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# Partnership with Doulas & Domestic Violence Services

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# Partnership with Doulas & Domestic Violence Services

by

Nora Smyth, B.S.W.

MSW Clinical Research Paper

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School of Social Work  
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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## PREGNANCY AND DOMESTIC VIOLENCE

### **Abstract**

This research explored the perspectives of doulas and domestic violence (DV) service providers on how strategic partnerships between them could enhance outcomes for pregnant women and new mothers who are experiencing DV. Research indicates that DV during pregnancy is a risk factor for women to experience more severe abuse including higher risk of death (Silverman, Decker, Reed, & Raj, 2006). DV service providers in partnership with doulas who have been trained to understand dynamics of DV may help many women get the support they need and likely reduce the amount of serious complications during childbirth associated with exposure to DV during pregnancy (Lesser, Maurer, Stephens, & Yolcut, 2005). Seven semi-structured interviews were conducted with DV service providers and doulas. The interviews were transcribed, coded and analyzed for themes. Ten major themes were identified: (a) What No One is Talking About, (b) Impact of DV on Childbirth, (c) A False Hope, (d) Assessment of DV during Childbirth, (e) The Power of Relationship, (f) Barriers to Safety during Childbirth (g) Challenges for Service Providers, (h) Safety Planning & Birth Planning, (i) A Power Shift, and (j) Call to Action. Discussion and potential implications of these findings were then discussed.

*Keywords:* Domestic Violence, Pregnancy, Childbirth,

## PREGNANCY AND DOMESTIC VIOLENCE

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# PREGNANCY AND DOMESTIC VIOLENCE

## Table of Contents

Abstract.....	i
Acknowledgments.....	ii
Introduction.....	1
Literature Review.....	3
Background Information on Doulas.....	5
Background Information on Domestic Violence .....	9
Prevalence of Domestic Violence .....	11
Economic Impacts of Domestic Violence.....	11
Barriers to Safety .....	12
Domestic Violence and Pregnancy .....	15
Implications of DV during Pregnancy .....	16
Intervention Services .....	18
Summary of Findings.....	19
Conceptual Framework.....	21

## PREGNANCY AND DOMESTIC VIOLENCE

Methods.....	24
Study Design.....	24
Sample and Sampling Procedure .....	24
Protection of Human Subjects .....	25
Data Collection .....	26
Data Analysis .....	27
Validity and Reliability of Data.....	27
Strenghts and Limitations of Study.....	28
Findings.....	29
Discussion.....	76
References.....	88
Appendix A.....	95
Appendix B.....	96
Appendix C.....	97
Appendix D.....	99

### Partnership with Doulas & Domestic Violence Services

Childbirth is considered to be a major developmental stage in a women's life span (Basile, 2012). In this study, the term childbirth includes pregnancy, birth and the postpartum period. Domestic violence (DV) will be defined as any violence (i.e., physical, sexual, psychological/emotional, and financial) between two intimate partners that are currently or formerly together, such as spouses and dating partners (Center for Disease Control [CDC], 2014). DV, also commonly referred to as intimate partner violence (IPV), is a significantly under-reported crime perpetrated mainly by men against women (Cooper, 2013; Gilliland, 2010; Moran, 2004).

DV is unfortunately common during childbirth leaving women and their children exposed to increased risk of harm (Basile, 2012). Beyond the immediate complications that may result, this harm can extend into the lifespan of the mother and her child including developmental and attachment issues that can manifest as a result of the abuse and trauma (Baird & Mitchell, 2014; Basile, 2012; Cooper, 2013). There is currently a gap in childbirth services for DV victims and research reveals that partnerships between DV service providers and doulas may help create safer births that also help the mother and her child thrive (Basile, 2012; Gilliland, 2010; Moran, 2004). This is an important issue to consider among anyone on a maternity care team, doulas,

social workers, and others who can screen for DV during pregnancy (Basile, 2012; Menezes Cooper, 2013; Moran, 2004;).

Research reveals that early intervention of DV during pregnancy will significantly increase the likelihood of having positive birth outcomes (Basile, 2012; Menezes Cooper, 2013; Moran, 2004; Pascali-Bonaro, 2003). Some positive outcomes may include having infants with healthy birth weights and also having a full term vaginal birth vs. a cesarean or premature delivery (Moran, 2004; Pascali-Bonaro, 2003). Research also suggests that doulas increase the probability of mothers choosing to breastfeed their infants. This will help to increase attachment and bonding from the skin to skin contact that happens when mothers breast feed instead of using a bottle. Even if mothers choose to breast feed one time right after birth this will still have significant health benefits. This is because the first secretion of milk that comes right after birth, the colostrum, is unique with special antibodies made by the mother that is impossible to duplicate in a formula (Cooper, 2013; Menezes Cooper, 2013; Moran, 2004).

When DV is a part of the childbirth experience, women and their children often struggle with a variety of issues impacting their wellbeing and ability to thrive (Basile, 2012; Menezes Cooper, 2013; Moran, 2004; Pascali-Bonaro, 2003). Research shows us that they may suffer from a range of issues such as premature birth, PTSD, depression, miscarriage, abortion, substance abuse, preeclampsia, cesarean section, behavior issues that manifest later in childhood



and many other mental and physical health issues (Basile, 2012; Beck, Tatano & Diana, 2006; Cooper, 2013; Menezes Cooper, 2013; Moran, 2004, Pascali-Bonaro, 2003). DV homicide, also known as femicide, is most common in the first trimester of pregnancy and is the leading cause of death for pregnant women (Basile, 2012; Menezes Cooper, 2013; Moran, 2004).

The primary purpose of this study is to examine how childbirth is impacted by DV from a feminist perspective. This research will examine how DV impacts childbirth and how DV service providers can partner with doulas to improve birth outcomes. In this study the following research questions will be examined: a) What is the prevalence of DV during pregnancy? b) What is the potential harm that is caused by DV during childbirth to both the mother and her infant? c) How can DV service providers' partner with doulas to improve outcomes for this client population?

### **Literature Review**

Domestic violence (DV) is a global public health crisis and social justice issue (Cooper, 2013; Moran, 2004). DV is largely perpetrated by men against women and it is estimated that one in three women will be impacted in their lifetime. Research reveals that pregnancy is linked to DV and is the number one cause of death for pregnant women, three out of four deaths occurring during the first trimester of pregnancy (Baird & Mitchell, 2014; Cooper, 2013). Screening women early in their pregnancy for DV and intervening with meaningful services to

help women achieve a safe and healthy childbirth experience may be an effective way to respond to these alarming statistics.

Childbirth is a time that is typically thought of to be precious, transformative and joyous (Cooper, 2013). Women are known to be in a state of vulnerability during childbirth. They require special attention to their sleep, diet, exercise and management of stress levels to be in optimal condition for the needs of the developing baby growing inside of them (Baird & Mitchell, 2014). During pregnancy a complex attachment process occurs that develops and shapes the mother and infant relationship. The infant's brain development and the mother's long term wellbeing and sense of identity as a mother are dependent on this complex attachment process (Piers de Almeida, Sa, Cunha, & Piers, 2013). DV during childbirth may disrupt and damage the attachment process required to allow the mother and her child to thrive (Baird & Mitchell, 2014; Cooper, 2013).

Critical developmental stages are significantly impacted by DV. This may result in a variety of negative outcomes, including death, that were avoidable (Harris et al., 2012). Early assessment and intervention offered to women is critical to increasing positive birth outcomes and saving lives (Amara, Fried, Cabral, & Zuckerman, 1990; Pascali-Bonaro, 2003; Moran, 2004; Smith, 2008). Statistics show significantly high rates of abuse during pregnancy and it is reported as the number one cause of death for pregnant women. When this is combined with the

understanding of how abuse may impact the mother and infants' ability to thrive, it suggests the need for a community commitment to prioritize an effective response. A strategic partnership between DV service providers, birth workers and the maternity care teams may provide urgently needed, holistic and supportive services to women and their infants who are victims of DV.

There is currently a failing among service providers to respond to this issue effectively or create strategic partnerships (Tower, 2006). This has left women and their infants without the support they need and deserve and also denies them the right to a safe and healthy childbirth. However, research tells us that it may be promising to examine how DV service providers can partner with doulas to achieve a continuum of care that reflects the needs of this population (Arat, 2013; Gilliland, 2010; Moran, 2004; Pascali-Bonaro, 2003). This literature review includes a) background information on doulas and a background on DV, b) barriers to safety for DV victims, c) impacts of DV during pregnancy, and d) utilization of doulas among DV service providers.

### **Background Information on Doulas**

The word *doula* translates from ancient Greek to literally mean *a woman who serves*. They are unique from other labor support because they are with the mom continuously before, during, and after childbirth (Basile, 2012). Typically, they will start working with women during the start of her pregnancy. They will help her to establish a birth plan and imagine all her

options. Women can call their doula during their pregnancy whenever they have questions or concerns and receive support, education and guidance. Doulas will remain with mothers during their labor, birth, and postpartum period (Gilliland, 2010). An irreplaceable central part of the process of forming attachment between mom and baby occurs right after birth. Doulas have proven to be very skilled at helping mothers understand how to take full advantage of this time (Odent, 2001).

Doulas focus is to provide information and be a support system that is based on the needs and desires of the mother (Basile, 2012). Doulas will work with the mother to help her make informed choices about her childbirth experience. This may include providing education on managing pain during labor without an epidural, benefits of breast feeding, and how to increase attachment and bonding (Gilliland, 2010.) Through physical, mental and spiritual support, doulas help women to feel empowered throughout their childbirth experience (Basile, 2012).

Doulas do not have medical degrees and do not replace any medical professional on the maternity care team. They are trained however and often certified to provide holistic support to new mothers and their families during birth, postpartum, abortion, adoption, miscarriage, and other reproductive experiences (Basile, 2012). They are found working in a variety of settings including family homes, hospitals, community-based programs, prisons and other locations (Basile, 2012). Doulas may volunteer their time to women in the community, work for an

employer or they may work in their own privately owned business. Doulas are also starting to be covered more and more by insurance.

Not everyone today is familiar with what doulas are or exactly what they do which contributes to their services being underutilized (Basile, 2012; Gilliland, 2010). However, they have been increasing in popularity over time because of their wisdom and knowledge of childbirth. Research has proven that the use of doulas during childbirth result in improved birth outcomes (Basile, 2012). Doulas are now recognized around the world as part of a movement that expands how we conceptualize childbirth and provides new ways of thinking about what are the best practices around childbirth (Basile, 2012). Doulas may be considered radical when their perspectives and services are not in alignment with the dominant medical model of birth. Doulas often disagree with modern values around reproductive rights and other social justice issues that may impact childbirth (Basile, 2012).

Women today, as a result of our how health insurance is designed, are often faced with a lack of choice in healthcare providers (Gilliland, 2010). There is no guarantee that the provider you do work with will be available during the actual labor. This is leaving women without the ability to establish a continuous support system that they trust (Gilliland, 2010, Romero, Tarca & Tromp, 2006). Research tells us that nurses, doctors, and other medical staff can tell a difference when there is a doula present in the delivery room. They will encourage and support doulas working

with the women because they are able to provide a sense of continuous calm and comfort that medical staff cannot offer (Lesser, Maurer, Stephens, & Yolcut, 2005).

Currently, the U.S. ranks as the worst developed country for maternal health. There are high rates of births resulting in cesareans and low rates of perinatal, neonatal and maternal health. This is alarming, especially when you also consider the fact that the U.S. spends more per capita on health care than any other nation (Basile, 2012; Howard, Oram, Galley, Trevillion, & Feder, 2013). Today, the most common operation in the world is a cesarean section, resulting in one in three births (Romero et al., 2006). While this may be a necessary and lifesaving operation in certain circumstances for some women, it should be avoided when possible. This is because it is an expensive and major medical procedure that carries extreme risk and complications (Romero et al., 2006). Birth physiology is interrupted by this operation by preventing the natural hormones and process that occur in the women's body during labor (Odent, 2001). Research has shown that when a doula is present during labor it is much less likely to result in a cesarean. This is because they use methods that promote the birth process and decrease the likelihood of a 'failure to progress' diagnosis in labor that would otherwise result in a cesarean (Gilliand, 2010).

Studies show an increase in overall satisfaction of care, a reduction in epidural rates, and an increase in breastfeeding when doulas are utilized (Lesser et al., 2005). Doulas also help women to increase the amount of time spent on skin to skin contact and eye gazing that is

associated with increased bonding (Odent, 2001). This is significant because research suggests that how human beings are born will have a significant influence on their overall physical and mental development (Odent, 2001). When doulas are utilized, mothers have increased self-esteem and improve bonding with their infants (Basile, 2012).

Doulas also help women and their families by assisting in communicating their desires to the maternity care team and helping to advocate for the type of birth experience they want (Pascali-Bonaro, 2003). Doulas ensure that concerns and questions women have are addressed in a way that encourages and empowers them (Pascali-Bonaro, 2003). Doulas also help family members to participate in the decision-making process. Doulas will also help women to create alternative birth plans as a back up for any unplanned complications (Pascali-Bonaro, 2003). Research proves the utilization of doulas is an effective method for increasing positive outcomes in childbirth and empowering women to have an experience that they desire.

### **Background Information on Domestic Violence**

DV is defined as any violence (i.e., physical, sexual, psychological/emotional, and financial) between two intimate partners that are currently or formerly together, such as spouses and dating partners (CDC, 2014). DV research reveals that the issue expands across the world, impacting everyone across all backgrounds and socio-economic status. It is occurring at epidemic rates and is a leading global public health crisis (Menezes Cooper, 2013).

Historically, there has not been protection for women and children against the abuse of power and control exhibited by men (Dutton, 1992). Women were viewed as property of men and faced the injustices of being abused, raped, beaten and killed in their own homes, at times in front of their children (Dutton, 1992). Today, DV is of international concern with many organizations addressing the problem. This is a huge improvement as it was until recently considered to be a private family matter (Dutton, 1992). Police would not want to intervene or respond to women seeking protection from DV. There continues to be stigma surrounding DV that is contributing to the many barriers DV victims face in (Dutton, 1992).

There has been a paradigm shift in the U.S. in the last decade around the issue of DV with the passing of the Violence Against Women Act (VAWA) (Renzetti, Edleson, & Bergen, 2011). This step helped in many ways including transforming how the issue is being defined. It is now understood as a social problem rather than as a private family matter implicating the responsibility for a societal response (Renzetti et al., 2011). These protections were long overdue and welcome, however there is still much work to be done to prevent DV and intervene after DV occurs, this is especially true in the context of childbirth (Moran, 2004).

It is beyond the scope of this research to describe DV in depth and will not cover many facets of DV. To help give context to how doulas and DV service providers may be a strategic partnership, this research will focus only briefly on background information on DV. This will



include the prevalence of DV, the economic impact of DV, and barriers to safety for DV victims.

**Prevalence of domestic violence.** According to the National Coalition Against Domestic Violence (NCADV) (2015), a woman is assaulted by an intimate partner every nine seconds in the U.S. and one in 15 children will be an eyewitness to DV. Women are disproportionately at risk of being a DV victim between the ages of 18 and 24 years old (NCADV, 2015). Men have been socialized to oppress and exploit women and they are allowed to act with violence against women (Côté & Lapierre, 2014). Prison sentences for men who intentionally murder their female partner are only two to six years. This is far less than the average 15-year sentence for women who act in self defense resulting in the death of their abusive male partner (NCADV, 2015). While victims typically experience this violence in isolation and behind closed doors, the impacts of it extend beyond the victim to their children, family, community and a variety of institutions.

**Economic impacts of domestic violence.** Economic impacts that are felt across the nation include victims losing eight million days of paid work annually (NCADV, 2015). Up to 60% of victims will lose their jobs as a result of DV (NCADV, 2015). This economic impact is not factoring into account the cost of the legal system including the judges, lawyers, prosecutors, child protection workers, guardian ad litem, legal advocates, and probation officers (Moran, 2004). In addition, healthcare costs are not being factored including ER visits, doctor

appointments, mental health providers, support groups and other services (Moran, 2004).

**Barriers to safety.** Why women do not just leave abusive relationships is a question that is often raised by society (Campbell, Rose, Kub & Nedd, 1998). It is logical to assume that an individual should choose to leave an abusive relationship. However, this question is extremely damaging. This needs to be addressed because it places the blame on the victim for the abusive behavior of their partner (Amara et al., 1990; Menezes Cooper, 2013; Moran, 2004). This takes responsibility for the abuse away from the abuser. It also releases communities from the burden of engaging and responding to the issue. Victims are left with the burden of feeling blamed for the situation they are in. They live a life in constant fear, trying to survive, isolated from support systems while stuck in a terrifying cycle of abuse.

Moran (2004) describes how the cycle of violence between intimate partners starts with a tension building stage that leads to the explosive abusive incident and is followed by a “honeymoon” stage that keeps the victim locked in a pattern of abuse. Victims live in isolation and fear during this cycle. They will often display many help seeking behaviors during the tension building stage and directly after an abusive incident has occurred. However, these attempts to reach out for help are often unmet by the systems they have contacted for a variety of reasons. Abusive partners methodically use methods of power and control over their victims that include but are not limited to physical, emotional, financial, and sexual abuse (Beck et al., 2006;

Campbell et al., 1998).

It is necessary to understand that victims who are trapped in this cycle experience an increase in frequency and severity of abuse over time that often leaves them isolated from social support and stripped of protective factors (Amara et al., 1990; Beck et al., 2006; Moran, 2004). Research shows that 98% percent of abusive relationships result in the abuser purposefully crippling their victim financially (CDC, 2014). According to the U.S. Department of Housing and Urban Development, DV is in fact the third leading cause of homelessness (as cited in CDC, 2014). While it may seem obvious that women can and should utilize a shelter, this remains an unreliable and often unattainable option for many women and their children. Resources provided across the nation for DV crime victims is too low to fill the high demand (Howard et al., 2013).

Women continue in the cycle, or more accurately are trapped in the cycle, for a variety of reasons that paradoxically include survival (Menezes Cooper, 2013). Women and consequently their children are at a greater risk for harm when they make moves to leave this type of relationship. In fact, a majority of homicide occurs when a victim attempts to leave or has already left the relationship (Menezes Cooper, 2013). Many have no friends or family able or willing to provide help. Shelters are often at full capacity due to ongoing high demand and emergency funds are limited and the criminal justice system often fails to respond effectively to victims (Mills, Barocas & Ariel, 2013; Moran, 2004). This means that safety plans and support

from friends, family, and service providers are absolutely critical for women to become safe (Menezes Cooper, 2013).

Abusers create patterns of behavior that result in domination and oppression of the victim that often are only witnessed and experienced by the victim. DV is often confused with men who have anger management issues, however this is a very misleading myth (Menezes Cooper, 2013). Abusers are actually master manipulators and can control their emotions very well in front of everyone else. In fact, they are typically considered by others as charming and they would be unsuspecting and skeptical of victim allegations of abuse (Menezes Cooper, 2013). This makes it very difficult for victims to seek help and be believed even by their own friends and family.

Common themes among DV victims, in relation to barriers to safety, include isolation from any support network. Victims are also often controlled by abusers in when they are allowed to leave the house. This may result in victims being chronically absent from family events, loosing several days of work, or missing doctor appointments (Moran, 2004). Victims of DV often experience more frequent and severe abuse during pregnancy; substance use by the abuser also increases during pregnancy (Moran, 2004; Amara et al., 1990). Research reflects another theme that victims often need, or perceive they need, their abuser for basic needs to be met (CDC, 2014; Moran, 2004; Tower, 2006). Victims often do not speak out about the abuse or ask for help because they are labeled and stigmatized by society, the criminal justice system and

even their own family and friends (Beck et al., 2006). This stigma compounds the isolation and shame they feel making it even more difficult to seek out resources (Beck et al., 2006; Menezes Cooper, 2013, Smith, 2008).

### **Domestic Violence and Pregnancy**

Pregnancy in the context of DV is very important to consider among professionals and service providers who come into contact with this population (Menezes Cooper, 2013). It is the number one cause of death during pregnancy and it is considered to be the leading cause of a global health crisis among women and children (Amara et al., 1990; Menezes Cooper, 2013; Moran, 2004). The health of a woman and her child during childbirth is a top priority among service providers and birth workers (Menezes Cooper, 2013). It is indicated in the literature and given voice to by several health organizations, including the World Health Organization, that pregnant women and their infants are a vulnerable population in need of more protection and services to screen for and heal from DV (Menezes Cooper, 2013).

Each birth is unique and complex because they are influenced by the mother's culture, health, social status, spirituality and other factors and they assign meaning to their own unique experience (Beck et al., 2006; Moran, 2004). For many women, each birth experience is one that is restorative, healing, supportive and empowering. However, pregnant women who experience DV are often violated of their right to a safe and healthy childbirth (Beck et al., 2006; Moran,

2004). Women who experienced DV long before their current pregnancy may still encounter complications (Wanzhen et al., 2010).

When an abusive partner is not the biological father or does not believe he is the biological father, the women and infant are at much higher risk for abuse and tend to experience more severe and frequent abuse (Campbell et al., 2009; Moran, 2004). Abusive partners are also more likely to use illegal substances and alcohol (Zuckerman, Amaro, Fried, Cabral, 2004.) Women are victimized with living in a state of fear, stress and trauma that is inherent in the dynamic of power and control exhibited by the abusive partner (Moran, 2004). Women often times feel powerless, anxious, have a lack of trust and other adverse consequences that prevent over all well-being (Menezes Cooper, 2013; Moran, 2004, Smith, 2008). The delicate physiology of childbirth is frazzled and disturbed by DV, leaving lasting consequences on the quality of life for the mother and her infant (Menezes Cooper, 2013; Moran, 2004; Smith, 2008).

### **Implications of Domestic Violence During Pregnancy**

Pregnant women who are abused experience increase in anxiety, lack of support, and lack of knowledge (Moran, 2004). Depression and other symptoms that result in decreased wellbeing are associated with a lack of support systems for women during childbirth (Webster, Nicholas, Velacott, Cridland, & Fawcett, 2011). Research reveals that DV is also a strong predictor of unplanned pregnancy and loss of pregnancy (Stock et al., 2012). Often unintended

pregnancy is a result of the perpetrator sabotaging birth control and according to a National Women's Study in 1996, half of the women who report being raped also got an abortion (Côté, & Lapierre, 2014; Moran, 2004).

Women experiencing DV during pregnancy report feeling they are not in control of their body, have a lack of support and insufficient knowledge around their childbirth (Moran, 2004). These factors contribute to women feeling they are unable to tolerate the pain, lack confidence and experience other negative attitudes around childbirth (Moran, 2004). DV during pregnancy is linked with increased stress and anxiety symptoms including postpartum depression (Moran, 2004; Urquia, O'Campo, Heaman, Janssen, & Thiessen, 2011). Research suggests that women who experience DV during pregnancy are more likely to have poor diet and unhealthy weight and are also at increased risk of getting a STD or HIV (Campbell et al., 1999; Moran, 2004).

Physical complications during the pregnancy and birth as a result of abuse may include “high blood pressure, premature rupture of the membranes, premature birth, preeclampsia, edema, urinary tract and bladder infections, vaginal bleeding, placenta prevail, excessive vomiting, dehydration, or homicide” (Menezes Cooper, 2013, p. 30). Pregnant victims of DV are at an increased risk of “physical, behavioral, and psychological problems including miscarriage, substance use, smoking, depression, and PTSD” (Hellmuth, Gordon, Stuart, & Moore, 2013, p.6) Mental health concerns include “high levels of symptoms of perinatal depression, anxiety, and

PTSD” (Howard et al., 2013, p. 1).

Infants exposed to DV during pregnancy are at an increased risk of many issues such as premature birth, low birth weight (i.e., 133 grams or less on average), and miscarriages (Menezes Cooper, 2013; Moran, 2004). An infant’s ability to receive all the health benefits that come from breast-feeding may be disrupted as a result of the abuse toward the mother (Keeling, 2012; Moran, 2004). This client population also shows an increased harm on the bonding and attachment they experience during childbirth than women who have not experienced DV (Piers et al., 2013). When DV has been a part of the childbirth experience, findings suggest that infants are at increased risk of developing behavioral issues (Howard et al., 2013; Moran, 2004). It is understood that the impacts of DV on the women and children who are either directly abused or witnessing the abuse will be at increased risk for mental health issues including depression and suicidal behaviors (Wanzhen et al., 2010).

### **Intervention Services**

Pregnancy has been linked to increased risk of DV and death creating a need to implement screening and safety measures to protect women and their infants (Bianchi et al., 2014; Shadigian & Bauer, 2004). Ideally, clinicians and others who work with pregnant women would assess for DV at each prenatal visit or at least periodically and again at birth, keeping in mind that it is much less likely to be reported at that time (Campbell et al., 1999).



Another issue that should be addressed by clinicians and other service providers in responding to this population is around increased risk of substance abuse during the pregnancy (Zuckerman et al., 1990). Education and training that will help DV service providers to screen women for pregnancy related issues and to offer effective services including referrals to doulas is recommended (Amaro et al., 1990). Doulas can influence the experience of childbirth by helping women feel empowered with a sense of control and mastery over her childbirth. They also offer continuous support in labor and pain management strategies based on informed choice (Arat, 2013; Lesser et al., 2005; Moran, 2004). Doulas may likely disrupt the isolation experience associated with DV during pregnancy that is associated as a protective factor and reduces harm (Beck et al., 2006; Moran, 2004).

### **Summary of Findings**

DV service providers in partnership with birth workers may likely play critical roles for women during childbirth who are also experiencing DV. DV service providers and doulas should have the proper training and resources to offer a supportive platform for pregnant victims to explore their options (Menezes Cooper, 2013; Moran, 2004). Survivors of DV deserve to be validated and given the support they need to develop their ability to trust and gain a sense of control over their life again, which is especially advantageous to women during childbirth (Côté & Lapierre, 2014; Pascali-Bonaro, 2003).

Because of the prevalence of violence against women and the association it has to childbirth, there is a sense of urgency for action to be taken by all stakeholders (Moran, 2004). Creating a culture that is more aware of this population's needs and responding to their needs in organizations and systems will be an important step (Menezes Cooper, 2013; Moran, 2004). Focusing on efforts to both prevent DV during childbirth and intervene when it has occurred as early as possible will be important to meet the needs of those currently suffering and contribute to the global effort to eradicate DV from society (Basile, 2012; Menezes Cooper, 2013; Moran, 2004; Pascali-Bonaro, 2003).

To accomplish a more accurate assessment of the issue and provide empowering solutions for barriers to safety, it is important to observe and challenge the entrenched patriarchy in society and in the criminal justice system (Mills et al., 2013). Victims of DV are often controlled in where they go, have no control of money, or may even become homeless making it difficult to have a healthy childbirth experience (Basile, 2012). By providing pregnant DV victims with a doula who has expertise in DV they could create a birth plan adapted to their needs to prioritize safety while also actualizing a childbirth experience that is healthy, empowering and transformative (Basile, 2012; Menezes Cooper, 2013; Moran, 2004).

With each childbirth experience enhanced for DV victims in this way, professionals may increase the likelihood of breaking the cycle of DV for that family with that infant. Research

supports that DV victims have the strength to survive the grip and horror of the cycle of violence when provided the support they need, it is reasonable to assume mothers and their children, when given the support they need, will also be able to thrive (Basile, 2012; Beck et al., 2006; Moran, 2004). Findings from studies indicate the strong correlation between DV and pregnancy often times compromising the health and attachment of mother and baby (Basile, 2012; Menezes Cooper, 2013; Moran, 2004, Pascali-Bonaro, 2003). Finally, findings from studies indicate that doulas are associated with positive birth outcomes and satisfaction of childbirth experience (Basile, 2012; Menezes Cooper, 2013; Moran, 2004; Pascali-Bonaro, 2003). This finding indicates the importance of creating doula partnerships with DV services as an intervention in supporting pregnant DV victims (Basile, 2012; Beck et al., 2006; Menezes Cooper, 2013; Moran, 2004, Pascali-Bonaro, 2003).

### **Conceptual Framework**

This research is seeking to gain a deeper understanding of how women can achieve a safe and healthy childbirth experience in the context of DV by utilizing doulas in partnership with DV services. Feminist theoretical framework is used because this lens allows the research to be grounded in women's perspectives and how their social status is experienced in society as second class to men (Baird & Mitchell, 2014). This is key when addressing childbirth as it is inherently a women's experience and DV is also a phenomena perpetrated overwhelmingly by men against

women (Baird & Mitchell, 2014; Menezes Cooper, 2013; Moran, 2004). Doulas work in a profession that is nearly exclusively facilitated by women, and while they may support the father in their work, it is always in the context of being in alignment with the mother's highest good and desires (Moran, 2004).

Men have typically dominated every part of society throughout history and around the world including medicine, law, media and other systems (Baird & Mitchell, 2014; Cooper, 2013). This was preventing women from having independence or control over their body, mind and soul and ultimately the direction and quality of their life and their children (Baird & Mitchell, 2014, Cooper, 2013; Dutton, 1992). Contrast this to men's experiences in society that is allowing them to be in control of their own sense of agency, be the head of the family, dominate policy and enforce or not enforce laws (Baird & Mitchell, 2014, Cooper, 2013).

While many movements and grassroots work was done over the last few decades that provided more freedom to women in society, gender inequality continues to be a threat to women and their children at epidemic rates around the world (Baird & Mitchell, 2014; Cooper, 2013; Moran, 2004). Feminist theory argues that gender is a key factor when assessing societal status and that men have historically been held above women as privileged with dominance in politics, employment, education and other aspects of society (Baird & Mitchell, 2014). Feminism allows the oppression of women's narratives and experiences to be lifted and provides a supportive

platform for women's issues to be explored from their perspectives (Baird & Mitchell, 2014).

Using a feminist lens to conduct research, interpret or make conclusions on issues that are undeniably falling on the lived experience of women is key to working towards improving gender equality (Baird & Mitchell, 2014). Power and control exhibited by men over women in society manifests in many ways including but not limited to epidemic rates of DV, sexual assault and severely damaging childbirth experiences (Baird & Mitchell, 2014).

Research has provided evidence that proves women do not have the choice in childbirth that is generally perceived (Crossley, 2007). Feminists argue that childbirth has been medicalized and as a consequence it has inherently striped the women's sense of power and choice over their own bodies (Baird & Mitchell, 2014; Cooper, 2013; Menzes Cooper, 2013; Moran 2004). This causes a women's childbirth experience to be at increased risk of physical, mental and emotional harm (Baird & Mitchell, 2014; Cooper, 2013).

Feminist theory values the knowledge that arises from personal or subjective experience emphasizing that women contain a collective and individual reality that deserves equal attention (Baird & Mitchell, 2014; Cooper, 2013). Feminist theory is empowering to women and allows solutions to be women-centered around issues that are predominately experienced by them. This is giving women the expertise and control over their own body, mind and soul (Cooper, 2013). This is especially critical when women are experiencing childbirth in the context of DV as

research has found that a woman's ability to feel a sense of mastery over her body and environment are key to overcoming the trauma inherent in such circumstances (Baird & Mitchell, 2014; Cooper 2013). In the following section, the researcher will review the methodology of the study.

## **Methods**

### **Study Design**

This was explanatory qualitative research that inherently allowed more flexibility in identifying relevant observations and the researcher utilized the grounded theory study design (Monett et al., 2011; Padgett, 2008). This design fits with the study because the researcher will use data gathered from interviews to add to the existing literature. Grounded theory design is a respected and commonly used method in qualitative research that allows the theory to be developed straight from the data gathered and analyzed effectively removing the limitation of a preexisting theory and therefore increasing the probability of a more valid representation of the phenomena (Monette et al., 2011, Padgett, 2008).

### **Sample Procedure**

Criterion sampling was used in this study to select individuals who have expertise in DV and birth work (Monett et al., 2011). The sample included doulas and also DV service providers. They were over the age 18 and had experience working with clients who have

experienced trauma or stress before or during their childbirth. This study recruited seven participants, which is considered to be less than the typical sample size for grounded theory design (Padgett, 2008). However, qualitative sample sizes may need to be flexible due to the nature of qualitative research methodology and the need to focus on depth of interviews over quantity (Padgett, 2008). I developed a flyer that I provided to identify people in the community who passed along the information to potential qualified individuals based on the criterion for this study (Padgett, 2008). People in the community were selected and contacted by email or phone (see Appendix A) to pass along a flyer to doula and DV service providers to learn about the study and how to participate (see Appendix B). These people were found on public searches that are affiliated with DV service providers and doula business and organizations located in Minnesota.

### **Protection of Human Subjects**

I have provided an Institutional Review Board (IRB) approved copy of the consent form to all the respondents before the interview and made sure they understood and answered any questions had (see appendix C). I explained that I am a graduate student at St. Catherine University and the University of St. Thomas in the clinical social work program and was conducting a research project under the supervision of my chair. Conducting the interview for this study was completely voluntary throughout the entire process. I first had the respondent

agree to participate in the interview by signing the consent form that we went over in detail. I then provided a copy of the IRB approved 11 interview questions (see appendix D).

The study provided no benefits and low risk of harm to the participants. However, participants did receive reimbursement in the form of \$5.00 gift certificates to Panera Bread as incentive to participate in the study. The consent form was in compliance with the exempt-level University of St. Catherine Institutional Review Board. Data was kept confidential by omitting respondent names from field notes, transcripts and the written report. The audiotape of the interviews was recorded and stored on my personal computer that is password protected and was destroyed by May 31, 2016 after the transcription was completed.

### **Data Collection**

I conducted seven semi-structured interviews that ranged from 45 minutes to 1 hour and 30 minutes and they were audio recorded for transcription and analysis (Monette et al., 2011, Padgett, 2008). These interviews were done in an environment that was controlled for noise and confidentiality such as a study room in a library or private office space (Monette et al., 2011, Padgett, 2008). Questions were open ended because of the exploratory nature of the study allowing participants to expand (Monette et al., 2011). The questions were designed to ask for the participant's current education and skills around the impacts of trauma on pregnancy and what they would like to learn about this client population. This was followed by questions that



ask the respondent to describe their perception on the prevalence and impact of this issue, the barriers this client population experiences and solutions to meet the needs of pregnant women and new moms who are experiencing DV. The questions were developed and supported by the literature review on DV occurring during pregnancy, birth and postpartum period.

### **Data Analysis**

Questions developed were guided by a literature review and a written transcription of the raw data gathered from the audiotaped interviews was used. Data was reviewed multiple times line by line for thematic analysis that was coded for themes based on at least three instances of a code (Padgett, 2008, Monette et al., 2011). Coding in qualitative research helps the researcher to categorize the raw data into distinct categories and becomes a part of the measurement and theory building (Monette et al., 2011). Content analysis in qualitative research allows the researcher to quantify the phenomenon being studied, however, methods that provide more depth into the data are preferred (Padgett, 2008). Grounded theory was used and prioritized “higher-ordered thinking and interpretation” (Padgett, 2008). The researcher conducted all interviews and also conducted the transcription of all interviews, there was no use of outside transcribers.

### **Validity and Reliability of Data**

Validity and reliability is measured by what is true and the frequency of it (Padgett,

2008). Reliability was done using a transcript to triangulate data and measured “ability to yield consistent results each time it is applied” (Monette et al., 2011). Validity is the accuracy of the variable to be measured (Monette et al., 2011). Content validity was used to measure all the content, elements and instances being included in the measurement device to accurately describe the benefit of using doulas during DV (Monette et al., 2011).

### **Strengths and Limitations of Study**

This study is important because it highlights the current gap in services existing for women experiencing DV during childbirth and their unique safety and health needs during this time while offering evidence that suggests a partnership with doulas would significantly close this gap (Bianchi et al., 2014; Côté & Lapierre, 2014; Helmut et al., 2013; Lesser, 2005; Menezes Cooper, 2013; Moran, 2004; Pascali-Bonaro, 2003; Smith, 2008; Wanzhen et al. 2010; Webster et al., 2011). This study contributes to many professions including social work, doctors, nurses, mental health professionals, community-based workers, and others. This is because they will most likely work with this client population at some point even if it is not the presenting problem or service requested. This study provided insight for developing and managing partnerships between DV service providers and doulas.

This researcher was inspired by personal experience with a childbirth experienced during DV and also working with doulas that supported women who have experienced trauma during

their childbirth. These experiences may have helped in the study by having giving the researcher a greater awareness of the issue. This can be a limitation in that it may have created personal bias that interfered with how data was gathered and analyzed therefore influencing the conclusions and implications determined.

### **Findings**

This section will discuss the findings of the study based on the coding and content analyses of the 7 interviews conducted. Ten major themes were identified: (a) What No One is Talking About (b) Impact of DV on Childbirth, (c) A False Hope, (d) Assessment of DV during Childbirth, (e) The Power of Relationship, (f) Barriers to Safety during Childbirth (g) Challenges for Service Providers, (h) Safety Planning & Birth Planning, (i) A Power Shift, and (j) Call to Action. Pseudonyms for the 7 participants was utilized for confidentiality: Elizabeth, Maria, Karen, Cindy, Anna, Molly, and Julia. All participants were female and identified as having some experience working with women during their pregnancy, birth and postpartum periods while they were experiencing DV or had a history of it. Two of the participants stated they have experience working as a doula. Five of the participants stated that they had experience only in DV related work. One of the participants was currently working as a DV service provider and doula. Their role and experience in working with victims of DV during their childbirth ranged from doula work to DV work in shelters, criminal justice system, advocacy programs, and prison

based settings, non-profit DV organizations, family crisis support organizations, and hospitals.

The ten themes that were identified will now be presented.

### **What No One is Talking About**

Based on analyses of the data the first theme that surfaced was in relation to a lack of education and awareness surrounding the issue of DV during childbirth, it is what no one is talking about. Most participants reported that they have had no training or education that was specific to linking the dynamics of pregnancy and domestic violence. Karen stated, "...honestly the ones I have gone to have not focused on childbirth or pregnancy..." Cindy reflectively stated as she thought back on her years of education and trainings, "...yeah that is a good question...there was no specific training on DV during pregnancy..." Many participants talked about sexual assault in the context of birth and related trainings because they felt it was relevant and crossed over. Many participants also discussed training around trauma and how that may be relevant in working with this population. Karen expressed:

I have received a lot of training on sexual assault ...it intersects with it...but it's not a focus...which could be an issue or concern ...but...honestly the ones I have gone to have not focused on childbirth or pregnancy...but that's a big part of it.

Cindy explained, “I feel like most of my learning has come from workshops around trauma around violence and being supportive...” Molly mentioned relevant education coming from “...being involved in the national child traumatic stress network...” Maria described:

We just did a training last fall and we had a midwife that came and talked about how sexual violence history can impact birth so not just DV but all sorts of abuses and traumas and how to support your client through that...making sure that mom feels safe during the birth process and understanding that it could...cause labor to stall out and ...it could be something that was suppressed and maybe she doesn't remember it and maybe it was like childhood sexual trauma that she doesn't even know about.

Anna stated, “...at no time in their education do they dive deep into DV... they will gloss over sexual violence...” Elizabeth shared when asked about her training or education specific to DV and pregnancy:

Part of my personal background has been in the area of sexual assault and early childbirth... so it's really through those kinds of experiences working with women in health care settings through parenthood clinics through childbirth association and for when I was doing volunteer work for about 5 years with the sexual violence center.

Many participants talked about how the learning came from direct client centered care that provided them with the awareness of their condition, needs and options. Molly shared from her perspective how her education came from direct experience working with women, "...it's just kind of the experience of what women have responded well to..." Elizabeth reflected on how her awareness was gained from her own intuition in combination with research on stress and trauma during childbirth:

It was mostly seeing the connection ourselves as well as some of the research that's been done in the area of DV, they talk about, you know, the increased stress and tension during pregnancy and the increased level of DV when women are pregnant...so it's really pointing to the fact that this is a really stressful and dangerous time for survivors of DV....so just intuitively understanding this and those dynamics...research is absolutely supporting what we intuitively know.

Anna discussed how her awareness was developed from her own intrinsic interest in this population:

As far as trainings...there are not a lot that are specific to pregnancy during DV...I think not a lot of people feel that interested in the impacts on pregnancy and its development

throughout life and so...it is for sure a little bit of a special thing I bring into the line of work I'm in right now.

All respondents reported that their place of employment would benefit from more specific training and awareness on domestic violence during pregnancy. They also stated that the general population, policy makers, funders, and both the victim and perpetrator of domestic violence during pregnancy are more often than not lacking awareness about the issue.

### **Impact of Domestic Violence on Childbirth**

While the pervious theme flushed out the lack of education and awareness in relation to the issue, this theme is highlighting why it matters by discussing the impact DV has on women and their infants throughout childbirth. Increased isolation was mentioned by many of the participants as one of the major implications. Karen shared her experience working in the shelter, "it can be a really isolating process ...these women have chosen to leave their abuser...at that point they are dealing with it likely on their own..." Anna agreed stating that, "women in the shelter who are going to have their babies...they are usually alone..." Cindy shared an example of a time she helped a woman from out of town who was alone in the hospital:

I was there for a day and a half with her and she had her baby...I didn't ever really know her and then she went back out of town from where she came from...so she was alone and no one knew her so it was...just being able to be there for her...it was powerful.

Another example of a women Cindy helped:

I had a women who told me I'm spotting...I told her do you feel like you need to go to the hospital...maybe you need to get checked...yeah...so I was there almost 10 hours...and so then there I was downtown waiting at the doctor's office...didn't even really know her she was in and out three different times and finally the doctor said... you had a miscarriage...but just the way he said it to her...I just remember feeling like what...you know these were her hopes and dreams and he...it was just the way he said it to her I don't think he was really conscious of ...I mean he kind of sat like this...it just felt like...I was shocked...she asked me to come in the last time... and I just sat with her...offered her the support she needed and listened to her talk.

Elizabeth expressed how victims may experience isolation as a tactic of control by their abusers:

Abusers are really self absorbed and egotistical and when there is a risk of someone else having a focus of the survivor even if it's a pregnancy then...man that's a real challenge



to an abusive person who wants the sole focus and attention on them and the survivor to pay attention to them and not turning it to anyone else.

Many participants also discussed fear, stress and freezing as common issues that this population copes with. Karen talked about how “it’s just really scary you know...its...having to protect someone else who can’t protect themselves...” Elizabeth pointed to the research on stress and trauma, “very much adversely affected by stress and tension... is not good during pregnancy not helpful to them...” She continued on to provide an example of how the fear and stress might manifest:

You have got an infant that might not be sleeping through the night or you got this or that going on or you have an abuser who is all ticked off screaming and yelling because you can’t keep that baby quiet and a survivor who all though they might think I know I need to get out of here...they feel so vulnerable... they can’t... how am I going to go through this on my own how am I going to raise this baby on my own...so it’s just a myriad of things going on being pregnant having a child just adds to the level of complexity of survivors feeling frozen sometimes because there is just so much to deal with in just making a decision and then if they are considering leaving then trying to figure out how am I going to feed myself or my baby I need him at this moment...it just adds to that level of complexity.

Julia described the fear victim's face:

I mean imagine... you know imagine being physically threatened when you're pregnant ...I mean you feel... you feel very vulnerable...so to have the threats of I'll punch you in the gut ...I'll tie you up or whatever is very real... emotionally there are always threats about I'm not going to pay any money cause it's not my kid...I'm going to toss you out the house...I'm going to call CPS for drugs and alcohol... you know there is another level of threat of emotional and physical violence that occurs.

Another impact discussed by many participants was the general increased risk of health complications including potential for decreased level of prenatal care during the pregnancy and increased likelihood of having post partum depression after birth. Anna stated:

Everybody needs to sort of be very mindful of what a women goes through and physically and mentally and emotionally as she grows another human being....because there is just so much I just think until you actually go through it it's hard to relate to...but you can always bring to it a understanding and empathy without having to say you know ohhh I can't relate...we can't meaningfully talk about what it means or to be depressed with a brand new baby that should bring nothing but joy without understanding the stigma they face...I just had this beautiful baby and I don't feel good about any of this.

Julia talked about how, "...the more stress the mother is under the more impaired the baby can be..." Cindy warns, "it can create early delivery ...there is probably a lot we really don't get that effect that baby... heart rates and...she not eating well or sleeping..." She added:

I have seen women go through depression just because of all the chemical changes and then just life can be really hard in those situations...they are at increased risk for experiencing postpartum depression and other complications... and then its reflective on the baby.

Participants also included concerns they had for this population including legal implications, losing or having to share custody with the abuser and being separated from their infants. They also talked about clients experiencing a lack of control, having additional ties to the abuser for co-parenting purposes, and general safety concerns. Karen talked about how in the criminal justice system or child protection system DV is "...something that can be used against the victim... they are looking to make sure the child is safe..." Karen continued to share an example of how pregnancy was impacted by DV with a client she had:

I have a client who I have worked with in the past and we have worked really, really, really hard to try to get her away from her abuser...and... but it's just a situation where she can't just walk away...and when there were rumors of her being pregnant I can

honestly say...it made me scared for her because it ties you to them for upwards of 20 years or longer...

Elizabeth explained how a having a history of DV in the criminal justice system or trying to leave an abuser can impact the women's pregnancy:

If there has been a history of DV if that history is known if there are other children and maybe cps got involved because of the DV...or maybe he's been abusive to the children as well then CPS is just going to pay a lot of attention so she is concerned about I don't want this child to be taken away from me...abusers almost always try to get custody if she determines to leave him...abusers are very manipulative and come off as just a parent who wants to have contact with their child and that's all they want...and you know...and she's looking like the crazy person trying to turn the child or keep them from dad...so yes legally there is always that concern.

Participants discussed a range of implications for this population including stress, fear, isolation, legal concerns, and increased risk of health complications.

### **A False Hope**

Participants talk in this theme about their experiences and perceptions of the frequency and severity of DV during pregnancy and the false hope victims will often express for abusers to

change the behavior. Participants talked about how women experience a sense of hope that the abuser may be able to change their abusive behaviors so they can be safe without having to leave their relationship. This is especially true for women who are pregnant or have young children. Participants described their thoughts on why this may be true including the women's desire to make their family work and the need for support in raising children. Molly shares her experience of the hope women have:

I also have talked with women who say the violence actually stopped during the pregnancy but then after the baby was born is when it escalated...because it was sort of that what about me factor... your spending all this time tending to this new person in our life... and it's a myth that the violence is going to end...you know perfect happy family... but you know women certainly talk about that hope.

Cindy also talked about the hope that women will often express to her as well:

I believe it's a lot more than people will say...there is a lot more violence then we hear about more so than we talk about... I see it a lot...a lot of times it is not mentioned when they are not that far along but they knew...you know what I mean they are not going to make a big deal of it if she's three months along...but pregnancy itself can be the stressor that pushes everything over the edge... I just don't think they always tell...or the women

we work with ... once you do come upon it...they don't want to share it...because they are trying to hold a vision of a family that they want and trying to survive and...yeah that is what they want so bad that they keep trying.

Elizabeth described how women who have just got married and are expecting a new baby may not desire to leave the abuser and have hope for change:

I don't know how many times women have said... he didn't start physically abusing me until our wedding night...you know... they had gone all through the relationship and then that was it... I'm so sorry it will never happen again it's just so much stress about the wedding... I have been drinking too much and it will never happen again... but it does...it does...so obviously you are not going to go out the next day and get a divorce, and now you find out you are pregnant... are you going to go out and get a divorce... no... so... it happens...when you already know that 30% of relationships have DV going on but I think it doesn't come to the attention of medical personal and people don't seek help through programs when they are pregnant.

Karen reported having calls daily to the shelter and also shared her experience in the criminal justice system that reflects the frequency and severity of DV during pregnancy:

At least one month where there's an incident that occurs and we are really disappointed just because it occurred while the woman is pregnant... but the prosecutors take those very seriously because it is kind of an aggravating factor whether the law recognizes that or not...whether it is something that is provable is still just pretty scary...its pretty...violent you know... the likelihood is that this abuser knows...and ...its still happening... it pretty well known that reported incidents are not necessarily the only incidents... if there is just two....then there is probably 10 between them.

Molly points out the stigma pregnant DV victims face when they choose to stay, "I just think the increased stigma... pressure to leave if she's really hoping...if she just really loves her partner and doesn't want to leave..." Julia agrees with Molly, adding that 'love and connection is something that you can't just dismiss... most women wanted their partner not to be abusive and they didn't want the relationship to end."

Participants stated that one in three women will experience DV at some point in their life and that it is highly under reported for a variety of reasons that may include a woman's desire that the abusive partner will change. They highlight how pregnancy can be a triggering factor for DV and how it often escalates after birth. This is despite the hope that women would express during their pregnancy for the abuse to stop and not necessarily their relationship to end.

**Assessment of Domestic Violence during Childbirth**

The next theme identified is in relation to assessment for DV during the childbirth period. Participants discuss how they perceive the effectiveness of assessment methods and suggestions for improving them. Many participants talked about a variety of concerns they had about the lack of conversation and the comfort level service providers have with asking women about DV in their relationship. Molly talked about a formal assessment that is used in the criminal justice system called a lethality assessment. She described how pregnancy is one of the factors considered on the lethality assessment because of the increased risk women and their infants are in during this time:

So law enforcement... so when they respond to a call, they ask a set of standardized questions, and then based on that scoring, they can help predict, not always obviously, but, it can be helpful in predicting factors that are more likely to result in homicide, and so then, they are able to advocate, and ask for higher bail from judges...based off that lethality assessment... one of the questions is... are you pregnant...and then another is...does your partner know you are pregnant.

Other participants either felt that formal assessments being done are not comfortable to them or not being conducted effectively. Building relationship, trust and having a conversation was



generally highlighted as key factors to producing a meaningful assessment. They also discussed concerns around stigma as Cindy pointed out:

In our work being able to talk about it like that may leave the door open... cause if we say DV right away they are going to protect ...it's a stigma...but I can continue to validate and support....and connect to them...so maybe she would feel more empowered...so continuing to create the trust and connection.

Julia points out how doctors will get different responses from women reflective of their approach to them during assessment:

Doctors who are interested are the ones who have the extraordinary levels of domestic violence in their practice, and all the other doctors will say... you get them all... and those doctors will say... you have the same people, you just don't ask the question in a way that women are more comfortable to say yes.

Julia also added:

I get screened for DV when I go to the doctor, and I make them really screen me, and if they don't look up, I'll just stop talking, and when they look up I'll say, so... let's just assume I was a victim of DV...how likely do you think it is I would have just said yes...you know... I educate them all the time.

Julia shares her frustration with the myth that DV doesn't happen in wealthy neighborhoods and how it impacts assessment:

I think that people have a lot of like... you know... they will look at a family from Edina and not do that...but then they will look at a family who is from Franklin Ave in Minneapolis and then they screen... and there is... just ridiculous beliefs about it...

Anna described how her method is not useful, "...I give them a questionnaire they fill out on their own and I have yet to have a client answer a question about the current relationship she's in..." Julia pointed out flaws in the screening and intake process at hospitals and clinics, "...they don't even look up during the screening...quite often it was an uneven response...so it's very likely that the issue was being very underreported...even though they screen for DV they really don't ..." She adds:

Everyone should be able to look a woman straight in the face and say do you feel safe in your home...not be looking at the papers or the ceiling or not be part of 31 questions you just rattle off and really give the energy that says... I'm interested in your answer... not because it's on a piece of paper... if she says no and you have suspicions...you can continue the conversation because again there is all that research that says your medical professional has to ask six or seven times to feel comfortable in saying yes...

Elizabeth agreed with the need for having a conversation stating, “you know they just kind of skip over it...they don’t really say anything about it...you won’t get an answer that way... you have got to have a conversation...it has to be a conversation...” She feels that assessment can be a part of prevention when screening is conducted by healthcare providers effectively:

It is a great opportunity to talk to medical students and nurses and lots of public health nurses... it is a great opportunity for us to intervene before police intervention... but they can’t if it’s just a question on the medical history...survivors are not going to say yes.

She also talked about how red flags can be seen just by observation:

That’s a tip off anytime you have an abuser who will hardly let her be alone and if every time they ask a question and the survivor is kind of looking at the abuser first there are all sorts of non verbal queues that you will see just the interaction itself between you know... the behaviors of the abuser and sort of how the survivor acts around the abuser are going to be a dead give away with someone who has a trained eye and can interpret that stuff.

Maria commented on her personal discomfort with the practice and described how in her perspective it did not feel helpful to assess for DV:

I think even on the form we have I don't ask it... like do you have a history of abuse... I don't ask it... I use it as a space to write notes but I don't ask it... that's not that focus at all... I think it's personal...

Karen pointed out that it is unusual in her workplace to feel as comfortable as she does with screening and described how she will have those conversations:

If someone is coming in and you know they need to talk to someone about it...it's a conversation I have regularly...are you being safe...do you feel like there is a potential for an STD or pregnancy... do you need to get tested...I took that training and they encouraged everyone to be pretty candid but I also think that it's also part of my personality...I wouldn't necessarily say that that's the status quo...only if people are comfortable...its not really something that comes up ...it's an uncomfortable conversation...when you're trying to develop a report and it's kind of an accusatory question...I think it comes from a place of positive intentions but it's a thoughtful conversation that's for sure...so I wouldn't necessarily say there is an assessment its normally more a conversation when the opportunity presents itself which it typically does but it just depends how comfortable the advocate or social worker is on having that conversation.

Anna shared her concerns with the screening process even when it does elicit an honest response:

We have to know how to screen in a way that is not abrasive...I went with a client once and during the screening the nurse was asking all these questions, and just said to her, are you experiencing DV at home... and she answered it honestly, but I just thought... that was uncomfortable.

Participants also talked about the language used in the forms given to women about DV. They stated concerns that this language may not reflect how women understand their situation and so they do not even identify what they are experiencing as DV and as a result do not report it. Anna shared her process and how having conversations is key:

So being more creative in how we ask these questions...so like have you ever experienced any type of trauma... and I will list off everything from tornados and house fires to being sexually assaulted... and I try to list it out so they have a broad understanding of what trauma looks like... and I'll ask them... have you ever felt uncomfortable in your relationship....if they can talk to their partner without feeling afraid...and in terms of where it gives them a picture of what it might actually look like rather than giving it a name DV and then expecting them to know what that is and what it looks like.

Elizabeth agreed with using language that would describe DV behaviors to women and added:

So its describing what's it looks like and then going the next step and describing how that might affect someone...we are concerned because when your under that kind of stress and tension it can have ill effects on your health and pregnancy and we want to ask people so we can help... now that kind of opens a door...now the person may say no because they feel like they don't want to talk about this and the stigma and feeling embarrassed and guilty about the fact that they are being battered and it's their fault... but they also know that this person is someone they can tell when they are ready to tell and...so there are wonderful opportunities for that to happen for them to say you know me... I'm always going to be asking are you safe in your relationship.

All the participants described some form of assessment, however, they ranged from formal and mandatory to informal and un-utilized. One participant mentioned a lethality assessment by police that includes pregnancy as a risk factor in lethality. This informed their assessment to include questions that asked if the victim of DV is pregnant and if the partner knew they were pregnant. Participants ranged in their own level of comfort with doing the assessment as well as their desire to use it in their practice. Participants described questionnaires and just having normalizing conversations to help assess and identify potential risk. Also important to note was how the language needed to be geared in a way that women can really

relate when they are being asked about their experience with DV and not assuming they understand what that means. Participants also mention the value of planting seeds and building a support system for when women are ready to seek help.

### **The Power of Relationship**

This theme examines the response to DV during pregnancy from the experience of the participants ranging from doula focused to DV focused responses. Most participants stated that education was a commonly used prevention method. Providing resources and breaking isolation by identifying support systems were also highlighted. However, the key to any response that was discussed the most was the quality of the connection and relationship built between the women and the DV service provider or doula. Participants noted the need to be able to guide women in a supportive way, aiding in ability to make choices with more clarity and towards safety without bias or judgment. One participant highlighted, "...just trying to be especially sensitive to the fact that their whole world is changing..."

Participants described how they understand the victim to be the expert in their own situation and their role is to be present with them. Cindy touched on the women being the expert, "...I think it's their decision and they know what's best for them...I feel they just don't feel their

own power at all...but it's about survival not thriving right now..." Anna described how it looks in practice to let the women determine what she needs:

We want to know what she identifies as her top need...so she might say I need to leave he is going to kill me, so it's like okay, let's get shelter and find room or find a hotel, but we will make sure you are safe... if she says she wants the abuse to stop but she loves him, then we just we just listen to her and talk to her about safety planning and what to do if he attacks her or if he, you know, maybe he tried to take the child...telling her what are his and her rights...and so...it might just be that he's upset that she spent all the money on diapers, and he is mad she didn't get beer...we will get her money to go get him beer... because that's what she identified as her priority to keep herself safe...and so we have to... you know... we are not going to tell her that's silly or not the right move because she is the expert of her own life and we are not going to tell her what to do in that moment.

Participants described themselves as believers who will normalize and offer empathy and a safe space to build a trusting relationship. Elizabeth points out how abusers can often appear innocent to everyone else but the victim, "...understanding the dynamics, that frequently... most of the time, to the outside world, that abuser looks like, oh my god you're so lucky to be married to him...so, you're like, I think I'm crazy..." Participants discussed how they will identify



themselves to women as someone they can always talk to when they are ready. Anna stated that, “...we want to make sure she is able to know that even when she is not ready to leave she can come back and talk to us when she is ready ...”

Maria shared a story of a personal experience she had helping a woman just feel safe:

I did see that at HCMC where I was once called in for a mom who had a labor that stalled because they said an abusive partner had dropped her off in the middle of the night to labor by herself...and she was all by herself in the middle of the night, and she was so tired and she couldn't sleep...she's alone in the hospital and so all I did was sit in the room with her and she zonked out and slept so deep and so long and all I did was just sit in there... doctors and nurses coming in and out and she was not in labor yet...so I just sat for like 4 hours and she just slept...so again just making her feel safe.

Cindy talked about how important it is to provide education:

Providing them the choice and the access and providing them with education is the best thing to do...just opening those doors...it may seem small but it is a very powerful intervention... I really think it is ...its not easy, and they don't say, oh yeah I want to take that class...they are not always like that...but they listen and they hear and they

remember even if it's just planting a seed...that seed might give them strength to allow them to move away from that situation later.

Karen agreed and described how important it is to offer women support and empathy. She noted how it is key to do it in a way that is recognizing they are in a crisis and their priority right now is safety:

Its more about providing those resources providing that emotional support talking through it... my role is not to judge or tell them what to do and I think it's just giving information and sometimes it's not that people have not thought about it but maybe it's not at the forefront at their mind because safety for them is at the forefront of their mind.

Julia emphasized the importance of trust and some of the fears women may have:

Nothing happens unless you have some sort of level of trust with the person you are talking to...you have to have trust especially with being pregnant because they think if someone finds out they might take the baby away from me so again there is that extra level of fear.

Elizabeth expanded on building trust, education and also mentions safety planning in her response:

Just educating, not trying to scare them or push them toward any decision, but simply to say, this is what we know from the research, that you know...stress and tension of pregnancy combined with DV is a lot to deal with...if the survivor is wanting to leave, then it's a matter of finding resources...if she doesn't want to leave, its around getting her some support within her system...and what's based on her needs and getting her connected with some kind of resources...we do safety planning.

She also mentioned how a strategic partnership between doulas and DV service providers may be a benefit for women and their infants:

I think the partnership would be so cool... because you don't have to be an expert, you got one to work with, you and they have lots of resources to bring to the table... knowing where shelters are... lock changes, orders for protection, financial resources and all the things that go on...so as a medical professional all you have to do is educate and provide resources and the DV service provider will take it to the next step if the survivor wants to.

Elizabeth adds about concerns women have in relation to legal issues and how medical providers can help. She is describing how they can document evidence that can be used in the future for a trial if a woman ever needs to prove allegations of DV to obtain protection or custody of children they have in common.

When they do apply for divorce, and when they do tell their attorney, I have been a victim of domestic violence, and the attorney tries to present that information, it's like well, there is no police reports... I think she is doing this to get a leg up in custody... and if it has been recorded, then she has her evidence...you know...I had bruises on my arm, I had a black eye, I told them yes, I had been abused...I didn't report it to the police...but I did report it to my medical provider, and the doctor would be noting, there was a bruise the size of a quarter, the patient said it was the result of her husband throwing her up against the wall.

In this theme, participants discussed how they have been responding to this population by building relationships with them and gaining trust. They also are providing education, building a support system, providing resources, safety planning, using trauma informed and strength based approach, and motivational interviewing. Participants talked about how they will always help them feel validated and empowered to take the lead in making their own informed choices without judgment.

### **Barriers of Pregnant Women Experiencing Domestic Violence**

The next theme that was developed after analyses describes the specific barriers pregnant women who are experiencing DV may face as perceived by the participants. Some of these

included an increased likelihood of experiencing complications at birth and having post-partum depression, having a lack of resources and support, legal consequences ranging from citizenship to custody and stigma in relation to marriage or religion. Elizabeth points out:

It's like unbelievably overwhelming, I can't think of anything but feeding this baby and getting some sleep... it's like that's all...and maybe I'll take a shower... it is too overwhelming to think about leaving on top of surviving ...so that's a huge barrier...just the fact that your pregnant and trying to make plans for taking care of this baby and how are you going to take care of yourself so you can have a healthy baby.

Julia points out the importance of having realistic conversations about what to expect and how stigma can contribute to depression:

I am supposed to be happy I have this beautiful brand new baby and I'm crying, I'm miserable, and I'm depressed, and I had to get on medication... and so again, anything that challenges that this is the most wonderful time... and you know the truth of the matter is... you know... having a new baby is really hard work...you know... it's not as lovely as you think it is...you don't get any sleep, and if you nurse, your boobs hurt, and you know.... you're tired... and there is this idealist myth around it... and it doesn't fit for anyone.

Maria described how stress may impact birth:

Maybe birth would stall out, and they need to feel safe, to let their body go through it... I do see it more in trauma victims... not having control over your sexual organs...you know... in like the case of a trauma... that happened to you and now at birth, you don't have control over your body and what's going on.

Anna discussed how women who have been raped may experience unique consequences that impact a women's ability to have a safe and healthy experience:

Some have conceived a child though rape so their ability to connect to that child is going to be impacted by that or their history of trauma... to be able to process...those things you or I may take as a very natural part of being a women or becoming a mother.

All participants also talked about fear as being a significant barrier for women. Also mentioned were lack of resources, and real or perceived dependence on the abuser preventing women from being able to become safe. Julia shared a story of a woman she worked with many years ago:

This woman was pregnant, and he was unemployed and looking for a job, and he would not allow her to stay in the apartment by herself with this newborn...it was January and so it was freezing and she would have to sit with him the car... freezing cold because he

would not allow her to be by herself... you know...there is no routine, no nap time, there is no her lying down, there is no nursing.

Karen shared the concerns she has experienced in her work with women, "... this idea that there's another mouth to feed... there is just a lack of those resources...shelter space ...safe places for women to be..." Some mentioned cultural and political influences including marriage, religion, and citizenship. Anna described it as:

Multi layered issues...poverty... mental health... possible chemical health issues... possibly undocumented in the county or not speaking English... putting up with a man or a woman who is being abusive to them...in order to keep the family intact...in order to honor whatever arrangement they have or religious beliefs... there is a lot to process through.

Most participants highlighted poverty, housing and a general lack of support from society as barriers. Karen said, "...we just don't have the government revenue the support outside of the nonprofit world...donations...being tax exempt...all these things to be able to provide staffing and then everything for the participants..." Cindy points out how the general public feels making it hard to find financial support for them, "...they love baby but may judge mom..." Julia adds:

Being pregnant is seen as being this blissful time you know like, oh my gosh I'm painting the nursery ...is it a boy... is it a girl ...and you have to say, it's not blissful...it is a huge stigma and very, very difficult.

Some participants talked about how the abuser would use the pregnancy as a tool for power and control. Julia shared her memories, "I remember some partners didn't want them to have a baby shower because they were jealous of it or they didn't want to be without her for any period of time..." Anna shared a story of a woman who struggled with this:

We recently had a woman who was pregnant with her boyfriend she tried to leave 2 other times...and he's made it very clear to her that when the baby is born, he will get the baby, because she has mental health issues and she's incompetent to raise their infant, and that their child will not have a mother...and so for her, the baby has been used as a tool to be abusive to ...abusers are very smart and spend a lot of time planting all of these seeds and brain washing...so it's a process.

Molly talked about how there were:

Barriers around expectations and judgment... from family, friends, loved ones... society... those of us in the helping profession... you know how sometimes we will just



say things like how can you bring a child into a home with so much violence... you know... those kind of things.

She adds how specifically women in the shelter may feel:

It's hard to be at the shelter it's hard to rest if your living with 70 other people... moods are up and down you don't know what to expect... no matter how nice we try to make it it's hard to parent in a fish bowl...it's hard to feel like people are judging you about you're your eating, what's your exercise...you know you may feel as though everybody...staff...volunteers...other residents...everybody up in your business and got to tell you something about here's how you should do it...you know... so some of that is the shadow side of that ....the positive side....you got people who are like I know this is hard ....and you see intergenerational kind of cool conversations happen where you see some of the older residents in the shelter with some of the first time moms being able to just say you're going to be alright...so you know there is also opportunity for some...interactions that maybe...wouldn't otherwise happen so I think it can be a double edged sword...

This theme is examining the specific barriers pregnant women who are experiencing DV may face. An increased likelihood of experiencing post-partum depression was highlighted by all

participants. It was also described as a very stressful, complex and overwhelming experience for women and their infants that may result in birth complications or related health issues. Also noted were lack of resources and support.

### **Challenges for Service Providers**

This theme goes into the personal and professional challenges that face service providers that come into contact with this population. Maria talked about her challenges with helping women who fear losing their baby:

She will just say well it doesn't matter so why should I put myself through being attached to this baby...and then getting them to think it's like this baby is growing inside of you and loves you and doesn't know anything different... so like we try to get them to think about that... how can you connect with this baby... its going to be beneficial for the entire life of the baby... if you could just give that love to the baby, you know, and when they are born... all that skin to skin... all of that connection... you know, the baby remembers those things...and nursing is important, even if you're not going be with baby after that... it like seals the lining of their stomach and everything... gives them all these antibodies that help them...even if you nurse your baby one time.

Anna described her struggles with being able to plan with women because they often so focused on their basic needs and survival:

Anyone, especially women in poverty, or experiencing DV, they are very present focused...really thinking about what they need in that moment of any day, so it's hard to plan for the future or to think about it or conceptualize it because it's such a foreign concept...preservation happens in the moment of every day when you're in an abusive relationship.

Another issue that surfaced was a lack of awareness in the media and politics resulting in a swing of funding depending on the trends. Molly stated, "...trends will come and go what's hot what people want to talk about and what people want to fund..." Elizabeth explained how:

This is not like a new idea by any means....there has been a ton of work nationally and this is something that is coming and going in its popularity...always has to do with the funding, you know, some knew thing will come along and then the work they already have done goes on the back burner...its always been... advocacy that push to keep it in the forefront...absolutely always ....that's why I spend so much time with city councilmen and county commissioners...got to constantly remind them it has not gone away here is the latest data...here is the latest stats...here is how many we serve."

There are also challenges related to an increase in caseloads and limited resources for clients.

Julia expressed frustration with housing:

It would be nice if we had more transitional housing associated with shelters...women finish their time in the shelter and then and they may go back to the abuser...so I think housing is a huge.... a huge problem.

Some participants shared limitations that they felt. Maria talked about how "...if you're not comfortable or they don't want to share it...it might be a barrier..." Karen expressed her limitations:

I don't have kids so it's really hard for me to reflect on a situation I have never been in...I'm educated I do have an understanding but I think there is little things that I can't understand and I think understanding that is really important because I'm not going to try to pretend like I know everything...you know it's really hard to understand if it's not something you experienced.

Julia explained how important it is to have self awareness and boundaries:

When you want to throw all these resources at these women, you still have to have a sense of what is that they want... as a professional can you live with someone saying, I just don't want him to beat me, he can scream at me... that's tough...you have to have

your own house in a row in terms of you react or don't react when a woman says something you don't agree with... a big barrier to all of this is your self and how you screen and what you're willing to hear and willing to do and not do...

Participants also mentioned stigma as a barrier. Elizabeth shared a comment that she heard made by a health care professional, "we are in Edina... I'm not asking her... I have played golf with her husband..." This highlighted the myth that many providers still believe implying that DV is not an issue in wealthy communities. Anna described how stigma in relation to gender roles interferes especially in rural areas:

Traditional mindsets... so that women put up with these things they just stay home and if it's happening in the family... it must have been something she did and it's a private matter and all the stigma that comes with it.

Anna also explained how systems may act as a barrier to women and their infants:

What we struggle with a lot is the police kind of passing the buck and saying you know she just keeps going back to him so she is a lost cause or... chemical dependency treatment centers saying you know addiction is a disease, and we will just help you cope with it, but they never ask... you know... what are you using for... what are you coping with, how is it helping you cope, and what are you trying to mask it with?

This theme described the specific barriers that participants face in helping women who are experiencing DV during their pregnancy, birth and post partum period. This included poor screening practices, stigma, lack of awareness and education, self awareness, personal comfort, large case loads, training, funding, and politics.

### **Safety Planning and Birth Planning**

The following theme that emerged explores what participants perceive as effective safety and birth planning. They reflected on what tips and advice has been successful for them to offer women however the main factor was keeping women informed of all options and supporting them in any choice they make. Anna talked about her perspective on the value of self care and social connectedness:

Self care is super important so you know you are always planning for safety but you need to plan to take care of yourself too...so knowing what your resources are... you know different support groups that can provide a sense of belonging or sense of community... I think that one of the other bigger barriers is if they feel so alone or they are the only ones going through it or they are crazy and so helping them feel a sense of community is very much a part of safety planning, so you feel empowered and like you belong somewhere.

Julia showed the importance of having supportive conversations:

Telling women that it's not unusual helps because you know women feel like they are the only one... again everyone is having a wonderful pregnancy and they are knitting booties and their husband is getting them ice-cream and pickles in the middle of the night and so to say this is not everyone's reality is normalizing what's happening... it's really a big deal.

Maria felt that when the focus of services was on birth planning that safety planning was best done in less direct approach where she would provide referrals, "...in general resources... like if you were ever to experience DV during pregnancy here is a place you can contact to develop a safety plan..." Cindy talked about how she may develop safety planning with women:

If you are being hit or hurt what would you do in that moment, do you know who to call, you know right now writing down the number... and then...it is easier to do it like that and not make it so much about them...if I find that they are like, oh nothing is wrong, I will try to do some scenarios with them and this is how you would respond or what you could do...just so you know.

Elizabeth shared what kinds of things may be considered in a safety plan she would do:

Let's talk about when does the abuse usually occur, what if it happens at home, do you have anything so that you can leave at a moment's notice if you have to, again... many

have friends who say you can come stay with me anytime and if I'm not home here is where I keep my spare key, you get it, you go in... and some don't have that, they have been isolated and she has no one to depend on, then in those circumstances it's the 24 hour crisis line...do you have a car, can you get away...if you leave where is it you're going to go...

Karen talked about things she would consider when developing a safety plan with women specifically during pregnancy:

We look at put your keys in your purse, instead of just throwing them everywhere like everyone else, kind of keeping in them in one place, and making sure you have extra clothes in the car... some cash in the car... little things like that...but I would definitely say there are some pieces that would be tailored...imaging how like if you don't know when the exact day and time...so you are just left in limbo and maybe it's a situation where they are super isolated, and maybe relying on him for transportation to the hospital...do they feel safe about that ...when is my water going to break... when it goes is he going to be there... locking yourself in the bathroom with a hidden phone because...you would never want a situation where you rely on the abuser to take you to the hospital.



Anna shared a story of a personal experience she had with a woman who lacked transportation and lived in a rural area:

We worked with a woman once who had two young children who she left at home... and stole a neighbor's bike to a pay phone three miles away in order to call the police and pick her up and bring her to the shelter.

She adds how the shelter may help a women do a safety plan:

Make sure she understands her rights to a order for protection if she doesn't have one already that she can call the police at anytime if he is causing any issues...we encourage her to change up her daily routine especially towards the end of your pregnancy when you are going to the hospital... once a month or weekly and space them out and don't keep them same day or time and make sure the doctor is aware... if it's a very severe situation keeping a picture of him if you need to hand it over to security they have it.

Molly described safety planning in the context of pregnancy:

The logistics of all of that health insurance... so when you go to the doctor...and you're on your abusive partner's insurance, how can you talk with the insurance company... I think it's those kind of things...making sure that...no its not okay to leave a message...you know...about the results of pregnancy test...even though it's my cell

phone because...I don't have access you know and my abuser does know all my passwords.

Cindy described what a birth plan may look like and some of the factors that she would have women consider feeling safe and empowered:

Birth plans are who do you want there...do you want music...did you think of music...whatever they want there... I had somebody have a water birth... I had somebody want to try with no pain medications at all... just informing them of what's happening to their bodies and what choices they have and things they can do...giving them a sense of control over their experience and pain management.

Molly also described birth planning emphasizing the need to honor the pregnancy and inform women of all their options:

I think the birth planning is trying to bring in that celebratory piece... what kind of experience do you want to have...you would have choices...it doesn't just have to be you go there and they drug you up...if that's what you want we are not saying it's bad...but did you know it could be all of these different things that some people really want to have, and they really get into the whole what to expect when you're expecting kind of conversation.

This theme described safety and birth planning. Participants who were DV service providers felt that the same process used in safety planning for women who were not pregnant should apply to women who are but with additional considerations. Participants focused on the issue of isolation and lack of financial resources. They talked about the importance of being prepared with multiple plans, and providing education. They noted the importance of not having expectations for women to make a certain choice. They also talked about the importance of early intervention, self care, and social connectedness. What was valued most was to allow women to take the lead of their own life and make informed choices.

### **A Power Shift**

In this theme, participants addressed the status of women today and how that influences the issue of pregnancy and DV. Participant's perspectives reflect the tension between personal and social responsibility and accountability for the causes of DV. Anna talked about how:

It's hard when we have we still have a culture of violence and you know violence is a sign of masculinity and then we have all these mental health and chemical health issues on top of it all that are blurring the lines for how we understand all of this stuff.

Molly talked about the lack of awareness in the general public and how media minimizes the issue:

Well there is a lot of attitude around, you know ...kind of special privileges for pregnant people...you know what I mean... we are talking specifically about higher risk during times of pregnancy... your at a higher risk for violence... but that's ignored...and yet when someone reads in the news that there has been some violence at the hands of a stranger, there is outrage...especially if it's a pregnant women...then ohhh watch out...you know...complete and utter outrage...which is very...very different then...the compassion we have toward women who experience DV...even in the DV organizations often.

Maria shares her own discomfort with the issue:

I mean as a doula we don't necessarily get that whole history, where we sit and ask a lot of questions about that...and I think we are conscious of that...I mean we want to know about things that might come up during the birth, but we don't want to.... I mean for me I'm not a therapist, you know, so I don't want to re traumatize her by asking her a lot of super personal questions when I don't really know her all that much.

Julia points out her frustration with how doctors often respond to women, "...I think they feel like if you have a problem then go to your social worker...it's not in my scope of practice..."

Karen expressed her concern with the how individuals with power including policy makers, law enforcement, healthcare providers and others may not have empathy or understanding for the issue pregnant victims of DV experience:

What makes me sad, and I find really scary, is you see these people, at these levels, who just don't have an understanding...its privileged... maybe you have not encountered domestic violence or know anyone who has, but... these people have lived in a life style were they were so privileged...so it's just...we are still operating in this governmental, para military, hierarchal society, where the people making these rules are middle aged white men.

She further explained:

I mean it's just that willful blindness combined with the lack of resources... you know... we have not as a society prioritized...ending domestic violence...we haven't, you can see it in... in our society... it's still...it's something that is a personal problem and needs to be hidden... you know...its... kind of a lack of awareness but also a willful blindness.

Elizabeth agreed and described:

...it's a worldwide issue that the status of women has do to with whether or not they are victims...you know we are seen as less then... it has to do with the value we place on

women and girls and the status of women and girls...and it has to do with the acceptance of violence...that anyone has the right to control another person because they are stronger or bigger or white or male or any of that kind of stuff...we all get to be safe in our human person and regardless of age of gender or race...you know until we get to that point we will deal with domestic violence... any group that uses violence to control another or resources is what we need to fight...sorry folks...this isn't simple.

This theme described the participant's views on the cause of DV and the ongoing issue over personal or social responsibility to respond to it. This theme addressed media, athletes, status of women, equality, and acceptance of violence, male privilege, hierarchal society, and stigma as influences on the perception of the causes of DV and roles of individuals and systems.

### **Call to Action**

This theme reflects the participants hope, vision and goals for improving the status of women in general and specifically interventions for pregnant women experiencing DV. They discuss what strategies they would like to see supported by society, the media, their employers, funders and policy makers to improve outcomes for women and their infants. Maria talked about some of her reasons for supporting this population:

Mom hormonally is primed to care for her baby...there is just some like mother bear thing that comes over to protect their young and how that is not to be minimalized... just get service providers to understand that...how a baby needs mom to be safe to connect with...and mom needs to feel safe to give birth...because ...a lot of things can happen during the labor that slow it down or cause problems.

Karen talked about her desire for training that is affordable and also mentions online options for training to make it easy to fit in:

I think training regarding childbirth and pregnancy and safety planning would be really helpful...the other thing I would add with that is that...you know we don't have the financial support for training and that would be a big piece of it...but I think I would be awesome to have a training...having it online to be taken whenever would be even better.

Anna shared her perspective on what it will take to shift the culture that supports DV:

Up till 15 years ago we all sat around smoking cigarettes while we were answering the crisis line, and then we would sit at the bar and smoke cigarettes, and then we would sit in the car on the way home smoking...and so over time there was a huge shift in that culture over time...can't smoke in bars...not inside work...cars with kids...you know so we have to make it as unacceptable as smoking... there is going to be no where that we

can create change without a bunch of people coming together and saying enough is enough.

Anna described the importance of providing quality training to service providers:

Instead of asking what's wrong with...ask what happened to you instead of treating symptoms we need to treat the root cause it takes a lot of time and training and those are all things that people...it's easy for us to make a judgment call and just say oh it's this...it takes a lot of time to ask...what it is that's really happening and not blame someone's behavior on their choices and the impact of trauma on their decision making and so I think we just we need a whole lot of training across the board and you know a lot less judgment and that all takes money and informed individuals to do all of that.

Elizabeth explained how education and partnerships is key:

Its constantly pushing that information out there and boy...it sometimes feels like a uphill battle because we are so indicated with explicit violence that we become oblivious to it...but...every level we can educate about domestic violence and relationships is important...and you know DV folks need to know about the research and...I think reminding DV folks of the importance of what's going on during pregnancy and what are



the concerns we might have about DV when a person is pregnant and right after delivery...it's in the strategic plan of the collation... we need to create more partnerships.

Julia agreed, "...I just think teaching and training in other medical schools and midwives and doulas and everywhere and the police also because they have such a big role..."

Molly also highlights how she believes in and engages in education:

So if I'm presenting about it and I just talk about some of the statistics...people are horrified because it's never occurred to them...that during pregnancy... that maybe they are at higher risk and people are like ohhh what...and they gasp... you know... that gets people's attention... and so I think it's about raising awareness and then that's where helping with some of the judgment may come as they get educated about it.

Cindy described her hope for interventions:

I think...confidential and free resources for youth...I'm a big advocate of schools having... like teens can have a clinic in the school...you know... or other resources for clinics that help families...by giving them resources, where to look for work...also just feeling connected... you know just a safe space to be or to attend where if that's what you need you'll be able to get that... like a home away from home.

This theme explored participants desire to take action in support of this population. This was including building strategic partnerships such as between doulas and DV service providers. They also described the importance of creative problem solving, early intervention, education, making training accessible and a priority, increased funding for resources and using client centered solutions that are supported by a society that won't tolerate violence against women.

In conclusion, this section discussed the findings of the study based on the coding and content analyses of the 7 interviews conducted. The ten major themes identified: (a) What No One is Talking About, (b) Impact of DV on Childbirth, (c) A False Hope, (d) Assessment of DV during Childbirth, (e) Responses to Pregnant Women Experiencing DV, (f) Barriers to Safety during Childbirth (g) Challenges for Service Providers, (h) Safety Planning & Birth Planning, (i) A Power Shift (j) Call to Action. Participants were all female and ranged in their experience from DV work to doula work. The following section will present the discussion of the findings by doing a comparative analysis to the literature review and recommendations are discussed for future research, direct practice and policy.

### **Discussion**

The primary purpose of this study was to examine how women and their infants are impacted by DV during the pregnancy, birth and postpartum period. The research was examining

the prevalence of DV during childbirth, the impact DV has during childbirth and how a strategic partnership between DV service providers and doulas may be beneficial. The researcher was able to gain insight into these questions and add to the discussion after conducting seven semi-structured qualitative interviews with DV service providers and doulas. All participants had personal experience working with the women and their infants during this vulnerable and sacred period of their uniquely bonded lives. Participants in this study did generally support the literature review. While participants mostly supported each other in their experiences there was a range of personal comfort expressed with assessment of DV during pregnancy. In the following section the findings will be compared to the literature review, strengths and limitations of the study will be addressed, and finally implications for future research, direct practice and policy will be explored.

### **Comparison to Research**

Benefits of a strategic partnership between doulas and DV service providers was supported in both the literature review and findings of the study (Basile, 2012; Beck et al., 2006; Menezes Cooper, 2013; Moran, 2004, Pascali-Bonaro, 2003). All participants agreed in the benefit to having doulas as part of a prevention and intervention to DV during the childbirth period. Doulas were recognized by participants and the literature review for reducing birth complications and increasing positive birth outcomes by providing a uniquely continuous and

holistic support during the entire pregnancy, birth and post partum period. (Arat, 2013; Lesser et al., 2005; Moran, 2004). It was very clear that there is a high prevalence of DV during pregnancy despite the lack of education and awareness of the issue in our culture today (Menezes Cooper, 2013; Moran, 2004). Participants also pointed out the male dominated society and acceptance of violence as factors that contribute to the issue which is supported by the literature review. Participants and findings of previous studies reflected this as a public health epidemic and that this population is vulnerable and deserving of more protection (Menezes Cooper, 2013, NCADV, 2015). Both also supported the fundamental human rights of pregnant women to a transformative, empowering, healthy childbirth experience (Basile, 2012; Menezes Cooper, 2013; Moran, 2004).

Findings that examined the implications of DV during childbirth were supported by the literature review. Increased isolation, stress and risk of post partum depression were highlighted. Another connection made between findings of previous studies and findings was the lack of support, barriers to services, and lack of knowledge in relation to their childbirth (Côté, & Lapierre, 2014; Moran, 2004, Webster, Nicholas, Velacott, Cridland, & Fawcett, 2011). Findings of studies in the review of the literature and the participants discussed how women may also be more likely to abuse substances during childbirth as a way to cope with the DV (Hellmuth, Gordon, Stuart, & Moore, 2013, p.6). Impact on health was supported in relation to decrease in

breast feeding, attachment issues and a variety of physical health complications (Keeling, 2012; Moran, 2004, Urquia, et al., 2011).

Barriers addressed in several studies in the review of the literature in relation to limited emergency funds, lack of shelter space and patriarchy in the criminal justice system and culture in general were supported by the findings in this study (Mills, Barocas & Ariel, 2013; Moran, 2004). Also supported was the real or perceived dependency on the abuser that women often experience as a barrier. Some of the participants talked about how women may have the tendency to be self absorbed because they are so focused on survival all the time. Women are described as not being able to put focused energy toward the very things that would allow them to experience their right to feel empowered in creating a safe and healthy childbirth experience. (Wanhan et al., 2010). These findings coincided from findings of several studies in the review of the literature the need to be very intentional about creating relationships and building trust with this population in order to be effective in providing services (Côté & Lapierre, 2014; Pascali-Bonaro, 2003). Participants emphasized the need to have repeated, sincere, normalizing conversations to provide the opportunity for women to feel safe enough to seek help.

Findings in this study were also different from findings of other studies. Other studies discussed the increased risk of behavioral issues or mental health issues in children who were exposed to DV during childbirth and the participants in this study did not (Howard et al., 2013;

Moran, 2004 & Wanzhen et al., 2010). Findings in this study did not mention a connection made in findings of other studies where women were found to have an increased risk of having a poor diet, unhealthy weight and risk of sexually transmitted diseases (Campbell, Torres, Ryan, King, Campbell, Stallings, & Fuchs, 1999; Moran, 2004). Utilization of screening practices was supported in both the findings and findings of other studies, however it should be noted that there was a wide range in the perception on how effective screening is (Amaro et al., 1990).

### **Strengths and Limitations of the Study**

This study was examining the benefits of a partnership between doulas and DV service providers in order to meet their unique safety and health needs. This will contribute to a variety of professions including social work, doctors, nurses, community-based workers, mental health professionals and others. Pregnant DV victims may seek help from a wide range of services, and wherever a woman may end up seeking help, that service provider should be prepared to effectively respond within their role and collaborate as needed.

This study may provide insight into developing and managing strategic partnerships between doulas and DV service providers. A strength of this study was that it combined perspectives of both doulas and DV service providers and all interviews were conducted in a private room offering confidentiality. Another strength is that the participants in this study were

able to expand on the perspectives of the professionals who come into contact with this population.

This researcher was inspired by a personal experience with DV during pregnancy. This researcher also experienced working with doulas that supported women who have experienced trauma during their childbirth. These experiences may help in the study by having an awareness of the issue beyond a literature review or data gathered that may expand this researcher's perspective and lens to a greater depth. This may be a limitation in that it may create personal bias that interferes with how data was gathered and analyzed, therefore influencing the conclusions and implications determined.

Other limitations of the study include the small sample size of the participants and the findings are limited to these specific perspectives. While they offered both perspectives of doulas and DV service providers it was not an equal representation with more DV service providers than doulas. Only one of the participants was from a rural area limiting the perspective of that demographic. This study also lacks the perspective of the women who are experiencing DV during pregnancy, birth, and postpartum directly from their own experience.

### **Implication for Direct Practice**

Implications for direct practice based on this study would include expanding education and awareness about the prevalence, impact, assessment, and responses to the issue. All health care providers and DV service providers who come into contact with this population should be prepared to confidently assess for DV during pregnancy and offer women affordable and accessible help without judgment. They should focus on safety as being the main priority and allow the women to be the expert of her situation and lead based on informed choices.

For those who are involved as a DV service provider, they should be screening for pregnancy despite that pregnancy is not the presenting issue or concern like it would be for a doula or maternity care team. Understanding what the additional considerations are to provide safety planning in the context of the pregnancy, birth and post partum period are key factors to best practice with this population. Professionals working in DV service agencies should know resources that they can offer and provide more specific and additional support with the pregnancy, birth and post partum period including doulas as an option. Also, professionals would benefit from having an understanding and awareness of the impacts and consequences that DV may manifest in women and their infant during the childbirth period.

Doulas or health care providers who serve this population should be prepared to screen for DV. They should be given the support, training and resources needed to feel confident in building the trust that allows women to feel safe enough to share their experiences and seek help.



Doulas or health care providers should also know who they can refer women to for additional support and services in relation to the DV they are experiencing. They should also have some understanding of the dynamics of DV and its impacts on the pregnancy, birth and postpartum period.

### **Implication for Policy**

Given the increased risk of several health complications during pregnancy, and DV being the number one cause of death during pregnancy, this study indicates that a social policy at the macro level to increase funding for DV service organizations and doulas to create meaningful partnerships (Baird & Mitchell, 2014; Cooper, 2013). While there is some coverage that is offered for doula services, this study indicates the need for doulas to be universally and fully covered by insurance when requested as an intervention in DV during the childbirth period. Both the literature review and findings of the study revealed lack of funding as a major barrier to being able to respond to this population in the most effective way, including utilizing doulas. This study also revealed the need to enforce the rights of women and their infants experiencing DV to healthcare and safety during childbirth by making both doula and DV services affordable and accessible to them.

Also indicated by the study for macro and mezzo level change is the need for more awareness and education campaigns about DV during childbirth among policy makers, funders, healthcare providers, doulas, DV organizations, criminal justice system and the general public. Increased education and awareness that is provided effectively to all of these professionals and systems would likely lead to providing a more rapid and meaningful response to women and their infants as they navigate the various services they seek to support them. Increased education and awareness would also likely contribute to ending stigma and myths about the issue.

Participants spoke about the need for ongoing advocacy efforts at all levels in society ranging from formal meetings with policy makers to grassroots social media awareness to take the burden of the issue off of the victim, placing responsibility on the perpetrator of the abuse, and finally supporting society to play their role in responding them both to manifest healing, rehabilitation and social justice.

This study also indicated the need for major improvements in how the screening is performed as well as providing the support and resources to support the follow up of the screening. Role play and more training for those who would conduct screening is advised. Allowing time for conversation, building relationships, and gaining trust are key factors that must be included in the policy to be effective in creating positive outcomes.

A mezzo implication for policy change is in relation to the screening procedures in hospitals, clinics, organizations or any place that may serve this population. Assessment of DV during pregnancy needs to be conducted in an intentional and thoughtful way that promotes a sense of trust that was gained from a relationship that was formed between the provider and the women they are screening. Providers should also be trained to ask the women each time they see her understanding that it often takes several attempts before women feel ready to ask for help.

It is also recommended that they conduct the screening in a private room and emphasize confidentiality. Also important is the need to use language in the conversation that women will relate to and not assuming they will understand what DV means. Identifying DV service providers that have partnerships with doulas would be highly beneficial in offering immediate, holistic and effective support to women.

Also included are the responses to women experiencing DV during the pregnancy, birth and postpartum. Findings of this study suggest creating strategic partnerships between doulas and DV service providers will create improved responses. The findings of this study suggest that a strategic partnership is achieved by first identifying who are the doulas and DV service providers that are willing to work together with this specific population. Then there would be the need to offer them relevant training and resources to feel comfortable in assessing and responding to this population in partnership with DV service providers. This may include

providing doulas with the local referrals to DV service providers to include in their general information they provide. It may also include providing DV service providers with a list of referrals to local doulas who women may want to connect with for more education and support with her childbirth experience.

Doulas and DV service providers would both need to be provided with a specific training on the dynamics and impacts of DV in the context of pregnancy, birth and post partum period. This study also suggests that DV service providers receive training to help them with assessment and response to women during pregnancy in the context of DV. This would be focusing on the need to build relationships, gain trust and asking every time. This partnership would result in increased support, education and resources to women and their infants experiencing DV during pregnancy, birth and post partum period. This would likely improve outcomes by establishing a more holistic approach to the unique safety and birth planning needs of this population. A strategic partnership would also be beneficial in reducing isolation, informing women in more depth of all their options, and reducing the risk of harm that women and their infants are inherently at risk of.

### **Implication for Future Research**

More research that examines the complex issue of DV during pregnancy, birth and postpartum period will benefit the women and infants. More research will help by informing direct practice and giving creditability to those seeking the funding and policy changes that allow the direct services to be provided effectively. Research that would address the specific benefits that doulas provide to the childbirth experience in the context of DV to continue to expand the conversation on best practice with this population is suggested. A more extensive study that incorporates data from a larger sample size and includes a balance between DV service providers and doulas is recommended for a more general response in findings. Allowing the participants to expand from service providers to the women who are actually experiencing or have experienced DV during pregnancy would also contribute to the study giving more insight to the needs and experiences of the population.

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## Appendix A

### Phone/Email Script:

Hello,

I am conducting a study exploring how domestic violence services in partnership with doulas would benefit pregnant women and new mom's experiencing domestic violence. I invite you to distribute a flyer to any doulas or domestic violence (DV) services providers who work with women and or children to recruit participants for this study. You were selected to pass out these flyers because you are a member in the community who works with or has access to individuals that meet the criteria for participation in this study.

I will conduct a semi-structured interview at least 60 minutes in length. I will audiotape the interview that will later be transcribed for coding and thematic analysis. The study has no risks. Findings may benefit community in general and service providers who work with this population. The records of this study will be kept confidential. Research records will be kept in a locked file in my office. I will also keep the electronic copy of the transcript in a password protected file on my computer. I will delete any identifying information from the transcript. Findings from the transcript will be published. The recording and transcript will be destroyed by May 30th, 2016.

Participation in this study is entirely voluntary. Participants may skip any questions they do not wish to answer and may stop the interview at any time. Participants decision whether or not to participate will not affect any current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. Participants are free to withdraw at any time without penalty. Participants who decide to withdraw will not have their data collected or used.

### **Contacts and Questions**

My name is Nora Smyth. You may ask any questions you have now. If you have questions later, you may contact me at XXX-XXX-XXXX or XXX-XXX-XXXX. You may also contact Catherine L. Marrs Fuchsel PhD., LICSW, LCSW Associate Professor School of Social Work at 651-690-6146. You may also contact the St. Catherine University of Institutional Review Board at 651-690-6204 with any questions or concerns. You will be given a copy of this form to keep for your records.

Sincerely,

Nora Smyth, LSW

**Appendix B****RECRUITING DOULAS AND DOMESTIC VIOLENCE SERVICE PROVIDERS FOR A RESEARCH STUDY!!**

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*This research will explore perspectives on how partnerships between domestic violence (DV) services and doula services could enhance outcomes for pregnant women and new mothers who are experiencing DV.*

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**Criteria for participation in this study:**

- Must be over the age 18
- Have experience working with women who have experienced trauma or stress (including but not limited to DV) before or during their childbirth.
  - Work as a doula OR a DV service provider for women/children

*Commitment: 1-hour long interview that will be audio recorded in a private room*

***Receive a \$5.00 gift card to Panera Bread for your time and commitment!!***

Please call Nora Smyth at XXX-XXX-XXXX or e-mail at [sample@email.com](mailto:sample@email.com) to discuss the study and set up interview.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS AS A SUBJECT/PARTICIPANT IN THIS RESEARCH, OR IF YOU FEEL YOU HAVE BEEN PLACED AT RISK, YOU CAN CONTACT THE CHAIR OF THE HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD, THROUGH ST. CATHERINE UNIVERSITY AT (651) 690-7739

## Appendix C

### Blank Consent Form

Consent Form  
St. Catherine University  
GRSW682 Research Project

#### Partnership Between Doulas & Domestic Violence Services

I am conducting a study exploring how domestic violence services in partnership with doulas would benefit pregnant women and new mom's experiencing domestic violence.

I invite you to participate in this research. You were selected as a possible participant because you provide services to victims of domestic violence or have expertise in childbirth as a doula and have worked with women who experienced trauma. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Nora Smyth, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Catherine L. Marrs Fuchsel PhD., LICSW, LCSW.

#### **Background Information:**

The purpose of this study is: To identify the needs of women during childbirth who are also experiencing domestic violence. The second purpose of this study is to explore how a partnership between domestic violence victim services and doula referrals may improve childbirth outcomes.

#### **Procedures:**

If you agree to be in this study, I will ask you to do the following things: I will conduct a semi-structured interview at least 60 minutes in length. I will audiotape the interview that will later be transcribed for coding and thematic analysis.

#### **Risks and Benefits of Being in the Study:**

The study has no risks. Findings may benefit community in general and service providers who work with this population.

#### **Confidentiality:**

The records of this study will be kept confidential. Research records will be kept in a locked file in my office. I will also keep the electronic copy of the transcript in a password protected file on my computer. I will delete any identifying information from the transcript. Findings from the transcript will be published. The recording and transcript will be destroyed by May 30th, 2016.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

**Contacts and Questions**

My name is Nora Smyth. You may ask any questions you have now. If you have questions later, you may contact me at XXX-XXX-XXXX or XXX-XXX-XXXX. You may also contact Catherine L. Marrs Fuchsel PhD., LICSW, LCSW Associate Professor School of Social Work at 651-690-6146. You may also contact the St. Catherine University of Institutional Review Board at 651-690-6204 with any questions or concerns. You will be given a copy of this form to keep for your records.

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

---

Signature of Study Participant

---

Date

---

Print Name of Study Participant

---

Signature of Researcher

---

Date



## **Appendix D**

### Interview Questions

1. What skills or education have you received in your work related to DV during pregnancy?
2. Describe your understanding of how pregnancy is impacted during DV?
3. Describe the prevalence of DV during pregnancy that you have experienced in your work?
4. Describe how you assess for DV during pregnancy?
5. How do you respond to DV victims during pregnancy, birth and postpartum?
6. What specific barriers do you feel DV victims face during pregnancy, birth and postpartum?
7. What barriers do you face in supporting pregnant women and new mom's experiencing DV?
8. Describe what safety planning and birth planning during DV may look like?
9. What do you think needs to happen to shift the culture surrounding the issue?
10. What would you like to have around education and training on DV during childbirth?
11. Is there anything else you think is relevant to discuss?