batista, 1992; Villavicencio & Sebastián, 1999).

Research has consistently shown that men's alcohol consumption is associated with the perpetration of IPV. However, these factors will be further analyzed in the current study because it is essential to more thoroughly understand how alcohol is related to IPV, especially in Spain, where alcohol use is often used as a way to make social connections (Ruiz-Pérez & Plazaola-Castaño, 2005).

1.2.2.5. Partner's Drug Use

Research consistently supports the relationship between men's drug use and IPV toward women (Tjaden & Thoennes, 2000). For example, Kyriacou et al. (1999) reported that women were at greater risk of IPV when their partners used drugs. Schumacher, Feldbau-Kohn, et al. (2001) concluded that IPV was consistently and highly associated with drug dependence. In a meta-analysis, Stith et al. (2004) suggested, that men being abusive toward their partners was highly correlated with men's drug use. Researchers have also suggested, in a similar way to alcohol, men may use drugs as an excuse for their violent behavior (Jacobson & Gottman, 1998;

Lorente & Lorente, 1998; Villavicencio & Batista, 1992; Villavicencio & Sebastián, 1999). Most of this research has been conducted in the U.S., and therefore, it is important to further explore how drug use among male perpetrators is associated with IPV toward women in Spain

1.2.3. Couple Risk Factors

1.2.3.1. Household Income

Household income has also shown to be a significant variable associated with IPV, such that women who are victims of IPV consistently had a lower income in studies conducted in the U.S., and in Spain. Finkelhor and Yllö (1985) found that women with lower household income reported more abuse by their partners than women from higher household income. In a meta-analysis, Schumacher, Feldbau-Kohn, and colleagues (2001) reported that lower income was related to increased risk for women's abuse. Additionally, a study performed in eight U.S. states also showed that low household income was associated with IPV (Vest et al., 2002). In Spain, women with low household income were also more likely to experience violence (Ruiz-Pérez, Plazaola-Castaño, Álvarez-Kindelán, et al., 2006). Since European and American research (Helmut et al., 2004) consistently highlights the importance of household income and IPV, household income will also be considered in this study.

1.2.3.2. Dyadic Adjustment

Research conducted to identify the relation between dyadic adjustment and women's experiences of being the victim of IPV has shown that couples who reported lower marital satisfaction also reported more victimization towards women around the world, in the U.S. and in Spain (Rosenbaum & O'Leary, 1981). Wives in non-violent relationships showed considerably more marital satisfaction than women who reported violence in their relationships (Cordova, Jacobson, Gottman, Rushe, & Cox,

1993). Men who reported lower marital satisfaction also reported more aggression towards their partners (Sagrestano, Heavey, & Chistensen, 1999). In a meta-analysis, Schumacher, Feldbau-Kohn, et al. (2001) reviewed six studies and suggested that men's marital satisfaction was negatively related to men's aggression towards their partners. Marital satisfaction has been also considered a potential risk factor for men's perpetration (Riggs et al., 2000) and, more specifically, for men being violent towards women (Stith et al., 2004). In Spain, research conducted by Cáceres (2007) found that couple satisfaction negatively correlated with IPV.

Research done in this area consistently reported that lower satisfaction correlates with higher IPV victimization in women around the world, in the U.S., and in Spain. Relationship quality is an important factor to consider when evaluating IPV within relationships; therefore, dyadic adjustment will also be assessed in this study (Stith et al., 2004).

1.2.3.3. Jealousy

Most research analyzing the relation between jealousy and women's victimization of IPV has found that couples who reported jealousy as a problem also reported more IPV (Dutton, Van Ginkel, & Landolt, 1996; Holtzworth-Munroe, Stuart, & Hutchinson, 1997), although one study did not support this association (e.g., Murphy, Meyer, & O'Leary, 1994). Schumacher, Feldbau-Kohn, et al. (2001) suggested that dyadic jealousy was significantly associated with women's victimization. Riggs et al. (2000) also found that men's jealousy was a potential risk factor for perpetration of IPV.

Although one study did not find an association, the majority of the research shows that a couple's jealousy may put women at greater risk for victimization.

Jealousy will be further explored as potential risk factor associated with IPV, because it appears that it has yet to be explored in Spain.

1.2.3.4. Dyadic Commitment

In the present study, commitment will be defined based on the couple's engagement status. Generally, research supports that women cohabiting are at greater risk for IPV than married women (Colson, 1995; Jackson, 1996; Stets, 1991; Stets & Straus, 1989; Yllö & Straus, 1981). A study done by the U.S. Justice Department found that cohabiting women are 62 times more likely to be assaulted by their partners than married women (Colson, 1995). In another study, Yllö and Straus (1981) found that cohabitors might be more violent and may be four times as likely to experience severe violence compared to married couples. Additionally, Stets (1991) reported that around 14% of cohabitors were violent compared to 5% of married couples.

The majority of the research reports cohabitation is associated with a greater risk for IPV than being married. Thus, level of commitment will be analyzed in the current Spanish sample since it appears as though this relation has not been yet explored in Spain.

1.2.3.5. History of Violence in the Current Relationship

There appears to be very little research focused on the history of violence within the current relationship (Bybee & Sullivan, 2005; Riggs et al., 2000), but the research has been conducted consistently suggests that a history of violence in the current relationship is associated with women's victimization (Feld & Straus, 1989; Leonard & Senchak, 1996).

Leonard and Senchak (1996) found that premarital violence was linked to marital aggression. Additionally, Feld and Straus (1989) reported that 50% of violent

men who were violent before they became married were also violent during the first 18 months of marriage, in comparison to 10% of men who were non-violent before they married. Meta-analysis suggested that a history of violence in the current relationship was associated with continuous victimization (Riggs et al., 2000).

Around the world and especially in the U.S., several risk factors have been consistently identified as being associated with IPV, including women's overall history of violence, partner's alcohol consumption, and low household income. However, there are still some risk factors that, due to inconsistent methodological use between studies (e.g., different samples, procedures), have not been as consistently linked to IPV (Vest et al., 2002). As a result, continuing to identify the relationship between certain risk factors and IPV is necessary in order to better understand how to develop effective ways of preventing IPV. Therefore, further research needs to be completed on these risk factors (e.g., women's drug use, social support, marital satisfaction, and pregnancy) in samples around the world and in Spain because of the limited amount of research conducted thus far (Stith et al., 2004).

1.3. IPV Toward Pregnant Women

Intimate partner violence during pregnancy is considered a serious public health problem (Jasinski, 2004) due to the possible short and long-term negative consequences that have been identified with experiencing IPV during pregnancy (Cokkinides, Coker, Sanderson, Addy, & Bethea, 1999; Petersen, Gazmararian, & Clark, 2001; Plichta, 2004; Ruiz-Pérez et al., 2004; Seng, 2002; Shadigian & Bauer, 2004) and the future newborn (Escribà-Agüir, Ruiz-Pérez, & Saurel-Cubizolles, 2007; Ruiz-Pérez et al., 2004; Shadigian & Bauer, 2004). Research has focused specifically on prevalence, negative outcomes associated with IPV during pregnancy

(Gazmararian et al., 1996), and the importance of identifying victims of IPV among pregnant women (Escribà-Agüir et al., 2007; Gazmararian et al., 1996).

1.3.1. Prevalence of IPV Toward Pregnant Women

IPV during pregnancy occurs in all social classes, cultural groups, and ages. However, due to inconsistencies between the studies in terminology (Petersen, Saltzman, Goodwin, & Spitz, 1997), methodological measurement, procedures (Gazmararian et al., 1996; Petersen, Gazmararian, Spitz, Rowley, Goodwin, et al., 1997), and samples (Jasinski, 2004), it has become difficult to clearly determine the prevalence of IPV during pregnancy (Gazmararian et al., 1996; Petersen, Gazmararian et al., 1997; Petersen, Saltzman, et al., 1997). In a review of 13 studies, Gazmararian and colleagues (1996) found that violence during pregnancy ranged between 0.9% and 20.1%, but suggest that a range of 4% to 8% is more reasonable, which also supported by Jasinski (2004). Some researchers considered IPV to be more common during pregnancy (Cokkinides et al., 1999; Gazmararian et al., 2000). Dunn and Oths (2004) reported that 10.9% of women from ethnically diverse backgrounds experienced physical abuse during pregnancy, which is supported by other researchers as well (e.g., Cokkinides & Coker, 1998; McFarlane, Parker, Soeken, & Bullock, 1992).

Data from 24,000 women from 10 countries around the world (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia, Montenegro, Thailand, and the United Republic of Tanzania) recognized that in almost every location, over 5% of women had been physically abused in at least one of their pregnancies; the range was from 1% to 28% (WHO, 2005). Amor et al. (2002) reported that in Spain, 43% of women were abused during pregnancy, and similarly, Garcia-Linares et al. (2005) reported 36.5% of pregnant women had been physically abused. It is important,

however, to note that many cases of IPV go unreported, suggesting that the prevalence of IPV during pregnancy is probably much higher.

Due to lack of research in the area, there are many unanswered questions with regards to prevalence (Jasinski, 2004). Therefore, it is important to also look at studies that focus on the negative outcomes of IPV.

1.3.2. Negative Outcomes Associated With IPV Toward Pregnant Women

Intimate partner violence, specifically physical and sexual abuse, during pregnancy is associated with many negative consequences in the mental and physical health of the mother and fetus that might affect them in the present and the future (Jasinski, 2004). The following are general findings from research conducted worldwide, but for the most part in the U.S., on psychological and emotional negative outcomes related to the experience of IPV in pregnant women. Abused women tend to have more stress and a lower self-esteem. There is also evidence that women who are victims of IPV are more likely to be depressed (Smith et al., 2004) and more anxious (Austin, Hadzi-Pavlovic, Leader, Saint, & Parker, 2005). This, in turn, puts the fetus at risk for the consequences associated with parental depression both during pregnancy and post-partum, which can have a profound impact on infants and children (Smith et al., 2004). Mothers with depressive symptoms were more likely to deliver prematurely, have low birth weight babies, and the newborns of depressed mothers had less optimal habituation, orientation, motor, range of state, autonomic stability, and higher depressed scores (Field, 2004). When women have high levels of maternal anxiety, it can be predicted that there will be difficult temperament in the infant (Austin et al., 2005).

From a physical health point of view, women who suffer from physical violence during pregnancy are more likely to not only have injuries (Hedin & Janson,

1999), but also complications related to the pregnancy, including, for instance, a delay of the first prenatal care visit (Taggart & Mattson, 1996), delivery by caesarean, hospitalization before delivery for maternal complications such as kidney infection, trauma due to falls, blows to the abdomen (Cokkinides et al., 1999), and placental abruptions (Connolly, Katz, Bash, McMachon, & Hansen, 1997). This, consequently, puts the infant and mother at increased risk for premature labour (Cokkinides et al., 1999; Rachana, Suraiya, Hisham, Abdulaziz, & Hai, 2002; Shumway et al., 1999), low birth weight (Bullock & McFarlane, 1989; Parker, McFarlane, & Soeken, 1994; Rosen, Seng, Tolman, & Mallinger, 2007), fetal trauma (Rachana et al., 2002; Renker, 1999; Ruiz-Pérez et al., 2004), spontaneous abortions (Hedin & Janson, 1999; Ruiz-Pérez et al., 2004), miscarriages (Hedin & Janson, 1999; Jacoby, Gorenflo, Black, Wunderlich, & Eyler, 1999), fetal injuries, and in some cases, deaths (Bohn, 1990; Ruiz-Pérez et al., 2004; Webster, Chandler, & Battistutta, 1996).

Women who suffer from intimate partner violence during pregnancy could be at risk for unhealthy maternal care habits, such as smoking, drinking, and using drugs (Cokkinides & Coker, 1998; Cokkinides et al., 1999; Grimstad, Schei, Backe, & Jacobson, 1997; Martin, English, Clark, Cilenti, & Kupper, 1996; McFarlane & Parker, 1996; Wiemann, Agurcia, Berenson, Volk, & Rickert, 2000), as well as at increased risk of homicide and suicide.

Although, in general, the research findings on negative outcomes are fairly consistent, contradictory results between studies have been reported. For example, some studies found no association between low birth weight and IPV (Cokkinides et al., 1999; Jasinski, 2004; Shumway et al., 1999). There are also conflicting results on premature labour (Cokkinides et al., 1999; Grimstad et al., 1997). These differences could be due to the lack of control for other variables and/or methodological variation.

Further research needs to be done in order to clarify the prevalence and negative outcomes of IPV during pregnancy (Jasinski, 2004). Identifying risk factors that lead to these outcomes is an important step and, luckily, studies have been conducted with this focus.

1.4. Risk Factors Associated With IPV Toward Pregnant Women

Around the world and mainly in the U.S., research has been done to identify risk factors associated with IPV toward women during pregnancy (Campbell, Poland, Waller, & Ager, 1992; Reichenheim, Ferreira-Patricio, & Leite-Moraes, 2008). However, it appears that in Spain, no such work has been done. In other countries, risk factors have been related to a variety of women's individual characteristics, although some risk factors have also been related to women's partner's characteristics and characteristics of the expecting couple's relationship. However, the key risk factors associated with being the victim of IPV during pregnancy still need to be identified (Jasinski, 2004; Petersen, Saltzman, et al., 1997). These issues need further exploration especially in Spain, since no research with this specific focus has been conducted. Hence, there is a need to identify the risk factors associated with IPV among pregnant women in Spain. Identification of these risk factors will be useful in helping to develop prevention and intervention programs aimed at assisting the victims of IPV (Jasinski, 2004).

Research has shown that a number of risk factors have been associated with IPV in pregnant women. However, there remain some inconsistencies in the findings among these studies. These inconsistencies may be due to the use of different samples and methodologies of measurement. Hence, more research is needed to help further clarify which risk factors may be consistently associated with IPV among pregnant women (Stith et al., 2004). For the purpose of the current study, risk factors that have

been previously identified as being associated with IPV within the literature will be evaluated.

The literature on women's individual characteristics that have been associated with IPV during pregnancy will now be reviewed, including women's age, education, unemployment, alcohol consumption, drug use, history of violence, stress, depression, anxiety, and social support.

1.4.1. Women's Risk Factors

Research has shown that a variety of characteristics about women who are victims of IPV might also be risk factors for IPV among pregnant women including age, level of education, and unemployment. Studies that have analyzed women's age and its association with IPV have shown mixed results. Some studies conducted in the U.S. and Europe report that older women are at higher risk for IPV than younger women (Campbell et al., 1992; Hedin, 2000; Horrigan, Schroeder, & Schaffer, 2000; Reichenheim et al., 2008), while other studies have found no association between these two factors (Amaro, Fried, Cabral, & Zuckerman, 1990; Helton, McFarlane, & Anderson, 1987). Such discrepancies could be based on where the research was carried out. It appears that those studies that concluded that older age is positively associated with IPV have primarily been conducted in Europe, whereas studies that found no association, or that younger women are at higher risk of IPV, were typically from the U.S. However, the majority of research in this area has established that younger pregnant women are more likely to be abused than older pregnant women (Campbell et al., 1992; Cokkinides & Coker, 1998; Cokkinides et al., 1999; Gazmararian et al., 1995; Goodwin et al., 2000; Hedin, Grimstad, Möller, Schei, & Janson, 1999; Hedin & Janson, 2000; Parker et al., 1994; Reichenheim et al., 2008; Stewart & Cecutti, 1993).

Younger pregnant women have reported more IPV than older pregnant women (Hedin et al., 1999; Martin, Mackie, Kupper, Buescher, & Moracco, 2001; Muhajarine & D'Arcy, 1999). This suggests that being young and pregnant may be particularly stressful (Jasinski, 2004) and leave one more likely to be the victim of IPV. Additionally, pregnant women with less than a high school education have been consistently shown to report more experiences of IPV than women with more education (Cokkinides & Coker, 1998; Goodwin et al., 2000; Hedin et al., 1999; Martin et al., 2001; Saltzman, Johnson, Gilbert, & Goodwin, 2003).

Finally, unemployed pregnant women have also been found to be more likely to experience abuse than employed women (Cokkinides & Coker, 1998; Stewart & Cecutti, 1993). Besides these socio-demographic characteristics, research has also focused on analyzing pregnant women's consumption of alcohol and drug use as a possible secondary effect of IPV. Pregnant women's experiences of IPV have been related to alcohol consumption (Campbell et al., 1992; Cokkinides et al., 1999; Curry, 1998; Grimstad et al., 1997; Martin et al., 1996; Parker et al., 1994) and drug use (Berenson, Stiglich, Wilkinson, & Anderson, 1991; Campbell et al., 1992; Parker et al., 1994). Research has shown that abused pregnant women were more likely to be users of alcohol and drugs than non-abused pregnant women (Amaro et al., 1990). For example, Martin et al. (1996) study found that prenatal patients were more likely to smoke, drink, and use drugs during pregnancy when they were also experiencing IPV. Moreover, regardless of the specific dynamics of pregnancy-related violence, most of the research has found that women who were abused while they were pregnant also had a history of victimization (Glander, Moore, Michielutte, & Parsons, 1998; Horrigan et al., 2000; Smikle, Sorem, Stain, & Hankins, 1996). For example, pregnant women who witnessed domestic violence during their childhood and those who had

experienced violence in the year before getting pregnant were more likely to report being the victim of IPV compared to women who had not had a history of experiencing violence (Castro, Peek-Asa, & Ruiz, 2003).

A substantial body of research indicates that women's depression and anxiety are derivate effects of IPV (Karaçam & Ançel, 2007; Nayak & Al-yattama, 1999).

When pregnant women experienced higher levels of IPV, they were more likely to have a history of depression, report more depressive symptoms at the time of pregnancy (Amaro et al., 1990; Campbell et al., 1992), and have been diagnosed with severe depression (Horrigan et al., 2000). Similar results have been found with women's experiences of anxiety and IPV (Campbell et al., 1992). Abused pregnant women also reported having less social support available to them than non-abused women (Glander et al., 1998; Wiemann et al., 2000). Abused pregnant women tend to receive less support from their partners and others (Curry & Harvey, 1998; Muhajarine & D'Arcy, 1999; Reichenheim et al., 2008).

Based on this review of the literature exploring factors associated with being the victim of IPV during pregnancy, it appears as though several risk factors are related to women being more likely to experience IPV. These factors include women's age, level of education, unemployment, alcohol consumption, drug use, history of violence, stress, depression, anxiety, and low social support. However, more research needs to be done to further clarify these relations in populations outside of the U.S. and particularly in Spain.

1.4.2. Partner's Risk Factors

The characteristics of pregnant women's partners that have been identified as being associated with IPV include men's age, education, unemployment, alcohol cunsumption, and drug use. Regarding men's age as a potential risk factor, in a study

conducted in Sweden, younger men and those with less education have been found to be more likely to perpetrate abuse towards their pregnant partners (Hedin et al., 1999). This same relation has been found with men's employment status, where unemployed men were more likely to perpetrate IPV against their pregnant partners (Leung, Leung, Lam, & Ho, 1999).

Additionally, Tilley and Brackley (2004) found that male partners who consumed alcohol were more likely to perpetrate IPV. According to previous studies conducted in Sweden and Canada, pregnant women who had partners with drinking problems were 3.4 times more likely to have been abused than women with partners who did not have drinking problems (Hedin & Janson, 2000; Muhajarine & D'Arcy, 1999). Regarding drug use, abused pregnant women were also more likely to have a partner who used drugs (Reichenheim et al., 2008). Overall, research seems to support that the more abuse a woman experiences in her relationship, the more likely her partner is to abuse drugs and alcohol both before and during pregnancy (Cokkinides & Coker, 1998).

In general, research shows that certain characteristics of male partners, including age, education, unemployment, alcohol consumption, and drug use, may indeed be risk factors associated with pregnant women's experiences of IPV. However, since the majority of the research has been done in the U.S, it is necessary to conduct more research in Europe and abroad in order to evaluate whether characteristics of male partners may put women at increased risk of experiencing IPV during pregnancy, especially in Spain where there appears to be no research aimed at examining IPV that occurs during pregnancy.

1.4.3. Relationship's Risk Factors

There are also characteristics of the couple's relationship that have been associated to IPV during pregnancy, such as low income, overall quality of the relationship, jealousy problems, the level of commitment, and having a history of violence in the relationship. Pregnant women with a low-income seem to be particularly vulnerable to experiencing IPV (Cokkinides & Coker, 1998; Martin et al., 2001; Tolman & Rosen, 2001). When comparing abused and non-abused women, abused women tend to have incomes that are lower (Hedin & Janson, 2000). Additionally, low levels of couple satisfaction have been associated with increased reports of IPV. Research also suggests that jealousy toward the unborn child, typically stemming from the male partner, could put the couple at risk for experiencing IPV (Campbell, Oliver, & Bullock, 1993). It has been speculated that perhaps men who tend to accuse their partners of infidelity may feel jealous of the unborn child and could potentially be questioning their paternity (Burch & Gallup, 2004). Having a history of violence in the current relationship before pregnancy may also put couples at risk of experiencing IPV during pregnancy (Martin et al., 1996; Martin et al., 2001; Saltzman et al., 2003). Ninety-five percent of Swedish women abused during pregnancy had been abused prior to the pregnancy (Hedin & Janson, 2000). Finally, in regards to dyadic commitment, studies in Sweden and the U.S. have shown that unmarried/cohabiting pregnant women are more likely to be the victims of IPV than married pregnant women (Hedin & Janson, 2000; Cokkinides et al., 1999; Goodwin et al., 2000; Martin et al., 2001; Parker et al., 1994; Saltzman et al., 2003).

Overall, research has shown that a variety of couple characteristics, including low income, relationship quality, jealousy problems, the level of commitment (i.e., cohabitation), and having a history of violence in the relationship, may indeed be risk

factors associated with pregnant women's experiences of IPV. The majority of these studies are from the U.S., therefore, additional research needs to be done in other countries in order to further evaluate whether couple characteristics may put women at increased risk of experiencing IPV during pregnancy. Research like this is especially needed in Spain, where there appears to be no research on violence that occurs during pregnancy.

In general, research has shown that a variety of risk factors have been associated with IPV in pregnant women. Further research needs to be done on female victims of IPV during pregnancy in order to elucidate the many unanswered questions concerning prevalence and negative outcomes and risk factors of women victimization of IPV (Jasinski, 2004).

1.4.4. Pregnancy as a Risk Factor

The pregnancy has been also analyzed as a possible factor associated with increased levels of IPV. Research has been done to identify the role that women's pregnancy status plays in these relationships (Jasinski, 2004; Gelles, 1990). Global research, especially work done in the U.S., has demonstrated a relation between pregnancy status and IPV, although this research has focused on comparing primarily experiences of IPV reported by women before and during pregnancy based on small hospital/clinic samples. These studies suggest that women abused before pregnancy tend to be abused during pregnancy. Only a few studies have directly compared the prevalence of IPV in pregnant and non-pregnant women within community samples. These studies showed that pregnant women are less likely to be victims of IPV than non-pregnant women. These contradictions between the studies may be due to the use of different definitions of violence and methodologies. For example, some studies may have focused on pregnant women from clinical versus community samples; other

studies may have made comparisons between pregnant women and non-pregnant women who otherwise might have kids (Jasinski, 2004). Other studies have used a variety of procedures (Jasinski, 2004; Petersen, Gazmararian, et al., 1997; Petersen, Saltzman, et al., 1997). For example, the time of data collection often varied; some asked women to report on their experience while being pregnant, while other asked them to retrospectively recall experiences that they had during pregnancy. These differences make it difficult to compare and contrast studies (Jasinski, 2004; Petersen, Gazmararian, et al., 1997; Petersen, Saltzman, et al., 1997).

Studies analyzing the relation between pregnancy status and IPV that do not use control groups may not be able to identify the variety of roles that pregnancy status may play regarding putting women at risk of experiencing IPV. For example, in some cases, pregnancy has been shown to act as a buffer, where IPV has stopped or decreased during pregnancy (Martin et al., 1996; Saltzman et al., 2003). In other studies pregnancy has been identified as a neutral factor, where violence was maintained during pregnancy (Hedin & Janson, 2000). And finally, pregnancy has been identified as a risk factor, where pregnancy status is reported to potentially put women at risk of experiencing more IPV, or experiencing IPV for the first time (Burch & Gallup, 2004; Garcia-Linares et al., 2005). Therefore, only studies that use pregnant and non-pregnant women have the ability to capture this range of possible relations.

Studies have suggested that pregnancy may make women less likely to be the victims of violence. Research has shown that, during pregnancy violence may stop. Studies from developing and industrialized countries have showed that pregnancy may be a period of time characterized by lower levels of IPV (Campbell, Garcia-Moreno, & Sharps, 2004). Additionally, in another cross-cultural study, the majority

of women reported that violence during pregnancy was less severe or frequent than before the pregnancy (Martin et al., 2001; Silverman, Decker, Reed, & Raj, 2006; WHO, 2005). For example, across 16 states in the U.S., 7.2% of women reported experiencing IPV before pregnancy and 5.3% during pregnancy, which shows a marked decrease (Saltzman et al., 2003). Some studies showed that, during pregnancy, experiences of victimization may stop almost completely (Campbell, Oliver, & Bullock, 1998; Campbell, Pugh, Campbell, & Visscher, 1995). For example, Martin et al. (1996) found that 23% of women experienced violence only before pregnancy. Also, research has shown that violence typically does not start within a relationship during pregnancy (Castro et al., 2003).

Pregnancy status has also been shown to be unrelated to experiences of IPV. Some research has indicated that 2% of women experienced IPV both before and during pregnancy (Martin et al., 1996). In addition, international studies have demonstrated that for the majority of the women the same frequency and severity of IPV were present before and during pregnancy (Martin et al., 2004; WHO, 2005). In other words, experiences of IPV did not seem to change with pregnancy, but instead remained the same during pregnancy (Hedin et al., 1999). For example, Hedin and Janson (2000) found that 95% percent of Swedish women who were abused during pregnancy had also been abused prior to the pregnancy.

In contrast to this research, pregnancy has been shown to be a risk factor associated with IPV. These studies show that the pregnancy may increase the likelihood that violence may occur (Berenson et al., 1991; Burch & Gallup, 2004; Campbell et al., 1992; Campbell et al., 1995; Evins & Chescheir, 1996; Gelles, 1974; Stewart & Cecutti, 1993; Taggart & Mattson, 1996; Tilley & Brackley, 2004; Webster, Sweett, & Stolz, 1994). Indeed, pregnant women have been reported to be at

high risk of experiencing IPV and homicide (Shadigian & Bauer, 2004). In another study, women who were the victims of IPV were twice as likely to experience abuse when they were pregnant (Burch & Gallup, 2004). A cross-cultural study showed that in some countries, between 13% and 50% of women were beaten for the first time during pregnancy (WHO, 2005). In Spain 9.3% abused women reported that violence began during pregnancy (Garcia-Linares et al., 2005).

Although these studies without control groups have provided some insight towards what could be going on over the periods of time before and during pregnancy, none were focused specifically on the question of whether pregnancy was associated with experiences of IPV (e.g., negatives outcomes, victimization screening). Rather, these studies were based on databases where women were generally asked if, over the last 12 months, they had been abused, and if they were pregnant, or had a baby. Also, studies that used a control group of non-pregnant women often included women that may have had kids. There is only one study that had two waves where women were asked about abuse currently and five years later, but the database that this study used was not originally collected to evaluate IPV (Jasinski, 2004). Despite these limitations, few studies have explored the relation between pregnancy and IPV by directly comparing pregnant and non-pregnant women. Thus, it is unknown whether pregnant women are more or less likely to be the victim of IPV compared to non-pregnant women (Gelles, 1990; Jasinski, 2004).

Overall, research seems to suggest that women who were abused before pregnancy tend to be abused during pregnancy as well. Only a few studies have shown that pregnant women are less likely to be a victim of IPV than non-pregnant women. Based on the limitations of the research conducted in this area, more studies need to be designed to include both pregnant women and non-pregnant women to

serve as controls (Jasinski, 2004). There is a large need for work like this to be done in Spain, especially because there appears to be no other studies that have explored the relation between pregnancy and IPV. Thus, there is a need to analyze whether pregnancy status in Spanish women is associated with increased victimization of IPV. Moreover, there is a need to evaluate how pregnancy status interacts with other risk factors to predict IPV. It seems as though no other research has specifically analyzed whether levels of various risk factors may interact with pregnancy status to make women more or less likely to experience IPV. In addition, studies have not consistently found direct links between pregnancy status and IPV. Therefore, other variables may play a role in this relationship. Indeed, Jasinski (2004) has suggested that perhaps this relationship may depend on the presence of other factors. Hence, it will be important to evaluate the interaction between pregnancy status and these other factors in order to accurately predict IPV.

1.5. Goals for the Study

This study focuses on evaluating women's experiences as victims of IPV in Spain. It is important to further our understanding of the social and health problems and risk factors that are associated with IPV in order to further develop effective prevention and intervention programs.

This study specifically evaluates pregnant women expecting their first child. As discussed, studies focused on pregnancy and violence often include women who may be pregnant with their first child in the same group as women who have already had previous births. Moreover, research supports the notion that women who are at their reproductive age may be at greatest risk for experiencing IPV (Greenfeld et al., 1998). Additionally, couples expecting their first child may feel more stress than couples that have already had children (Jasinski, 2001). Changes of social roles, such

as the transition to parenthood, are associated with stress, which could also increase the risk of violence in a relationship (Curry & Harvey, 1998; Lavee, McCubbin, & Olson, 1987; Pearlin, Lieberman, Menaghan, & Mullan, 1981). The women are facing more difficulties at their workplace; therefore they tend to be worried about discriminization due to their condition and the possibility of losing their jobs. Additionally, women suffer from the symptoms of pregnancy, such as nausea. As a result, women could end up feeling burned out as they are unable to relieve their stress. Couples who are expecting their first child have greater expenses, they have to make more decisions together, their sexual activity decreases, and they tend to be worried about the pregnancy development and the upcoming delivery.

The first pregnancy in particular tends to have a profound negative impact on the couple. The transition to parenthood is associated with multiple marital difficulties that may be part of the cascade toward divorce (Shapiro & Gottman, 2005), with marital quality decreasing precipitously for up to 67% of couples in the first year of the infant's life (Shapiro et al., 2000). Thus, the difficulties of the transition to parenthood may be associated with higher risk for IPV during pregnancy with the first child. Some research has been done analyzing having a baby and violence, and they constantly imply that the birth of a child could be a time of violence cessation (Campbell et al., 1993; Jasinski, 2001).

However, it looks as though no studies have been conducted that analyze pregnancy with the first child and women being victims of IPV. The present study aimed to expand the research in this field by analyzing the frequency of women's victimization due to IPV during pregnancy with the first child, while on the cusp of the transition to parenthood and identifying whether pregnant women are at higher risk for victimization or not.

Based on the lack of research done in this area within Spain (Instituto de la Mujer, 1999; Raya Ortega et al., 2004; Vives et al., 2003), the current work aimed to achieve the following:

1) Analyze the relation between IPV and a variety of risk factors commonly associated with IPV in a sample of Spanish women.
2) Compare potential differences in women's experiences of IPV and risk factors commonly associated with IPV across pregnant versus non-pregnant women from Spain.
3) Evaluate potential interactions between the risk factors commonly associated with IPV and women's pregnancy status.

1.6. Hypothesis

Based on the wealth of research exploring the relationship between IPV, associated risk factors, and women's pregnancy status, the following was hypothesized:

H1: Risk factors that are commonly associated with IPV among women around the world will also be associated with IPV in Spanish women. Specifically, a series of women's individual characteristics, women's partner's characteristics, and characteristics of the couple's relationship are expected to be correlated with IPV, as supported by previous research on theses factors.

H2: Spanish women who are pregnant will experience less IPV and a lower frequency of risk factors of IPV than non-pregnant women.

H3: Pregnancy status and risk factors associated with IPV will interact to predict IPV. Specifically, Spanish women who are pregnant with their first child will experience more IPV when they also report higher levels of risk factors in their lives.

2. METHODS

2.1. Participants

Participants for this study were n=232 women who were recruited through public and private centres that provide services to women located in the greater Bilbao area. These services were primarily gynaecological check-ups, prenatal care visits, podiatrist visits, and language, painting, exercise, and birth preparation classes. Participants completed an anonymous survey that was made available at the service centres. All women met the following eligibility criteria: between 18 and 45 years old, Spanish nationality, without children (biological or non-biological), living with their current male partner for at least one year (married or unmarried), and able to read in Spanish. One hundred and fifty-five of the women in the sample were pregnant with their first child for at least six months at the time of the study and 77 women were not pregnant.

The majority of non-pregnant participants in the study (n=75) were from the regional council of Biscay, although a small number (n=2) were from other regional councils of Spain. Women were, on average, 32.19 years old (SD= 4.69). Women were in relationships with their current partners for an average of 99.44 months (SD= 64.06) or 8.29 years and reported living with their partners for 46.86 months (SD= 41.92) or 3.91 years, on average. A majority of the non-pregnant participants were non-married (44.2%), while 19.5% were engaged and 36.4% were married for an average of 19.40 months (SD= 39.77) or 1.62 years. More than half of the women (53.2%) had obtained a B.A. or B.S., 15.6% reported professional training and 15.6% completed graduate degrees. The rest of the women's education ranged from having completed first grade to some college work. Regarding employment, 73.7% indicated that they were full-time employees, 9.2% were self-employed, 7.9% were employed

part-time, and 6.6% were unemployed. The rest of the women were either part-time working students or retired. The median household gross income was between 42.001€ and 48.000€ *($56,001 and $64,000).* Women reported income in euros but for the purpose of the present study, euros were converted into American dollars; both euros and American dollars will be reported.

The majority of pregnant participants in the study (n=146) were from the regional council of Biscay, although a small number (n=9) were from other regional councils of Spain. The mean age of participants was 33.06 years old (SD= 3.40). Participants mean length of their current relationship was 123.58 months (SD= 49.25) or 10.30 years and reported living with their partners for 49.06 months (SD= 27.33) or 4.09 years, on average. Most of the participants were married (87.1%) for an average of 30.55 months (SD= 24.07) or 2.55 years, 10.3% were non-married, and 2.6% engaged. Nearly half of the women (46.5%) had obtained a B.A. or B.S., 21.9% reported professional training, and 14.8% completed a graduate degree. The rest of the women's education ranged from having completed eighth grade to some college work. Regarding employment, 69.7% indicated that they were full-time employees, 11.6% were unemployed, and 7.1% were self-employed. The rest of the women were either part-time working students or homemakers. The median household gross income was between 42.001€ and 48.000€ *($56,001 and $64,000).*

Independent samples t-tests that assumed unequal variances due to the nature of the data were conducted comparing all of the demographic variables of interest in this research for pregnant and non-pregnant women. The results showed that significant differences between pregnant and non-pregnant women only existed for the following variables: pregnant women had significantly longer relationships ($t(122.26) = 2.91$, p =.00) and the married ones were married longer ($t(104.47) = 2.26$,

p =.03) than non-pregnant women. For means and standard deviations, see Table 1, and for frequency of categorical variables, see Table 2.

Table 1: *Means and Standard Deviations for all Variables*

	Mean	S.D.	Mean	S.D.	Mean	S.D.
Variable	Pregnant		Non-pregnant		Pregnant & non-pregnant	
IPV in the last 12 months	1.34	3.32	2.97	5.17	1.88	4.09
Minor psychological aggression	1.26	3.11	2.47	4.47	1.66	3.65
Severe psychological aggression	.01	.11	.09	.52	.04	.31
Minor physical assault	.01	.08	.05	.28	.02	.17
Severe physical assault	.00	.00	.00	.00	.00	.00
Minor injury	.00	.00	.03	.16	.01	.09
Severe injury	.00	.00	.00	.00	.00	.00
Minor sexual coercion	.08	.44	.33	1.39	.16	.88
Severe sexual coercion	.00	.00	.00	.00	.00	.00
IPV before the last 12 months	.14	.74	.04	.20	.10	.61
Age	33.06	3.40	32.19	4.69	32.77	3.89
Report of partner age	35.02	3.89	33.75	5.04	34.60	4.33
Education	14.06	1.87	14.17	2.26	14.09	2.00
Report of partner education	13.10	2.48	13.78	2.47	13.33	2.49
Unemployment	.12	.32	.07	.25	.10	.30
Partner unemployment	.00	.00	.04	.195	.01	.11
Exposed to father physically abusing mother	.17	1.11	1.08	4.87	.47	2.96
Exposed to mother physically abusing father	.09	.97	.05	.46	.08	.84
Injured by parents	.54	3.51	.70	3.15	.59	3.39
Physically abused by parents or adults	.74	2.72	1.79	5.29	1.09	3.79

Table 1: *Means and Standard Deviations for all Variables (continued)*

	Mean	S.D.	Mean	S.D.	Mean	S.D.
Variable	Pregnant		Non-pregnant		Pregnant & non-pregnant	
Physically abused or injured by ex-partners before 18	.16	2.01	.06	.47	.13	1.66
Physically abused or injured by ex-partners after 18	.05	.37	.09	.49	.06	.41
Sexually abused before 18	.52	2.00	.32	.99	.46	1.73
Sexually abused after 18	.03	.17	.09	.52	.05	.34
Alcohol consumption	.29	.70	.72	1.17	.44	.91
Report of partner alcohol consumption	.48	1.03	.69	1.09	.55	1.06
Drug use	.15	.45	.48	.87	.26	.64
Report of partner drug use	.31	.61	.60	1.04	.41	.79
Depression	4.29	3.44	4.32	2.26	4.30	3.72
Anxiety	65.54	14.83	74.01	18.57	68.42	16.65
Social support satisfaction	3.86	.85	3.49	1.06	3.74	.94
Couple income	8.16	3.37	7.69	3.09	8.01	3.28
Dyadic adjustment	126.84	10.45	122.25	13.73	125.38	11.76
Jealousy	.36	.61	.74	.98	.49	.77
Dyadic commitment	1.77	.62	.92	.90	1.49	.83
Relationship duration	123.58	49.25	99.44	64.06	115.54	55.67
Duration living together	49.06	27.33	46.86	41.92	48.33	32.82
Duration married	30.55	24.07	19.40	39.77	26.85	30.57

N = 155 pregnant women, 77 non-pregnant women, 232 total women

Table 2: *Frequency of Categorical Variables*

	Pregnant	Non-pregnant	Pregnant & non-pregnant
Regional council			
Biscay	94.2%	97.3%	95.2%
Guipúzcoa	0.6%	0%	0.4%
Cantabria	3.9%	1.3%	3.1%
Burgos	0.6%	0%	0.4%
Cataluña	0%	97.3%	0.4%
Canaria Island	0.6%	0%	0.4%
Total	100.0%	100.0%	100.0%
Dyadic commitment			
Non-married, non-engaged	10.3%	44.2%	21.6%
Engaged	2.6%	19.5%	8.2%
Married	87.1%	36.4%	70.3%
Total	100.0%	100.0%	100.0%
Women education			
1	0%	1.3%	0.4%
8 or 2 ESO	3.9%	2.6%	3.4%
9 or 1 BUP or 3 ESO	1.3%	0%	0.9%
10 or 2 BUP or 4 ESO	0%	2.6%	0.9%
11 or 3 BUP or 1 BA	3.2%	1.3%	2.6%
12 or COU or 2 BA	4.5%	2.6%	3.9%
Professional training FP	21.9%	15.6%	19.8%
Some college work	3.9%	5.2%	4.3%
BA or BS (diplomatura & licenciatura)	46.5%	53.2%	48.7%
Graduate degree (MA, MD, PhD)	14.8%	15.6%	15.1%
Total	100.0%	100.0%	100.0%

Table 2: *Frequency of Categorical Variables (continued)*

	Pregnant	Non-pregnant	Pregnant & non-pregnant
Women occupation			
Work full-time (40 hours per week)	69.7%	73.7%	71.0%
Work part-time (20 hours per week)	6.5%	7.9%	6.9%
Self-employed	7.1%	9.2%	7.8%
Homemaker	3.9%	0%	2.6%
Student (20 hours per week) and work (20 hours per week)	1.3%	1.3%	1.3%
Without work	0%	6.6%	0%
Unemployed	11.6%	0%	10.0%
Retired	0%	1.3%	0.4%
Total	100.0%	100.0%	100.0%

Table 2: *Frequency of Categorical Variables (continued)*

	Pregnant	Non-pregnant	Pregnant & non-pregnant
Couple annual income with taxes			
No income	0%	0%	0%
Less than 6.000€	0%	0%	0%
6.000€ to 12.000€	0%	1.4%	0.5%
12.001€ to 18.000€	6.1%	4.2%	5.5%
18.001€ to 24.000€	6.1%	6.9%	6.4%
24.001€ to 30.000€	10.8%	12.5%	11.4%
30.001€ to 36.000€	13.5%	11.1%	12.7%
36.001€ to 42.000€	10.1%	12.5%	10.9%
42.001€ to 48.000€	12.8%	16.7%	14.1%
48.001€ to 54.000€	8.1%	11.1%	9.1%
54.001€ to 60.000€	9.5%	8.3%	9.1%
60.001€ to 66.000€	9.5%	6.9%	8.6%
66.001€ to 74.000€	2.7%	5.6%	3.6%
74.001€ to 78.000€	2.7%	0%	1.8%
78.001€ to 84.000€	3.4%	1.4%	2.7%
84.001€ to 90.000€	1.4%	0%	0.9%
90.001€ to 96.000€	1.4%	0%	0.9%
96.001€ to 102.000€	0.7%	0%	0.5%
102.001€ to 108.000€	0.7%	0%	0.5%
108.001€ to 114.000€	0.7%	0%	0.5%
114.001€ to 120.000€	0%	0%	0%
120.001€ to 126.000€	0%	0%	0%
More than 126.000€	0%	1.4%	0.5%
Total	100%	100%	100%

N = 155 pregnant women, 77 non-pregnant women, 232 total women

2.2. Procedures

Participants were recruited by professionals from the centres (excluding those who provided psychological and/or psychiatric services), and through advertisement fliers posted at the reception areas at service centres. Participants were given a survey packet by research team members and by professional staff at the service centres. Potential participants could also participate in the study by picking up a survey packet from reception areas at service centres that posted the basic eligibility criteria for participating in the study. The survey packet consisted of an envelope, which contained a packet of questionnaires, an information statement, and a thank you note with a resource list consisting of agencies and centres that could provide assistance for issues such as anxiety or depression (e.g., the non-governmental organization Acción Familiar Vizcaina provides free psychological assistance), domestic violence and emergencies (see Appendix I).

To ensure confidentiality, all participants were asked not to give any identifying information, such as their name and address. They were provided with an Information Statement informing participants that their participation in the study was completely voluntary and that some of the questions were about intimate partner violence. Participants were encouraged to fill out the questionnaires alone and in a safe place. In rare cases when men were present, women were not informed that some of the questions were about intimate partner violence due to safety issues, but were told that the survey contained all types of questions, some of them referring to possible difficulties and conflicts in the relationship. After participants agreed to participate and underwent the process of informed consent, they filled out a battery of questionnaires. Women who agreed to participate were asked to put completed surveys into a sealed envelope and return the completed survey to the professional

staff, a research team member, or to the reception desk. The questionnaire packet took participants approximately 45 minutes to complete. These self-report packets asked questions about the women's experiences and their perceptions of their partner's experiences in the relationship. Intimate Partner Violence (IPV), jealousy, anxiety, depression, alcohol consumption, and drug use were also assessed. Some basic demographic data was also collected, such as age, education, occupation, gross household income, and a variety of relationship measures.

2.3. Measures

2.3.1. Intimate Partner Violence (IPV)

2.3.1.1. Revised Conflict Tactics Scale (short form) (CTS2S)

The CTS2S (Straus & Douglas, 2004) was used to assess women's experiences of being the victim of intimate partner violence (IPV). Women's reports of men's violent behaviours were gathered, since men have a tendency to underreport (Dobash, Dobash, Cavanagh, & Leis, 1998). Specifically, the frequency of IPV experienced by women over last 12 months was measured as the main variable of interest in the current study. In addition, the CTS2S was used to measure the prevalence of violence along with the prevalence and frequency of each type of IPV that occurred over last 12 months in their current relationship. Frequency of IPV reported was used to test the hypotheses proposed in this study, while the types of IPV were primarily used to provide more detailed description of the study sample.

The CTS2S consists of 20 items and measures IPV in the previous 12 months, with higher scores indicating more frequent experiences of IPV. It also provides specific information about the types of violence experienced in relationships such as: psychological aggression, physical assault, injury, and sexual coercion. Each type of violence is also separated into minor and severe forms of violence. The present study

used the following 8 items: minor psychological aggression (My partner insulted or swore or shouted or yelled at me), severe psychological aggression (My partner destroyed something belonging to me or threatened to hit me), minor physical assault (My partner pushed, shoved, or slapped me), severe physical assault (My partner punched or kicked or beat-me-up), minor injury (I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner), severe injury (I went see a doctor [M.D.] or needed to see a doctor because of a fight with my partner), minor sexual coercion (My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force)), and severe sexual coercion (My partner used force (like hitting, holding down, or using a weapon) to make me have sex)).

Participants were presented with statements about IPV and were asked to respond by selecting how often those experiences had occurred in their current relationship. Response options were as follows: this has never happened, once in the last 12 months, twice in the last 12 months, 3-5 times in the last 12 months, 6-10 times in the last 12 months, 11-20 times in the last 12 months, more than 20 times in the last 12 months, and not in the last 12 months but it did happen before (Straus & Douglas, 2004).

As recommended by Straus the annual prevalence for each type of violence was computed by assuming midpoints in the response categories (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Therefore the scores for each type of violence ranged from 0 (none frequency of each type of violence) to 25 (the highest frequency of each violence type). Additionally due to the positive correlations among all IPV variables, see Table 3, the frequency of IPV experienced by women in the last 12

months was scored by summing the scores for each type of violence described above ranging from 0 (no violence) to 200 (the highest amount of IPV).

The prevalence of IPV and each type of IPV experienced in the last 12 months was measured dichotomously; participants that reported at least one or more instances of each type of violence were given a score of one, while women who did not report any instances of violence were given a score of zero (Straus et al., 1996; Straus & Douglas, 2004).

The revised conflict tactics scale long form (CTS2) is frequently used for measuring intimate partner violence and is very suitable for cross-cultural applications (Straus, 2004), since this form is the most commonly used one to assess violence in intimate partner relationships (Calvete, Corral, et al., 2007), and has high internal consistency: psychological aggression (α= .79), physical assault (α= .86), sexual coercion (α= .87), and injury (α= .95) (Straus et al., 1996). Furthermore, additional versions of the CTS2 have been established (Straus, 2004; Straus & Douglas, 2004), including the Spanish version (Calvete, Corral, et al., 2007). In the Spanish version, the five scales for victimization showed strong internal consistency with alpha coefficients ranging from .80 to .94. There was also adequate discrimination between women who filled out the questionnaire who were obtaining services related to IPV victimization and those who were not (Calvete, Corral, et al., 2007).

However, some research has focused on comparing the long and short forms of violence measurements and concluded that in general, measurements on the short form were correlated with measurements on the long form, and occasionally performed better (Nelson, Nygren, McInerney, & Klein, 2004). Therefore, the CTS2S is comparable in validity to the CTS2. The four violence types used in the Spanish version of the CTS2 were highly correlated with the scales from the original CTS2:

physical assault (r=.69), injury (r=.94), sexual coercion (r=.67), and psychological aggression (r=.69). However, the prevalence rates of the CTS2S are lower; the CTS2 prevalence rate ranged from 20% to almost double that of the CTS2S (Straus & Douglas, 2004). Despite this limitation, the CTS2S was used in this study as a result of feedback provided by women and professional staff during a pilot study. In this pilot study, when the CTS2 was administered, women reported feeling defensive and alarmed by the number of questions asking about violence in their relationship. Therefore, professional staff assisting with the study requested a shorter version of the questionnaire. Additionally, it was observed that some women had a tendency to answer all the questions by circling all zeros, which could suggest that they were not reading each question carefully. Due to these limitations, it was considered more appropriate and valid to use the short form.

The Spanish version was created by back-translation a technique that ensures that the translation and the original have the same meaning. It consists of translating a document that has already been translated into a foreign language back to the original language, preferably by an independent translator, and then comparing the two versions. The translation was pilot tested with bilingual persons and women with and without the eligibility criteria.

In order to determine how experiences of IPV may have changed before and during pregnancy, an additional question was added to the standard CTS2S. The additional question was; "Specify, if this behaviour happened during the pregnancy?" with the following choices as options: "started, increased, maintained, reduced, or never happened".

2.3.2. Risk Factors Associated With IPV

2.3.2.1. Age of Women and Their Partners

Age was calculated based on two dates, the birth date and the date the questionnaire packet was filled out. In a few cases, when the respondent did not fill in the birth month, January was entered. When the questionnaire date was not filled out, the date it was received was entered. Age was calculated by subtracting the birth date from the current date.

2.3.2.2. Education Level of Women and Their Partners

Questions that assessed education level contained sixteen response options that were coded as follow: no studies (0), 1 *(1º EGB or 1º primaria)* (1), 2 *(2º EGB or 2º primaria)* (2), 3 *(3º EGB or 3º primaria)* (3), 4 *(4º EGB or 4º primaria)* (4), 5 *(5º EGB or 5º primaria)* (5), 6 *(6º EGB or 6º primaria)* (6), 7 *(7º EGB or 1º ESO)* (7), 8 *(8º EGB or 2º ESO)* (8), 9 *(1º BUP or 3º ESO)* (9), 10 *(2º BUP or 4 ESO)* (10), 11 *(3º BUP or 1º bachillerato)* (11), 12 *(COU or 2º bachillerato)* (12), 13 professional training *(formación profesional)* (13), 14 some college work *(estudios universitarios no terminados: licenciatura, diplomatura)* (14), 15 complete college (BA, BS) *(Diplomatura, Licenciatura)* (15), 16 graduate degree (*estudios de postgrado: master , doctorado*) (16).

2.3.2.3. Unemployment of Women and Their Partners

Dichotomous variables recoded as employed (0), unemployed (1). The women were asked to indicate their occupation using one of the following response options: work full-time, work part-time, self-employed, student (20 hours per week) and work (20 hours per week), which were considered employment; the following responses were considered unemployed: homemaker, student full-time, disabled, and retired.

2.3.2.4. Women's History of Violence

History of Women's Victimization During Their Lifetime:

This questionnaire was created for this study and is based on the Briere (1992) measurements and Gottman's domestic violence screening tool. This questionnaire consisted of 12 items about women's experiences with being the victim of violence before and after age 18. Eight individual history of violence variables were created from the questionnaire by collapsing items when significant positive correlations appeared between them (women exposed to father physically abusing mother before 18 and women exposed to father physically abusing mother since 18 (r=.62, p<.01); women exposed to mother physically abusing father before 18 and women exposed to mother physically abusing father since 18 (r=.86, p<.01); injured by parents before 18 and injured by parents since 18 (r=.74, p<.01); and physically abused by parents or adults before 18 and physically abused by parents or adults since 18 (r=.32, p<.01)). As presented above, these eight history of violence variables were assigned the following names: 1) exposed to father physically abusing mother, 2) exposed to mother physically abusing father, 3) injured by parents, 4) physically abused by parents or adults, 5) physically abused or injured by ex-partners before 18, 6) physically abused or injured by ex-partners after 18, 7) sexually abused before 18, and 8) sexually abused after 18.

The questions assessed the frequencies of the following: 1) women exposed to father physically abusing mother before 18; 2) since 18 (both questions 1 and 2 were computed as one variable); 3) women exposed to mother physically abusing father before 18; 4) since 18 (both questions 3 and 4 were computed as one variable); 5) injured by parents before 18; 6) since 18 (both questions 5 and 6 were computed as one variable); 7) physically abused by parents or adults before 18; 8) since 18, (both

questions 7 and 8 were computed as one variable); 9) physically abused or injured by ex-partners before 18; 10) physically abused or injured by ex-partners since 18; 11) sexually abused before 18; and 12) sexually abused since 18. Following the CTS2S, the frequency of each history of violence question was reported via the following answer choices: 0 (this has never happened), 1 (once), 2 (twice), 3 (3-5 times), 4 (6-10 times), 5 (11-20 times), and 6 (more than 20). Also following the lead of Straus' CTS2S, scoring responses were then recoded as follows: 3 (3-5 times in the last 12 months) = 4, 4 (6-10 times in the last 12 months) = 8, 5 (11-20 times in the last 12 months) = 15, and 6 (more than 20 times in the last 12 months) = 25.

The ranges for each of the eight individual history of violence variables were: exposed to father physically abusing mother before and since 18 (0-50), exposed to mother physically abusing father before and since 18 (0-50), injured by parents before and since 18 (0-50), physically abused by parents or adults before and since 18 (0-50), physically abused or injured by ex-partners before 18 (0-25), physically abused or injured by ex-partners after 18 (0–25), sexually abused before 18 (0–25), and sexually abused after 18 (0–25). For all the variables, a positive response was represented with a high numerical value indicating more victimization, whereas negative responses were represented with low numerical values indicating less victimization.

History of Women Victimization in the Current Relationship

In addition, the frequency of IPV experienced by the participants prior to the previous 12 months was measured using the CTS2S (Straus & Douglas, 2004). The range for frequency of IPV before last 12 months was 0-8, where a higher score indicated more victimization in the women's past, whereas lower scores indicated lower occurrences of victimization in the past.

2.3.2.5. Alcohol Consumption of Women and Their Partners. Short Michigan Alcoholism Screening Test (SMAST-13)

The SMAST-13 (Selzer, Vinojur, & Van Rooijen, 1975) detects alcoholism by assessing the extent of problems related to alcohol use. The SMAST-13 consists of 13 items that can be summed to create a total score measuring problems with alcoholism. An example item is: Do you feel that you are a normal drinker? (By normal drinker, we mean some body who drinks less than or as much as most other people). The option responses and scoring are yes = 1 and no = 0 for 10 of the items, but for the item numbers 1, 4 and 5, scoring is yes = 0 or no = 1. The scores range from 0 (least severe score) to 13 (most severe score), and the cut-off for alcoholism is 3 (Selzer et al., 1975).

The SMAST-13 is a frequently used screening measure with good psychometric properties. The validity and reliability from the short version appear to be as effective as the long version in screening alcoholism. The SMAST-13 has been shown to be higly correlated with the SMAST-25 (r= .97), suggesting that these 13 items and the 25 items are equally effective in measuring the presence of alcoholism. The SMAST-13 has good internal reliability (α= .93). Additionally, the SMAST-13 correlates with clinical diagnoses of alcoholism, with Pearson correlation coefficients ranging from .83 to .94, showing strong validity of this measure (Selzer et al., 1975). However, Fleming and Barry (1988) examined the psychometric properties of the SMAST-13 and suggested that epidemiological studies that have used the SMAST-13 to estimate the prevalence of alcohol problems among family members of alcoholics might need to reconsider their findings because they acquired more false positives due to the wording used on items. Additionally, Escobar et al. (1994) did not recommend the use of the SMAST-13 for diagnosing alcoholism within primary care because it

was a test with moderate sensitivity for screening purposes. Despite these findings that seem to question the detection of alcoholism of the SMAST-13, it was used in this study for two reasons. First, the primary goal of this study was not about assessing the prevalence of alcoholism; it was more focused on analyzing the impact of alcohol consumption as it related to the relationship. Second, this study used the DAST-10 to assess the extent of the problems related to drug misuse and the DAST was created as a parallel screening test of the MAST (Skinner, 1982). Both measurements assess the extent of problems related to substance misuse.

In order to assess women's partners' alcohol consumption, a parallel question was added to each standard question in the SMAST-13 asking the women to report about their partners. It was scored and recoded the same as women's alcohol consumption mentioned above. The Spanish version was created using back-translation. The translation was pilot tested with bilingual persons and women with and without the eligibility criteria.

2.3.2.6. Women and Their Partner's Drug Use. Drug Abuse Screening Test (DAST-10)

The DAST-10 (Skinner, 1982) assesses the extent of problems related to drug use with higher scores indicating more severe problems with using drugs. This test consists of ten items that can be summed to create a total score that measures the degree to which drug use is a problem for the individual. An example item includes: "Have you used drugs other than those required for medical reasons?". The response options and scoring are yes = 1 and no = 0 for 9 of the 10 items, with the exception of item 3 which is "Are you able to stop using drugs when you want to?", scoring yes=0 and no=1. The scores range from 0 (least severe) to 10 (most severe) and scores higher than 3 indicate significant problems related to drug use (Skinner, 1982).

The longer version of the DAST-10 is the DAST-28, which has shown fairly high internal reliability (α= .92) in a study of 256 drug/alcohol abuse clients (Skinner, 1982). Yudko, Lozhkina, and Fouts (2006) did a comprehensive review of the psychometric properties of all the DAST versions (10, 20, 28, and the adolescent's version) and found acceptable reliability and validity for application in clinical and research settings. Cocco and Carey (1998) also showed that the DAST-10 possessed good psychometric properties in their sample of psychiatric outpatients. The estimate of internal consistency was (α= .86) and was a significantly good discriminator among past abusers and those who have never abused drugs. The Spanish versions of the DAST-10 were reliable, one-dimensional, and differentiated drug abusers from non-substance and alcohol abusers (Bedregal, Sobell, Sobell, & Simco, 2006).

In order to assess women's partners' drug abuse, a parallel question was added to each standard question in the DAST-10 asking women to report about their partner's use of drugs. It was scored and recoded the same as the women's drug misuse mentioned above.

The Spanish version was created by back-translation. The translation was pilot tested with bilingual persons and women with and without the eligibility criteria.

2.3.2.7. Women's Depression. Beck Depression Inventory (BDI)

The BDI (Beck, 1979) assesses characteristic attitudes and symptoms of depression and consists of 21 items: mood, pessimism, sense of failure, lack of satisfaction, guilty feeling, sense of punishment, self-hate, self-accusations, self punitive wishes, crying spells, irritability, social withdrawal, indecisiveness, body image, work inhibition, sleep disturbance, fatigability, loss of appetite, weight loss, somatic preoccupation, and loss of libido (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

The response options use a scoring from 0 to 3 (e.g., Item1: 0 = I do not feel sad, 1 = I feel sad, 2 = I am sad all the time and I can't snap out of it, and 3 = I am so sad or unhappy that I can't stand it). An overall rate is obtained by summing the scores for each item with total scores ranging from 0 (less severe) to 63 (most severe). A score of 18 or higher indicated the presence of significant clinical depression and a score above 24 revealed moderate to severe depression (Beck et al., 1961).

The BDI is often used to detect depression because of its high reliability and validity (Beck et al., 1961). Convergent validity is considered satisfactory because the correlation of clinical depression evaluation oscillates between (r=.62) to (r=.66) (Beck et al., 1961). Sanz and Vázquez (1998) conducted a study to analyze the utility of the 1978 version of the BDI (Beck, 1979) as an instrument to identify subjects with sub-clinical depression; it was considered an effective instrument to evaluate depressive symptoms. Sanz and Vázquez (1998) analyzed the use of the BDI to classify individuals as depressed or not depressed. The reliability of the BDI was high (α= .83) and test-retest correlations ranged from (r=.60) to (r=.72).

For the purpose of the current study, the Spanish version of the original BDItranslated by Vázquez and Sanz (1999) was used.

2.3.2.8. Women's Anxiety. State-Trait Anxiety Inventory (STAI)

The STAI (Spielberg, Gorusch, & Lushene, 1970) was created as a research instrument for the study of anxiety in adults and is used in research and clinical settings. The form X (1970) was used in this study and consists of two scales: state anxiety and trait anxiety.

State anxiety is measured using 20 items on a four-point scale (0-3) ranging from Not at all to Very much so (e.g., indicate how you feel right now, that is, at this moment: I feel calm; response options 0=Not at all, 1=Somewhat, 2=Moderately so,

and 3=Very much so). Trait anxiety is measured using 20 items on a four-point scale (0-3) ranging from Almost never to Almost always (e.g., indicate how you generally feel: I feel pleasant; response options 0 = Almost never, 1 = Sometimes, 2 = Often, and 3 = Almost always). Each STAI item is recoded following the scoring made by Spielberg et al. (1970). The overall range for each scale goes from 20 (less severe) to 80 (most severe). A cut off score of 61 or higher suggests that individuals are experiencing clinically significant anxiety (Spielberg et al., 1970).

Test-restest reliability was high (r =.81) in the trait anxiety, while test-retest for the state anxiety was much lower (r=.40). The reliability of this inventory oscillates between (α =.83) and (α =.92) (Spielberg et al., 1970). Barnes, Harp, and Jung (2002) conducted a reliability generalization study for the STAI where 816 research articles using the STAI from 1990 to 2000 were reviewed. The reliability was relatively stable across studies for both scales; however, as expected, the stability reliability were inferior for scores on the state scale as opposed to the trait scale. The internal consistency reliability was generally satisfactory on diverse populations. The results did not show preferences in the use of the new form (Y) of the STAI (1983) over the old form (X) (1970) (Barnes et al., 2002).

The Spanish version of the original STAI (1970) by Seisdedos (1982) was used. The STAI has been shown to be a reliable and valid measure of anxiety. This Spanish version showed good internal consistency. Reliability of the trait anxiety scale ranged between (r=.84) and (r=.87) and state anxiety between (r=.90) and (r=.93). These findings on reliability and validity were similar to previous studies developed in Spain (Seisdedos, 1982).

2.3.2.9. Couple Income

This was calculated base on women's and their partner's annual range of income including taxes: I don't have personal income (0), less than 6.000€ *($8,000)* (1), 6.000€ to 12.000€ *($8,000-$16,000)* (2), 12.001€ to 18.000€ *($16,001-$24,000)* (3), 18.001€ to 24.000€ *($24,001-$32,000)* (4), 24.001€ to 30.000€ *($32,001-$40,000)* (5), 30.001€ to 36.000€ *($40,001-$48,000)* (6), 36.001€ to 42.000€ *($48,001-$56,000)* (7), 42.001€ to 48.000€ *($56,001-$64,000)* (8), 48.001€ to 54.000€ *($64,001-$72,000)* (9), 54.001€ to 60.000€ *($72,001 to $80,000)* (10), 60.000€ or over *($80,000)* (11). These women's and their partner's annual range of income were added and fit in a new range of couple annual income including taxes: I don't have personal income (0), less than 6.000€ *($8,000)* (1), 6.000€ to 12.000€ *($8,000-$16,000)* (2), 12.001€ to 18.000€ *($16,001-$24,000)* (3), 18.001€ to 24.000€ *($24,001-$32,000)* (4), 24.001€ to 30.000€ *($32,001-$40,000)* (5), 30.001€ to 36.000€ *($40,001-$48,000)* (6), 36.001€ to 42.000€ *($48,001-$56,000)* (7), 42.001€ to 48.000€ *($56,001-$64,000)* (8), 48.001€ to 54.000€ *($64,001-$72,000)* (9), 54.001€ to 60.000€ *($72,001-$80,000)* (10), 60.001€ to 66.000€ *($80,001-$88,000)* (11), 66.001€ to 72.000€ *($88,001-$96,000)* (12), 72.001€ to 78.000€ *($96,001-$104,000)* (13), 78.001€ to 84.000€ *($104,001-$112,000)* (14), 84.001€ to 90.000€ *($112,001-$120,000)* (15), 90.001€ to 96.000€ *($120,001-$128,000)* (16), 96.001€-102.000€ *($128,001-$136,000)* (17), 102.001€ to 108.000€ *($136,001-$144,000)* (18), 108.001€ to 114.000€ *($144,001-$152,000)* (19), 114.001€ to 120.000€ *($152,001-$160,000)* (20), 120.001€ to 126.000€ *($160,001-$168,000)* (21) more than 126.000€ *($168,001).*

2.3.2.10. Dyadic Adjustment. Dyadic Adjustment Scale (DAS)

The DAS (Spanier, 1976) was used to assess dyadic adjustment, defined as the evaluation of characteristics and interactions of the relationship. The DAS consists of 32 items that can be summed to create a total dyadic adjustment score which measures relationship quality defined as couple's perception of satisfaction, cohesion, consensus, and affectional expression occurring in their relationships. An example item is: How often do you discuss or have you considered divorce, separation or terminating your relationship? The range of scores for this measure is from 0 (the most negative score) to 151 (the most positive score) (Spanier, 1976). While there is no empirical support for a specific cut-off score to differentiate distressed and non-distressed couples (Crane, Allgood, Larson, & Griffin, 1990), in Spain and the U.S. a cut-off score of 100 has been used (Cáceres, 1996; Echeburúa & de Corral, 1998).

The DAS continues to be a commonly used measure in relationship research (Crane et al., 1990; Graham, Liu, & Jeriorski, 2006). It has shown high criterion validity and it is highly correlated with the Locke Wallace Marital adjustment scale (1959), which measures relationship satisfaction (r=.93). The internal reliability of the DAS is also quite high (α= 96) (Spanier, 1976); however, it is important to note that Graham et al. (2006) reported in a meta-analysis of the measure that the total DAS score had acceptable internal consistency but lower across 91 published studies. Despite this, the DAS is the most appropriate measure to test dyadic adjustment because it is one of the most commonly used measures to assess relationship quality in couple research, especially in Spain. Therefore, the Spanish version of the original DAS translated by Bornstein and Bornstein (1988) was used.

In addition to assessing relationship quality using the DAS, two questions were added to this questionnaire: One in regards to jealousy: "How frequently do you

and your partner have problems with jealousy?" using the following scoring: all the time = 5, most of the time = 4, more often than not = 3, occasionally = 2, rarely = 1, and never = 0; and the other regarding satisfaction with social support: "How satisfied are you with the support and help that you receive from the people around you?" using the following scoring: very unsatisfied = 1, a little unsatisfied=2, satisfied = 3, more than satisfied = 4, and very satisfied = 5.

2.3.2.11. Dyadic Commitment

The level of commitment in the relationship was based on the couple´s engagement status (cohabitors, engaged, or married). Participants were assigned the following values to represent their varying degrees of commitment with higher values representing more commitment: cohabitors (0), engaged (1), and married (2).

3. RESULTS

3.1. Descriptive Statistics

Means and standard deviations for all variables are provided in Table 1. Frequencies for all categorical variables are reported in Table 2. Results are reported for the entire sample as well as by group (pregnant or non-pregnant). In general, (39.3%) of Spanish women indicated that they had experienced IPV. The highest prevalence between the types of violence was minor psychological aggression 37.8% and minor sexual coercion 5.2% (see Table 4).

3.2. Hypothesis 1

It was hypothesized that risk factors commonly identified as being associated with IPV among women around the world would also be associated with IPV in Spanish women. Specifically, a series of women's individual characteristics, women's partner's characteristics, and characteristics of the couple's relationships were hypothesized to be related to IPV in the same manner that has been found in other research. The first hypothesis was tested by evaluating correlations between all risk factors and the frequency of IPV victimization in the last 12 months (see Table 5). All significant correlations were in the expected direction. Results indicated that the frequency of IPV correlated positively with experiences of sexual abuse after 18 years of age, alcohol consumption, and partner's alcohol consumption. In other words, higher levels of reported IPV were associated with more experiences of having been a victim of sexual abuse and greater alcohol consumption by the participant and their partners. The results also showed a negative correlation between violence and dyadic commitment such that lower levels of IPV were related to higher commitment in the relationship.

3.3. Hypothesis 2

It was hypothesized that Spanish women who were pregnant would experience less IPV and would report lower frequencies of risk factors associated with IPV than women who were not pregnant. Independent samples t-tests were conducted between pregnant and non-pregnant women in order to analyze potential differences between groups on all IPV variables (total IPV score and individual scores for each type of violence), and for each risk factor associated with IPV. Results from the independent samples t-tests using unequal variances indicated that between pregnant and non-pregnant women there were only significant differences in the following variables: that pregnant women experienced significantly less IPV (t (106.73) = -2.51, p= .01) than non-pregnant women. Results also suggested that pregnant women experienced significantly less minor psychological aggression in the last 12 months (t (111.87) = -2.13, p= .04) than non-pregnant women. Overall, pregnant women reported less IPV than non-pregnant women (see Table 1). Additionally the previous finding was also supported on a descriptive analysis on the ocurrence of IPV during pregnancy, see Table 6. The most frequent responde chosen by pregnant women was "Never happened during pregnancy" for every violence type.

Risk factors associated with IPV were compared between pregnant and non-pregnant using independent samples t-test assuming unequal variances. Significant differences between pregnant and non-pregnant women were only found with the following risk factors: 1) pregnant women reported significantly less alcohol consumption (t(102.91) = -2.95, p=.00) than non-pregnant women; 2) pregnant women reported significantly less drug use (t(86.78) = -2.93, p=.00) than non-pregnant women; 3) pregnant women reported significantly less partner drug use (t(90.78) = -2.12, p=.04) than non-pregnant women; 4) pregnant women reported

significantly more social support satisfaction ($t(126.44) = 2.67$, $p=.01$) than non-pregnant women; 5) pregnant women reported significantly less anxiety ($t(117.06) = -3.34$, $p=.00$) than non-pregnant women; 6) pregnant women reported significantly less jealousy ($t(106.46) = -3.11$, $p=.00$) than non-pregnant women; 7) pregnant women reported significantly more dyadic adjustment ($t(96.83) = 2.36$, $p=.02$) than non-pregnant women; and 8) pregnant women were more committed to their relationships ($t(113.25) = 7.41$, $p = .00$) than non-pregnant women. For means and standard deviations see Table 1.

3.4. Hypothesis 3

It was hypothesized that pregnancy status and risk factors associated with IPV would interact to predict IPV. Specifically, Spanish women who were pregnant with their first child and report higher levels of other risk factors were expected to experience more IPV.

The test of this hypothesis involved calculating a series of regression analyzes designed to test for moderation. Following the suggestions made by Baron and Kenny (1986) and Aiken, West, and Reno (1991), hierarchical regression analyzes were conducted with centred variables to assess whether pregnancy status moderated the relations between each risk factor and the frequency of IPV experienced by women in the last 12 months. In cases where regression analyzes suggested significant moderation (see Table 7), regression lines for high and low values of the moderator (pregnancy status) were plotted. Slopes of the lines in each graph were then tested to evaluate whether each was significantly different from zero. As hypothesized, results indicated that pregnancy status functioned as a moderator in the relation between specific risk factors and the frequency of women's experiences of being the victim of IPV in the last 12 months. Regression analyses evaluating the interaction between

pregnancy status and risk factors associated with IPV revealed several significant findings. Overall, pregnancy status and risk factors interacted to predict different degrees of IPV.

First, pregnancy status moderated the relationship between women's age and being the victim of IPV in the last 12 months (see Table 7). When this model was plotted, there was a significant negative relation between women's age and IPV for non-pregnant women (t=-1.97, p<.05). For pregnant women, there was no relation between women's age and IPV, (t=.95, p=n.s.), see Figure 1.

Second, pregnancy status moderated the relation between being the victim of sexual abuse after age 18 (sexual abused experienced after 18) and being the victim of IPV (frequency of IPV) in the last 12 months (see Table 7). When this model was plotted, there was a significant positive relationship between being the victim of sexual abuse (after 18) and being the victim of IPV for the non-pregnant women, (t=3.94, p<.05), see Figure 2. For pregnant women, there was no relation between being the victim of sexual abuse (after 18) and being the victim of IPV (t= -.65, p=n.s.).

Third, pregnancy status moderated the relation between women's report of partner drug use and being the victim of IPV in the last 12 months (see Table 7). When this model was plotted, there was no relation between partner drug use and being the victim of IPV for non-pregnant women (t=-.57, p= n.s.). In contrast, for pregnant women, there was a significant positive relation between partner drug use and being the victim of IPV (t=2.82, p<.05), see Figure 3.

Fourth, pregnancy status moderated the relation between dyadic adjustment and IPV (see Table 7). When this model was plotted, there was no relation between dyadic adjustment and being the victim of IPV for non-pregnant women (t=.88, p=

n.s.). However, for pregnant women, there was a significant negative relation between dyadic adjustment and being the victim of IPV (t=-2.51, p<.05), see Figure 4.

Fifth, pregnancy status moderated the relation between dyadic commitment and being the victim of IPV in the last 12 months (see Table 7). When this model was plotted, there was no relation between dyadic commitment and IPV for non-pregnant women (t=.64, p= n.s.). For pregnant women, there was a significant negative relation between dyadic commitment and IPV, (t=-2.60, p<.05), see Figure 5.

Sixth, pregnancy status moderated the relation between being the victim of physical violence or injury perpetrated by ex-partners before age 18 and currently being the victim of IPV (see Table 7). When this model was plotted, there was a significant positive relationship between being the victim of physical violence or injury perpetrated by ex-partners and being the victim of IPV among non-pregnant women, (t=5.93, p<.05), see Figure 6. For pregnant women, there was a significant negative relation between being the victim of physical violence or injury by ex-partners and being the victim of IPV (t=-3.41, p<.05).

Seventh, pregnancy status moderated the relation between jealousy as a problem in the relation and being the victim of IPV in the last 12 months (see Table 7). When this model was plotted, there was a trend where jealousy as a problem was negatively related to IPV for non-pregnant women, but this slope was not significant at the .05 level (t=-1.77, p<.10). For pregnant women, there was also a trend where jealousy was positively related to IPV, (t=1.85, p<.10), but again, this slope was not statistically significant, see Figure 7.

Eighth, pregnancy status moderated the relationship between women's depression and being the victim of IPV in the last 12 months (see Table 7). When this model was plotted, there was only a negative trend between women's depression and

IPV for non-pregnant women (t=-1.73, p<.10); this relation was not statistically significant. For pregnant women, there was no relation between women's depression and IPV, (t=1.09, p= n.s.), see Figure 8.

Ninth, pregnancy status moderated the relationship between satisfaction with social support and IPV (see Table 7). When this model was plotted, there was a positive trend between social support satisfaction and IPV for non-pregnant women (t= 1.15, p<.10). In contrast, for pregnant women, there was a negative trend between social support satisfaction and IPV, (t=-1.86, p<.10), see Figure 9.

To summarize, non-pregnant women reported more IPV in the last 12 months when they reported younger age and higher sexual abuse after age 18. However, women who were pregnant with their first child reported higher frequencies of IPV in the last 12 months when they reported more drug use by their partners, less dyadic adjustment, and less dyadic commitment. Pregnant women reported higher frequencies of IPV when they reported lower physical assault or injury by ex-partners before 18. On the contrary, non-pregnant women reported higher frequencies of IPV when they also reported higher physical assault or injury by ex-partners before 18. Pregnant women tended to report higher frequencies of IPV when they reported higher jealousy problems, while non-pregnant women reported lower jealousy problems with increased IPV, although these two relations were only trends. Non-pregnant women had a tendency to report lower frequencies of IPV when they reported higher depression problems, whereas pregnant women tended to display higher frequencies of IPV when they reported lower social support satisfaction, although again, these relations were only trends. Results also showed a significant interaction between pregnancy status and risk factors in predicting the frequency of IPV. Non-pregnant women experienced more IPV when they were younger in age.

However, pregnant women experienced higher IPV when they reported higher drug use by the partners, lower dyadic adjustment, and lower commitment. Unexpectedly, pregnant women experienced lower IPV when they reported more violence in the past (physical assault or injury by ex-partners before 18), while the opposite was true for non-pregnant women.

Table 3: *Correlations Between all IPV Variables*

	Minor psychological aggression	Severe psychological aggression	Minor physical assault	Minor injury	Minor sexual coercion
Minor psychological aggression	--	.217**	.336**	.253**	.125
Severe psychological aggression	--	--	.865**	.287**	.546**
Minor physical assault	--	--	--	.259**	.435**
Minor injury	--	--	--	--	-.017

** $p<0.01$ level

$N = 232$ total women

Table 4: *Prevalence of IPV in Pregnant and Non-Pregnant Women*

	Pregnant	Non-pregnant	Total Sample
Minor psychological aggression	32.5%	48.7%	37.8%
Severe psychological aggression	1.3%	3.9%	2.2%
Minor physical assault	0.7%	3.9%	1.7%
Severe physical assault	0.0%	0.0%	0.0%
Minor injury	0.0%	2.6%	0.9%
Severe injury	0.0%	0.0%	0.0%
Minor sexual coercion	3.9%	7.9%	5.2%
Severe sexual coercion	0.0%	0.0%	0.0%
IPV in the last 12 months	33.3%	51.3%	39.3%

N = 155 pregnant women, 77 non-pregnant women, 232 total women

Table 5: *Correlations Between Risk Factors Associated With IPV and IPV in the Last 12 Months*

Variable	IPV in the last 12 months
IPV before the last 12 months	.007
Age	-.082
Report of partner age	-.112
Education	.006
Report of partner education	-.036
Unemployment	-.071
Partner unemployment	-.034
Exposed to father physically abusing mother	.031
Exposed to mother physically abusing father	-.038
Injured by parents	-.022
Physically abused by parents or adults	.111
Physically abused or injured by ex-partners before 18	.064
Physically abused or injured by ex-partners after 18	-.011
Sexually abused before 18	-.018
Sexually abused after 18	.256**
Alcohol consumption	.201**
Report of partner alcohol consumption	.191**
Drug use	.117
Report of partner drug use	.069
Depression	-.045
Anxiety	.069
Social support satisfaction	-.050
Couple income	-.091
Dyadic adjustment	-.069
Jealousy	.015
Dyadic commitment	-.136*

**. $p<0.01$ level

*. $p<0.05$ level

$N = 232$ total women

Table 6: *Occurrence of IPV During Pregnancy*

	Reduced during pregnancy	Never happened	Maintained during pregnancy	Increased during pregnancy	Started during pregnancy	Total
Minor psychological aggression	10.3%	72.9%	14.8%	0.0%	1.3%	100%
Severe psychological aggression	1.3%	98.7%	0.0%	0.0%	0.0%	100%
Minor physical assault	0.0%	98.7%	0.0%	0.0%	0.0%	100%
Severe physical assault	0.0%	100%	0.0%	0.0%	0.0%	100%
Minor injury	0.0%	100%	0.0%	0.0%	0.0%	100%
Severe injury	0.0%	100%	0.0%	0.0%	0.0%	100%
Minor sexual coercion	0.6%	98.1%	1.3%	0.0%	0.0%	100%
Severe sexual coercion	0.0%	100%	0.0%	0.0%	0.0%	100%

$N = 155$ pregnant women

Table 7: *Pregnancy Status Moderates Relations Between Risk Factors Associated With IPV and Women as Victim of IPV in the Last 12 Months*

Step	Predictor	R^2	ΔR^2	B	ΔF
Risk factors — with IPV	IPV in the last 12 months				
1	Women's age	.01	.01	-.09	1.52
2	Pregnancy status	.04	.03	-1.58**	7.75**
3	Women's age X Pregnancy status	.06	.02	.28*	4.00*
1	Sexually abused after 18	.07	.07	3.07***	15.79***
2	Pregnancy status	.09	.03	-1.48**	7.12**
3	Sexually abused after 18 X Pregnancy status	.12	.02	-4.45*	6.02*
1	Report of partners drug use	.01	.01	.37	.95
2	Pregnancy status	.03	.02	-1.28*	4.13*
3	Report of partners drug use X Pregnancy status	.07	.04	2.24**	8.87**
1	Dyadic adjustment	.01	.01	-.02	.93
2	Pregnancy status	.02	.02	-.99	2.62
3	Dyadic adjustment X Pregnancy status	.06	.04	-.14**	7.94**
1	Dyadic commitment	.02	.02	-.68*	4.29*
2	Pregnancy status	.04	.02	-1.39*	4.65*
3	Dyadic commitment X Pregnancy status	.07	.03	-1.93**	7.07**
1	Physical assault or injured by expartners before 18	.00	.00	.16	.93
2	Pregnancy status	.04	.04	-1.65**	8.52**
3	Physical assault and injured by expartners before 18 X Pregnancy status	.17	.13	-5.44***	33.95***

N = 155 pregnant women, 77 non-pregnant women, 232 total women

4. DISCUSSION

4.1. Research Findings and Conclusions

Worldwide, the prevalence of IPV toward women and the adverse consequences oftentimes associated with IPV are high. In 2005, the WHO Multi-country Study on Women's Health and DVAW estimated that 15% to 71% of women experience violence by their partners in their lifetime (WHO, 2005). The present study provides information regarding the magnitude of IPV toward women in Spain, as well as a variety of risk factors commonly associated with IPV. The current research is one of the first studies (Ruiz-Pérez & Plazaola-Castaño, 2005) specifically designed to analyze the frequency of IPV and the associated risk factors among Spanish women. Results from this study support previous research conducted around the world, and specifically in Spain, that has identified a variety of factors that may put women at risk of being the victim of IPV (Ruiz-Pérez et al., 2004; Ruiz-Pérez. Plazaola-Castaño, Alvarez-Kindelán, et al., 2006).

In the present study, the following factors were identified as being associated with increased experiences of IPV: sexual abuse after age 18, increased alcohol consumption by women and their partners, and lower commitment (e.g., cohabitors, engaged, or married). Other researchers have also found similar results (e.g., Corsi, 1995; Fernández-Montalvo & Echeburúa, 1997; Heise & García-Moreno, 2002; Jackson, 1996; Medina, 2002; Painter & Farrington, 1998; Schumacher, Feldbau-Kohn, et al., 2001; Stets, 1991; Stets & Straus, 1989; Stith et al., 2004; Yllö & Straus, 1981). Additionally, Spanish women in the current study who were pregnant experienced less IPV and less risk factors associated with IPV than women who were not pregnant. Finally, results showed that pregnancy status interacted with risk factors to predict IPV. Three significant moderation models were found. First, non-pregnant

women were found to be at greater risk for experiencing IPV if they were sexually abused after 18. This same relation was found for who were younger in age. Second, pregnant women were more likely to experience IPV if they reported partner drug use, low dyadic adjustment, and low dyadic commitment. Third, non-pregnant women were more likely to experience IPV in current relationships if they were physically abused before age 18. The opposite was true for pregnant women; less physical abuse before age 18 was related to more IPV in their current relationships.

Risk Factors and IPV. The following factors were identified as being associated with increased experiences of IPV: sexual abuse after age 18, increased alcohol consumption by women and their partners, and lower commitment. Although the majority of research conducted focuses on evaluating past experiences of violence, it tends to look at experiences of violence during childhood rather than violence that occurred during adulthood. In the present study women who had been sexually abused during adulthood were more likely to be the victims of IPV in their current relationships. This has been supported by global studies (Black et al., 2001; Painter & Farrington, 1998; Russell et al., 1989), and in Spain (Garcia-Linares et al., 2005; Pico-Alfonso et al., 2006). As prior research suggests, women who experienced abuse during childhood may view violence as a somewhat normal aspect of intimate relationships in adulthood, and therefore, tolerate violence in their relationships more than women who have never experienced abuse during childhood (Jewkes et al., 2002). In addition, it is possible that women who experienced abuse during adulthood could also view violence as a normal part of their current relationships.

Another risk factor that was associated with IPV among Spanish women in the current study was alcohol consumption by women and their partners. The finding of alcohol consumption by women as a potential risk factor for IPV has been supported

by research, primarily in the U.S. (Coker, Davis, et al., 2002; Kantor & Straus, 1989; Magdol et al., 1997; Stith et al., 2004), although it has also been supported in Spain (Labrador et al., 2004; Ruiz-Pérez & Plazaola-Castaño, 2005). In addition, the finding related to alcohol consumption by their partners as a possible risk factor for IPV has been supported by research around the world (Heise & García-Moreno) and in Spain (Cerezo, 2000; Lorente, 2001; Medina, 2002). In Spain, researchers have speculated that women who were the victims of IPV may use alcohol as a coping strategy to deal with the stress related to IPV (Ramos-Lira et al., 2001; Ruiz-Pérez & Plazaola-Castaño, 2005). It is possible that abused women tend to consume alcohol as a way to cope with the stress that comes from the uncertainty of when and how severely they will be abused the next time, or possibly as a way to avoid having to decide whether or not to leave their partners. Perhaps this could help explain why increased alcohol consumption was associated with increased IPV.

Additionally, the more alcohol consumption by women's partners, the more likely they were to perpetrate IPV in the present. Recent research in U.S. and in Spain suggests that partners, in some cases, may use alcohol consumption as an excuse for their violent behaviours. Violent partners may use alcohol as a way of justifying their pre-planned violence (Jacobson & Gottman, 1998; Lorente & Lorente, 1998; Villavicencio & Batista, 1992; Villavicencio & Sebastián, 1999). Another explanation could be that more frequent consumption of alcohol creates more opportunities for disinhibited behaviour, which may lead to abuse (Bennet & Williams, 2003).

Alcohol consumption as a risk factor for IPV may be one to pay close attention to in Spain because alcohol consumption is socially and legally more acceptable than in other countries, such as the U.S. In Spain, alcohol tends to be used as way to let loose, and as one of the main reasons (more commonly for men) to meet

socially (e.g., "Vermouth time", "go out to drink a few wines", "binge drinking"); alcohol consumption is considered to be an integral part of social interactions (Ruiz-Pérez & Plazaola-Castaño, 2005). Additionally, in Spain the legal drinking age is low (18 years) and drinking is more socially acceptable than other countries. Thus, the more social acceptability of alcohol consumption in Spanish culture may encourage men and women to use and abuse alcohol more frequently, (i.e., for men as an excuse to batter and for women as a way to cope), which may lead to more IPV.

The last risk factor that was associated with experiences of IPV among Spanish women was low dyadic commitment. This result suggested that lower commitment in relationships was associated with increased experiences of IPV. Other research, principally done in the U.S., has supported this finding (Colson, 1995; Jackson, 1996; Stets, 1991; Yllö & Straus, 1981). The current study seems to be the first to look at dyadic commitment and IPV in Spain. Results in the current study may be explained based on the level of commitment, as shown in previous studies. While cohabitors only have a personal commitment, married couples have a social, legal and, in some cases, religious commitment to their relationship (Macklin, 1972); the union is more formal and requires more effort to be maintained (Stets & Straus, 1989).

This low level of dyadic commitment, refering to those cohabitating unmarried couples, can make the relationship more easily dissolvable (Yllö & Straus, 1981). Hence, it is possible that cohabitating couples tend to be more violent due to the lack of marriage commitment (Yllö & Straus, 1981). This lack of commitment in relationships may result in men being more violent toward women for two reasons. First, it might be because the potential consequences suffered as a result of the violence may be lower for cohabitators than for married couples (Stets & Straus,

1989). For example, violence in a marriage might end in divorce, whereas violence for cohabitating couples would not have this as a potential consequence. Therefore, cohabitors may lose less materially, socially, and psychologically from break-ups due to violence than married individuals (Stets, 1991). Alternatively, male cohabitors might also be violent toward their female partners because they may feel insecure or threatened that their partners may possibly leave them (Cáceres, 1999; Jacobson & Gottman, 1998). Therefore, as Yllö and Straus (1981) reported, men could also be using violence as a way to make the women believe that they belong to them or to maintain closeness. These previous characteristics of violence reflect the *Pitbull* or *Reactive* violence typology; those in this violent typology are unable to control their emotions; they are deeply insecure, jelouse, and tend to depend on and control their partners (Cáceres, 1999; Jacobson & Gottman, 1998). Hence, it could be that Spanish cohabitating men are violent toward their partners due to the lack of commitment in the relationship, which may make them more open to using violence because they have less to lose than married men, or because they feel the need to be in control of their partners.

Additionally, it is important to note that in Spain there is a traditional point of view of marriage and couple relationships; therefore getting married is more prevalent than cohabiting (Manjavacas, 2006). Based on the census (2001) National Statistics Institute, 8.9 million people were married while 563,723 were cohabiting. However, cohabiting is starting to occur more frequently. At the same time the number of reported cases of women's victimization of IPV is increasing. In Spain in 2002, 43,313 cases of IPV were reported, while in 2006, 62,170 cases were reported. Looking specifically at the Basque Country region where the data of the current study was collected, 22 cases were reported in 2002 and 116 cases in 2006 (Instituto de la

Mujer, 2002/2006). Perhaps the increase in cohabitation could somehow be related to the increase in IPV.

Pregnancy and IPV. No previous studies in Spain compared women expecting their first child to those who had never been pregnant. Pregnancy with the first child can be experienced as a very stressful time (Jasinski, 2004; Stamp, 1994), while also an eager and exciting time (e.g., Feldman & Nash, 1984). Hence, it is important to explore IPV among women who are specifically experiencing their first pregnancy. The findings from the present study tend to support the view of pregnancy as a happy time. As was expected, women who were pregnant with their first child were less likely to experience IPV than non-pregnant women. Similar findings have been found in previous studies of women expecting their first child (Jasinski, 2001), and women experiencing other pregnancies (Gelles, 1990; Raush, Barry, Hertel, & Swain, 1974) established that the nature of the marriage changes noticeably once the wife becomes pregnant. Husbands are more conciliatory during their wives' pregnancy than before or after pregnancy. Hence, pregnant women may experience less violence than non-pregnant women since their partners may be more agreeable and less likely to be confrontational during this period.

Pregnancy and Risk Factors Associated With IPV. As expected, being pregnant with the first child appears to make women less likely to experience risk factors associated with IPV. Specifically, pregnant women reported less alcohol and drug use, less drug use by their partners, less anxiety, more satisfaction with their social support, fewer jealousy problems, greater dyadic adjustment, and more commitment with their relationships compared to non-pregnant women. It appears as though expecting the first child might make Spanish couples try to be more caring of themselves and each other in order to ensure the health of their child.

Pregnancy is a time when women take better care of themselves, as the present study shows, where pregnant women reported less alcohol consumption and less drug use than non-pregnant women. These findings were similar to other international studies, including some done in Spain, which showed that women tended to stop drinking (Bachman, O'Malley, Johnston, Rodgers, & Schulenberg, 1992; Bolumar, Rebagliato, Hernández-Aguado, & du V Florey, 1994; Palma et al., 2007), and using drugs (Bachman et al., 1992; Bolumar et al., 1994; Fleisher & Krienert, 2004). Pregnancy is a time in which women's partners also seem to take better care of themselves. It has been suggested that perhaps men also prepare themselves for arrival of the first child by adapting more healthy behaviours (Bachman et al., 1992). This was seen in the current study where partners expecting the first child used fewer drugs than partners who were not expecting.

In the present study, the women also reported higher satisfaction with their social support and reported less anxiety than non-pregnant women. This caring period of social support may be a result of their relationship quality with their partners. Pregnant women in the current sample also indicated that they were more commited and satisfied with their relationships and had fewer problems with jealousy than non-pregnant women. This seemingly high relationship commitment and quality could also be based on religious and cultural values regarding how to treat one's family and pregnant wife. In Spain, the primary religion is Catholicism, in which having children is considered the main goal of marriage. Additionally, Spain still has a traditional family system (Flaquer, 2002). Spaniards consider the two things that make them happy are to be in good health and family (Manjavacas, 2006). Therefore, Spanish couples might be more caring toward themselves and family members during this period because they are expecting a child. Men may try to avoid harming their future

children and, instead, focus on providing the best circumstances that they can for them, including a healthy life and relationship.

Interaction Between Pregnancy Status and Risk Factors. The results of the present study, as expected, showed that pregnancy status interacted with risk factors to predict IPV. The three main models found were: 1) non-pregnant women were more likely to experience IPV if they also reported sexual abuse after 18 and younger age, 2) pregnant women were more likely to experience IPV if they also reported partner drug use, low dyadic adjustment and/or low dyadic commitment, and 3) there was a relation between physical abuse or injury by ex-partners before 18 and experiences of IPV, but the direction of the relation depended on pregnancy status (e.g., there was a positive relation for non-pregnant and negative for pregnant).

Non-pregnant women were more likely to report a higher frequency of IPV when they reported a higher frequency of being sexually abused after 18 and is supported by other research conducted worldwide (Black et al., 2001) and in Spain (Garcia-Linares et al., 2005; Pico-Alfonso et al., 2006). Research suggests that women who were abused during childhood may view violence in the current relationship as a normative event that they tolerate (Jewkes et al., 2002). It may also be the case that women who experience sexual abuse in adulthood also have a certain level of tolerance, but pregnant women may be less tolerant of violence in their lives because they are expecting their first baby.

In addition, younger non-pregnant women were at greater risk of IPV, whereas this was not the case with pregnant women. Overall research has supported the finding that younger age is related to IPV (Escribà-Agüir et al., 2006; Ruiz-Pérez, Mata-Pariente, et al., 2006; Ruiz-Pérez, Plazaola-Castaño, Alvarez-Kindelán, et al., 2006; WHO, 2005). Although in the present study the groups did not differ in age, the

difference between the two groups, pregnant and non-pregnant women, could have been explained by variations in life experiences or perhaps level of maturity. Maturity is often measured as a component of age, although it actually has a closer association with life experiences. It could be that pregnant women have a broader range of life experiences due to the pregnancy. Thus, they may be more mature than non-pregnant counterparts, despite similarities in age. Hence, younger age may not be a risk factor for IPV among pregnant women whereas it is a risk factor among non-pregnant women.

While partner drug use was not associated with IPV for non-pregnant women, partner's drug use was identified as a risk factor for pregnant women; more drug use was related to more IPV. Although men expecting their first child generally used fewer drugs than non-expecting men, it is possible that men expecting their first baby may be experiencing stress which could result in the use of drugs as a way to cope. As a result, the use of drugs might make them more disinhibited, similar to the case with alcohol, which may lead to more violence towards their partners (Bennet & Williams, 2003). It is also possible that men abuse substances as a pre-emptive way to justify their abusive actions, although this may not be very prevalent (Jacobson & Gottman, 1998; Lorente & Lorente, 1998; Villavicencio & Batista, 1992; Villavicencio & Sebastián, 1999).

Another difference between non-pregnant and pregnant women was that pregnant women expecting their first child reported higher dyadic adjustment and commitment than non-pregnant women. Higher IPV may be related to lower marital satisfaction and commitment such as in other studies (Goodwin et al., 2000), pregnant women showed that when dyadic commitment was lower, they were at higher risk for IPV. However, it appears that couples expecting their first child are more caring about

their relationships and sensitive toward the relationship because they were expecting a child; resulting in less IPV than non-pregnant women. Thus lower dyadic adjustment and commitment were associated with more IPV among pregnant women. It could be that less satisfied and less committed men continue to be violent towards their partners because they are anxious about the transition to parenthood or fear that their partners may leave them. Therefore, they may use violence as a way to control their partners (Yllö & Straus, 1981). Therefore, although pregnant women were more satisfied and significantly more committed than non-pregnant women, it seems that the factors related to dyadic adjustment, dyadic commitment, and partner's drug use were the most significant factors that put women at the greatest risk for violence.

Unexpectedly, there was a significant relationship between past experiences of violence in previous relationships and current IPV for non-pregnant women and not for pregnant women. Past experiences of violence in previous relationships for pregnant women were associated with lower IPV in the current relationship. The finding in regards to non-pregnant women was supported by research (Black et al., 2001; Coker et al., 2000; Garcia-Linares et al., 2005; Labrador & Alonso, 2005/2006; Riggs et al., 2000; Ruiz-Pérez, Plazaola-Castaño, Blanco-Prieto, et al., 2006), while the results regarding pregnant women are contradictory to what other research has shown (Castro et al., 2003; Glander et al., 1998; Horrigan et al., 2000; Smikle et al., 1996). A possible explanation for this contradictory finding is that women with a history of physical abuse or injury by ex-partners before 18 may be particularly sensitive to the issue of violence, which may lead them to take better care of themselves because they are also caring for their child. Women may remember past experiences and not want that for the child. Additionally, the woman's partner may also attempted to take better care his family in anticipation of having their first baby,

which may also result in less IPV reported by pregnant women with a past history of IPV in relationships. Another explanation could be that women's partners know about her history of victimization and act more sensitively, empathetically, and caringly.

The current study revealed that pregnancy was related to decreased IPV and fewer risk factors associated with IPV among Spanish women. However, both non-pregnant and pregnant women did indeed experience and report IPV and risk factors for IPV. The risk factors associated with IPV that were most robust for non-pregnant women related mostly to women's individual characteristics (e.g., younger age and sexual abuse after 18), whereas risk factors for pregnant women seemed to be related to characteristics of their partner's behavior and their relationship (e.g., partners' drug use, dyadic adjustment and commitment). Moreover, the only individual characteristic that was related to IPV for pregnant women turned out to seemingly protect women from IPV; specifically, higher presence of physical abuse or injury by ex-partner before 18 years of age predicted less IPV among pregnant women, while the opposite held true for non-pregnant women.

These results suggest that the differences between the types of risk factors related to IPV for non-pregnant versus pregnant women could possibly be due to the pregnancy status. The risk factors that seem to put non-pregnant women at risk of experiencing IPV seem to be more closely related to their own individual characteristics. In contrast, pregnant women may be at increased risk of IPV when qualities of their relationships or characteristics of their spouses are problematic. In particular, the differences between pregnant and non-pregnant women and the relative importance of relationship adjustment and commitment may be a function of their disposition in life. Pregnant women in Spain are highly likely to be in married, committed relationships compared to non-pregnant women, which was seen in the

current study. Hence, non-pregnant women may be more influenced by characteristics related to themselves versus their partners or relationships. Pregnant women, on the other hand, may be at a point in their lives where they are highly in tune and committed to their relationships and the father of their child. Thus, they may be more likely to be impacted by characteristics related to the relationship and partner.

Overall, a variety of risk factors were identified that put women at an increased risk of being the victim of IPV. Furthermore, these risk factors varied as a function of pregnancy status. Characteristics of the relationship and partner were more indicative of IPV among pregnant women, whereas individual characteristics of the women themselves predicted IPV among non-pregnant women. Finally, experiences of violence by another partner during adulthood acted as a buffer for pregnant women and as a risk factor for IPV among non-pregnant women. In sum, expecting one's first child may be a protective factor that leads to fewer experiences of IPV among pregnant Spanish women, although characteristics of the partner and the relationship may influence the relation between pregnancy and violence.

4.2. Limitations and Future Research

The current study used an anonymous and voluntary survey for data collection from centres that provide services to women. Findings from the current project may not necessarily generalize to other populations of women. First, there may be fundamental differences in the women who volunteered to participate in the study and those who chose not to. Additionally, there may be differences in women from the health centers that agreed to support the current work (i.e., those who cooperated and allowed for recruitment of participants) and women who use services at the non-cooperating health centers. Due to these limitations, caution should be used when interpreting the current findings and attempting to generalize them to other

populations. There were some other limitations to the current study, such as an unequal number of subjects in the non-pregnant and pregnant groups, the potential influence of social prejudice while answering due to the high prevalence of high marital satisfaction, and the overall low prevalence of IPV and risk factors reported by these subjects. Therefore, the results for the non-pregnant women might have been less representative than the results for pregnant women in Spain. Additionally, the descriptive statistics and results may have underestimated the presence of IPV and some of the risk factors and may have not identified other risk factors associated with IPV in other research.

Despite these limitations, the current research study provides further information about IPV in Spain and also highlights the need for more research to be conducted in Spain to further support the overall findings from the current work. Future research could involve screening participants into four separate groups, all with an equal number of subjects: pregnant without IPV, non-pregnant without IPV, pregnant with IPV, and non-pregnant with IPV. This would ensure adequate representation of each of these characteristics: pregnancy status and victimization of IPV. It would also be important for future studies to use longitudinal designs in order to capture changes in the individuals as well as IPV over time. For example, it would be important to assess violence and risk factors before, during, and after pregnancy in order to analyze the cause-effect relationship and to determine the direction of effects between IPV and risk factors.

Results of this study suggest that there may be differences in the risk factors related to IPV for non-pregnant and pregnant women from Spain. The risk factors for non-pregnant women were related to women's characteristics. In contrast, for the most part, risk factors for the pregnant women were related to partner and relationship

characteristics. One of the women's characteristic that was identified as being related to IPV with pregnant women was having a history of violence during adulthood. However, this was a negative relation so, surprisingly, history of violence predicted lower IPV for pregnant women, whereas a history of violence predicted more IPV for non-pregnant women.

Overall research has tended to focus on women's characteristics rather than characteristics of the partner or certain aspects of the relationship with their partners. Therefore, it will be important that future research with pregnant women, explore other risk factors specific to the characteristics of women's partners and the dyadic relationship, such as partner's history of violence and couple's style of communication could be examined as potential risk factors. Future research may also benefit from exploring pregnancy related risk factors such as, surprise or unplanned pregnancy, miscarriages, abortions, late entrance into the first prenatal care visit, and women's partners not being the father of the unborn child.

Future research should also consider the importance of the number of other pregnancies that the woman might have experienced. For example, there might be a difference between women expecting the first child versus the second or third. Most research has focused on women pregnant with their first child in the same group as women who have already had previous deliveries. Due to the fact that most of this research has not focused on the number of pregnancies, future research should pay attention to the number of births women have experienced to evaluate potential differences between women expecting the first child versus others.

Finally, it will be important to replicate this study among diverse cultures to determine if pregnancy with the first child and associated risk factors interact to predict IPV, or whether findings from this study are culturally specific to Spain. In

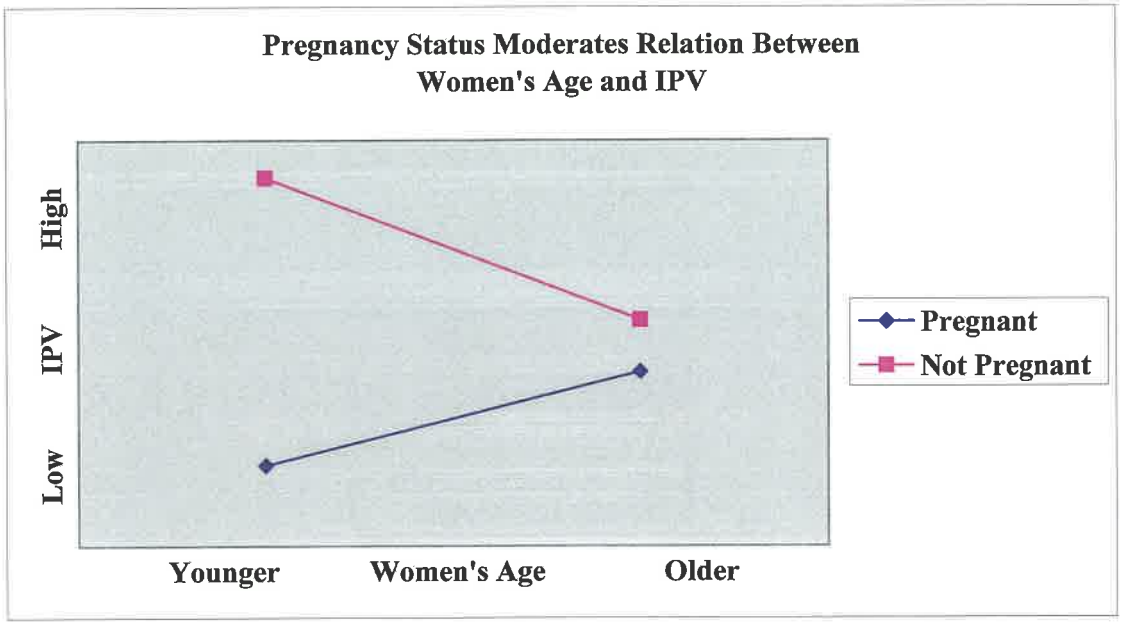
addition, cross cultural comparisons of IPV and associated risk factors for pregnant women will be essential to help further clarify the roles that each of these variables play in Spain and abroad.

Results from this study have implications for prevention and intervention of IPV. First, it is important to be able to accurately identify the victims of IPV, as well as the risk factors associated with it, so that we can potentially intervene in cases where there is IPV and prevent the occurrence or re-occurrence of IPV following intervention.

Since results from this study suggest that a variety of risk factors may relate to IPV, in addition to the fact that women use a variety of health related services especially when they are pregnant, it is important to take a multidisciplinary approach within the field of IPV in order to implement prevention and intervention of IPV toward women.

The present study evaluated women expecting their first child. Research has shown that this time period—the transition to parenthood—is associated with marital complications that may lead to divorce (Shapiro & Gottman, 2005). Marital quality decreases for up to 67% of couples in the first year of the infant's life (Shapiro et al., 2000). During pregnancy, it is, thus, important to promote the use of intervention programs focused on strengthening relationships before and during the transition to parenthood, especially in couples who display risk factors related to IPV. This may minimize couple difficulties and prevent IPV toward women and unborn children.

Figure 1: *Significant Interaction Between Pregnancy Status and Women's Age Predicting IPV in the Last 12 Months*

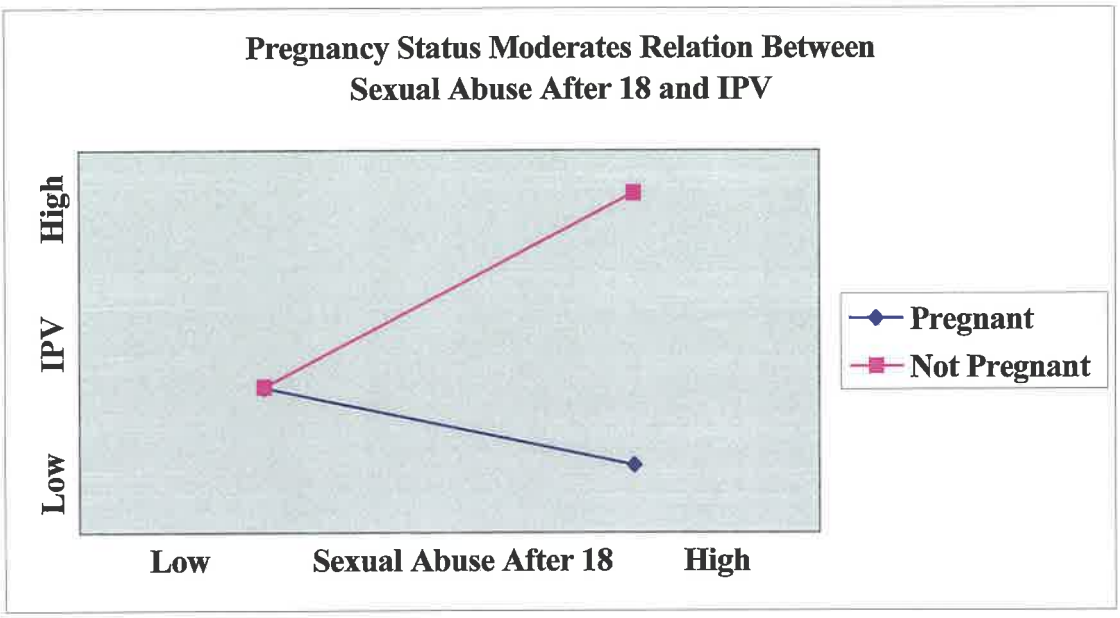


Non-pregnant=p<.05

Summary:

Pregnancy acts as a buffer between women's age and IPV. For pregnant, there is no relation between age and IPV. However, when women are non-pregnant, younger age puts one at risk of experiencing more IPV.

Figure 2: *Significant Interaction Between Pregnancy Status and Being the Victim of Sexual Abuse After 18 Predicting IPV in the Last 12 Months*

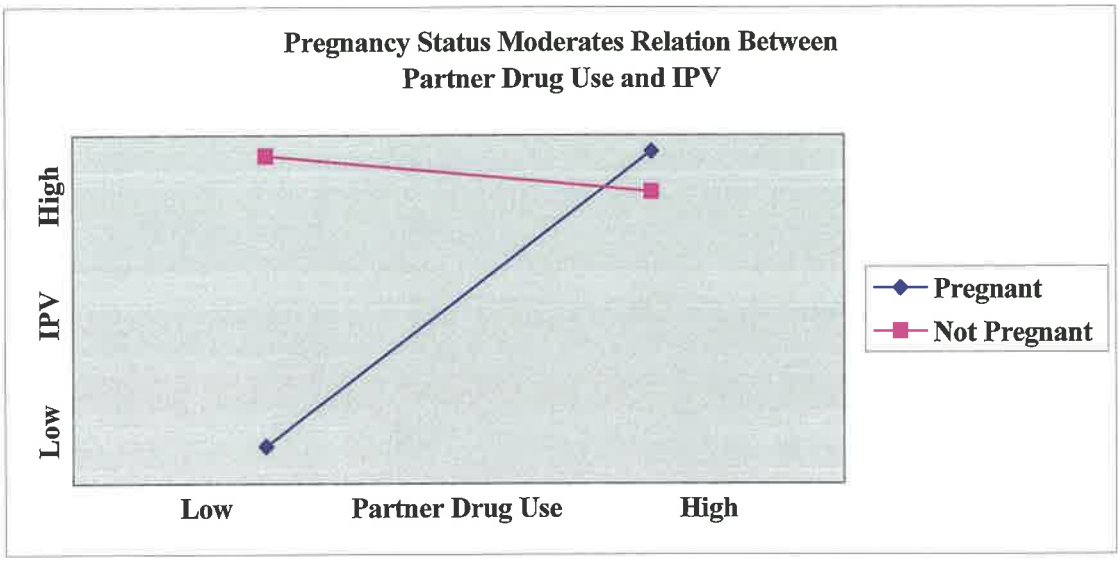


Non-pregnant=$p<.05$

Summary:

Pregnancy acts as a buffer between women's experiences of sexual abuse after 18 and IPV. For pregnant women, there is no relation between sexual abuse after 18 and IPV. However, when women are not pregnant, sexual abuse after 18 puts one at risk of experiencing more IPV.

Figure 3: *Significant Interaction Between Pregnancy Status and Report of Partner Drug Use Predicting IPV in the Last 12 Months*

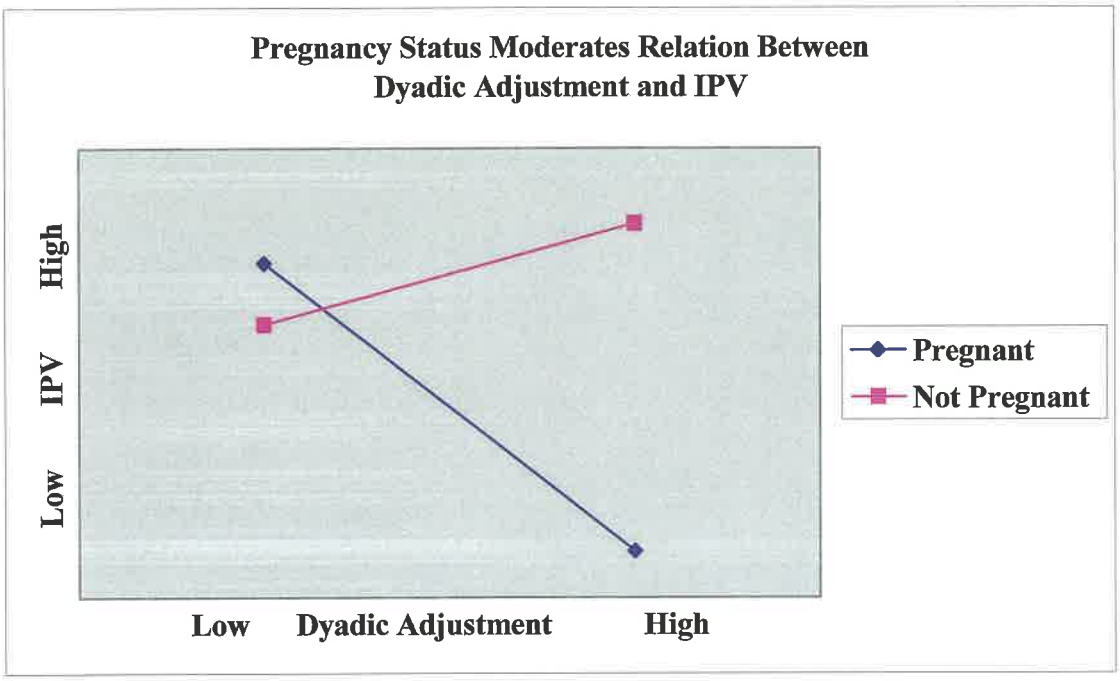


Pregnant=$p<.05$

Summary:

Pregnancy acts as a risk factor for IPV when women's partners use drugs. For pregnant women, women's partners' drug use puts one at risk of experiencing more IPV. However, when women are not pregnant, there is no relation between women's partners' drug use and IPV.

Figure 4: *Significant Interaction Between Pregnancy Status and Dyadic Adjustment Predicting IPV in the Last 12 Months*

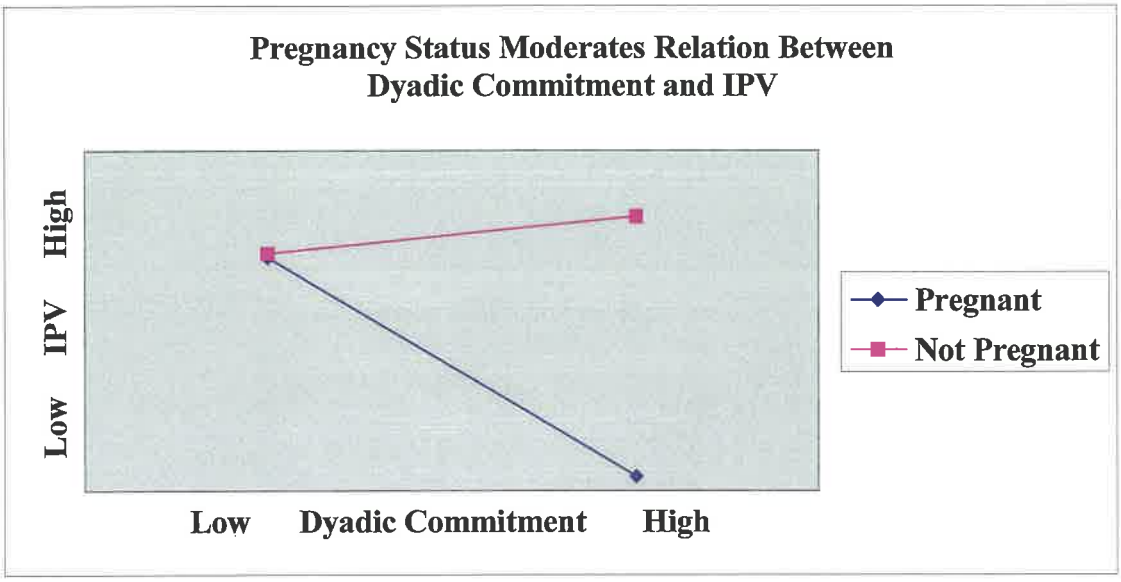


Pregnant=p<.05

Summary:

Pregnancy acts as a risk factor for IPV when women report lower dyadic adjustment. For pregnant women, lower dyadic adjustment puts one at risk of experiencing more IPV. However, when women are not pregnant, there is no relation between dyadic adjustment and IPV.

Figure 5: *Significant Interaction Between Pregnancy Status and Dyadic Commitment Predicting IPV in the Last 12 Months*

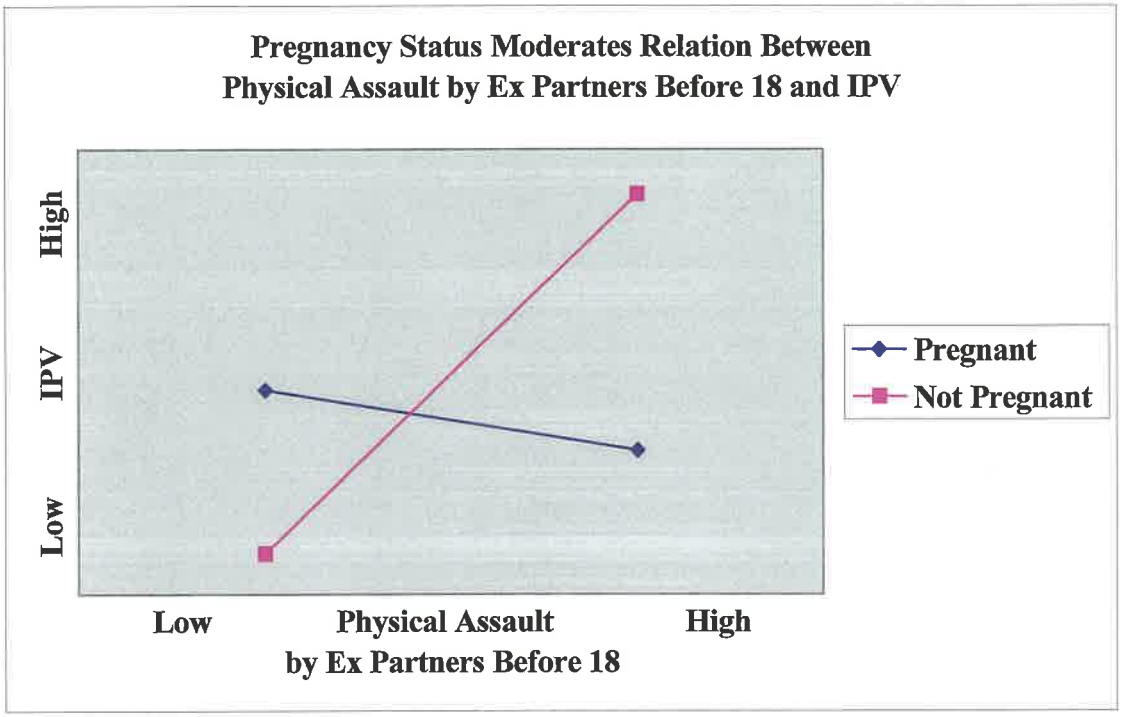


Pregnant=p<.05

Summary:

Pregnancy acts as a risk factor for IPV when women report lower dyadic commitment. For pregnant women, lower dyadic commitment puts one at risk of experiencing more IPV. However, when women are not pregnant, there is no relation between dyadic commitment and IPV.

Figure 6: *Significant Interaction Between Pregnancy Status and Physically Assaulted or Injured by Ex-partners Before 18 Predicting IPV in the Last 12 Months*



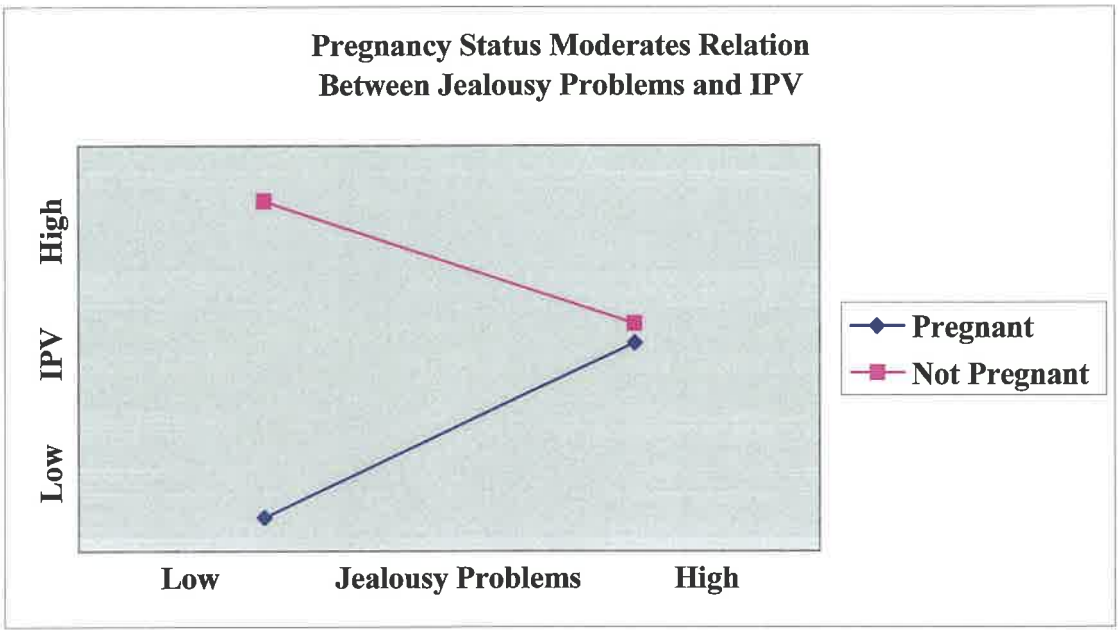
Pregnant=p<.05

Non-pregnant=p<.05

Summary:

Pregnancy acts as a protective factor for IPV when women report physical abuse (assault or injured) by ex-partners before 18. For non-pregnant women, higher physical abuse (assault or injured) by ex-partners before 18 puts one at risk of experiencing more IPV.

Figure 7: *Significant Interaction Between Pregnancy Status and Jealousy Problems Predicting IPV in the Last 12 Months*



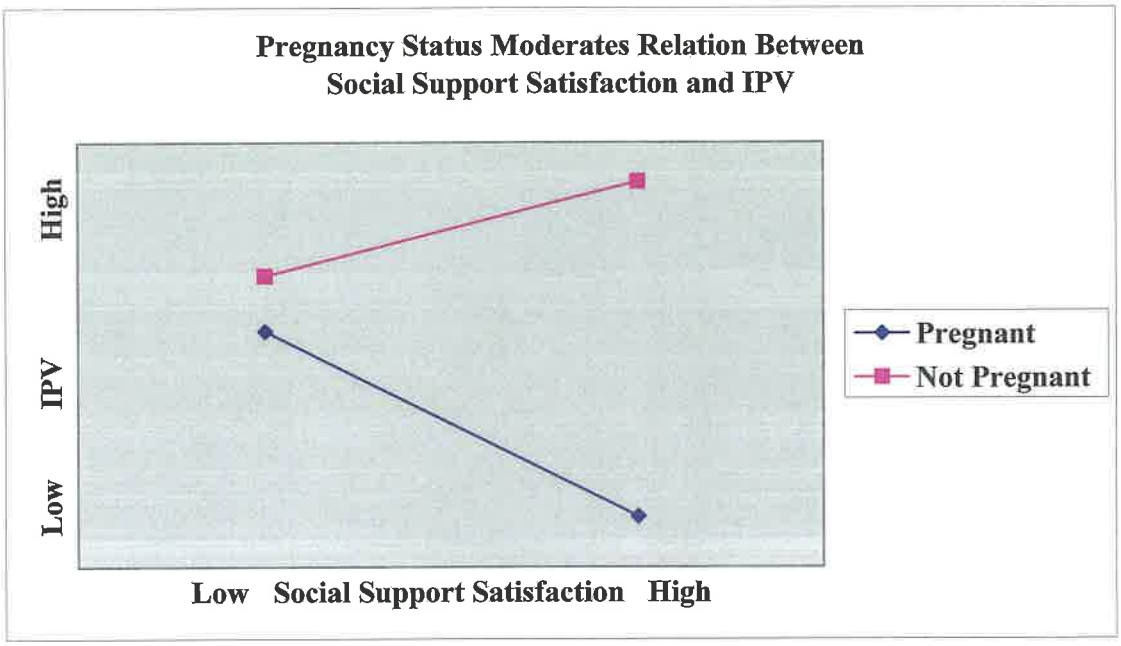
Pregnant=p<.10

Non-pregnant=p<.10

Summary:

Pregnancy puts one at risk of experiencing IPV when women report higher jealousy problems. For non-pregnant women, higher jealousy problems act as a protective factor and are related to lower IPV.

Figure 8: *Significant Interaction Between Pregnancy Status and Social Support Satisfaction Predicting IPV in the Last 12 Months*

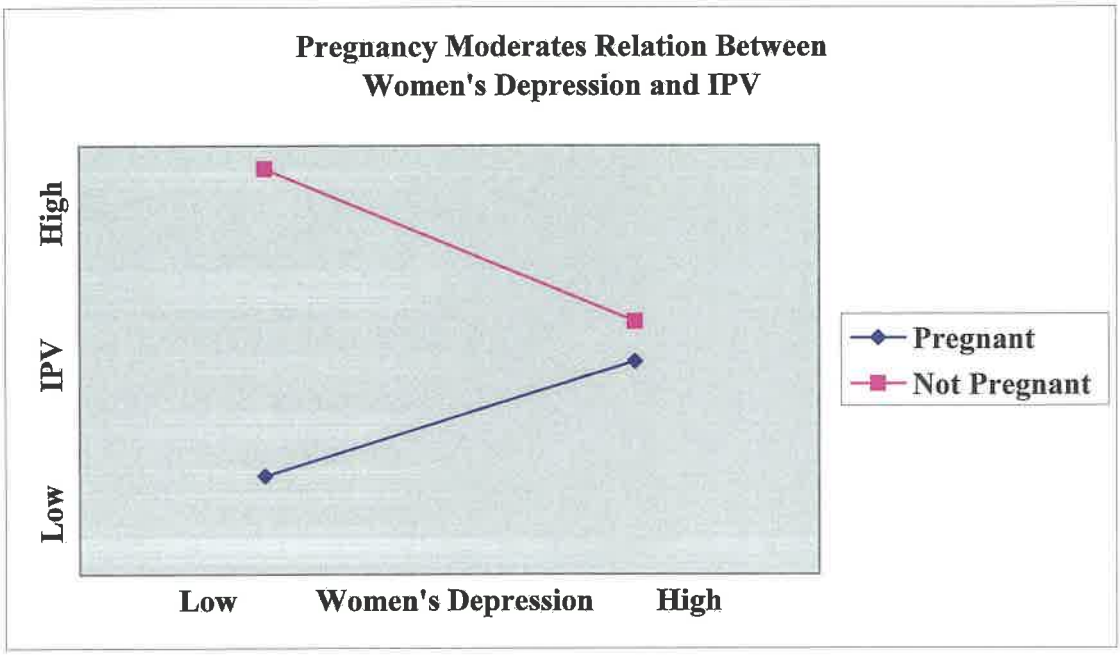


Pregnant=p<.10

Summary:

Pregnancy puts one at risk of experiencing IPV when women report lower social support satisfaction. However, not being pregnant acts as a buffer between low social support satisfaction and IPV.

Figure 9: Significant Interaction Between Pregnancy Status and Women's Depression Predicting IPV in the Last 12 Months



Non-pregnant=$p<.10$

Summary:

For non-pregnant women, depression acts as a protective factor for IPV. High levels of depression relate to lower IPV. For pregnant women, there is no relation between depression and IPV.

5. REFERENCES

Aiken, L. S., West, S. G., & Reno, R.R. (1991). *Multiple regression: Testing and interpreting interactions*. Newbury Park, CA: Sage Publications.

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

American Psychological Association. (1996). *Violence and the Family: Report of the APA Presidential Task Force on Violence and the Family --Executive Summary*. Retrieved April 24, 2008, from http://www.apa.org/pi/viol&fam.html.

Amor, P. J., Echeburúa, E., de Corral, P., Zubizarreta, I., & Sarasua, B. (2002). Repercusiones psicopatológicas de la violencia doméstica en la mujer en función de las circunstancias del maltrato [Psychopathological repercussions of domestic violence in the woman depending on abusive circumstances]. *Revista Internacional de Psicología Clínica y de la Salud,* 2(2), 227-246.

Astin, M.C., Ogland-Hand, S.M., Foy, D., & Coleman, E. M. (1995). Posttraumatic stress disorder and childhood abuse in battered women: Comparison with martially distressed women. *Journal of Consulting and Clinical Psychology,* 63, 308-312.

Austin, M.P., Hadzi-Pavlovic, D., Leader, L., Saint, K., & Parker, G. (2005). Maternal trait anxiety, depression and life event stress in pregnancy: relationships with infant temperament. *Early Human Development,* 81, 183-190.

Babcock, J.C., Jacobson, N., Gottman, J. M., & Yerington, T. P. (2000). Attachment, emotional regulation, and the function of marital violence: Differences between secure, preoccupied, and dismissing violent and nonviolent. *Journal of Family Violence*, 15(4), 391-409.

Bachman, J. G., O'Malley, P. M., Johnston, L. D., Rodgers, W. L., & Schulenberg, J. (1992). *Changes in drug use during the post-high school years.* (Monitoring the future occasional paper No. 35) Ann Arbor, MI: Ann Arbor Institute for Social Research Michigan University.

Baldry, A. C. (2003). "Stick and stones hurt my bones but his glance and words hurt more": The impact of physiological abuse and physical violence by current and former partners on battered women in Italy. *International Journal of Forensic Mental Health*, 2(1), 47-57.

Baldry, A.C., & Winkel, F.W. (2008). *Intimate partner violence: The risk assessment and management approach.* Hauppauge, NY: Nova Science Publishers.

Barnes, L. B., Harp, D., & Jung, W. S. (2002). Reliability generalization of scores on the Spielberg State-Trait Anxiety Inventory. *Educational and Psychological Measurement*, 62(4), 603-618.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, 51, 1173-1182.

Beck, A. T. (1979). *Terapia cognitiva de la depresión* [Cognitive therapy of depression]. Bilbao: Desclee de Brower.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-571.

Bedregal, L. E., Sobell, L. C., Sobell, M. B., & Simco, E. (2006). Psychometric characteristics of a Spanish version of the DAST-10 and the RAGS. *Addictive Behaviours*, 31, 309-319.

Belfrage, H., Rying, M. (2004). Characteristics of spousal homicide perpetrators: A study of all cases of spousal homicide in Sweden 1990-1999. *Criminal Behaviour and Mental Health,* 14(2), 121-133.

Bensley, L., Van Eenwyk, J., & Simmons, K. W. (2003). Childhood family violence history and women's risk for intimate partner violence and poor health. *American Journal of Preventive Medicine*, 25(1), 38-44.

Bennet, L., & Williams, O. J., (2003). Substance abuse and men who batter. *Violence Against Women*, 9(5), 558-575.

Berenson, A. B., Stiglich, N. J., Wilkinson, G. S., & Anderson, G. D. (1991). Drug abuse and other risk factors for physical abuse in pregnancy among White non-Hispanic, Black, and Hispanic women. *American Journal of Obstetrics and Gynecology*, 164, 1491-1499.

Bergman, B., & Brismar, B. (1991). A 5-year follow-up study of 117 battered women. *American Journal of Public Health*, 81(11), 1486-1489.

Berns, S. B., Jacobson, N. S., & Gottman, J. M. (1999). Demand-withdraw interaction in couples with a violent husband. *Journal of Consulting and Clinical Psychology*, 67(5), 666-674.

Black, D. A., Heyman, R. E., & Slep, A. M. (2001). Risk factors for male-to-female partner sexual abuse. *Aggression and Violent Behaviour*, 6, 269-280.

Blanco, P., Ruiz-Jarabo, C., Garcia de Vinuesa, L. G., & Martín-Garcia, M. (2004). La violencia de pareja y la salud de las mujeres [Couple violence and women's health]. *Gaceta Sanitaria*, 18(1), 182-188.

Bohn, D. K. (1990). Domestic violence and pregnancy: Implications for practice. *Journal of Nurse-Midwifery*, 35(2), 86-98.

Bolumar, F., Rebagliato, M., Hernandez-Aguado, I., & du V Florey, C. (1993). Smoking and drinking habits before and during pregnancy in Spanish women. *Journal of Epidemiology and Community Health*, 48, 36-40.

Bornstein, P., & Bornstein, M. (1988). *Terapia de pareja. Enfoque conductual-sistémico*. Madrid: Pirámide.

Breiding, M. J., Black, M. C., & Ryan, G. W. (2008). Prevalence and risk factors of intimate partner violence in eighteen U.S. states/territories, 2005. *American Journal of Preventive Medicine*, 34(2), 112-118.

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park, CA: Sage Publications.

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

Burch, R. L., & Gallup Jr., G. G., (2004). Pregnancy as a stimulus for domestic violence. *Journal of Family Violence*, 19(4), 243-247.

Bureau of Justice Statistics. (2003/2005a). *Homicide trends in the U.S.: Intimate homicide*. Retrieved April 2, 2008, from http://www.ojp.usdoj.gov/bjs/homicide/tables/intproptab.htm.

Bureau of Justice Statistics. (2003/2005b). *Intimate partner violence in the U. S.: Victims*. Retrieved April 2, 2008, from http://www.ojp.usdoj.gov/bjs/intimate/table/vomen.htm.

Bureau of Justice Statistics. (2005). *Crime characteristics*. Retrieved April 2, 2008, from http://www.ojp.usdoj.gov/bjs/cvict_c.htm).

Bybee, D., & Sullivan, C. M. (2005). Predicting re-victimization of battered women 3 years after exiting a shelter program. *American Journal of Community Psychology*, 36(1/2), 85-96.

Cáceres, J. (1996). *Manual de Terapia de Pareja e Intervención en Familias* [Couple therapy manual and family intervention]. Madrid: Fundación Universidad Empresa.

Cáceres, J. (1999). Discusiones de pareja, violencia y activación cardiovascular [Couple arguments, violence and cardiovascular activation]. *Análisis y Modificación de Conducta*, 25(104), 909-938.

Cáceres, J. (2002). Análisis cuantitativo y cualitativo de la violencia doméstica en la pareja [Quantitative and qualitative analysis of domestic violence in the relationship]. *Cuadernos de Medicina Psicosomática y Psiquiatría de Enlace*, 60, 57-67.

Cáceres, J. (2004). Violencia física, psicológica y sexual en el ámbito de la pareja: Papel del contexto [Physical, psychological, and sexual violence in the relationship setting: Dependent upon the context]. *Clínica y Salud*, 1, 33-34.

Cáceres, J. (2007). Violencia domestica: Lo que revela la investigacion basica con parejas [Domestic violence: what basic research reveals about couples]. *Papeles del Psicologo*, 28(1), 57–62.

Cáceres, A., & Cáceres, J. (2006). Violencia en relaciones intimas en dos etapas evolutivas [Violence in intimate relationships in two developmental stages]. *International Journal of Clinical and Health Psychology*, 6(2), 271–284.

Calvete, E., Corral, S., & Estévez, A. (2007). Factor structure and validity of the revised conflict tactics scales for Spanish women. *Violence Against Women*, 13(10), 1072-1087.

Calvete, E., Estévez, A., & Corral, S. (2007). Intimate partner violence and depressive symptoms in women: Cognitive schemas as moderators and mediators. *Behaviour Research and Therapy*, 45, 791-804.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, 359, 1331-1336.

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

Campbell, J. C., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., et al. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, 162, 1157-1163.

Campbell, J. C., Oliver, C. E., & Bullock, L. F. (1993). Why battering during pregnancy? *AWHONNS Clinical Issues in Perinatal and Women's Health Nursing*, 4(3), 343-349.

Campbell, J. C., Oliver, C. E., & Bullock, L. F. (1998). The dynamics of battering during pregnancy: Women's explanations of why. In J. C. Campbell (Ed.), *Empowering survivors of abuse* (pp. 81-89). Thousand Oaks, CA: Sage.

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

Campbell, J. C., Pugh, L. C., Campbell, D., & Visscher, M. (1995). The influence of abuse on pregnancy intention. *Women's Health Issues*, 5(4), 214-223.

Cascardi, M., O'Leary, K. D., Lawrence, E. E., & Schlee, K. A. (1995). Characteristics of women physically abused by their spouses and who seek treatment regarding marital conflict. *Journal of Consulting and Clinical Psychology*, 63(4), 616-623.

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, 1110-1116.

Centro Reina Sofía. (2003/2007). *Estadísticas. Violencia en el ámbito familiar en España. Femicidios de pareja* [Statistics. Violence in the family setting. Relationship femicide]. Retrieved April 2, 2008 from http://www.centroreinasofia.es/paneldecontrol/est/pdf/EST014-3274.pdf

Cerezo, A. (2000). *El homicidio en la pareja: Tratamiento criminológico* [Homicide in the couple: Criminological treatment]. Valencia: Tirant Lo Blanch.

Coan, J., Gottman, J. M., Babcock, J., & Jacobson, N. (1998). Battering and the male rejection of influence from women. *Aggressive Behaviour*, 23(5), 375-388.

Cocco, K., & Carey, K. (1998). Psychometric properties of the Drug Abuse Screening Test in psychiatric outpatients. *Psychological Assessment*, 10, 408–414.

Coid, J., Petruckevitch, A., Chung, W. S., Richardson, J., Moorey, S., & Feder, G. (2003). Abusive experiences and psychiatric morbidity in women primary care attenders. *British Journal of Psychiatry*, 183, 332-339.

Coid, J., Petruckevitch, A., Feder, G., Chung, W., Richarson, J., & Moorey. (2001). Relation between childhood sexual and physical abuse and risk of revictimisation in women: a cross-sectional survey. *Lancet*; 358, 450-454.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., et al. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine*, 23(4), 260-268.

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.

Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health & Gender-Based Medicine*, 11(5), 465-476.

Coker, A. L., Watkins, K. W., Smith, P. H., & Brandt, H. M. (2003). Social support reduces the impact of partner violence on health: Application of structural equation models. *Preventive Medicine*, 37, 259-267.

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

Cokkinides, V. E., 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.

Colson, C. (March 20, 1995). *Trial marriages on trial: Why they don't work.* Retrieved April 2, 2008, from http://www.breakpoint.org/listingarticle.asp?ID=3006

Connolly, A., Katz, V. L., Bash, K. L., McMachon, M. J., & Hansen, W. F. (1997). Trauma and pregnancy. *American Journal of Perinatology*, 14(6), 331-336.

Cordova, J. V., Jacobson, N. S., Gottman, J. M., Rushe, R., & Cox, G. (1993). Negative reciprocity and communication in couples with a violent husband. *Journal of Abnormal Psychology*, 102, 559-564.

Corsi, J. (1995). *Violencia masculina en la pareja. Una aproximación al diagnóstico y a los modelos de intervención* [Male violence in the relationship: An approach to diagnosis and treatment models]. Buenos Aires, Argentina: Paidós.

Council of Europe. (2002). *The protection of women against violence.* Retrieved April 2, 2008, from. http://www.coe.int/T/E/Human_Rights/Equality/PDF_Rec(2002)5_E.pdf

Crane, D. R., Allgood, S. M., Larson, J. H., & Griffin, W. (1990). Assessing marital quality with distressed and nondistressed couples: A comparison and equivalency table for three frequently used measures. *Journal of Marriage and the Family*, 52, 87-93.

Curry, M. A. (1998). The interrelationships between abuse, substance use, and psychosocial stress during pregnancy. *JOGNN*, 27, 692-699.

Curry, M. A., & Harvey, S. M. (1998). Stress related to domestic violence during pregnancy and infant birth weight. In J. C. Campbell (Ed.), *Empowering Survivors of Abuse* (pp. 98-108). Thousand Oaks, CA: Sage.

Dahlberg, L. L., & Krug, E. G. (2002). Violence – a global public health problem. In E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, and R. Lozano (Eds.), *World report on violence and health* (pp. 3-21). Geneva, World Health Organization.

Danielson, K. K., Moffitt, T. E., Caspi, A., & Silva, P. A. (1998). Comorbidity between abuse of an adult and DSM-III-R mental disorders: Evidence from an epidemiological study. *American Journal of Psychiatry*, 155, 131-133.

Dearwater, S. R., Coben, J. H., Campbell, J. C., Nah, G., Glass, N., McLoughlin, E., et al. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *Journal of the American Medical Association*, 280(5), 433-438.

Desai, S., Arias, I., Thompson, M. P., & Basile, K. (2002). Childhood victmization and subsequent adult revictimization assessed in a nationally representative sample of women and men. *Violence and victims*, 17(6), 639-653.

Dobash, R. P., Dobash, R. E., Cavanagh, K., & Leis, R. (1998). Separate and intersecting realities: A comparison of men's and women's accounts of violence against women. *Violence Against Women*, 4(4), 382-414.

Dunn, L. L., & Oths, K. S. (2004). Prenatal predictors of intimate partner abuse. *JOGNN*, 33(1), 54-63.

Dutton, D. G., Van Ginkel, C., & Landolt, M. A. (1996). Jealousy, intimate abusiveness, and intrusiveness. *Journal of Family Violence*, 11(4), 411-423.

Echeburúa, E. (1994). *Personalidades violentas*. Madrid: Pirámide.

Echeburúa, E., & de Corral, P. (1998). *Manual de violencia familiar* [Handbook of family violence]. (pp. 41-43). Madrid: Siglo XXI.

Echeburua, E., de Corral, P., Sarasua, B., & Zubizarreta, I. (1996).Tratamiento cognitivo-conductual del trastorno de estrés postraumático crónico en víctimas de maltrato domestico: un estudio piloto [Cognitive-behavioural treatment of chronic post-traumatic stress disorder in victims of domestic violence: a pilot study]. *Análisis y Modificación de Conducta*, 22, 85.

Escobar, F., Gonzalez, E. F., Lopez, J. L., Vercher, R., Arnal, J. A., & Galdamez, A. M. (1994). Validación del cuestionario SMAST para el diagnostico del alcoholismo en atención primaria [An evaluation of the SMAST questionnaire for the diagnosis of alcoholism in primary care. The self-administered Short Michigan Alcoholism Screening Test]. *Atención Primaria*, 14, 627-630.

Escribà-Agüir, V., Barona-Vilar, C., Calvo-Mas, C., Carpio-Gesta, M. L., & Fullana-Montoro, A. (2006). Lesiones por violencia doméstica en la Comunidad Valenciana [Injuries from domestic violence in the Valenciana Community]. *Gaceta Sanitaria*, 20(6), 510-512.

Escribà-Agüir, V., Ruiz-Pérez, I., & Saurel-Cubizolles, M. J. (2007). Screening for domestic violence during pregnancy. *Journal of Psychosomatic Obstetrics & Gynecology*, 28(3), 133-134.

Evins, G., & Chescheir, N. (1996). Prevalence of domestic violence among women seeking abortion services. *Women's Health Issues*, 6(4), 204-210.

Feld, S. L., & Straus, M. A. (1989). Escalation and desistance of wife assault in marriage. *Criminology*, 27(1), 141-161.

Feldman, S. S., & Nash, S. C. (1984). The transition from expectancy to parenthood: Impact-of the first-born child on men and women. *Sex Roles*, 11, 61-78.

Fernández-Montalvo, J., & Echeburúa, E. (1997). Variables psicopatológicas y distorsiones cognitivas de los maltratadores en el hogar: Un análisis descriptivo [Psychopathological variables and cognitive distortions in male batterers at home: A descriptive analysis]. *Análisis y Modificación de Conducta, 23*, 151-180.

Field, T. (2004). Prenatal depression effects on the fetus and the newborn. *Infant Behaviour & Development*, 27(2), 216.

Finkelhor, D., & Yllö, K. (1985). *License to Rape*. New York: Free Press.

Flaquer, L. (2002). Family policy and the maintenance of the traditional family in Spain. In A. Carling, S. Duncan, and R. Edwards (Eds.), *Analyzing families: Morality and rationality in policy and practice* (pp. 84-92). London: Routledge.

Fleisher, M. S., & Krienert, J. L. (2004). Life-course events, social networks, and the emergence of violence among female gang members. *Journal of community psychology*, 32(5), 607-622.

Fleming, M. F., & Barry, K. L (1988). A study examining the psychometric properties of the SMAST-13. *Journal of Substance Abuse*, 1, 173-182.

Garcia-Linares, M. I., Pico-Alfonso, M. A., Sanchez-Lorente, S., Savall-Rodriguez, F., Celda-Navarro, N., Blasco-Ros, C., et al. (2005). Assessing physical, sexual, and psychological violence perpetrated by male partners toward women: A Spanish cross-sectional study. *Violence and Victims*, 20(1), 99-123.

Garcia-Linares, M. I., Sanchez-Lorente, S., Coe, C. L., & Martinez, M. (2004). Intimate male partner violence impairs immune control over herpes simplex virus type 1 in physically and psychologically abused women. *Psychosomatic Medicine*, 66, 965-972.

Gazmararian, J. A., Adams, M. M., Saltzman, L. E., Johnson, C. H., Bruce, C., Marks, J. S., et al. (1995). The relationship between pregnancy intendedness and physical violence in mothers of newborns. *Obstetrics &* Gynecology 85(6), 1031-1038.

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

Gazmararian, J. A., Petersen, R., Spitz, A. M., Goodwin, M. M., Saltzman, L. E., & Marks, J. S. (2000). Violence and reproductive health: Current knowledge and future research directions. *Maternal and Child Health Journal*, 4(2), 79-84.

Gelles, R. J. (1974). *The violent home: A study of physical aggression between husbands and wives* (Vol. 13). Beverly Hills, CA: Sage Publications.

Gelles, R. J. (1990). Violence and pregnancy: Are pregnant women at greater risk of abuse? In M. A. Straus and R. J. Gelles (Eds.), *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp.279-286). New Brunswick, NJ: Transaction Books.

Gelles, R. J., & Harrop, J. W. (1989). Violence, battering, and psychological distress among women. *Journal of Interpersonal Violence*, 4(4), 400-420.

Gilbert, L. (1996). Urban violence and health: South Africa 1995. *Social Science and Medicine*, 43, 873-886.

Glander, S. S., Moore, M. L., Michielutte, R., & Parsons, L. H. (1998). The prevalence of domestic violence among women seeking abortion. *Obstetrics y Gynecology*, 91(6), 1002-1006.

Goodwin, M., Gazmararian, J. A., Johnson, C. H., Gilbert, B. C., Saltzman, L. E., & Group, P. W. (2000). Pregnancy intendedness and physical abuse around the time of pregnancy: Findings from the Pregnancy Risk Assessment Monitoring System, 1996-1997. *Maternal and Child Health Journal*, 4(2), 85-92.

Gottman, J., Jacobson, N. S., Rushe, R., Shortt, J., & Babcock, J. (1995). The relationship between heart rate reactivity, emotionally aggressive behaviour and general violence in batterers. *Journal of Family Psychology*, 9(3), 227-248.

Graham, J. M., Liu, y. J., & Jeriorski, J. L. (2006). The dyadic adjustment scale: A reliability generalization meta-analysis. *Journal of Marriage and Family*, 68, 701-711.

Greenfeld, L., Rand, M., Craven, D., Klaus, P., Perkins, C., Warchol, G., et al. (1998). *Violence by intimates: Analysis of data on crimes by current or former spouses, boyfriends, and girlfriends*. Washington, DC: U. S. Department of Justice.

Grimstad, H., Schei, B., Backe, B., & Jacobson, G. (1997). Physical abuse and low birthweight: A case-control study. *British Journal of Obstetrics and Gynecology*, 104, 1281-1287.

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., Möller, 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, 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.

Heise, L., Ellsberg, M., & Gottemoeller, M. (1999). *Ending violence against women-population Reports, series L, n°11*. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

Heise, L., & García-Moreno, C. (2002). Violence by intimate partners. In E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, and R. Lozano (Eds.), *World report on violence and health* (pp. 89-121). Geneva, World Health Organization.

Helmut, K., Oberhfell-Fuchs, J., & Woessner, G. (2004); The extent of family violence in Europe: Comparison of national surveys. *Violence Against Women*, 10(7), 749-769.

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

Henning, K., Leitenberg, H., Coffey, P., Turner, T., & Bennett, R. T. (1996). Long-term psychological and social impact of witnessing physical conflict between parents. *Journal of Interpersonal Violence*, 11(1), 35-51.

Heyman, R. E., O'Leary, K. D., & Jouriles, E. N. (1995). Alcohol and aggressive personality styles: Potentiators of serious physical aggression against wives? *Journal of Family Psychology*, 9(1), 44-57.

Holtzworth-Munroe, A., Stuart, G. L., & Hutchinson, G. (1997). Violent versus nonviolent husbands: Differences in attachment patterns, dependency, and jealousy. *Journal of Family Psychology*, 11(3), 314-331.

Horrigan, T. J., Schroeder, A. V., & Schaffer, R. M. (2000). The triad of substance abuse, violence, and depression are interrelated in pregnancy. *Journal of Substance Abuse Treatment*, 18, 55-58.

Instituto de la Mujer. (1999). *La violencia contra las mujeres. Resultados de la macroencuesta* [Violence against women. Results of the macro-survey]. Madrid, Spain: Instituto de la Mujer y Ministerio de Trabajo y Asuntos sociales.

Instituto de la Mujer. (2002/2006). *Violencia. Estadísticas. Violencia. Denuncias. Enlace a tablas. Denuncias por malos tratos producido por la pareja o expareja, según C.C.A.A.* [Violence. Statistics. Violence. Reports. Link to tables. Reports of abuse by intimate partners or ex-partners, based on regional councils]. Retrieved April 2, 2008, from http://www.mtas.es/mujer/mujeres/cifras/violencia/denuncias_tablas.htm

Instituto de la Mujer, (2004). *Denuncias por malos tratos producidas por el cónyuge o análogo. Año 2003*. [Reported maltreatment by spouses or partners. year 2003]. Madrid, Spain.

Jackson, N. I. (1996). Observational experiences of intrapersonal conflict and teenage victimization: A comparative study among spouses and cohabitors. *Journal of Family Violence*, 11(3), 191-203.

Jacobson, N. S., & Gottman, J. M. (1998). *When men batter women: New insights into ending abusive relationships*. New York, NY: Simon & Schuster.

Jacobson, N. S., Gottman, J. M., Gortner, E., Berns, S., & Shortt, J. W. (1996). Psychological factors in the longitudinal course of battering: When do the couples split up? When does the abuse decrease? *Violence and Victims*, 11, 371-392.

Jacobson, N. S., Gottman, J. M., Waltz, J., Rushe, R., Babcock, J., & Holtzworth-Munroe, A. (1994). Affect, verbal content, and psychophysiology in the arguments of couples with a violent husband. *Journal of Consulting and Clinical Psychology*, 62, 982-988.

Jacoby, M., Gorenflo, D., Black, E., Wunderlich, C., & Eyler, A. E. (1999). Rapid repeat pregnancy and experiences of interpersonal violence among low-income adolescents. *American Journal of Preventative Medicine*, 16(3), 195-203.

Jasinski, J. L. (2001). Pregnancy and violence against women: An analysis of longitudinal data. *Journal of Interpersonal Violence*, 16(7), 713-734.

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

Jewkes, R., Levin, J., & Penn-Kekana, L. (2002). Risk factors for domestic violence: Findings from a South African cross-sectional study. *Social Science & Medicine*, 55, 1603-1617.

Kantor, G. K., Jasinski, J. L., & Aldarondo, E. (1994). Sociocultural status and incidence of marital violence in Hispanic families. *Violence and Victims*, 9(3), 207-222.

Kantor, G. K., & Straus, M. A. (1989). Substance abuse as a precipitant of wife abuse victimizations. *American Journal of Drug and Alcohol Abuse*, 15(2), 173-189.

Karaçam, Z., & Ançel, G. (2007). Depression, anxiety and influencing factors in pregnancy: a study in a Turkish population. *Midwifery*. Retrieved August 1, 2008, from http://www. doi:10.1016/j.midw.2007.03.006

Keeling, J., & Van Wormer, K.S. (2007). Roles for health care professionals in the United Kigdom and the United States in addressing the problem of domestic violence. In E. C. Roberts (Ed.), *Battered women and their families: Intervention strategies and treatment programs,* (3rd Ed) (pp. 277-300). New York, NY: Springer Publishing Co.

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, 1892-1898.

Labrador, F. J., & Alonso, E. (2005/2006). Trastorno de estrés postraumático en mujeres víctimas de violencia doméstica: Un programa de intervención breve y específico [Posttraumatic stress disorder in women victims of domestic violence: A short and specific intervention program]. *Cuadernos de Medicina Psicosomática y Psiquiatría de Enlace*, 76-77, 47-65.

Labrador, F. J., Fernández-Velasco, M. R., & Rincón P.P. (2006). Eficacia de un programa de intervención individual y breve para el trastorno de estrés postraumático en mujeres víctimas de violencia doméstica [Efficiency of an individual and short intervention program for the posttraumatic stress disorder in women victims of domestic violence]. *International Journal of Clinical and Health Psychology*, 6(3), 527-547.

Labrador, F. J., Rincón, P. P., de Luis, P., & Fernández-Velasco, R. (2004). *Mujeres víctimas de la violencia doméstica* [Women victims of domestic violence]. Madrid: Pirámide.

Lavee, Y., McCubbin, H. I., & Olson, D. H. (1987). The effect of stressful life events and transitions on family functioning and well-being. *Journal of Marriage and the Family*, 49(4), 857-873.

Lejoyeux, M., Fichelle, A., & Saliou, V. (2007). Domestic violence: main results form French studies. In P. M. Verrity (Ed.), *Violence and aggression around the globe*. Hauppauge, NY: Nova Science Publishers.

Leonard, K. E., & Senchak, M. (1996). Prospective prediction of husband marital aggression within newlywed couples. *Journal of Abnormal Psychology*, 105(3), 369-380.

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 y Obstetrics*, 66, 23-30.

Locke, H. J., & Wallace, K. M. (1959). Short marital adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living*, 21, 251-255.

Loewenberg, S. (2005). Domestic violence in Spain. *The Lancet*, 365, 464.

Lorente, M. (2001). *Mi marido me pega, lo normal* [My husband hits me, this is nothing new]. Barcelona: Ares & Mares.

Lorente, M., & Lorente, J. A. (1998). *Agresión a la mujer: Maltrato, violación y acoso* [Aggression towards women: Harassment, rape and stalking]. Granada: Comares.

Lown, E. A., & Vega, W. A. (2001). Prevalence and predictors of physical partner abuse among Mexican American women. *American Journal of Public Health*, 91, 441–445.

Macklin, E. D. (1972). Heterosexual cohabitation among unmarried college students. *The Family Coordinator*, 21(4), 463-472.

Magdol, L., Moffitt, T. E., Caspi, A., Newman, D. L., Fagan, J., & Silva, P. A. (1997). Gender differences in partner violence in a birth cohort of 21-year-olds: Bridging the gap between clinical and epidemiological approaches. *Journal of Consulting and Clinical Psychology*, 65(1), 68-78.

Manjavacas, M. (2006). La felicidad de los españoles se apoya en la familia y la salud [Spaniards happiness is based on family and health]. *Revista de Estadística y Sociedad.* Enero (14).

Marchiori, E., Rossi, L; Colombo, G. (2004). The battered woman syndrome in Italy. A psychological prospective study [Uno studio in prospecttiva psicopatologica]. *Minerva Psichiatrica.* 45(1), 43-53.

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., Harris-Britt, A., Li, Y., Moracco, K. E., Kupper, L. L., & Campbell, J. C. (2004). Changes in intimate partner violence during pregnancy. *Journal of Family Violence*, 19(4), 201-210.

Martin, S. L., Mackie, L., Kupper, L. L., Buescher, P. A., & Moracco, K. E. (2001). Physical abuse of women before, during, and after pregnancy. *Journal of the American Medical Association*, 285(12), 1581-1584.

McFarlane, J., & Parker, B. (1996). Physical abuse, smoking, and substance use during pregnancy: Prevalence, interrelationships, and effects on birth weight. *Journal of Obstetrics, Gynecology, and Neonatal Nursing*, 25, 313-320.

McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for abuse during pregnancy. *Journal of the American Medical Association*, 267(23), 3176-3178.

McKenry, P. C., Julian, T. W., & Gavazzi, S. M. (1995). Toward a biopsychosocial model of domestic violence. *Journal of Marriage and the Family*, 57(2), 307-320.

Medina, J. (2002). *Violencia contra la mujer en la pareja: investigación comparada y situación en España* [Violence against women in the relationship: Comparative research and context in Spain]. Valencia: Tirant lo Blanch.

Medina-Ariza, J., & Barberet, R. (2003). Intimate partner violence in Spain: Findings from a national survey. *Violence Against Women*, 9, 302-322.

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

Murphy, C. M., Meyer, S. L., & O'Leary, K. D. (1994). Dependency characteristics of partner assaultive men. *Journal of Abnormal Psychology*, 103(4), 729-735.

Nayak, M. B., & Al-yattama, M. (1999). Assault victim history as a factor in depression during pregnancy. *Obstetrics and Gynechology*, 94(2), 204-208.

National Statistics Institute. *Census 2001*. Retrieved April 2, 2008, from http://www.ine.es.

Neilsen, J., Russell, E., & Ellington, B. (1992). Social isolation and wife abuse: A research report. In E. C. Viano (Ed.), *Intimate violence: Interdisciplinary perspectives* (pp. 49-59). Washington, DC: Hemisphere Publishing Corp.

Nelson, H. D., Nygren, P., McInerney, Y., & Klein, J. (2004). Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. preventive services task force. *Annals of Internal Medicine*, 140(5), 387-396.

Painter, K., & Farrington, D. P. (1998). Marital violence in Great Britain and its relationship to marital and non-marital rape. *International Review of Victimology*, 5, 257-276.

Palma, S., Pardo-Crespo, R., Mariscal, M., Pérez-Iglesias, R., Llorca, J., & Delgado-Rodríguez, M. (2007). Weekday but not weekend alcohol consumption before pregnancy influences alcohol cessation during pregnancy. *European Journal of Public Health*, 17(4), 394-399.

Pan, H. S., Neidig, P. H., & O'Leary, K. D. (1994). Predicting mild and severe husband-to-wife physical aggression. *Journal of Consulting and Clinical Psychology*, 62(5), 975-981.

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

Pearlin, L. I., Lieberman, M. A., Menaghan, E. G., & Mullan, J. T. (1981). The stress process. *Journal of Health and Social Behaviour*, 22, 337-356.

Petersen, R., Gazmararian, J., & Clark, K. A. (2001). Partner violence: Implications for health and community settings. *Women's Health Issues*, 11(2), 116-125.

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

Petersen, R., Saltzman, L. E., Goodwin, M., & Spitz, A. (1997). *Key scientific issues for research on violence occurring around the time of pregnancy.* Atlanta, GA: Centres for Disease Control.

Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety and suicide. *Journal of Women's Health*, 15(5), 599-611.

Plichta, S. (2004). Intimate partner violence and physical health consequences: Policy and practice implications. *Journal of Interpersonal Violence*, 19, 1296-1323.

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.

Ramos-Lira, L., Saltijeral-Mendez, M. T., Romero-Mendoza, M., Caballero-Gutierrez M. A., & Martinez-Velez N. A. (2001). Violencia sexual y problemas asociados en una muestra de usuarias de un centro de salud [Sexual violence and associated problems in an sample of a healthcare centre]. *Salud Publica de México*, 43, 182–91.

Raush, H. L., Barry, W. A., Hertel, R. K., & Swain, M. A. (1974). *Communication, conflict, and marriage.* San Francisco: Jossey-Bass.

Raya-Ortega, L., Ruiz-Pérez, I., Plazaola-Castaño, J., Brun-López-Abisab, S., Rueda-Lozano, D., García de Vinuesa, L., et al. (2004). La violencia contra la mujer en la pareja como factor asociado a una mala salud física y psíquica [Violence against women in the relationship as an associated factor of bad physical and psychological health]. *Atención Primaria*, 34, 117–24.

Reichenheim, M. E., Ferreira-Patricio, T., & Leite-Moraes, C., (2008). *Detecting intimate partner violence during pregnancy: awareness-raising indicators for use by primary healthcare professionals.* Public Health: Elsevier

Renker, P. R. (1999). Physical abuse, social support, self-care, and pregnancy outcomes of older adolescents. *Journal of Obstetrics, Gynecology, and Neonatal Nursing*, 28, 377-388.

Riggs, D. S., Caulfield, M. B., & Street A. E. (2000). Risk for domestic violence: Factors associated with perpetration and victimization. *Journal of Clinical Psychology*, 56(10), 1289-1316.

Rincón, P. P., Labrador, F. J., Arinero, M., & Crespo, M. (2004). Efectos psicopatológicos del maltrato doméstico [Psychopathological effects of domestic abuse]. *Avances en Psicología Latinoamericana*, 22, 105-116.

Roberts, A.R. (2007). *Battered women and their families: Intervention strategies and treatment programs*, (3rd Ed.). New York: Springer.

Romito, P., Crisma, M., & Saurel-Cubizolles, M. J. (2003). Adul outcomes in women who experienced parental violence duirng childhood. *Child Abuse & Neglect*, 27(10), 1127-1144.

Rosen, D., Seng, J. S., Tolman, R. M., & Mallinger, G. (2007). Intimate partner violence, depression, and posttraumatic stress disorder as additional predictors of low birth weight infants among low-income mothers. *Journal of Interpersonal Violence*, 22(10), 1305-1314.

Rosenbaum, A., & O'Leary, K. D. (1981). Marital violence: Characteristics of abusive couples. *Journal of Consulting and Clinical Psychology*, 49(1), 63-71.

Ruiz-Pérez, I., Blanco-Prieto, P., & Vives-Cases, C. (2004). Violencia contra la mujer en la pareja: Determinantes y respuestas sociosanitarias [Violence against women: Determinants and socio-health care responses]. *Gaceta Sanitaria*, 18(2), 4-12.

Ruiz-Pérez, I., Mata-Pariente, N., & Plazaola-Castaño, J. (2006). Women's response to intimate partner violence. *Journal of Interpersonal Violence*, 21(9), 1156-1168.

Ruiz-Pérez, I., & Plazaola-Castaño, J. (2005). Intimate partner violence and mental health consequences in women attending family practice in Spain. *Psychosomatic Medicine*, 67, 791-797.

Ruiz-Pérez, I., Plazaola-Castaño, J., Alvarez-Kindelán, M., Palomo-Pinto, M., Arnalte-Barrera, M., Bonet-Pla, A., et al. (2006). Sociodemographics associations of physical, emotional, and sexual intimate partner violence in Spanish women. *Annals of Epidemiology*, 16, 357-363.

Ruiz-Pérez, I., Plazaola-Castaño, J., Blanco-Prieto, P., González-Barranco, J. M., Ayuso-Martín, P., & Montero-Piñar, M. I. (2006). La violencia contra la mujer en la pareja. Un estudio en el ámbito de la atención primaria [Intimate partner violence. A survey in primary care settings]. *Gaceta Sanitaria*, 20(3), 202-208.

Ruiz-Pérez, I., Plazaola-Castaño, J., & del Río-Lozano, M. (2006). How do women in Spain deal with an abusive relationship? *Journal of Epidemiology and Community Health*, 60, 706-711.

Russell, M. N., Lipov, E., Phillips, N., & White, B. (1989). Psychological profiles of violent and nonviolent martially distressed couples. *Psychotherapy*, 26(1), 81-87.

Sagrestano, L. M., Heavey, C. L., & Christensen, A. (1999). Perceived power and physical violence in marital conflict. *Journal of Social Issues*, 55(1), 65-79.

Saltzman, L. E., Green, Y. T., Marks, J. S., & Thacker, S. B. (2000). Violence against women as a public health issue: Comments from the CDC. *American Journal of Preventive Medicine*, 19(4), 325-329.

Saltzman, L. E., Johnson, C. H., Gilbert, B. C., & Goodwin, M. M. (2003). Physical abuse around the time of pregnancy: An examination of prevalence and risk factors in 16 states. *Maternal and Child Health Journal*, 7(1), 31-43.

Sanz, J., & Vázquez, C. (1998). Fiabilidad , validez y datos normativos del inventario para la depresión de Beck [Reliability, validity and normative data of the Beck depression inventory]. *Psicothema*, 10(2), 303-318.

Schumacher, J. A., Feldbau-Kohn, S., Slep, A. M. S., & Heyman, R. E. (2001). Risk factors for male-to-female partner physical abuse. *Aggression and Violent Behaviour*, 6, 281-352.

Schumacher, J. A., Slep, A. M. S., & Heyman, R. E. (2001). Risk factors for male-to-female partner psychological abuse. *Aggression and Violent Behaviour*, 6, 255-268.

Seisdedos, N. (1982). *STAI cuestionario de ansiedad-estado-rasgo*. Madrid: TEA.

Selzer, M. L., Vinojur, A., & Van Rooijen, L. A. (1975). A self-administered Short Michigan Alcoholism Screening Test (SMAST). *Journal of Studies on Alcohol*, 36, 117-126.

Seng, J. S. (2002). A conceptual framework for research on lifetime violence, posttraumatic stress, and childbearing. *Journal of Midwifery & Women's Health*, 47(5), 337-345.

Shadigian, E. M., Bauer, S. T. (2004). Screening for partner violence during pregnancy. *International Journal of Gynecology and Obstetrics*, 84, 273-280.

Shapiro, A. F., & Gottman, J. M. (2005). Effects on marriage of a psycho-communicative-educational intervention with couples undergoing the transition to parenthood, evaluation at 1-year post intervention. *Journal of Family Communication*, 5(1), 1-24.

Shapiro, A. F., Gottman, J. M., & Carrère, S. (2000). The baby and the marriage: Identifying factors that buffer against decline in marital satisfaction after the first baby arrives. *Journal of Family Psychology*, 14(1), 59-70.

Shumway, J., O'Campo, P., Gielen, A., Witter, F. R., Khouzami, A. N., & Blakemore, K. J. (1999). Preterm labour, placental abruption, and premature rupture of membranes in relation to maternal violence or verbal abuse. *The Journal of Maternal-Fetal Medicine*, 8(3), 76-80.

Silva, C., McFarlane, J., Soeken, K., Parker, B., & Reel, S. (1997). Symptoms of posttraumatic stress disorder in abused women in a primary setting. *Journal of Women's Health*, 6(5), 543-552.

Silverman, J. G., Decker, M. R., Reed, E., & Raj, A. (2006). Intimate partner violence victimization prior to and during pregnancy among women residing in 26 U.S. states: Associations with maternal and neonatal health. *American Journal of Obstetrics and Gynecology*, 195, 140-148.

Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behaviours*, 7, 363-371.

Smikle, C. B., Sorem, K. A., Stain, A. J., & Hankins, G. D. (1996). Physical and sexual abuse in middle-class obstetric population. *Southern Medical Journal*, 89(10), 983-988.

Smith, M. V., Rosenheck, R. A., Cavaleri, M. A., Howell, H. B., Poschman, K., & Yonkers, K. A. (2004). Screening for and detection of depression, panic disorder, and PTSD in public-sector obstetric clinics. *Psychiatric Services*, 55(4), 407-414.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing quality of marriage and similar dyads. *Journal of Marriage and the Family*, 38, 15-28.

Spielberg, C.D., Gorusch, R. L., & Lushene, R. E. (1970). *Manual for the State/Trait Anxiety Inventory*. Palo Alto CA: Consulting Psychologists Press.

Stamp, G. H. (1994). The appropriation of the parental role through communication during the transition to parenthood. *Communication Monographs*, 61, 89-112.

Stein, M. B., & Kennedy, C. (2001). Major depressive and post-traumatic stress disorder comorbidity in female victims of intimate partner violence. *Journal of Affective Disorders*, 66, 133-138.

Stets, J. E. (1991). Cohabiting and marital aggression: The role of social isolation. *Journal of Marriage and the Family*, 53(3), 669-680.

Stets, J., E. & Straus, M. A. (1989). Marriage license as a hitting license: A comparison of assaults in dating, cohabiting, and married couples. In M. A. Straus and R. J. Gelles (Eds.), *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp. 227-244). New Brunswick, NJ: Transaction Books.

Stewart, D. E., & Cecutti, A. (1993). Physical abuse in pregnancy. *Canadian Medical Association Journal*, 149(9), 1257-1263.

Stith, S. M., Smith, D. B., Penn, C. E., Ward, D. B., & Tritt, D. (2004). Intimate partner physical abuse perpetration and victimization risk factors: A meta-analytic review. *Aggression and Violent Behaviour*, 10, 65-98.

Straus, M. A. (2004). Cross-cultural reliability and validity of the revised conflict tactics scales; a study of university students dating couples in 17 nations. *Cross-Cultural Research*, 38, 407-432.

Straus, M. A., & Douglas, E. M. (2004). A short from of the revised conflict tactics scales, and typologies for severity and mutuality. *Violence and Victims*, 19, 507-520.

Straus, M. A., & Gelles, R. J. (1990). How violent are American families? Estimates from the National Family Violence Resurvey and other studies. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American Families* (pp. 95-131). New Brunswick, NJ: Transaction Publishers.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflicts Tactics Scale. *Journal of Family Issues*, 17, 283-316.

Swahnberg, K., Wijma, B., Schei, B., Hilden, M., Irminger, K., & Wingren, G. B. (2004). Are sociodemographic and regional and sample factors associated with prevalence of abuse?. *Acta Obstetricia et Gynecologica Scandinavica*, 83, 276-288.

Taggart, L., & Mattson, S. (1996). Delay in prenatal care as a result of battering in pregnancy: Cross-cultural implications. *Health Care for Women International*, 17(1).

Telch, C. F., & Lindquist, C. U. (1984). Violent versus nonviolent couples: A comparison of patterns. *Psychotherapy*, 21(2), 242-248

Tilley, D. S., & Brackley, M. (2004). Violent lives of women: Critical points for intervention–Phase I focus groups. *Perspectives in Psychiatric Care*, 40(4), 157-166.

Tjaden, P., & Thoennes, N. (2000). *Full report of the prevalence, incidence, and consequences of violence against women.* Washington, DC: National Institute of Justice, Centres for Disease Control and Prevention.

Thompson, R. S., Bonomi, A. E., Anderson, M., Reid, R. J., Dimer, J. A., Carrell., et al. (2006). Intimate Partner Violence Prevalence, Types, and Chronicity in Adult Women. *American Journal of Preventive Medicine*, 34(6):478-85.

Tolman, R. M., & Rosen, D. (2001). Domestic violence in the lives of women receiving welfare. *Violence Against Women*, 7(2), 141-158.

Tremblay, S. (1999). *Crime statistics in Canada, 1998.* Ottowa, ON: Canadian Centre for Justice Statistics.

Tsui, K. L., Chan, A. Y., So, F. L., & Kam, C. W. (2006). Risk factors for injury to married women from domestic violence in Hong Kong. *Hong Kong Medical Journal,* 12(4), 289-293.

Vázquez, C., & Sanz, J. (1999). Fiabilidad y validez de la versión española del Inventario para la Depresión de Beck de 1978 en pacientes con trastornos psicológicos. *Clínica y Salud, 10,* 59-81.

Vest, J. R., Catlin, T. K., Chen, J. J., & Brownson, R. C. (2002). Multistate analysis of factors associated with intimate partner violence. *American Journal of Preventive Medicine*, 22(3), 156-164.

Villavicencio, P., & Batista, N. M. (1992). Un problema específico de salud en la mujer: la situación de maltrato [A specific women's health problem: Abusive situation]. Revisión teórica. *Clínica y Salud, 3*(3), 239-249.

Villavicencio. R., & Sebastián, J. (1999). *Violencia doméstica: Su impacto en la salud fisica y mental de las mujeres* [Domestic violence: Its impact on women's physical and mental health]. Instituto de la Mujer, Ministerio de Trabajo y Asuntos Sociales, Madrid.

Vives, C., Alvarez-Dardet, C., & Caballero, P. (2003). Violencia del compañero íntimo en España [Intimate partner violence in Spain]. *Gaceta Sanitaria*, 17(4), 268-274.

Watts, C., & Zimmerman, C. (2002). Violence against women: global scope and magnitude. *The Lancet*, 359, 1232–1237.

Webster, J., Chandler, J., & Battistutta, D. (1996). Pregnancy outcomes and health care use: Effects of abuse. *American Journal of Obstetric Gynecology*, 174(2), 760-767.

Webster, J., Sweett, S., & Stolz, T. A. (1994). Domestic violence in pregnancy: A prevalence study. *The Medical Journal of Australia*, 161(17), 466-470.

Wiemann, C. M., Agurcia, C. A., Berenson, A. B., Volk, R. J., & Rickert, V. I. (2000). Pregnant adolescents: Experiences and behaviours associated with physical assault by an intimate partner. *Maternal and Child Health Journal*, 4(2), 93-101.

Williams, S. T., & Mickelson K.D. (2004). *The Nexus of Domestic Violence and Poverty. Violence Against Women*, 10(3), 283-293.

World Health Organization. (2005). *WHO multi-country study on women's health and domestic violence against women: Summary report of initial results on prevalence, health outcomes and women's responses.* Geneva: World Health Organization

World Health Organization (1996). Global Consultation on Violence and Health. *Violence: A public health priority*. Geneva: World Health Organization.

Yllö, K., & Straus, M. A. (1981). Interpersonal violence among married and cohabiting couples. *Family Relations*, 30(3), 339-347.

Yudko, E., Lozhkina, O., & Fouts, A (2006). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *Journal of Substance Abuse Treatment*, 32, 189-198.

Zlotnick, C., Kohn, R., Petersen, J., & Pearlstein, T. (1998). Partner physical victimization in a national sample of American families. *Journal of Interpersonal Violence*, 13, 156-166

6. APPENDIX I: SURVEY

To be filled out by project personnel only:

Identification number:

Date:

To be filled out by project personnel only:

Initial identification number:

UNIVERSITY OF WASHINGTON

INFORMATION STATEMENT

"Learning from your relationship" Dissertation research study

Primary Investigator: Itziar Luzarraga Monasterio, Ph.C
Doctoral Candidate, Universidad de Deusto
Visiting Scientist, University of Washington. Department of Psychology
Dissertation research study
(206)-484-3378

Co-investigators: Alyson Shapiro, Ph.D, and Dan Yoshimoto, Ph.D

Faculty Sponsor: John M. Gottman, Ph.D

24-HOUR CRISIS LINE: (206) 461-3222
Toll Free: 866.4CRISIS (866 427-4747)
TDD Line: (206) 461-3219

INVESTIGATOR'S STATEMENT

We are asking you to participate in a dissertation research study conducted for the completion of a doctoral degree. The purpose of this information statement is to provide you with the information you will need to help decide whether or not you would like to participate in this study. Please read the form carefully. If you have questions regarding the purpose of the research, possible risks and benefits, or your rights as a volunteer please call (206) 484-3378. Once all of your questions have been answered, you may choose to participate in this study or not. This process is called "informed consent."

PURPOSE OF THE STUDY

The purpose of this study is to enhance our understanding of women's experiences in committed relationships. Specifically, we are interested in women's experiences -including partner violence- in intimate relationships during their first pregnancy. Pregnancy is considered a particularly stressful period for women and their relationships. Therefore, this anonymous survey study is meant to examine how the dynamics of these relationships may change during the first pregnancy. We are also interested in comparing the experiences of women who are not pregnant.

PROCEDURES

If you choose to participate in this study you will be asked to fill out a questionnaire packet, which consists of a range of questions asking you to give information about you and your male partner. In general, questions will ask about some basic demographic information such as age and ethnicity, socio-economic status, experiences with drugs and alcohol, emotional health, satisfaction in your relationship, including you a your partner violence history and illegal behaviour. Some questions may be more relevant to your situation and experiences than others. Some examples of the most sensitive questions are: Do you ever regret that you married (or lived together)? Have you ever had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner? Did any of your parents, stepparents, or foster parents ever do something on purpose to you that left marks, gave you bruises or scratches, broken bones or teeth, made you bleed, or required medical treatment? Before you were 18, did any person(s) at least 5 years older than you ever touch you in a sexual way, make you touch their sexual parts or had sex with you?

This survey is completely anonymous and you will not be asked to provide any personal identifying information about you and your partner. Since this questionnaire packet includes questions related to experiences with emotional and physical aggression in committed relationships we would like to recommend that you complete this questionnaire in a place you deem safe. You may choose to skip any questions that you do not wish to answer. This questionnaire packet takes about 45 minutes to complete.

RISK, STRESS OR DISCOMFORT

You may experience some discomfort answering some of these questions. **Please note: It is very important that if you decide to participate that you fill out the questionnaire pack in a safe place, if a violent partner discovers the questionnaire it might increase the subject's risk of being harmed.** To avoid possible risk to your safety please do not take the Information Statement with you. A list of "Seattle libraries" where you can fill out the questionnaire is provided on the previous page.

There are no identifiers in the questionnaire, it ill not be possible for my self, project personnel or the professionals from the Cooperating Centres to follow up on disclosure of depression, suicidal thoughts, or abuse. If you experience some distress as a result of completing this questionnaire or you feel that you may need help there is a resource list provided in each packet. This is a list of individual practitioners, mental health professionals, and community agencies that you may contact for assistance. We would also like to remind you of the 24-hour crisis line number listed at the top of this Information Statement and in the resource list.

BENEFITS OF THE STUDY

There are no direct benefits to you for participating in this study. By participating in this study, the information you provide might help enhance our understanding of women's experiences in relationships and with intimate partner violence, especially during a woman's first pregnancy.

OTHER INFORMATION

The study is completely anonymous and all data will be stored in a locked cabinet, in a locked building. No other individuals in addition to the project personnel will have access to this information. You are free to refuse to participate in the study.

If you have questions regarding the research you can contact the principal researcher, Itziar Luzarraga Monasterio at (206) 484-3378. If you have questions about your rights as a research subject, you can call the Human Subjects Division at the University of Washington at (206) 543-0098.

Important: Please remember that this is anonymous survey, so please do not write your name, last name, address or other identifying information anywhere on the questionnaire, and fill out the questionnaire in a safe place.

Itziar Luzarraga ITZIAR LUZARRAGA

INVESTIGATOR'S SIGNATURE INVESTIGATOR'S NAME DATE

UNIVERSITY OF WASHINGTON

INFORMATION STATEMENT

"Learning from your relationship"
Dissertation research study

Primary Investigator: Itziar Luzarraga Monasterio, Ph.C
Doctoral Candidate, Universidad de Deusto
Visiting Scientist, University of Washington. Department of Psychology
Dissertation research study
(206)-484-3378

Co-investigators: Alyson Shapiro, Ph.D, and Dan Yoshimoto, Ph.D

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PROCEDURES

If you choose to participate in this study you will fill out a questionnaire using internet, which consists of a range of questions asking you to give information about you and your male partner. In general, questions will ask about some basic demographic information such as age and ethnicity, socio-economic status, experiences with drugs and alcohol, emotional health, satisfaction in your relationship, including you a your partner violence history and illegal behaviour. Some questions may be more relevant to your situation and experiences than others. Some examples of the most sensitive questions are: Do you ever regret that you married (or lived together)? Have you ever had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner? Did any of your parents, stepparents, or foster parents ever do something on purpose to you that left marks, gave you bruises or scratches, broken bones or teeth, made you bleed, or required medical treatment? Before you were 18, did any person(s) at least 5 years older than you ever touch you in a sexual way, make you touch their sexual parts or had sex with you?

This survey is completely anonymous and you will not be asked to provide any personal identifying information about you and your partner. Since this questionnaire includes questions related to experiences with emotional and physical aggression in committed relationships we would like to recommend that you complete this questionnaire alone.

You may choose to skip any questions that you do not wish to answer. This questionnaire takes about 45 minutes to complete.

RISK, STRESS OR DISCOMFORT

You may experience some discomfort answering some of these questions. **Please note: If you decide to participate it is very important that you fill out the questionnaire alone. If a violent partner sees you filling out the questionnaire it might increase the risk of being harmed.**

There are no identifiers in the questionnaire; it will not be possible for myself, project personnel or the professionals from the Cooperating Centres to follow up on disclosure of depression, suicidal thoughts, or abuse. If you experience some distress as a result of completing this questionnaire or you feel that you may need help there is a resource list provided at the end of the questionnaire. If you wish you may print a copy of the resource list. This is a list of individual practitioners, mental health professionals, and community agencies that you may contact for assistance. We would also like to remind you of the 24-hour crisis line number listed at the top of this Information Statement and in the resource list.

BENEFITS OF THE STUDY

There are no direct benefits to you for participating in this study. By participating in this study, the information you provide might help enhance our understanding of women's experiences in relationships and with intimate partner violence, especially during a woman's first pregnancy.

OTHER INFORMATION

The study is completely anonymous and all data will be stored in the WebQ system developed by the UW and administered on Catalyst, which is a secure UW server. WebQ and Catalyst are approved by the Human Subjects Division for research use. No other individuals in addition to the project personnel will have access to this information. You are free to refuse to participate in the study.

If you have questions regarding the research you can contact the principal researcher, Itziar Luzarraga Monasterio at (206) 484-3378. If you have questions about your rights as a research subject, you can call the Human Subjects Division at the University of Washington at (206) 543-0098.

Important: Please remember that this is anonymous survey, so please do not type your name, last name, address or other identifying information anywhere on the questionnaire, and fill out the questionnaire alone. Answer the questions honestly.

Itziar Luzarraga — ITZIAR LUZARRAGA

Here will be my signature

INVESTIGATOR'S SIGNATURE | INVESTIGATOR'S NAME | DATE

- Version 1
- Date revision: Dec 6th2006

APPROVED

DEC 0 8 2006

UW Human Subjects Review Committee

"Learning From Your Relationship" dissertation research study

If you are looking for a quiet, safe place to fill out the questionnaire, we suggest one of the Seattle Public Libraries listed below

1) Central Library
1000 Fourth Ave.
Phone: (206) 386-4636
Since Monday to Wednesday: 10 am - 8 pm
Thursday and Friday: 10 am - 6 pm
Saturday: 10 am - 6 pm
Sunday: 1pm - 5 pm

2) Washington Talking Book & Braille Library
2021 9th Avenue
Monday to Friday: 8:30 am - 5 pm
Saturday and Sunday: closed

3) Ballard Branch
5614 22nd Ave. N.W.
Phone: (206) 684-4089
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: 1 pm - 5 pm

4) Beacon Hill Branch
2821 Beacon Ave. S.
Phone: (206) 684-4711
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

5) Broadview Branch
12755 Greenwood Ave. N.
Phone: (206) 684-7519
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: 1 pm - 5 pm

6) Capitol Hill Branch
425 Harvard Ave. E.
Phone: (206) 684-4715
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: 1 pm - 5 pm

7) Columbia Branch
4721 Rainier Ave. S.
Phone: (206) 386-1908
Monday and Tuesday: 1 pm - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: 1 pm - 5 pm

8) Delridge Branch
5423 Delridge Way S.W
Phone: (206) 733-9125
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

10) Fremont Branch
731 N. 35th St.
Phone: (206) 684-4084
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

11) Green Lake Branch
7364 E. Green Lake Dr. N.
Phone: (206) 684-7547
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

12) Greenwood Branch
8016 Greenwood Ave. N.
Phone: (206) 684-4086
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

13) High Point Branch
3411 S.W. Raymond St.
Phone: (206) 684-7454
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

14) International District / Chinatown Branch
713 Eighth Ave. S.
Phone: (206) 386-1300
Monday and Tuesday: 1pm - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

27) University Branch
5009 Roosevelt Way N.E.
Phone: (206) 684-4063
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

16) Madrona-Sally Goldmark Branch
1134 33rd Ave.
Phone: (206) 684-4705
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am – 6pm
Sunday: 1 pm - 5 pm

17) Magnolia Branch
2801 34th Ave. W.
Phone: (206) 386-4225
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am – 6pm
Sunday: 1 pm - 5 pm

18) Montlake Branch
2300 24th Ave. E.
Phone: (206) 684-4720
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am – 6pm
Sunday: 1 pm - 5 pm

19) New Holly Branch
7058 32nd Ave. S
Phone: (206) 386-1905
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

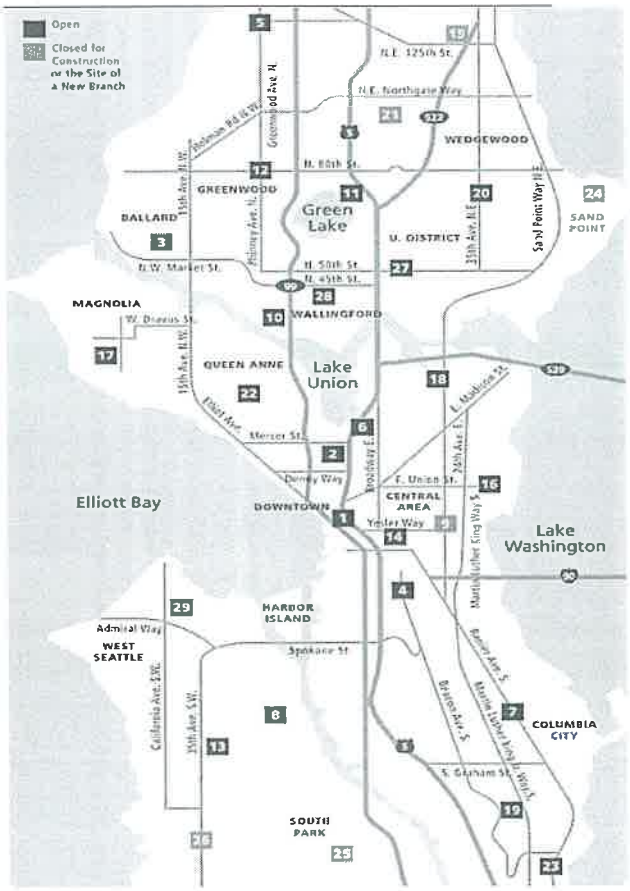
20) North East Branch
6801 35th Ave. N.E.
Phone: (206) 684-7539
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am – 6pm
Sunday: 1 pm - 5 pm

22) Queen Anne Branch
400 W. Garfield St.
Phone: (206) 386-4227
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am - 6 pm
Sunday: closed

23) Rainier Beach Branch
9125 Rainier Ave. S.
Phone: (206) 386-1906
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am – 6pm
Sunday: 1 pm - 5 pm

28) Wallingford Branch
1501 N. 45th St.
Phone: (206) 684-4088
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am – 6pm
Sunday: 1 pm - 5 pm

29) West Seattle Branch
2306 42nd Ave. S.W.
Phone: (206) 684-7444
Monday and Tuesday: 1 - 8 pm
Wednesday: 10 am - 8 pm
Thursday, Friday and Saturday: 10 am – 6pm
Sunday: 1 pm - 5 pm



To be filled out by project personnel only:
Identification number:
Date:

PERSONAL INFORMATION

Please fill out the following questions:

1) **Today's date:** Month [ ] Year [ ]

2) **Birth date:** Year [ ]

3) **Country you were born in:** _____.

4) **City you reside in:** _____.

5) **Nationality:** _____.

6) **This study is being conducted in United States and Spain, therefore please fill out the following questions:**

Please mark with an X all the cultural groups with which YOU identify:

- ☐ Spaniard.
- ☐ Mexican, Mexican – American, Chicano.
- ☐ Puerto Rican.
- ☐ Cuban.
- ☐ Other cultural group Hispanic: Please enter one or more cultural groups with which you identify, for example: Argentinian, Columbian, Dominican, Nicaraguan, Salvadoran, Bolivian, etc. Please specify: _____.
- ☐ Other cultural group: Please enter one or more cultural groups with which you identify, for example: French, German, Italian, African American, Native American, etc. Please specify: _____.

Please mark with an X one or more of YOUR origins:

- ☐ White – A person having origins in any of the original people of Europe.
- ☐ Middle East.
- ☐ North Africa.
- ☐ Black or African American – A person having origins in any of the black racial groups of Africa.
- ☐ Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example: China, the Philippine Islands, Vietnam, Thailand, Malaysia, Pakistan, India, and so on.
- ☐ Native Hawaiian or other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ American Indian – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ Other race and/or ethnicity, please specify: _____.

7) **EDUCATION**

Please specify the highest level of education YOU have completed:

- ☐ No studies.
- ☐ 1.
- ☐ 2.
- ☐ 3.
- ☐ 4.
- ☐ 5.
- ☐ 6.
- ☐ 7.
- ☐ 8.
- ☐ 9.
- ☐ 10.
- ☐ 11.
- ☐ 12.
- ☐ Professional training (electrician, technician etc.).
- ☐ Some college work.
- ☐ Completed college (BA, BS)
- ☐ Graduate degree (MA, MD, Ph.D., etc.).
- ☐ Others, please specify: _____

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire

8) WORK

- Please indicate YOUR occupation. Mark with an X all that apply:

- ❑ Work full time (40 hours per week).
- ❑ Work part time (20 hours per week).
- ❑ Self employed.
- ❑ Homemaker.
- ❑ Student (20 hours per week) and work (20 hours per week).
- ❑ Student full time (40 hours per week).
- ❑ Without work, unemployed.
- ❑ Disabled.
- ❑ Retired.
- ❑ Other, please specify: _____ _____.

- Please briefly describe YOUR work or profession: _____ _____.

- During the last twelve months have there been some days or months YOU were not working?

❑ YES ↓ ❑ NO (Please skip to question number 9.)

If YES, please mark with an X the days or months that YOU were not working:

Less than 1 month	Between 1 to 3 months	Between 3 to 6 months	Between 6 to 9 months	Between 9 to 12 months

9) YOUR TOTAL ANNUAL INCOME:

Please indicate **YOUR gross (with taxes) total annual income, including unemployment and Government subsidies.**

- ❑ I don't have personal income.
- ❑ I am receiving unemployment (mark the square that indicates the total of your gross annual income).
- ❑ Less than $ 8,000.
- ❑ $ 8,000 to $ 16,000.
- ❑ $ 16,001 to $ 24,000.
- ❑ $ 24,001 to $ 32,000.
- ❑ $ 32,001 to $ 40,000.
- ❑ $ 40,001 to $ 48,000.
- ❑ $ 48,001 to $ 56,000.
- ❑ $ 56,001 to $ 64,000.
- ❑ $ 64,001 to $ 72,000.
- ❑ $ 72,001 to $ 80,000.
- ❑ More than $ 80,000.

YOUR RELATIONSHIP HISTORY

10) Please indicate YOUR relationship history, including your current relationship:

- How many relationship(s) have you had that you consider stable? (including your current relationship) _____. What is the average length of your stable(s) relationship(s)?, (including your current relationship) _____year(s) and _____month(s).

- How many partner(s) or boyfriend(s) have you lived with? (including your current relationship)_____. What is the average length of time that you have lived with your partner(s) or boyfriend(s)? (including your current relationship) _____year(s) and _____month(s).

- How many times have you been married? (including your current relationship) _____.

- How many times have you been in the process of legal separation? (including your current relationship) _____.

- How many times have you been legally separated? (including your current relationship) _____.

- How many times have you been divorced? (including your current relationship)_____.

- How many times have you been widowed? (including your current relationship)_____.

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

CURRENT RELATIONSHIP

11) Do you have a partner, boyfriend or spouse?

❑ YES ❑ NO ↓

IF YOU ANSWER NO, PLEASE ANSWER THE REST OF THE QUESTIONS REFERRING **TO YOUR MOST RECENT RELATIONSHIP.**

12) Beginning date of the relationship: (If you don't remember, please indicate as close to the date as possible).
Month ☐ Year ☐

13) Are you living with your partner ?

❑ YES ↓ ❑ NO (Please skip to question number 14.)

If YES, please write the date when you began living together (If you don't remember, please indicate as close to the date as possible). Month ☐ Year ☐

14) What is your current relationship status? (Please select all that are appropriate.)

❑ Together ❑ Engaged ❑ Married Wedding Date: Month ☐ Day ☐ Year ☐ ❑ Widowed

❑ In the process of breaking up ❑ Broken up ❑ In process of legal separation ❑ Legally separated ❑ Divorced

INFORMATION ABOUT YOUR PARTNER

15) Sex of <u>your partner</u>: ❑ Male ❑ Female

16) Birth date of <u>your partner</u>: Year ☐

17) Country <u>your partner</u> was born in: _____.

18) City <u>your partner</u> lives in: _____.

19) <u>Your partner's</u> nationality: _____.

20) This study is being conducted in United States and Spain, therefore please fill out the following questions about <u>YOUR PARTNER</u>:
Please check all the cultural groups with which <u>YOUR PARTNER</u> identifies:

- ❑ Spaniard.
- ❑ Mexican, Mexican – American, Chicano.
- ❑ Puerto Rican.
- ❑ Cuban.
- ❑ Other cultural group Hispanic: Please enter one or more cultural groups with which your partner identifies, for example: Argentinian, Columbian, Dominican, Nicaraguan, Salvadoran, Bolivian, etc. Please specify: _____.
- ❑ Other cultural group: Please enter one or more cultural groups with which your partner identifies, for example: French, German, Italian, African American, Native American, etc. Please specify: _____.

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

Please select one or more of YOUR PARTNER´S origins:

- ❑ White – A person having origins in any of the original people of Europe.
- ❑ Middle East.
- ❑ North Africa.
- ❑ Black or African American – A person having origins in any of the black racial groups of Africa.
- ❑ Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example: China, the Philippine Islands, Vietnam, Thailand, Malaysia, Pakistan, India, and so on.
- ❑ Native Hawaiian or other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ❑ American Indian – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ❑ Other race and/or ethnicity, please specify: _____.

21) EDUCATION

Please specify the highest level of education that YOUR PARTNER has completed:

- ❑ No studies.
- ❑ 1.
- ❑ 2.
- ❑ 3.
- ❑ 4.
- ❑ 5.
- ❑ 6.
- ❑ 7.
- ❑ 8.
- ❑ 9.
- ❑ 10.
- ❑ 11.
- ❑ 12.
- ❑ Professional training (electrician, technician etc.).
- ❑ Some college work.
- ❑ Completed college (BA,BS).
- ❑ Graduate degree (MA, MD, Ph.D., etc.).
- ❑ Others, please specify: _____

22) WORK

- Please indicate YOUR PARTNER´S occupation. Mark with an X all that apply:

- ❑ Work full time (40 hours per week).
- ❑ Work part time (20 hours per week).
- ❑ Self employed.
- ❑ Homemaker.
- ❑ Student (20 hours per week) and work (20 hours per week).
- ❑ Student full time (40 hours per week).
- ❑ Without work, unemployed.
- ❑ Disabled.
- ❑ Retired.
- ❑ Other, please specify: _____ _____.

- Please describe briefly YOUR PARTNER´S work or profession:: _____ _____.

- During the last twelve months have there been some days or months YOUR PARTNER was not working?

❑ YES ↓ ❑ NO (Please skip to question number 23.)

IF YES, please mark with an X the days or months that YOUR PARTNER was not working:

Less than 1 month	Between 1 to 3 months	Between 3 to 6 months	Between 6 to 9 months	Between 9 to 12 months

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

23) YOUR PARTNER'S TOTAL ANNUAL INCOME: Please **indicate YOUR PARTNER'S gross (with taxes) total annual income, including unemployment and Government subsidies.**

- ❑ Doesn't have personal income.
- ❑ My partner is receiving unemployment (mark the square that indicates the total of your partner's gross annual income
- ❑ Less than $ 8,000.
- ❑ $ 8,000 to $ 16,000.
- ❑ $ 16,001 to $ 24,000.
- ❑ $ 24,001 to $ 32,000.
- ❑ $ 32,001 to $ 40,000.
- ❑ $ 40,001 to $ 48,000.
- ❑ $ 48,001 to $ 56,000.
- ❑ $ 56,001 to $ 64,000.
- ❑ $ 64,001 to $ 72,000.
- ❑ $ 72,001 to $ 80,000.
- ❑ More than $ 80,000.

INFORMATION ABOUT YOUR PARTNER'S RELATIONSHIP HISTORY

In this section please report your partner's relationship history:

24) Please indicate YOUR PARTNER'S relationship history, including your current relationship:

- How many relationship(s) has your partner had that you or your partner consider stable? (including your current relationship) _____. What is the average length of your partner's stable relationship(s)?, (including your current relationship) _____year(s) and _____month(s).

- How many partner(s) or girlfriend(s) has your partner lived with? (including your current relationship) _____. What is the average length of time that your partner has lived with his partner(s) or girlfriend(s)?, (including your current relationship) _____year(s) and _____month(s).

- How many times has your partner been married? (including your current relationship) _____.

- How many times has your partner been in the process of legal separation? (including your current relationship)_____.

- How many times has your partner been legally separated? (including your current relationship)_____.

- How many times has your partner been divorced? (including your current relationship)_____.

- How many times has your partner been widowed? (including your current relationship)_____.

FAMILY STATUS

25) Do you have children?

❑ YES ↓ ❑ NO (Please skip to question number 26.)

If YES, **how many children do you have?** _____. ↓

- How many of them are from **YOUR CURRENT relationship**? _____. Indicate children's age_____.

- How many of them are from **YOUR PAST relationships**? _____. Indicate children's age _____.

- How many of them are from **YOUR PARTNERS PAST relationships**? ___. Indicate children's age _____.

- How many of them are **ADOPTED**? _____. Indicate children's age _____.

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

26) Are you pregnant?

- ❑ YES Please answer the following questions regarding information about the pregnancy ↓
- ❑ NO Please skip to the RELATIONSHIP QUESTIONNAIRE

INFORMATION ABOUT THE PREGNANCY

- How many months along in the pregnancy are you? _____.

- Is you current partner the biological father of your unborn child?

❑ YES ❑ NO ❑ I don't know.

- Is this the first time you have been pregnant?

❑ YES ❑ NO

Did you have a miscarriage? ❑ YES ❑ NO

- Is this the first time you carried a baby for 6 months or longer?

❑ YES ❑ NO

- At the time you became pregnant, were you trying to become pregnant?

❑ YES ❑ NO, the pregnancy was a surprise.

- How long were you trying to become pregnant?

It was surprise	1 Month	3 Months	6 Months	1 Year	More than 1 Year

- Have you completed your first prenatal care visit?

❑ YES ↓ ❑ NO

If YES, please write the date. (If you don't remember, please indicate as close to the date as possible.)

Month [ ] Year [ ]

- Are you taking birth preparation classes or parenting preparation classes?

❑ YES ❑ NO

- How do you and your partner feel with regard to having a baby?

	Very unhappy	Fairly unhappy	A little unhappy	Neither unhappy nor happy	A little happy	Fairly happy	Very happy
YOU							
YOUR PARTNER							

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

To be filled out by project personnel only:
Identification number:
Date:

RELATIONSHIP QUESTIONNAIRE (DAS)

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Mark with an X your response to each question.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	☐	☐	☐	☐	☐	☐
2. Matters of recreation	☐	☐	☐	☐	☐	☐
3. Religious matters	☐	☐	☐	☐	☐	☐
4. Demonstrations of affection	☐	☐	☐	☐	☐	☐
5. Friends	☐	☐	☐	☐	☐	☐
6. Sex relations	☐	☐	☐	☐	☐	☐
7. Conventionality (correct or proper behavior)	☐	☐	☐	☐	☐	☐
8. Philosophy of life	☐	☐	☐	☐	☐	☐
9. Ways of dealing with parents or in-laws	☐	☐	☐	☐	☐	☐
10. Aims, goals, and things believed important	☐	☐	☐	☐	☐	☐
11. Amount of time spent together	☐	☐	☐	☐	☐	☐
12. Making major decisions	☐	☐	☐	☐	☐	☐
13. Household tasks	☐	☐	☐	☐	☐	☐
14. Leisure time interests and activities	☐	☐	☐	☐	☐	☐
15. Career decisions	☐	☐	☐	☐	☐	☐

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation or terminating your relationship?	☐	☐	☐	☐	☐	☐
17. How often do you or your mate leave the house after a fight?	☐	☐	☐	☐	☐	☐
18. In general, how often do you think that things between you and your partner are going well?	☐	☐	☐	☐	☐	☐
19. Do you confide in your mate?	☐	☐	☐	☐	☐	☐
20. Do you ever regret that you married? (or lived together)	☐	☐	☐	☐	☐	☐
21. How often do you and your partner quarrel?	☐	☐	☐	☐	☐	☐
22. How often do you and your mate "get on each other's nerves?"	☐	☐	☐	☐	☐	☐
23. How frequently do you and your partner have problems with jealousy?	☐	☐	☐	☐	☐	☐

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	Every Day	Almost Every Day	Occa-sionally	Rarely	Never
24. Do you kiss your mate?	☐	☐	☐	☐	☐

	All of them	Most of them	Some of them	Very few of them	None of them
25. Do you and your mate engage in outside interests together?	☐	☐	☐	☐	☐

HOW OFTEN WOULD YOU SAY THE FOLLOWING EVENTS OCCUR BETWEEN YOU AND YOUR MATE?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
26. Have a stimulating exchange of ideas	☐	☐	☐	☐	☐	☐
27. Laugh together	☐	☐	☐	☐	☐	☐
28. Calmly discuss something	☐	☐	☐	☐	☐	☐
29. Work together on a project	☐	☐	☐	☐	☐	☐

THERE ARE SOME THINGS ABOUT WHICH COUPLES SOMETIMES AGREE AND SOMETIME DISAGREE. INDICATE IF EITHER ITEM BELOW CAUSED DIFFERENCES OF OPINIONS OR WERE PROBLEMS IN YOUR RELATIONSHIP DURING THE PAST FEW WEEKS. (CHECK YES OR NO)

	Yes	No
30. Being too tired for sex	☐	☐
31. Not showing love	☐	☐

32. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship:

•	•	•	•	•	•	•
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

33. Which of the following statements best describes how you feel about the future of your relationship?

☐ I want desperately for my relationship to succeed, and *would go to almost any length* to see that it does.
☐ I want very much for my relationship to succeed, and *will do all I can* to see that it does.
☐ I want very much for my relationship to succeed, and *will do my fair share* to see that it does.
☐ It would be nice if my relationship succeeded, but *I can't do much more than I am doing* now to help it succeed.
☐ It would be nice if it succeeded, but I *refuse to do any more than I am doing* now to keep the relationship going.
☐ My relationship can never succeed, and *there is no more that I can do* to keep the relationship going.

34. How satisfied are you with the support and help that you receive from the people around you?

Very unsatisfied	A little unsatisfied	Satisfied	More than satisfied	Very satisfied

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

To be filled out by project personnel only:
Identification number:
Date:

COUPLE CONFLICTS (SCTS2)

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please mark how many times you did each to these things in the last 12 months, and how many times your partner did them in the last 12 months. If you or your partner did not do one of these things in the last 12 months, but it happened before that, mark a "7" on your answer sheet for that question. If it never happened, mark a "0" on your answer sheet.

If you are pregnant, be sure to **answer** questions **a, and b** for all the following items.

PLEASE CAREFULLY READ THE SCALE AND EACH QUESTION BEFORE MARKING YOUR RESPONSE.

SCALE:
How often did this happen during the last 12 months or before?

0 = This has never happened
1 = Once during the last 12 months
2 = Twice during the last 12 months
3 = 3-5 times during the last 12 months
4 = 6-10 times during the last 12 months
5=11-20 times during the last 12 months
6 = More than 20 times during the last 12 months
7 = Not in the last 12 months, but it happened before

1. a) **I explained my side or suggested a compromise for a disagreement with my partner.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

2. a) ***My partner*** **explained his side or suggested a compromise for a disagreement with me.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

3. a) **I insulted or swore or shouted or yelled at my partner.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

4. a) ***My partner*** **insulted or swore or shouted or yelled at me.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

PLEASE CAREFULLY READ THE SCALE AND EACH QUESTION BEFORE MARKING YOUR RESPONSE.

SCALE:

How often did this happen during the last 12 months or before?

0 = This has never happened
1 = Once during the last 12 months
2 = Twice during the last 12 months
3 = 3-5 times during the last 12 months
4 = 6-10 times during the last 12 months
5=11-20 times during the last 12 months
6 = More than 20 times during the last 12 months
7 = Not in the last 12 months, but it happened before

5. a) **I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

6. a) ***My partner*** **had a sprain, bruise, or small cut, or felt pain the next day because of a fight with me.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

7. a) **I showed respect for, or showed that I cared about my partner's feelings about an issue we disagreed on.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

8. a) ***My partner*** **showed respect for, or showed that he cared about my feeling about an issue we disagreed on.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

9. a) **I pushed, shoved, or slapped my partner.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

10. a) ***My partner*** **pushed, shoved, or slapped me.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

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PLEASE CAREFULLY READ THE SCALE AND EACH QUESTION BEFORE MARKING YOUR RESPONSE.

SCALE:

How often did this happen during the last 12 months or before?

0 = This has never happened
1 = Once during the last 12 months
2 = Twice during the last 12 months
3 = 3-5 times during the last 12 months
4 = 6-10 times during the last 12 months
5=11-20 times during the last 12 months
6 = More than 20 times during the last 12 months
7 = Not in the last 12 months, but it happened before

11. a) **I punched or kicked or beat-up my partner.**	0	1	2	3	4	5	6	7
b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened			
12. a) ***My partner*** **punched or kicked or beat-me-up.**	0	1	2	3	4	5	6	7
b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened			
13. a) **I destroyed something belonging to my partner or threatened to hit my partner.**	0	1	2	3	4	5	6	7
b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened			
14. a) ***My partner*** **destroyed something belonging to me or threatened to hit me.**	0	1	2	3	4	5	6	7
b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened			
15. a) **I went see a doctor (M.D.) or needed to see a doctor because of a fight with my partner.**	0	1	2	3	4	5	6	7
b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened			
16. a) ***My partner*** **went to see a doctor (M.D.) or needed to see a doctor because of a fight with me.**	0	1	2	3	4	5	6	7
b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened			

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

PLEASE CAREFULLY READ THE SCALE AND EACH QUESTION BEFORE MARKING YOUR RESPONSE.

SCALE:

How often did this happen during the last 12 months or before?

0 = This has never happened
1 = Once during the last 12 months
2 = Twice during the last 12 months
3 = 3-5 times during the last 12 months
4 = 6-10 times during the last 12 months
5=11-20 times during the last 12 months
6 = More than 20 times during the last 12 months
7 = Not in the last 12 months, but it happened before

17. a) **I used force (like hitting, holding down, or using a weapon) to make my partner have sex.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

18. a) ***My partner*** **used force (like hitting, holding down, or using a weapon) to make me have sex.**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

19. a) **I insisted on sex when my partner did not want to or insisted on sex without a condom (but did not use physical force).**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

20. a) ***My partner*** **insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force).**	0	1	2	3	4	5	6	7

b) Specify, if this behavior happened during the pregnancy?	☐ Started	☐ Increased	☐ Maintained	☐ Reduced	☐ Never happened

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

ALCOHOL CONSUMPTION INFORMATION (SMAST)

To be filled out by project personnel only:
Identification number:
Date:

The following questions are about the alcohol consumption of you and your partner. Answer the following questions by circling your answer.

ABOUT YOU			ABOUT YOUR PARTNER		
1) Do you feel that you are a normal drinker? (By normal drinker, we mean somebody who drinks less than or as much as most other people.)	YES	NO	1) Do you feel that your partner is a normal drinker? (By normal drinker, we mean somebody who drinks less than or as much as most other people.)	YES	NO
2) Does your partner, a parent, or other near relative ever worry or complain about your drinking?	YES	NO	2) Do you, a parent, or other near relative ever worry or complain about your partner's drinking?	YES	NO
3) Do you ever feel guilty about your drinking?	YES	NO	3) Does your partner ever feel guilty about his drinking?	YES	NO
4) Do friends or relatives think you are a normal drinker?	YES	NO	4) Do friends or relatives think your partner is a normal drinker?	YES	NO
5) Are you able to stop drinking when you want to?	YES	NO	5) Is your partner able to stop drinking when he wants to?	YES	NO
6) Have you ever attended a meeting of Alcoholics Anonymous (AA)?	YES	NO	6) Has your partner ever attended a meeting of Alcoholics Anonymous (AA)?	YES	NO
7) Has your drinking ever created problems between you and your partner, a parent, or other near relative?	YES	NO	7) Has your partner's drinking ever created problems between you and your partner; between your partner and a parent, or your partner and a near relative?	YES	NO
8) Have you ever gotten in trouble at work because of your drinking?	YES	NO	8) Has your partner ever gotten in trouble at work because of his drinking?	YES	NO
9) Have you ever neglected your obligations, your family, or your work for two or more days in a row because of drinking?	YES	NO	9) Has your partner ever neglected his obligations, family, or work for two or more days in a row because of drinking?	YES	NO
10) Have you ever gone to anyone for help about your drinking?	YES	NO	10) Has your partner ever gone to anyone for help about his drinking?	YES	NO
11) Have you ever been in a hospital because of drinking?	YES	NO	11) Has your partner ever been in a hospital because of drinking?	YES	NO
12) Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?	YES	NO	12) Has your partner ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?	YES	NO
13) Have you ever been arrested, even for a few hours, because of other drunken behavior?	YES	NO	13) Has your partner ever been arrested, even for a few hours, because of other drunken behavior?	YES	NO

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

To be filled out by project personnel only:
Identification number:
Date:

DRUG CONSUMPTION INFORMATION (DAST-10)

The following questions concern information **about you and your partner's** possible consumption of drugs **excluding alcohol and tobacco during the last 12 months**. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle in the appropriate answer beside the question.

In the statements "drug abuse" refers to, 1) the use of prescribed or over-the-counter drugs in excess of the directions and 2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do **not include alcohol or tobacco.**

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the last 12 months:

ABOUT YOU			ABOUT YOUR PARTNER		
1) Have you used drugs other than those required for medical reasons?	YES	NO	1) Has your partner used drugs other than those required for medical reasons?	YES	NO
2) Do you abuse more than one drug at a time?	YES	NO	2) Does your partner abuse more than one drug at a time?	YES	NO
3) Are you always able to stop using drugs when you want to?	YES	NO	3) Is your partner always able to stop using drugs when he wants to?	YES	NO
4) Have you had "blackouts" or "flashbacks" as a result of drug use?	YES	NO	4) Has your partner had "blackouts" or "flashbacks" as a result of drug use?	YES	NO
5) Do you ever feel bad or guilty about your drug use?	YES	NO	5) Does your partner ever feel bad or guilty about his drug use?	YES	NO
6) Does your partner (or parents) ever complain about your involvement with drugs?	YES	NO	6) Do you (or parents) ever complain about your partner's involvement with drugs?	YES	NO
7) Have you neglected your family because of your use of drugs?	YES	NO	7) Has your partner neglected his family because of his use of drugs?	YES	NO
8) Have you engaged in illegal activities in order to obtain drugs?	YES	NO	8) Has your partner engaged in illegal activities in order to obtain drugs?	YES	NO
9) Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES	NO	9) Has your partner ever experienced withdrawal symptoms (felt sick) when he stopped taking drugs?	YES	NO
10 Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	YES	NO	10 Has your partner had medical problems as a result of his drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	YES	NO

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

To be filled out by project personnel only:
Identification number:
Date:

YOUR PAST HISTORY (VH)

We would like to make you aware that the questions in this questionnaire are some of the most sensitive (delicate), they refer to some difficult experiences that you may have lived through. Please answer the following questions marking an X in the square that correspond with your answer.

1. Did you ever see <u>your father</u> hit or beat up your mother?

<u>Before age 18</u>, how many times?

0	1	2	3-5	6-10	11-20	More than 20

<u>Since you were 18</u> , how many times?

0	1	2	3-5	6-10	11-20	More than 20

2. Did you ever see <u>your mother</u> hit or beat up your father?

<u>Before age 18</u>, how many times?

0	1	2	3-5	6-10	11-20	More than 20

<u>Since you were 18</u> , how many times?

0	1	2	3-5	6-10	11-20	More than 20

3 Did any of your parents, stepparents, or foster parents ever do something on purpose to you that left marks, gave you bruises or scratches, broken bones or teeth, or made you bleed, or required medical treatment?

<u>Before age 18</u>, how many times?

0	1	2	3-5	6-10	11-20	More than 20

<u>Since you were 18</u> , how many times?

0	1	2	3-5	6-10	11-20	More than 20

4 How often IN THE WORST YEAR THAT YOU CAN REMEMBER were you hit by your parents, stepparents, or foster parents or other adults?

<u>Before age 18</u>, how many times?

0	1	2	3-5	6-10	11-20	More than 20

<u>Since you were 18</u> , how many times?

0	1	2	3-5	6-10	11-20	More than 20

5 Did any of your ex-boyfriends or ex-partners ever hit you or do something on purpose that left marks, gave you bruises or scratches, broken bones or teeth, or made you bleed, or required medical treatment?

<u>Before age 18</u>, how many times?

0	1	2	3-5	6-10	11-20	More than 20

<u>Since you were 18</u> , how many times?

0	1	2	3-5	6-10	11-20	More than 20

6 <u>Before you were 18</u>, did any person(s) *at least 5 years older* than your ever touch you in a sexual way, make you touch their sexual parts, or try to have or had sex with you?

<u>Before age 18</u>, how many times?

0	1	2	3-5	6-10	11-20	More than 20

<u>Since you were 18</u>, did any person(s) ever touch you in a sexual way, make you touch their sexual parts, or try to have or had sex with you *when you said you didn't want to?*

<u>Since you were 18</u> , how many times?

0	1	2	3-5	6-10	11-20	More than 20

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

7 **Have you ever hit any ex-boyfriend or ex-partner or any family member or done something on purpose to any of them that left marks, bruises or scratches, broken bones or teeth, or made them bleed, or required medical treatment?**

Before age 18, how many times?

0	1	2	3-5	6-10	11-20	More than 20

Since you were 18 , how many times?

0	1	2	3-5	6-10	11-20	More than 20

8 **Have you ever in a work or social situation hit someone or done something on purpose to someone that left marks, bruises or scratches, broken bones or teeth, or made them bleed , or required medical treatment?**

Before age 18, how many times?

0	1	2	3-5	6-10	11-20	More than 20

Since you were 18 , how many times?

0	1	2	3-5	6-10	11-20	More than 20

YOUR PARTNER'S PAST HISTORY

1.During your partner's childhood and/or adolescence, did your partner's father hit or beat up his mother?

❑ YES ❑ NO ❑ I don't know

2.During your partner's childhood and/or adolescence, did your partner's mother hit or beat up his father?

❑ YES ❑ NO ❑ I don't know

3. During your partner's childhood and/or adolescence, did any of his parents, stepparents or foster parents hit your partner or ever do something on purpose to him that left marks, gave him bruises or scratches, broken bones or teeth, or made him bleed, or required medical treatment?

❑ YES ❑ NO ❑ I don't know

4. Did any of your partner's ex-girlfriends or ex-partners ever hit your partner or do something on purpose to your partner that left marks, bruises or scratches, broken bones or teeth, or made him bleed, or required medical treatment?

❑ YES ❑ NO ❑ I don't know

5.During your partner's childhood and/or adolescence, did any adult touch your partner in a sexual way, make him touch their sexual parts, or try to have or had sex with your partner?

❑ YES ❑ NO ❑ I don't know

6. Since you partner was 18 has your partner ever hit any of his ex-girlfriends or ex-partners or any family member or done something on purpose to any of them that left marks, bruises or scratches, broken bones or teeth, or made them bleed , or required medical treatment?

❑ YES ❑ NO ❑ I don't know

7. Since you partner was 18 has your partner ever in any work or social situation hit someone or done something on purpose to someone that left marks, bruises or scratches, broken bones or teeth, or made them bleed , or required medical treatment?

❑ YES ❑ NO ❑ I don't know

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

To be filled out by project personnel only:
Identification number:
Date:

INFORMATION ABOUT HOW YOU FEEL (BDI)

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY!**. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group. Be sure to read all the statements in each group before making your choice.

1) 0- I do not feel sad. 1- I feel sad. 2- I am sad all the time and I can't snap out of it. 3- I am so sad or unhappy that I can't stand it.	**7)** 0- I don't feel disappointed in myself. 1- I am disappointed in myself. 2- I am disgusted with myself. 3- I hate myself.
2) 0- I am not particularly discouraged about the future 1- I feel discouraged about the future. 2- I feel I have nothing to look forward to. 3- I feel that the future is hopeless and that things cannot improve.	**8)** 0- I don't feel I am any worse than anybody else. 1- I am critical of myself for my weaknesses or mistakes. 2- I blame myself all the time for my faults. 3- I blame myself for everything bad that happens.
3) 0- I do not feel like a failure. 1- I feel I have failed more than the average person. 2- As I look back on my life, all I can see is a lot of failures. 3- I feel I am a complete failure as a person.	**9)** 0- I don't have any thoughts of killing myself. 1- I have thoughts of killing myself, but I would not carry them out. 2- I would like to kill myself. 3- I would kill myself if I had the chance.
4) 0- I get as much satisfaction out of things as I used to. 1- I don't enjoy things the way I used to. 2- I don't get real satisfaction out of anything anymore. 3- I am dissatisfied or bored with everything	**10)** 0- I don't cry any more than usual. 1- I cry more now than I used to. 2- I cry all the time now. 3- I used to be able to cry, but now I can't cry even though I want to.
5) 0- I don't feel particularly guilty. 1- I feel guilty a good part of the time. 2- I feel quite guilty most of the time. 3- I feel guilty all of the time.	**11)** 0- I am no more irritated now than I ever am. 1- I get annoyed or irritated more easily than I used to. 2- I feel irritated all the time now. 3- I don't get irritated at all by the things that used to irritate me.
6) 0- I don't feel I am being punished. 1- I feel I may be punished. 2- I expect to be punished. 3- I feel I am being punished.	**12)** 0- I have not lost interest in other people. 1- I am less interested in other people than I used to be. 2- I have lots most of my interest in other people. 3- I have lost all of my interest in other people.

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

13) 0- I make decisions about as well as I ever could. 1- I put off making decisions more than I used to. 2- I have greater difficulty in making decisions than before. 3- I can't make decisions at all anymore.	**18)** 0- My appetite is no worse than usual. 1- My appetite is not as good as it used to be. 2- My appetite is much worse now. 3- I have no appetite at all anymore.
14) 0- I don't feel I look any worse than I used to. 1- I am worried that I am looking old or unattractive. 2- I feel that there are permanent changes in my appearance that make me look unattractive. 3- I believe that I look ugly.	**19)** 0- I haven't lost much weight, if any, lately. 1- I have lost more than 5 pounds. 2- I have lost more than 10 pounds. 3- I have lost more than 15 pounds. I am on a diet to lose weight? YES NO
15) 0- I can work about as well as before. 1- It takes an extra effort to get started at doing something. 2- I have to push myself very hard to do anything. 3- I can't do any work at all.	**20)** 0- I am no more worried about my health than usual. 1- I am worried about physical problems such as aches and pains; or upset stomach; or constipation. 2- I am very worried about physical problems and it's hard to think of much else. 3- I am so worried about my physical problems that I cannot think about anything else.
16) 0- I can sleep as well as usual. 1- I don't sleep as well as I used to. 2- I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. 3- I wake up several hours earlier than I used to and cannot get back to sleep.	**21)** 0- I have not noticed any recent change in my interest in sex. 1- I am less interested in sex than I used to be. 2- I am much less interested in sex now. 3- I have lost interest in sex completely.
17) 0- I don't get more tired than usual. 1- I get tired more easily than I used to. 2- I get tired from doing almost anything. 3- I am too tired to do anything.	

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

To be filled out by project personnel only:
Identification number:
Date:

INFORMATION ABOUT HOW YOU FEEL (STAI)

A/E

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate value to the right of the statement to indicate how **YOU FEEL RIGHT NOW, that is, at this moment.** There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

0=Not at all 1=Somewhat 2=Moderately so 3=Very much so

1.	I feel calm	0	1	2	3
2.	I feel secure	0	1	2	3
3.	I am tense	0	1	2	3
4.	I am regretful	0	1	2	3
5.	I feel at ease	0	1	2	3
6.	I feel upset	0	1	2	3
7.	I am presently worrying over possible misfortunes	0	1	2	3
8.	I feel rested	0	1	2	3
9.	I feel anxious	0	1	2	3
10.	I feel comfortable	0	1	2	3
11.	I feel self-confident	0	1	2	3
12.	I feel nervous	0	1	2	3
13.	I feel jittery	0	1	2	3
14.	I feel "high strung"	0	1	2	3
15.	I am relaxed	0	1	2	3
16.	I feel content	0	1	2	3
17.	I am worried	0	1	2	3
18.	I feel over excited and "rattled"	0	1	2	3
19.	I feel joyful	0	1	2	3
20.	I feel pleasant	0	1	2	3

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

A/R

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate value to the right of the statement to indicate how **YOU GENERALLY FEEL**. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel:

0 = Almost never **1 = Sometimes** **2 = Often** **3 Almost always**

21.	I feel pleasant	0	1	2	3
22.	I tire quickly	0	1	2	3
23.	I feel like crying	0	1	2	3
24.	I wish I could be as happy as others seem to be	0	1	2	3
25.	I am losing out on things because I can't make up my mind soon enough	0	1	2	3
26.	I feel rested	0	1	2	3
27.	I am "calm, cool, and collected"	0	1	2	3
28.	I feel that difficulties are piling up so that I cannot overcome them	0	1	2	3
29.	I worry too much over something that really doesn't matter	0	1	2	3
30.	I am happy	0	1	2	3
31.	I am inclined to take things hard	0	1	2	3
32.	I lack self-confidence	0	1	2	3
33.	I feel secure	0	1	2	3
34.	I try to avoid facing a crisis or difficulty	0	1	2	3
35.	I feel blue	0	1	2	3
36.	I am content	0	1	2	3
37.	Some unimportant thought runs through my mind and bothers me	0	1	2	3
38.	I take disappointments so keenly that I can't put them out of my mind	0	1	2	3
39.	I am a steady person	0	1	2	3
40.	I get in a state of tension or turmoil as I think over my recent concerns and interests	0	1	2	3

Thank you for your participation. The following page is for you. If you wish, you may pull it out and keep it.

Please, once you have completed this questionnaire packet, seal it in the pre- paid, pre-addressed envelope provided. Drop it in any mailbox for return to the principal investigator Itziar Luzarraga Monasterio. *Please do not write your name, last name, address or other identifying information.*

Thank you very much for your participation.

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

A/R

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate value to the right of the statement to indicate how **YOU GENERALLY FEEL**. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel:

- Version 1
- Date revision: Dec 8th 2006

0 = Almost never **1 = Sometimes** **2 = Often** **3 Almos**

21. I feel pleasant	0	1	2	3
22. I tire quickly	0	1	2	3
23. I feel like crying	0	1	2	3
24. I wish I could be as happy as others seem to be	0	1	2	3
25. I am losing out on things because I can't make up my mind soon enough	0	1	2	3
26. I feel rested	0	1	2	3
27. I am "calm, cool, and collected"	0	1	2	3
28. I feel that difficulties are piling up so that I cannot overcome them	0	1	2	3
29. I worry too much over something that really doesn't matter	0	1	2	3
30. I am happy	0	1	2	3
31. I am inclined to take things hard	0	1	2	3
32. I lack self-confidence	0	1	2	3
33. I feel secure	0	1	2	3
34. I try to avoid facing a crisis or difficulty	0	1	2	3
35. I feel blue	0	1	2	3
36. I am content	0	1	2	3
37. Some unimportant thought runs through my mind and bothers me	0	1	2	3
38. I take disappointments so keenly that I can't put them out of my mind	0	1	2	3
39. I am a steady person	0	1	2	3
40. I get in a state of tension or turmoil as I think over my recent concerns and interests	0	1	2	3

Please, once you have completed this questionnaire click SUBMIT RESPONSES and your data will be safe and accessible to the principal investigator Itziar Luzarraga Monasterio.

Thank you for your participation. The following page is for you. If you wish, you may print a copy.
Link: Resource-list

Please do not fill out this questionnaire again.

Thank you very much for your participation.

Please remember not to write any identifying information, such as name, last name, address; and to fill out the questionnaire packet in a safe place. Answer the questions honestly.

RESOURCE LIST

There is a list of individual practitioners, mental health professionals, and community agencies that you may contact for assistance

If you're in immediate danger, call 911 or the 24 hr crisis line: (206) 461-3222, Toll free: 866.4CRISIS (866 427 4747), and TDD Line: (206) 461-3219

Agencies: free assistance for anyone in a domestic violence situation:

- **Abused Deaf Women's advocacy service Sexual assault Crisis Line** – (TDD/TTY) 1-800-833-6384
- **Domestic Violence Recorded Information Line** (206) 205-5555
- **New beginnings**
  P.O.Box 20128
  Seattle WA, 98102
  Bussiness #: (206) 324–7271
  Hotline/Crisis: (206) 324–4943
- **Catherine Booth House**
  P.O. Box 20128
  Seattle WA 98102
  Business #: (206) 324-7271
  Hotline/Crisis: (206) 324-4943
- **Family Services. Administration.**
  615 Second Avenue, #150
  Seattle, WA 98104-2200
  Bussiness #: (206) 826-3050
  Fax: 1-877-903-0711
  State-certified domestic violence treatment for men (sliding scale).

Agencies: Free assistance for anyone feeling Alcohol/drug issues:

- **Alcohol/Drug 24 hours help Line**
  Toll-Free Statewide: 1-800-562-1240
- **Alcoholics anonymous Seattle**
  5507 6th Avenue South
  Seattle, 98108.
  Bussiness #: (206) 587-2838
- **Marijuana Anonymous Seattle**
  Toll Free 1-800-766-6779
- **Cocaine anonymous Seattle**
  467 8189 District 4
  P.O. Box 17323
  Seattle, WA 98127
  Bussiness #: (206) 548-9034
- **Narcotic anonymous**
  Bussiness #: (206) 329-1618
  Toll-Free Statewide: 1-800-773-9999

If you are in a suicidal crisis, emotional crisis or family crisis call:

- **Crisis Clinic 24-Hour crisis Line**
  206-461-3222 9TDD/TTY accessible)

Agencies: Assistance for anyone feeling depressed or very anxious or needed counselling:

- **Family Services. Administration.**
  615 Second Avenue, #150
  Seattle, WA 98104-2200
  Bussiness #: (206) 826-3050
  Fax: 1-877-903-0711
  Individual, family and group counseling
  Sliding scale, medicaid coupons.
- **Seattle Counseling Service**
  1216 Pine Street, Suite 300
  Seattle, WA 98101
  Bussiness #: 206-323-1768
  Fax: (206) 323-2184
  Sliding scale. Medicaid coupons are accepted. Insurance is accepted in most cases. Some clients may qualify for grant-based funding.
- **Seattle Mental Health**
  Bussiness #: (206).302-2300
  TTY: (206).302-2209
- **Community Psychiatric Clinic. Administration**
  4319 Stone Way North
  Seattle, WA 98103-7490
  Bussiness #: (206) 461-3614

Individual practitioners: Sliding scale

- **Charles Maurer, Ph.D., ABPP**
  Phone: (206) 323-0905
  Focus: Individuals Adults & Couples. Problems gambling. Substance Abuse.
- **Miriam Ramos, M.A.**
  2800 Madison street, suite 208
  Seattle, WA 98112
  Phone: (206) 617-6672
  Focus: Anxiety, Depression, Couples and Family Therapy, and Domestic violence.
- **Jan Saurer, M.S.W., A.C.S.W.**
  Phone: (206) 522-6296
  Focus: working w/ children

Rellenar sólo por el personal del proyecto:

Número de identificación:

Rellenar sólo por el personal del proyecto:

Número de identificación:
Fecha:

UNIVERSIDAD DE DEUSTO (BILBAO)

Y

RELATIONSHIP RESEARCH INSTITUTE (SEATTLE)

DECLARACIÓN INFORMATIVA

Proyecto de investigación:
"Aprendiendo de su relación de pareja"

Investigador Principal: Itziar Luzárraga Monasterio, Doctoranda de la Universidad de Deusto y Becaria del Gobierno Vasco en el Relationship Research Institute (657-77 53 61)

DECLARACIÓN DEL INVESTIGADOR

Le solicitamos que participe en este proyecto de investigación. El propósito de este documento es darle la información necesaria que le ayude a decidir si participar o no en el estudio. Por favor, lea este documento detenidamente. Si tiene preguntas en relación al objetivo de la investigación como: en qué consiste su participación, posibles riesgos y beneficios, sus derechos como voluntaria, o cualquier otra cuestión en relación a la investigación, por favor llame al 657-77 53 61. Cuando hayamos respondido a todas sus cuestiones, podrá decidir si quiere o no participar en el estudio; a este proceso se le llama "declaración informativa".

OBJETIVO DE LA INVESTIGACIÓN Y BENEFICIOS

Este estudio ha sido desarrollado para aprender más sobre cómo se sienten las mujeres en sus relaciones de pareja; analizar los posibles cambios y dificultades que se pueden dar en las parejas.
La información adquirida en este estudio nos permitirá desarrollar futuros programas que puedan ayudar a las parejas a mantener y potenciar unas relaciones de pareja y familiares más saludables. Estos programas estarán también dirigidos a prevenir y ayudar a las parejas que experimenten algún grado de violencia.

Un posible beneficio que puede aportarle este estudio es darle la oportunidad de centrarse en el presente de su relación de pareja y de ser más consciente de la calidad de su relación, de los puntos fuertes y de los puntos en los que pueden mejorar. Las mujeres que han participado comentan que rellenar los cuestionarios les ha permitido valorar la calidad de sus relaciones de pareja. Al final de los cuestionarios encontrará una carta y una lista de Centros de asistencia, en el caso de que sienta que podrían serle de ayuda.

EN QUE CONSISTE SU PARTICIPACIÓN

Lea este documento antes de tomar una decisión sobre participar o no en el estudio. Este estudio es voluntario, por lo que usted decidirá por si misma si participar o no en el mismo.

Si decide participar en el estudio deberá rellenar de forma anónima y voluntaria los cuestionarios que se encuentran grapados a este documento:
Los cuestionarios en general recogen preguntas de todo tipo sobre aspectos demográficos, socio-económicos, consumo de alcohol y drogas, historia de abusos, nivel de satisfacción en su relación de pareja y estado de ánimo. Dado que ésto es una investigación, le queremos informar que con algunas cuestiones se sentirá identificada pero con otras puede que no. Algunos ejemplos de las cuestiones más delicadas son: ¿Se arrepiente en alguna ocasión de haberse casado (o de haberse ido a vivir juntos)?; Sufrí una torcedura, moratón o un pequeño corte, o sentí dolor físico al día siguiente a causa de una pelea con mi pareja; ¿Ha dejado de atender sus obligaciones, a su familia o a su trabajo durante dos o más días seguidos por beber?; ¿Se ha visto implicada en actividades ilegales con el fin de obtener drogas? etc. Las cuestiones más delicadas son sobre episodios de violencia, por ello es muy importante que si decide participar rellene los cuestionarios en un sitio seguro. Si prefiere no contestar a alguna pregunta, puede dejarla en blanco. No obstante, para que la información que nos facilite sea útil para desarrollar futuros programas que ayuden a las mujeres, es muy importante que sea sincera en cada pregunta. Rellenar los cuestionarios le llevará aproximadamente unos 45 minutos.

RIESGOS, ESTRÉS O INCOMODIDAD

Puede suceder que al responder a algunas de las preguntas se sienta algo incómoda.

OTRA INFORMACIÓN

Este estudio es completamente anónimo y todos los datos serán guardados con total seguridad y absoluta confidencialidad. Ninguna otra persona tendrá acceso a la información salvo el personal del proyecto. Si decide no participar es libre de hacerlo.

Si tiene alguna pregunta en relación a la investigación o alguna pregunta sobre sus derechos como participante, puede llamar al investigador principal, Itziar Luzarraga al 657-77 53 61, la atenderé gustosamente.

Si decide participar no olvide está petición:

"Por favor, recuerde que este cuestionario es anónimo, así que no escriba en los cuestionarios ni su nombre, apellido o dirección u otra información que le identifique" y "Rellene los cuestionarios en un lugar seguro".

Cuando termine de cumplimentar los cuestionarios, métalos en el sobre, ciérrelo con la pegatina y entrégueselo a la persona que se lo facilitó. Muchas gracias.

CERTIFICADO DEL INVESTIGADOR

FIRMA DEL INVESTIGADOR	NOMBRE DEL INVESTIGADOR	FECHA
Itziar Luzarraga	ITZIAR LUZARRAGA	15-06-2005
	D.N.I: 78.886.885 J	

Si decide participar, por favor conteste a las siguientes preguntas:

Cómo se enteró del estudio:_____.

Lugar: _____.

Fecha: _____.

Rellenar sólo por el personal del proyecto:

Número de identificación:
Fecha:

INFORMACIÓN PERSONAL

Por favor, responda a cada una de las preguntas:

1) Fecha actual: Mes ☐ Año ☐

2) Fecha de nacimiento: Año ☐

3) País de nacimiento:_____.

4) Ciudad de residencia actual:_____.

5) Nacionalidad:_____.

6) Este estudio se está llevando a cabo en varios países, por ello, necesitamos que rellene las siguientes preguntas:

Por favor, marque con una X todos los grupos culturales con los que <u>USTED</u> se siente identificada:

- ❑ Español.
- ❑ Mejicano, Mejicano-Americano, Americano de origen Mejicano.
- ❑ Portorriqueño.
- ❑ Cubano.
- ❑ Otro grupo cultural Hispano. Por favor, díganos el grupo o los grupos con los que se siente identificada, por ejemplo: Argentino, Colombiano, Dominicano, Nicaragüense, Salvadoreño, Boliviano, etc. Por favor, especifique: _____.
- ❑ Otro grupo cultural. Por favor, díganos el grupo o grupos con los que se siente identificada, por ejemplo: Francés, Alemán, Italiano, Afroamericano, Americano Nativo, etc. Por favor, especifique: _____.

Por favor, marque con una X uno o más de <u>SUS</u> orígenes:

- ❑ Blanco – Una persona que tiene sus orígenes o raíces en gente de Europa.
- ❑ Oriente Medio.
- ❑ África del Norte.
- ❑ Afroamericano o negro – Una persona que tiene sus orígenes o raíces en gente perteneciente a los grupos negros raciales de África.
- ❑ Asiático – Una persona que tiene sus orígenes o raíces en gente del Extremo Oriente, Sudeste de Asia o del Subcontinente Indio incluyendo, por ejemplo: China, Las Islas Filipinas, Vietnam, Tailandia, Malasia, Paquistán, India, etc.
- ❑ Hawaiano Nativo u otro Isleño del Pacífico – Una persona que tiene sus orígenes o raíces en gente de Hawai, Guam, Samoa u otras Islas del Pacífico.
- ❑ Indio Americano – Una persona que tiene sus orígenes o raíces en gente de América del Norte, Sudamérica (incluyendo Centroamérica) y quienes mantienen afiliación o unión con la comunidad.
- ❑ Otra raza / o etnia, por favor especifique: _____.

7) EDUCACIÓN

Por favor, especifique el nivel de estudios más alto que <u>USTED</u> ha finalizado:

- ❑ No cursó estudios.
- ❑ 1º EGB o 1º de enseñanza primaria.
- ❑ 2º EGB o 2º de enseñanza primaria.
- ❑ 3º EGB o 3º de enseñanza primaria.
- ❑ 4º EGB o 4º de enseñanza primaria.
- ❑ 5º EGB o 5º de enseñanza primaria.
- ❑ 6º EGB o 6º de enseñanza primaria.
- ❑ 7º EGB o 1º de ESO.
- ❑ 8º EGB o 2º de ESO.
- ❑ 1º BUP o 3º de ESO.
- ❑ 2º BUP o 4º de ESO.
- ❑ 3º BUP o 1º bachillerato.
- ❑ COU o 2º bachillerato.
- ❑ Formación profesional.
- ❑ Estudios universitarios NO terminados (Licenciatura, Diplomatura etc.).
- ❑ Diplomatura o carrera de 3 años.
- ❑ Licenciatura o carrera de 4 o 5 años.
- ❑ Estudios de postgrado: Master y doctorado.
- ❑ Otros, por favor especifique:_____.

8) TRABAJO

- Por favor, indique SU ocupación. Marque con una X todas las respuestas que considere necesarias:

- ❑ Trabajadora de jornada completa (40 horas a la semana).
- ❑ Trabajadora de media jornada (20 horas a la semana).
- ❑ Autónoma o Propio empleo.
- ❑ Ama de casa.
- ❑ Estudiante (20 horas a la semana) y empleada de media jornada (20 horas a la semana).
- ❑ Estudiante jornada completa (40 horas a la semana).
- ❑ En paro, desempleada.
- ❑ Incapacitada.
- ❑ Retirada o jubilada.
- ❑ Otro, por favor especifique:_____ _____.

- Por favor, explique brevemente en qué consiste SU trabajo o profesión:_____ _____.

- ¿Durante los últimos 12 meses ha estado USTED algunos días o meses sin trabajar?

❑ SÍ ↓ ❑ NO (Por favor, pase a la pregunta número 9).

Si ha respondido SÍ, por favor, marque con una X los días o meses que USTED no ha estado trabajando:

Menos de 1 mes	Entre 1 y 3 meses	Entre 3 y 6 meses	Entre 6 y 9 meses	Entre 9 y 12 meses

9) TOTAL DE SUS INGRESOS ANUALES:

Por favor, indique **el total de SUS ingresos anuales brutos (con impuestos), incluyendo el paro y las ayudas del Gobierno**:

- ❑ No tengo ingresos personales.
- ❑ Estoy cobrando el paro (marque el recuadro que indique el total de sus ingresos anuales brutos).
- ❑ Menos de 6.000 € (1.000.000 Ptas.).
- ❑ Entre 6.000 € (1.000.000 Ptas.) y 12.000 € (2.000.000 Ptas.).
- ❑ Entre 12.001 € (2.000.116 Ptas.) y 18.000 € (3.000.000 Ptas.).
- ❑ Entre 18.001€ (3.000.116 Ptas.) y 24.000 € (4.000.000 Ptas.).
- ❑ Entre 24.001 € (4.000.116 Ptas.) y 30.000 € (5.000.000 Ptas.).
- ❑ Entre 30.001 € (5.000.116 Ptas.) y 36.000 € (6.000.000 Ptas.).
- ❑ Entre 36.001€ (6.000.116 Ptas.) y 42.000 € (7.000.000 Ptas.).
- ❑ Entre 42.001 € (7.000.116 Ptas.) y 48.000 € (8.000.000 Ptas.).
- ❑ Entre 48.001 € (8.000.116 Ptas.) y 54.000 € (9.000.000 Ptas.).
- ❑ Entre 54.001€ (9.000.116 Ptas.) y 60.000 € (10.000.000 Ptas.).
- ❑ Más de 60.001 € (10.000.116 Ptas.).

HISTORIA DE SUS RELACIONES DE PAREJA

10) Por favor, conteste a las siguientes preguntas sobre la historia de SUS relaciones de pareja, incluyendo su relación de pareja actual:

- ¿Cuántas relaciones de pareja, que usted entienda como estables, ha tenido? (incluyendo su relación de pareja actual) _____. ¿Cuál ha sido la duración media de sus relaciones de pareja estables? (incluyendo su relación de pareja actual) _____año/s y _____mes/es.

- ¿Con cuántos novios o parejas ha convivido? (incluyendo su relación de pareja actual) _____. ¿Cuál es la duración media de la convivencia con sus parejas? (incluyendo su relación de pareja actual) _____año/s y _____mes/es.

- ¿Cuántas veces se ha casado? (incluyendo su relación de pareja actual) _____.

- ¿Cuántas veces ha estado en proceso de separación legal? (incluyendo su relación de pareja actual)_____.

- ¿Cuántas veces se ha separado legalmente? (incluyendo su relación de pareja actual) _____.

- ¿Cuántas veces se ha divorciado? (incluyendo su relación de pareja actual) _____.

- ¿Cuántas veces se ha quedado viuda? (incluyendo su relación de pareja actual) _____.

RELACIÓN DE PAREJA ACTUAL

11) ¿Tiene pareja, novio o esposo?

❑ SÍ ❑ NO ↓

SI CONTESTA NO, POR FAVOR CONTESTE EL RESTO DE LAS PREGUNTAS REFIRIÉNDOSE **A SU RELACIÓN DE PAREJA MÁS RECIENTE.**

12) ¿Fecha de inicio de la relación? (Si no la recuerda, por favor escriba una fecha aproximada)

Mes ☐ Año ☐

13) ¿Vive con su pareja?

❑ SÍ ↓ ❑ NO (Por favor, pase a la pregunta número 14)

Si contesta que SÍ, por favor escriba la fecha en la que empezaron a vivir juntos (Si no la recuerda, por favor escriba una fecha aproximada) Mes ☐ Año ☐

14) ¿Cuál es el status de su relación de pareja actual? (Marque todas las respuestas que considere necesarias)

❑ Mantenemos un relación de pareja ❑ Prometidos ❑ Casados Fecha de la boda: Día ☐ Mes ☐ Año ☐ ❑ Viuda

❑ En proceso de acabar con la relación ❑ Hemos roto ❑ En proceso de separación legal ❑ Separados legalmente ❑ Divorciados

INFORMACION SOBRE SU PAREJA

15) Sexo de su pareja

❑ Masculino ❑ Femenino

16) Fecha de nacimiento de su pareja: Año ☐

17) País en el que ha nacido su pareja: _____.

18) Ciudad en la que vive su pareja: _____.

19) Nacionalidad de su pareja: _____.

20) Este estudio se está llevando a cabo en varios países, por ello, necesitamos que rellene las siguientes preguntas sobre SU PAREJA:
Por favor, marque con una X todos los grupos culturales con los que SU PAREJA se siente identificada:

- ❑ Español.
- ❑ Mejicano, Mejicano-Americano, Americano de origen Mejicano.
- ❑ Portorriqueño.
- ❑ Cubano.
- ❑ Otro grupo cultural Hispano. Por favor, díganos el grupo o los grupos con los que su pareja se siente identificada: por ejemplo Argentino, Colombiano, Dominicano, Nicaragüense, Salvadoreño, Boliviano, etc. Por favor, especifique: _____.
- ❑ Otro grupo cultural. Por favor, díganos el grupo o grupos con los que su pareja se siente identificada: por ejemplo: Francés, Alemán, Italiano, Afroamericano, Americano Nativo, etc. Por favor, especifique: _____.

Por favor, marque con una X uno o más de los orígenes de SU PAREJA:

- ❑ Blanco – Una persona que tiene sus orígenes o raíces en gente de Europa.
- ❑ Oriente Medio.
- ❑ África del Norte.
- ❑ Afroamericano o negro– Una persona que tiene sus orígenes o raíces en gente perteneciente a los grupos raciales negros de África.
- ❑ Asiático – Una persona que tiene sus orígenes o raíces en gente del Extremo Oriente , Sudeste de Asia o del Subcontinente Indio incluyendo, por ejemplo: China, Las Islas Filipinas, Vietnam, Tailandia, Malasia, Paquistán, India, etc.
- ❑ Hawaiano Nativo u otro Isleño del Pacífico – Una persona que tiene sus orígenes o raíces en gente de Hawai, Guam, Samoa u otras Islas del Pacífico.
- ❑ Indio Americano – Una persona que tiene sus orígenes o raíces en gente de América del Norte, Sudamérica (incluyendo Centroamérica) y quienes mantienen afiliación o unión con la comunidad.
- ❑ Otra raza / o etnia, por favor especifique: _____.

21) EDUCACIÓN

Por favor, especifique el nivel de estudios más alto que ha finalizado SU PAREJA:

- ❑ No cursó estudios.
- ❑ 1° EGB o 1° de enseñanza primaria.
- ❑ 2° EGB o 2° de enseñanza primaria.
- ❑ 3° EGB o 3° de enseñanza primaria.
- ❑ 4° EGB o 4° de enseñanza primaria.
- ❑ 5° EGB o 5° de enseñanza primaria.
- ❑ 6° EGB o 6° de enseñanza primaria.
- ❑ 7° EGB o 1° de ESO.
- ❑ 8° EGB o 2° de ESO.
- ❑ 1° BUP o 3° de ESO.
- ❑ 2° BUP o 4° de ESO.
- ❑ 3° BUP o 1° bachillerato.
- ❑ COU o 2° bachillerato.
- ❑ Formación profesional.
- ❑ Estudios universitarios NO terminados (Licenciatura, Diplomatura etc.).
- ❑ Diplomatura o carrera de 3 años.
- ❑ Licenciatura o carrera de 4 o 5 años.
- ❑ Estudios de postgrado: Master y doctorado.
- ❑ Otros, por favor especifique:_____ _____.

22) TRABAJO

- Por **favor, indique la ocupación de SU PAREJA.** Marque con una X todas las respuestas que considere necesarias:

- ❑ Trabajador de jornada completa (40 horas a la semana).
- ❑ Trabajador de media jornada (20 horas a la semana).
- ❑ Autónomo o Propio empleo.
- ❑ Amo de casa.
- ❑ Estudiante (20 horas a la semana) y empleado de media jornada (20 horas a la semana).
- ❑ Estudiante jornada completa (40 horas a la semana).
- ❑ En paro, desempleado.
- ❑ Incapacitado.
- ❑ Retirado o jubilado.
- ❑ Otro, por favor especifique:_____ _____.

- Por favor, explique brevemente en qué consiste el trabajo o profesión de SU PAREJA:_____ _____.

- ¿Durante los últimos 12 meses ha estado SU PAREJA algunos días o meses sin trabajar?

❑ SI ↓ ❑ NO (Por favor, pase a la pregunta número 23).

Si ha respondido SÍ, por favor, marque con una X los días o meses que SU PAREJA no ha estado trabajando:

Menos de 1 mes	Entre 1 y 3 meses	Entre 3 y 6 meses	Entre 6 y 9 meses	Entre 9 y 12 meses

23) TOTAL DE LOS INGRESOS ANUALES DE SU PAREJA: Por favor, indique **el total de los ingresos anuales brutos (con impuestos) de SU PAREJA, incluyendo el paro y las ayudas del Gobierno:**

- ❑ No tiene ingresos personales.
- ❑ Mi pareja está cobrando el paro (marque el recuadro que indique el total de los ingresos anuales brutos de su pareja).
- ❑ Menos de 6.000 € (1.000.000 Ptas.).
- ❑ Entre 6.000 € (1.000.000 Ptas.) y 12.000 € (2.000.000 Ptas.).
- ❑ Entre 12.001 € (2.000.116 Ptas.) y 18.000 € (3.000.000 Ptas.).
- ❑ Entre 18.001€ (3.000.116 Ptas.) y 24.000 € (4.000.000 Ptas.).
- ❑ Entre 24.001 € (4.000.116 Ptas.) y 30.000 € (5.000.000 Ptas.).
- ❑ Entre 30.001 € (5.000.116 Ptas.) y 36.000 € (6.000.000 Ptas.).
- ❑ Entre 36.001€ (6.000.116 Ptas.) y 42.000 € (7.000.000 Ptas.).
- ❑ Entre 42.001 € (7.000.116 Ptas.) y 48.000 € (8.000.000 Ptas.).
- ❑ Entre 48.001 € (8.000.116 Ptas.) y 54.000 € (9.000.000 Ptas.).
- ❑ Entre 54.001€ (9.000.116 Ptas.) y 60.000 € (10.000.000 Ptas.).
- ❑ Más de 60.001 € (10.000.116 Ptas.).

INFORMACIÓN SOBRE LA HISTORIA DE LAS RELACIONES DE PAREJA DE SU COMPAÑERO

En este apartado responda a las preguntas sobre la historia de las relaciones de pareja de su compañero.

24) Por favor, indique la historia de las relaciones de pareja de SU COMPAÑERO, incluyendo vuestra relación:

- ¿Cuántas relaciones ha tenido su pareja que usted o su pareja entiendan como estables? (incluyendo vuestra relación)_____. ¿Cuál ha sido la duración media de las relaciones estables de su pareja? (incluyendo vuestra relación)_____año/s y _____mes/es.

- ¿Con cuántas novias o parejas ha convivido su pareja? (incluyendo vuestra relación)_____. ¿Cuál es la duración media de la convivencia de su compañero con sus parejas? (incluyendo vuestra relación)_____año/s y _____mes/es.

- ¿Cuántas veces se ha casado su pareja? (incluyendo vuestra relación) _____.

- ¿Cuántas veces ha estado su pareja en proceso de separación legal? (incluyendo vuestra relación)_____.

- ¿Cuántas veces se ha separado legalmente su pareja? (incluyendo vuestra relación)_____.

- ¿Cuántas veces se ha divorciado su pareja? (incluyendo vuestra relación)_____.

- ¿Cuántas veces se ha quedado su pareja viudo? (incluyendo vuestra relación)_____.

ESTATUS FAMILIAR:

25) ¿Tiene hijo/s?

❑ SÍ ↓ ❑ NO (Por favor, pase a la pregunta número 26.)

Si responde SÍ, **¿Cuantos hijos tiene?** _____. ↓

- ¿Cuántos de sus hijos son de **SU ACTUAL relación de pareja**? _____. Indique edad de los hijos_____.

- ¿Cuántos de sus hijos son de **SUS relaciones ANTERIORES**? _____. Indique edad de los hijos_____.

- ¿Cuántos de sus hijos son de **parejas anteriores de SU COMPAÑERO**? __. Indique edad de los hijos___.

- ¿Cuántos de sus hijos son **ADOPTADOS**? _____. Indique edad de los hijos_____.

"Por favor, acuérdese de no escribir ninguna información que le identifique (como: nombre, apellido, dirección), rellene el cuestionario en un lugar seguro. Por favor, sea sincera al responder".

26) ¿Está usted embarazada?

❑ SÍ. ❑ NO.

Por favor, rellene las preguntas del siguiente recuadro información sobre el embarazo. ↓

Por favor, pase al apartado "CUESTIONARIO SOBRE LA RELACION DE PAREJA".

INFORMACIÓN SOBRE EL EMBARAZO

- ¿En qué mes del embarazo se encuentra?_____.

- ¿Su pareja actual es el padre biológico del bebé que está esperando?

❑ SÍ ❑ NO ❑ No lo sé

-¿Es la primera vez que se ha quedado embarazada?

❑ SÍ ❑ NO Por favor, le agradeceríamos que nos dijera si ha perdido algún embarazo de forma natural ❑ SI ❑ NO

- ¿Es la primera vez que está embarazada de 6 o más meses?

❑ SI ❑ NO

- En el momento en que se quedó embarazada, ¿estaba intentando quedarse embarazada?

❑ SI ❑ NO, el embarazo fue sorpresa.

- ¿Cuánto tiempo estuvieron intentando que se quedara embarazada?

Fue sorpresa	Menos de 1 mes	Entre 1 y 3 meses	Entre 3 y 6 meses	Entre 6 y 12 meses	Más de 12 meses

- ¿Ha realizado su primera visita prenatal o de control del embarazo?

❑ SÍ ↓ ❑ NO

Si responde Sí. Por favor, indíquenos la fecha (Si no la recuerda, por favor escriba una fecha aproximada)

Mes ☐ Año ☐

- ¿Está usted asistiendo a clases de preparación maternal o al parto?

❑ SÍ ❑ NO

- ¿Cómo se sienten usted y su pareja en relación a tener un bebé?

	Muy infeliz	Bastante infeliz	Un poco infeliz	Ni infeliz ni feliz	Un poco feliz	Bastante feliz	Muy feliz
USTED							
SU PAREJA							

Rellenar sólo por el personal del proyecto:
Número de identificación:
Fecha:

CUESTIONARIO SOBRE LA RELACIÓN DE PAREJA (DAS)

La mayoría de las personas muestra algún tipo de desacuerdos en sus relaciones. Indique, por favor, el grado aproximado de acuerdo o desacuerdo entre usted y su pareja en cada uno de los elementos que figuran a continuación. Marque con una X su respuesta a cada pregunta.

	Siempre de acuerdo	Casi siempre de acuerdo	A veces en desacuerdo	A menudo en desacuerdo	Casi siempre en desacuerdo	Siempre en desacuerdo
1. Manejo de la economía doméstica	☐	☐	☐	☐	☐	☐
2. Tiempo de ocio	☐	☐	☐	☐	☐	☐
3. Religión	☐	☐	☐	☐	☐	☐
4. Demostraciones de cariño	☐	☐	☐	☐	☐	☐
5. Amistades	☐	☐	☐	☐	☐	☐
6. Relaciones sexuales	☐	☐	☐	☐	☐	☐
7. Muestras de educación (conductas correctas o apropiadas)	☐	☐	☐	☐	☐	☐
8. Filosofía de la vida	☐	☐	☐	☐	☐	☐
9. Relaciones con los familiares próximos	☐	☐	☐	☐	☐	☐
10. Cosas y objetivos considerados importantes	☐	☐	☐	☐	☐	☐
11. Cantidad de tiempo pasado juntos	☐	☐	☐	☐	☐	☐
12. Toma de decisiones importantes	☐	☐	☐	☐	☐	☐
13. Tareas domésticas	☐	☐	☐	☐	☐	☐
14. Intereses y actividades de ocio	☐	☐	☐	☐	☐	☐
15. Decisiones en relación con el futuro de uno	☐	☐	☐	☐	☐	☐

	Siempre	Casi Siempre	A menudo	A veces	Casi nunca	Nunca
16. ¿Con qué frecuencia hablan o consideran la posibilidad de divorciarse, separarse o de poner fin a su relación?	☐	☐	☐	☐	☐	☐
17. ¿Con qué frecuencia usted o su pareja se van de casa después de una riña?	☐	☐	☐	☐	☐	☐
18. ¿Con qué frecuencia considera que la relación entre usted y su pareja funciona, en general, adecuadamente?	☐	☐	☐	☐	☐	☐
19. ¿Confía usted en su pareja?	☐	☐	☐	☐	☐	☐
20. ¿Se arrepiente en alguna ocasión de haberse casado (o de haberse ido a vivir juntos)?	☐	☐	☐	☐	☐	☐
21. ¿Con qué frecuencia discuten usted y su pareja?	☐	☐	☐	☐	☐	☐
22. ¿Con qué frecuencia acaban usted y su pareja por perder el control en el transcurso de una discusión?	☐	☐	☐	☐	☐	☐
23. ¿Con qué frecuencia usted y su pareja tienen problemas por celos?	☐	☐	☐	☐	☐	☐

"Por favor, acuérdese de no escribir ninguna información que le identifique (como: nombre, apellido, dirección), rellene el cuestionario en un lugar seguro. Por favor, sea sincera al responder".

	Todos los días	Casi todos los días	A veces	Casi nunca	Nunca
24. ¿Besa usted a su pareja?	☐	☐	☐	☐	☐

	En casi todas	En la mayoría	En algunas	En casi ninguna	En ninguna
25. ¿Participan usted y su pareja en actividades externas a la familia?	☐	☐	☐	☐	☐

	Nunca	Menos de 1 vez al mes	1 o 2 veces al mes	1 o 2 veces a la semana	1 vez al día	Más a menudo incluso
26. ¿Tienen ustedes un intercambio enriquecedor de ideas?	☐	☐	☐	☐	☐	☐
27. ¿Se ríen juntos?	☐	☐	☐	☐	☐	☐
28. ¿Dialogan tranquilamente sobre cualquier cosa?	☐	☐	☐	☐	☐	☐
29. ¿Colaboran juntos en un proyecto?	☐	☐	☐	☐	☐	☐

HAY ALGUNOS ASPECTOS EN LOS QUE LAS PAREJAS ESTÁN A VECES DE ACUERDO Y A VECES EN DESACUERDO. INDIQUE SI ALGUNO DE LOS DOS ELEMENTOS SEÑALADOS A CONTINUACIÓN HA SIDO MOTIVO DE DISCORDIA O DE DIFERENCIAS DE OPINIÓN EN LA RELACIÓN DE PAREJA EN LAS ÚLTIMAS SEMANAS. (SEÑALE SI O NO)

	Sí	No
30. Demasiado cansado para practicar el sexo	☐	☐
31. Ausencia de muestras de cariño	☐	☐

32. Las alternativas que aparecen debajo de estas líneas representan grados diversos de felicidad en la relación de pareja. La alternativa central ("feliz") representa el grado de felicidad de la mayor parte de las relaciones. Rodee con un círculo, por favor, la alternativa que describa mejor el grado de felicidad, tras hacer un balance global, de su relación de pareja:

Muy Desgraciada	Bastante Desgraciada	Algo Desgraciada	Feliz	Bastante Feliz	Muy Feliz	Radiante

33. ¿Cuál de las frases que figuran a continuación describe mejor sus sentimientos acerca del futuro de su relación de pareja?

- ☐ Quiero a toda costa que mi relación tenga éxito y *haría cualquier cosa* para conseguirlo.
- ☐ Tengo mucho interés en que mi relación tenga éxito y *haré todo lo que pueda* para conseguirlo.
- ☐ Tengo mucho interés en que mi relación tenga éxito y *pondré de mi parte lo necesario* para conseguirlo.
- ☐ Sería muy agradable si mi relación de pareja tuviera éxito, pero *no puedo hacer mucho más de lo que ya hago* ahora para conseguirlo.
- ☐ Sería muy agradable si mi relación de pareja tuviera éxito, pero *me niego a hacer más de lo que ya hago* ahora para contribuir a que la pareja vaya bien.
- ☐ Mi relación de pareja no puede tener éxito nunca, y *yo no puedo hacer más* de lo que hago para mantener a la pareja con éxito.

34. ¿Cómo de satisfecha está con el apoyo y ayuda que recibe de la gente a su alrededor?

Muy insatisfecha	Un poco insatisfecha	Satisfecha	Bastante satisfecha	Muy satisfecha

Rellenar sólo por el personal del proyecto:
Número de identificación:
Fecha:

CONFLICTOS EN LA RELACIÓN DE PAREJA (SCTS2)

No importa lo bien que se lleve una pareja, hay momentos en que discuten, se sienten molestos con la otra persona, quieren diferentes cosas, o simplemente tienen riñas o peleas porque están de mal humor, cansados o por otra razón. Las parejas también tienen muchas maneras diferentes de arreglar sus diferencias. Ésta es una lista de comportamientos que pueden ocurrir cuando tienen diferencias. Por favor, señale cuántas veces tuvo esos comportamientos durante los últimos 12 meses y cuántas veces los tuvo su pareja. Si usted o su pareja no han tenido ninguno de estos comportamientos durante los últimos 12 meses pero han sucedido antes, entonces tiene usted que marcar el número "7" en esa pregunta. Si nunca ha pasado, marque el numero "0".

Si usted NO esta embarazada responda exclusivamente al apartado **A** de cada pregunta.
Si usted SI esta embarazada responda a los apartados **A y B** de cada pregunta.

POR FAVOR LEA DETENIDAMENTE LA ESCALA Y CADA UNA DE LAS PREGUNTAS ANTES DE DAR SU RESPUESTA.

ESCALA:
¿Con qué frecuencia ocurrió cada uno de estos comportamientos durante los últimos 12 meses o antes?

0= Nunca ha ocurrido
1= Una vez durante los últimos 12 meses
2= Dos veces durante los últimos 12 meses
3= De 3 a 5 veces durante los últimos 12 meses
4= De 6 a 10 veces durante los últimos 12 meses
5= De 11 a 20 veces durante los últimos 12 meses
6= Más de 20 veces durante los últimos 12 meses
7= Nunca durante los últimos 12 meses, pero ha ocurrido antes

1. a) **Expliqué a mi pareja mi punto de vista o le sugerí un acuerdo sobre un tema en el que teníamos diferentes opiniones.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

2. a) ***Mi pareja*** **me explicó su punto de vista o me sugirió un acuerdo sobre un tema en el que teníamos diferentes opiniones.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

3. a) **Le insulté, le dije palabrotas o le grité a mi pareja.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

4. a) ***Mi pareja*** **me insultó, me dijo palabrotas o me gritó.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

ESCALA:

¿Con qué frecuencia ocurrió cada uno de estos comportamientos durante los últimos 12 meses o antes?

0= Nunca ha ocurrido
1= Una vez durante los últimos 12 meses
2= Dos veces durante los últimos 12 meses
3= De 3 a 5 veces durante los últimos 12 meses
4= De 6 a 10 veces durante los últimos 12 meses
5= De 11 a 20 veces durante los últimos 12 meses
6= Más de 20 veces durante los últimos 12 meses
7= Nunca durante los últimos 12 meses, pero ha ocurrido antes

5. a) **Me quedó una torcedura, moratón o un pequeño corte, o sentí dolor físico al día siguiente a causa de una pelea con mi pareja.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

6. a) **A mi pareja le quedó una torcedura, moratón o un pequeño corte, o tuvo dolor físico al día siguiente a causa de una pelea conmigo**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

7. a) **Mostré respeto por mi pareja o que me preocupaba por sus sentimientos sobre un tema en el que no estábamos de acuerdo.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

8. a) ***Mi pareja*** **mostró respeto o mostró que se preocupaba por mis sentimientos sobre un tema en el que no estábamos de acuerdo.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

9. a) **Empujé a mi pareja o le di un bofetón.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

10. a) ***Mi pareja*** **me empujó o me dio un bofetón.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

ESCALA:

¿Con qué frecuencia ocurrió cada uno de estos comportamientos durante los últimos 12 meses o antes?

0= Nunca ha ocurrido
1= Una vez durante los últimos 12 meses
2= Dos veces durante los últimos 12 meses
3= De 3 a 5 veces durante los últimos 12 meses
4= De 6 a 10 veces durante los últimos 12 meses
5= De 11 a 20 veces durante los últimos 12 meses
6= Más de 20 veces durante los últimos 12 meses
7= Nunca durante los últimos 12 meses, pero ha ocurrido antes

11. a) **Le di un puñetazo, una patada o una paliza a mi pareja.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

12. a) ***Mi pareja*** **me dio un puñetazo, una patada o una paliza.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

13. a) **Destrocé algo que pertenecía a mi pareja o le amenacé con pegarle.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

14. a) ***Mi pareja*** **destrozó algo que me pertenecía o me amenazó con pegarme**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

15. a) **Fui al médico o necesité ir al médico a causa de una pelea con mi pareja.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

16. a) ***Mi pareja*** **fue al médico o necesitó ir al médico a causa de una pelea conmigo.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

ESCALA:

¿Con qué frecuencia ocurrió cada uno de estos comportamientos durante los últimos 12 meses o antes?

0= Nunca ha ocurrido
1= Una vez durante los últimos 12 meses
2= Dos veces durante los últimos 12 meses
3= De 3 a 5 veces durante los últimos 12 meses
4= De 6 a 10 veces durante los últimos 12 meses
5= De 11 a 20 veces durante los últimos 12 meses
6= Más de 20 veces durante los últimos 12 meses
7= Nunca durante los últimos 12 meses, pero ha ocurrido antes

17. a) **Usé la fuerza (como golpear, sujetar o usar un arma) para hacer que mi pareja tuviera relaciones sexuales conmigo.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

18. a) ***Mi pareja*** **usó la fuerza (como golpear, sujetar o usar un arma) para hacer que tuviera relaciones sexuales con él.**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

19. a) **Insistí en tener relaciones sexuales, cuando mi pareja no quería, o insistí en tener relaciones sexuales sin preservativo (pero no usé la fuerza física).**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

20. a) ***Mi pareja*** **insistió en tener relaciones sexuales, cuando yo no quería, o insistió en tener relaciones sexuales sin preservativo (pero no usó la fuerza física).**	0	1	2	3	4	5	6	7

b) Especifique, ¿Tuvo lugar este comportamiento durante el embarazo?	☐ Empezó	☐ Aumentó	☐ Se mantuvo	☐ Disminuyó	☐ Nunca se ha dado

INFORMACIÓN SOBRE EL CONSUMO DE ALCOHOL (SMAST)

Rellenar sólo por el personal del proyecto:
Número de identificación:
Fecha:

Las siguientes preguntas son sobre su consumo de alcohol y el de su pareja. Por favor, responda las siguientes preguntas haciendo un círculo en su respuesta:

SOBRE USTED		SOBRE SU PAREJA	
1) ¿Cree que es una bebedora normal? (Por bebedora normal entendemos que es una persona que bebe menos o igual que la mayoría de la gente)	SÍ NO	1) ¿Cree que su pareja es un bebedor normal? (Por bebedor normal entendemos que es una persona que bebe menos o igual que la mayoría de la gente)	SÍ NO
2) ¿Alguna vez su pareja, alguno de sus padres o familiares cercanos se ha preocupado o quejado de lo que bebe?	SÍ NO	2) ¿Alguna vez usted, alguno de los padres de su pareja o familiares cercanos se ha preocupado o quejado de lo que bebe su pareja?	SÍ NO
3) ¿Se ha sentido alguna vez culpable por beber?	SÍ NO	3) ¿Se ha sentido su pareja alguna vez culpable por beber?	SÍ NO
4) ¿Creen sus amigos o familiares que es una bebedora normal?	SÍ NO	4) ¿Creen sus amigos o familiares que su pareja es un bebedor normal?	SÍ NO
5) ¿Es capaz de dejar de beber cuando quiere?	SÍ NO	5) ¿Es su pareja capaz de dejar de beber cuando quiere?	SÍ NO
6) ¿Ha asistido alguna vez a una reunión de Alcohólicos Anónimos?	SÍ NO	6) ¿Ha asistido su pareja alguna vez a una reunión de Alcohólicos Anónimos?	SÍ NO
7) ¿Su consumo de alcohol le ha creado alguna vez problemas con su pareja o con alguno de sus padres o familiares cercanos?	SÍ NO	7) ¿El consumo de alcohol de su pareja le ha creado alguna vez problemas con usted o con alguno de los padres o familiares cercanos de su pareja?	SÍ NO
8) ¿Ha tenido alguna vez problemas en el trabajo por beber?	SÍ NO	8) ¿Ha tenido su pareja alguna vez problemas en el trabajo por beber?	SÍ NO
9) ¿Ha dejado alguna vez de atender sus obligaciones, a su familia o a su trabajo durante dos o más días seguidos por beber?	SÍ NO	9) ¿Ha dejado su pareja alguna vez de atender sus obligaciones, a la familia o a su trabajo durante dos o más días seguidos por beber?	SÍ NO
10) ¿Ha acudido alguna vez a alguien en busca de ayuda por su consumo de alcohol?	SÍ NO	10) ¿Ha acudido su pareja alguna vez a alguien en busca de ayuda por su consumo de alcohol?	SÍ NO
11) ¿Ha estado alguna vez en un hospital por beber?	SÍ NO	11) ¿Ha estado su pareja alguna vez en un hospital por beber?	SÍ NO
12) ¿Ha sido detenida alguna vez por conducir en estado de embriaguez (borracha) o por conducir después de haber bebido?	SÍ NO	12) ¿Ha sido su pareja detenido alguna vez por conducir en estado de embriaguez (borracho) o por conducir después de haber bebido?	SÍ NO
13) ¿Ha sido detenida alguna vez, aunque fuera por pocas horas, por su comportamiento cuando estaba bajo los efectos del alcohol (borracha)?	SÍ NO	13) ¿Ha sido su pareja detenida alguna vez, aunque fuera por pocas horas, por su comportamiento cuando estaba bajo los efectos del alcohol (borracho)?	SÍ NO

"Por favor, acuérdese de no escribir ninguna información que le identifique (como, nombre, apellido, dirección), rellene el cuestionario en un lugar seguro. Por favor, sea sincera al responder".

INFORMACIÓN SOBRE EL CONSUMO DE DROGAS (DAST-10)

Rellenar sólo por el personal del proyecto:
Número de identificación:
Fecha:

Las siguientes preguntas son sobre el posible consumo de drogas, **excluyendo alcohol y tabaco, de usted y su pareja durante los últimos 12 meses**. Por favor, lea con cuidado cada pregunta, decida si su respuesta es "Sí" o "No", y haga un círculo en su respuesta.

La palabra "abuso de drogas" se refiere a 1) el uso de medicinas compradas con receta médica o sin ella, que son ingeridas más de lo indicado y 2) el uso de cualquier droga no por razones médicas. Las diversas clases de drogas pueden incluir: cannabis (Ej: marihuana, hachís), solventes, tranquilizantes (Ej: Valium), barbitúricos, cocaína, estimulantes (Ej: speed), alucinógenos (Ej: LSD) o narcóticos (Ej: heroína). Recuerde que las preguntas **no incluyen alcohol o tabaco.**

Por favor, responda a cada pregunta. Si tiene dificultades con alguna de las preguntas escoja la que le parezca más correcta.

Estas preguntas se refieren a los últimos 12 meses:

SOBRE USTED		SOBRE SU PAREJA	
1) ¿Ha consumido drogas que no eran requeridas por razones médicas?	SÍ NO	1) ¿Ha consumido su pareja drogas que no eran requeridas por razones médicas?	SÍ NO
2) ¿Abusa de más de una droga a la vez?	SÍ NO	2) ¿Su pareja abusa de más de una droga a la vez?	SÍ NO
3) ¿Es capaz de parar de consumir drogas siempre que quiere?	SÍ NO	3) ¿Es su pareja, capaz de parar de consumir drogas siempre que quiere?	SÍ NO
4) ¿Ha tenido "pérdidas de conocimiento" o de "memoria repentina" como resultado del consumo de drogas?	SÍ NO	4) ¿Ha tenido su pareja "pérdidas de conocimiento" o de "memoria repentina" como resultado del consumo de drogas?	SÍ NO
5) ¿Alguna vez se ha sentido mal o culpable por el consumo de drogas?	SÍ NO	5) ¿Alguna vez su pareja se ha sentido mal o culpable por el consumo de drogas?	SÍ NO
6) ¿Su pareja (o alguno de sus padres) se ha quejado alguna vez por su consumo de drogas?	SÍ NO	6) ¿Usted (o alguno de los padres de su pareja) se ha quejado alguna vez del consumo de drogas de su pareja?	SÍ NO
7) ¿Ha desatendido a su familia debido al consumo de drogas?	SÍ NO	7) ¿Ha desatendido su pareja a la familia debido al consumo de drogas?	SÍ NO
8) ¿Se ha visto implicada en actividades ilegales con el fin de obtener drogas?	SÍ NO	8) ¿Se ha visto implicada su pareja en actividades ilegales con el fin de obtener drogas?	SÍ NO
9) ¿Alguna vez ha experimentado síntomas de abstinencia (sentirse enferma) cuando dejó de consumir drogas?	SÍ NO	9) ¿Alguna vez su pareja ha experimentado síntomas de abstinencia (sentirse enfermo) cuando dejó de consumir drogas?	SÍ NO
10) ¿Ha tenido problemas médicos como resultado del consumo de drogas (Ej: pérdida de la memoria, hepatitis, convulsiones, hemorragia, etc.)?	SÍ NO	10) ¿Ha tenido su pareja problemas médicos como resultado del consumo de drogas (Ej: pérdida de la memoria, hepatitis, convulsiones, hemorragia, etc.)?	SÍ NO

"Por favor, acuérdese de no escribir ninguna información que le identifique (como, nombre, apellido, dirección), rellene el cuestionario en un lugar seguro. Por favor, sea sincera al responder".

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SU HISTORIA DEL PASADO (VH)

Queremos informarle que las preguntas que se encuentran en este cuestionario son quizás las más delicadas, ya que se refieren a experiencias difíciles que podría usted haber vivido. Por favor, conteste con sinceridad y tranquilidad marcando con una X en la casilla que corresponda a su respuesta.

1. ¿Alguna vez vió a su padre pegar o dar una paliza a su madre?

Antes de cumplir los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

Desde que cumplió los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

2. ¿Alguna vez vió a su madre pegar o dar una paliza a su padre?

Antes de cumplir los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

Desde que cumplió los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

3. ¿Alguna vez alguno de sus padres, padrastros o padres adoptivos le hizo algo a propósito que le dejó marcas, moratones o rasguños, fracturas de huesos o dientes, le hizo sangrar o requerir tratamiento médico?

Antes de cumplir los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

Desde que cumplió los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

4. EN EL PEOR AÑO QUE USTED PUEDE RECORDAR ¿Con qué frecuencia le pegaban sus padres, padrastros, padres adoptivos u otros adultos?

Antes de cumplir los 18 años, ¿Cuántas veces en ese año?

0	1	2	3-5	6-10	11-20	Más de 20

Desde que cumplió los 18 años, ¿Cuántas veces en ese año?

0	1	2	3-5	6-10	11-20	Más de 20

5. ¿Alguna vez alguno de sus exnovios o exparejas le pegó o le hizo algo a propósito que le dejó marcas, moratones o rasguños, fracturas de huesos o dientes, le hizo sangrar o requerir tratamiento médico?

Antes de cumplir los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

Desde que cumplió los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

6. Antes de cumplir los 18 años, ¿Alguna vez alguna persona, *por lo menos 5 años mayor que usted*, le tocó de forma sexual, le hizo tocar sus partes sexuales o trató de tener o tuvo relaciones sexuales con usted?

Antes de cumplir los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

Desde que cumplió los 18 años, ¿Alguna vez alguna persona le tocó de forma sexual, le hizo tocar sus partes sexuales o trató de tener o tuvo relaciones sexuales con usted cuando *usted le dijo que no quería?*

Desde que cumplió los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

"Por favor, acuérdese de no escribir ninguna información que le identifique (como, nombre, apellido, dirección), rellene el cuestionario en un lugar seguro. Por favor, sea sincera al responder".

7. ¿Alguna vez ha pegado a algún exnovio, expareja o a algún familiar o ha hecho algo a propósito a alguno de ellos que les dejó marcas, moratones o rasguños, fracturas de huesos o dientes, les hizo sangrar o requerir tratamiento médico?

Antes de cumplir los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

Desde que cumplió los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

8. ¿Alguna vez en público o en el trabajo ha pegado a alguien o ha hecho algo a propósito a alguien que le dejó marcas, moratones o rasguños, fracturas de huesos o dientes, le hizo sangrar o requerir tratamiento médico?

Antes de cumplir los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

Desde que cumplió los 18 años, ¿Cuántas veces?

0	1	2	3-5	6-10	11-20	Más de 20

HISTORIA DEL PASADO DE SU PAREJA

1. Durante la niñez y/o adolescencia de su pareja, ¿El padre de su pareja pegaba o daba palizas a su madre?

❑ SI ❑ NO ❑ No lo sé

2. Durante la niñez y/o adolescencia de su pareja, ¿La madre de su pareja pegaba o daba palizas a su padre?

❑ SI ❑ NO ❑ No lo sé

3. Durante la niñez y/o adolescencia de su pareja, ¿Alguno de sus padres, padrastros o padres adoptivos pegaba a su pareja o alguna vez le hizo algo a propósito a su pareja que le dejó marcas, moratones o rasguños, fracturas de huesos o dientes, le hizo sangrar o requerir tratamiento médico?

❑ SI ❑ NO ❑ No lo sé

4. ¿Alguna vez alguna de las exnovias o excompañeras de su pareja pegó a su pareja o le hizo algo a propósito a su pareja que le dejó marcas, moratones o rasguños, fracturas de huesos o dientes, le hizo sangrar o requerir tratamiento médico?

❑ SI ❑ NO ❑ No lo sé

5. Durante la niñez y/o adolescencia de su pareja ¿En alguna ocasión algún adulto le tocó a su pareja de forma sexual, le hizo tocar sus partes sexuales o trató de tener o tuvo relaciones sexuales con su pareja?

❑ SI ❑ NO ❑ No lo sé

6. Desde que su pareja cumplió los 18 años ¿Alguna vez su pareja ha pegado a alguna de sus exnovias, exparejas o a algún familiar o ha hecho algo a propósito a alguno de ellos que les dejó marcas, moratones o rasguños, fracturas de huesos o dientes, les hizo sangrar o requerir tratamiento médico?

❑ SI ❑ NO ❑ No lo sé

7. Desde que su pareja cumplió los 18 años ¿Alguna vez su pareja en público o en el trabajo ha pegado a alguien o ha hecho algo a propósito a alguien que le dejó marcas, moratones o rasguños, fracturas de huesos o dientes, le hizo sangrar o requerir tratamiento médico?

❑ SI ❑ NO ❑ No lo sé

Rellenar sólo por el personal del proyecto:
Número de identificación:
Fecha:

INFORMACIÓN SOBRE COMO SE SIENTE (BDI)

En este cuestionario aparecen varios grupos de afirmaciones. Por favor, lea con atención cada una. A continuación, señale cuál de las afirmaciones de cada grupo describe mejor cómo se ha sentido **DURANTE ESTA ÚLTIMA SEMANA, INCLUIDO EL DÍA DE HOY**. Rodee con un círculo el número que está a la izquierda de la afirmación que haya elegido. Si dentro de un mismo grupo hay más de una afirmación que considere aplicable a su caso, haga un círculo en la afirmación que tenga la numeración más alta. Por favor, asegúrese de no elegir más de una afirmación dentro de cada grupo. Asegúrese de leer todas las afirmaciones dentro de cada grupo antes de efectuar la elección.

1. 0. No me siento triste. 1. Me siento triste. 2. Me siento triste continuamente y no puedo dejar de estarlo. 3. Me siento tan triste o tan desgraciada que no puedo soportarlo.	**7.** 0. No me siento descontenta conmigo misma. 1. Estoy descontenta conmigo misma. 2. Me avergüenzo de mí misma. 3. Me odio.
2. 0. No me siento especialmente desanimada respecto al futuro. 1. Me siento desanimada respecto al futuro. 2. Siento que no tengo que esperar nada. 3. Siento que el futuro es desesperanzador y que las cosas no van a mejorar.	**8.** 0. No me considero peor que cualquier otro. 1. Me autocritico por mis debilidades o por mis errores. 2. Continuamente me culpo por mis faltas. 3. Me culpo por todo lo malo que sucede.
3. 0. No me siento fracasada. 1. Creo que he fracasado más que la mayoría de las personas. 2. Cuando miro hacia atrás, sólo veo fracaso tras fracaso. 3. Me siento una persona totalmente fracasada.	**9.** 0. No tengo ningún pensamiento de suicidio. 1. A veces pienso en suicidarme, pero no lo haría. 2. Desearía suicidarme. 3. Me suicidaría si tuviese la oportunidad.
4. 0. Las cosas me satisfacen tanto como antes. 1. No disfruto de las cosas tanto como antes. 2. Ya no obtengo una satisfacción auténtica de las cosas. 3. Estoy insatisfecha o aburrida de todo.	**10.** 0. No lloro más de lo que solía. 1. Ahora lloro más que antes. 2. Lloro continuamente. 3. Antes era capaz de llorar, pero ahora no puedo incluso aunque quiera.
5. 0. No me siento especialmente culpable. 1. Me siento culpable en bastantes ocasiones. 2. Me siento culpable en la mayoría de las ocasiones. 3. Me siento culpable constantemente.	**11.** 0. No estoy más irritada de lo normal en mí. 1. Me molesto o irrito más fácilmente que antes. 2. Me siento irritada continuamente. 3. No me irrito absolutamente nada por las cosas que antes solían irritarme.
6. 0. Creo que no estoy siendo castigada. 1. Siento que puedo ser castigada. 2. Espero ser castigada. 3. Siento que estoy siendo castigada.	**12.** 0. No he perdido el interés por los demás. 1. Estoy menos interesada en los demás que antes. 2. He perdido la mayor parte de mi interés por los demás. 3. He perdido todo interés por los demás.

"Por favor, acuérdese de no escribir ninguna información que le identifique (como, nombre, apellido, dirección), rellene el cuestionario en un lugar seguro. Por favor, sea sincera al responder".

13. 0. Tomo decisiones más o menos como siempre he hecho. 1. Evito tomar decisiones más que antes. 2. Tomar decisiones me resulta mucho más difícil que antes. 3. Ya me es imposible tomar decisiones.	**18.** 0. Mi apetito no ha disminuido. 1. No tengo tan buen apetito como antes. 2. Ahora tengo mucho menos apetito. 3. He perdido completamente el apetito.
14. 0. No creo tener peor aspecto que antes. 1. Estoy preocupada porque parezco mayor o poco atractiva. 2. Creo que se han producido cambios permanentes en mi aspecto que me hacen parecer poco atractiva. 3. Creo que tengo un aspecto horrible.	**19.** 0. Últimamente he perdido poco peso o no he perdido nada. 1. He perdido más de 2 kilos. 2. He perdido más de 4 kilos. 3. He perdido más de 7 kilos. Estoy a dieta para adelgazar: SI ☐ NO ☐
15. 0. Trabajo igual que antes. 1. Me cuesta un esfuerzo extra comenzar a hacer algo. 2. Tengo que obligarme mucho para hacer todo. 3. No puedo hacer nada en absoluto.	**20.** 0. No estoy preocupada por mi salud más que lo normal. 1. Estoy preocupada por problemas físicos como dolores, molestias, malestar de estómago o estreñimiento. 2. Estoy preocupada por mis problemas físicos y me resulta difícil pensar en algo más. 3. Estoy tan preocupada por mis problemas físicos que soy incapaz de pensar en cualquier otra cosa.
16. 0. Duermo tan bien como siempre. 1. No duermo tan bien como antes. 2. Me despierto una o dos horas antes de lo habitual y me resulta difícil volver a dormir. 3. Me despierto varias horas antes de lo habitual y no puedo volverme a dormir.	**21.** 0. No he observado ningún cambio reciente en mi interés por el sexo 1. Estoy menos interesada por el sexo que antes 2. Ahora estoy mucho menos interesada por el sexo 3. He perdido totalmente mi interés por el sexo
17. 0. No me siento más cansada de lo normal. 1. Me canso más fácilmente que antes. 2. Me canso en cuanto hago cualquier cosa. 3. Estoy demasiado cansada para hacer nada.	

Rellenar sólo por el personal del proyecto:
Número de identificación:
Fecha:

INFORMACIÓN SOBRE COMO SE SIENTE (STAI)

A/E

A continuación encontrará unas frases que se utilizan corrientemente para describirse uno a sí mismo. Lea cada frase y señale la puntuación 0 a 3 que mejor indique cómo se **SIENTE USTED AHORA MISMO, en este momento.** No hay respuestas buenas ni malas. No emplee demasiado tiempo en cada frase y conteste señalando la respuesta que mejor describa su situación presente.

0= Nada 1= Algo 2= Bastante 3= Mucho

1.	Me siento calmada----------	0	1	2	3
2.	Me siento segura----------	0	1	2	3
3.	Estoy tensa----------	0	1	2	3
4.	Estoy contrariada----------	0	1	2	3
5.	Me siento cómoda (estoy a gusto)----------	0	1	2	3
6.	Me siento alterada----------	0	1	2	3
7.	Estoy preocupada ahora por posibles desgracias futuras----------	0	1	2	3
8.	Me siento descansada----------	0	1	2	3
9.	Me siento angustiada----------	0	1	2	3
10.	Me siento confortable----------	0	1	2	3
11.	Tengo confianza en mí misma----------	0	1	2	3
12.	Me siento nerviosa----------	0	1	2	3
13.	Estoy desasosegada----------	0	1	2	3
14.	Me siento muy "atada" (como "oprimida") --	0	1	2	3
15.	Estoy relajada----------	0	1	2	3
16.	Me siento satisfecha----------	0	1	2	3
17.	Estoy preocupada----------	0	1	2	3
18.	Me siento aturdida y sobreexcitada----------	0	1	2	3
19.	Me siento alegre----------	0	1	2	3
20.	En este momento me siento bien----------	0	1	2	3

"Por favor, acuérdese de no escribir ninguna información que le identifique (como, nombre, apellido, dirección), rellene el cuestionario en un lugar seguro. Por favor, sea sincera al responder".

A continuación encontrará unas frases que se utilizan corrientemente para describirse una a sí misma. Lea cada frase y señale la puntuación 0 a 3 que indique mejor cómo se **SIENTE USTED en GENERAL en la mayoría de ocasiones**. No hay respuestas buenas ni malas. No emplee demasiado tiempo en cada frase y conteste señalando lo que mejor describa cómo se siente usted generalmente.

0= Casi nunca 1= A veces 2= A menudo 3= Casi siempre

21. Me siento bien----------	0	1	2	3
22. Me canso rápidamente----------	0	1	2	3
23. Siento ganas de llorar----------	0	1	2	3
24. Me gustaría ser tan feliz como otros----------	0	1	2	3
25. Pierdo oportunidades por no decidirme pronto----------	0	1	2	3
26. Me siento descansada----------	0	1	2	3
27. Soy una persona tranquila, serena y sosegada----------	0	1	2	3
28. Veo que las dificultades se amontonan y no puedo con ellas-------	0	1	2	3
29. Me preocupo demasiado por cosas sin importancia----------	0	1	2	3
30. Soy feliz----------	0	1	2	3
31. Suelo tomar las cosas demasiado seriamente----------	0	1	2	3
32. Me falta confianza en mí misma----------	0	1	2	3
33. Me siento segura----------	0	1	2	3
34. No suelo afrontar las crisis o dificultades----------	0	1	2	3
35. Me siento triste (melancólica) ----------	0	1	2	3
36. Estoy satisfecha----------	0	1	2	3
37. Me rondan y molestan pensamientos sin importancia----------	0	1	2	3
38. Me afectan tanto los desengaños que no puedo olvidarlos----------	0	1	2	3
39. Soy una persona estable----------	0	1	2	3
40. Cuando pienso sobre asuntos y preocupaciones actuales, me pongo tensa y agitada----------	0	1	2	3

Le agradecemos sinceramente su participación y colaboración en esta investigación. La siguiente página es para usted, si lo desea puede tirar cuidadosamente de ella y guardarla.

Meta el cuestionario en el sobre, ciérrelo con la pegatina y entréguelo a la persona que se lo facilitó. Muchas gracias por su participación.

"Por favor, acuérdese de no escribir ninguna información que le identifique (como, nombre, apellido, dirección), rellene el cuestionario en un lugar seguro. Por favor, sea sincera al responder".

La Universidad de Deusto en un esfuerzo conjunto con el Relationship Research Institute y yo misma, le agradecemos sinceramente su interés y participación en este estudio.

El principal propósito de este estudio es adquirir más conocimientos para comprender mejor a las mujeres y sus relaciones de pareja. La información que nos ha proporcionado podrá ayudar a conocer mejor cuáles son algunos de los cambios importantes y dificultades que surgen en las vidas de las mujeres y permitirá a los investigadores desarrollar futuros programas que ayuden a las parejas a mantener y potenciar unas relaciones de pareja y familiares más saludables.

Esperamos que además de su aportación a la investigación, el rellenar estos cuestionarios le haya permitido también tener un tiempo para centrarse en el momento presente de su relación y ser más consciente de la calidad de su relación de pareja. Si en algún momento durante la participación en el estudio se sintió incomoda o pensó que quizás podría necesitar asistencia, en la parte de atrás le facilitamos una lista de centros que le pueden ser de ayuda.

Por favor, no dude en contactar con los Centros que le facilitamos.

De nuevo muchas gracias por su participación.

Un cordial saludo,

Itziar Luzárraga Monasterio
Doctoranda de la Universidad de Deusto
Becaria del Gobierno Vasco en el Relationship Research Institute

LISTA DE CENTROS DE ASISTENCIA

Esta lista de teléfonos y centros a nivel nacional y de la comunidad autónoma de Euskadi está destinada a personas que piensen que pueden necesitar ayuda o estén siendo abusada por sus parejas y viceversa.

GABINETE DE ORIENTACIÓN FAMILIAR "Te escuchamos".
Si está atravesando una situación difícil que está afectando a su calidad de vida personal y/o familiar, puede acudir al **servicio psicológico gratuito** de la ONG:
Acción familiar Vizcaína 94 416 72 12 / 415 70 71

Si está en peligro, llame ahora al 112

- TELÉFONOS Y CENTROS A NIVEL NACIONAL

- **Guardia Civil: 062** (pedir que le pasen con el EMUME correspondiente)
- **Policía Nacional**: **091**
- **Policía Local: 092**
- **Emergencias o Ertzaintza o SOS DEIAK: 112**

Si llama a la Policía (Ertzaintza: 112 o Policía Local: 092) o al Juzgado de Guardia, le acompañarán al Hospital o al Servicio Clínico correspondiente. Antes de poner la denuncia, llame o mande un mensaje al servicio gratuito 24 horas de asistencia letrada *Bizkaia*: **652 779 044,** *Gipuzkoa*: **652 779 043** y *Álava*: **652 779 045**

- **Información Instituto de la Mujer: 900 19 10 10** (Teléfono gratuito de información 24 horas)
- **Centro de Información malos tratos mujer**: **900 10 00 09** (Teléfono gratuito de información 24 horas)
- **Teléfono ciudadano** (información y denuncias): **902 22 22 01**
- **Personas con dificultades para la comunicación oral (fax-SOS-Deiak)**: *Bizkaia* **944 425 206,** *Gipuzkoa* **943 447 904** y *Álava* **945 136 873**

EMAKUNDE
INSTITUTO VASCO DE LA MUJER
VITORIA - GASTEIZ 2001

- COMUNIDAD AUTÓNOMA DE EUSKADI

A) SERVICIOS DE URGENCIAS:

• **Servicio de Urgencia**

El Departamento de Acción Social de la Diputación Foral de Bizkaia dispone de un servicio de urgencia en un Centro de Acogida a las víctimas de maltrato doméstico que requieran protección y alojamiento urgente fuera del horario de funcionamiento de los servicios sociales. Por motivos de seguridad se accede a través de la Ertzaintza **112**

• **Servicio Social de Urgencia**

El Servicio Social de Urgencia dependiente del Ayuntamiento de Bilbao da respuesta a las demandas urgentes de seguridad y alojamiento por parte de las víctimas de maltrato doméstico. En el se realiza una atención de urgencia a las víctimas y se les deriva a los recursos asistenciales o de acogida. Este servicio se presta para todo el Municipio de Bilbao y funciona de 8:00 a 22:00 con personal de atención directa Albergue Elejabarri 48007 y el resto del día con "busca". Si necesita un piso de acogida fuera del horario de oficina, llame al:
Bilbao **944 701 459** y **944 701 460**, *Resto de Bizkaia* y *Gipuzkoa* **112;** y *Álava* **945 134 444 y 112**

B) PROGRAMA DE ASISTENCIA PSICOLÓGICA PARA LA VIOLENCIA FAMILIAR Y SEXUAL: **Zutitu**
Campo Volantín 24, 4º piso, Dpto. 6. 48007 BILBAO. Telf: **94.445.07.60**