Domestic violence and pregnancy in Ireland: women's routes to seeking help and safety

2020

Siobán O'Brien Green

Declaration

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Signed By

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Siobán O'Brien Green

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Date

Dedication

My PhD study is dedicated to all the inspiring women survivors of gender-based violence I have met through my work and research over many years. Especially to the women who agreed to participate in this research study by being interviewed. Thank you so very much.

Three very important women in my life died during my PhD, I also want to dedicate my thesis to their memory.

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Summary

Background

Violence perpetrated by an intimate partner can begin, escalate and/or intensify during pregnancy and the post-natal period. The outcomes of domestic violence during pregnancy for both mother, baby and/or foetus can lead to multiple poor morbidities and long term consequences. International research indicates that domestic violence during pregnancy may lead to death, miscarriage, low birth weight, pre-term labour, anxiety, depression as well as severe physical injuries and high risk pregnancies. There is limited research on the factors and circumstances that enable women to disclose and seek support when experiencing domestic violence during pregnancy.

Aim

This study explores the factors associated with the disclosure of domestic violence and subsequent positive service utilisation during and after pregnancy by women in Ireland. The study aims to address a research gap by interviewing women who have direct personal experience of domestic violence during pregnancy and who had sought help. This is in order to understand and identify supports and enablers, in addition to barriers and inhibitors, which enhance and allow for, or detract from, safety and help seeking by women in these circumstances.

Methodology

The research employed a qualitative framework underpinned by feminist and intersectional methodologies and approaches. A study Conceptual Framework was developed to guide the study and to visualise and explain the interrelationship between elements examined and emerging from the research, in addition to structuring the data analysis. Eighteen women were interviewed, either during pregnancy, or up to approximately five years post-pregnancy, for the study. Four key informants were also interviewed for their comments and insights on the study sample composition, study Conceptual Framework and preliminary study themes. For the purposes of this study disclosure is defined as when a woman discloses that she is experiencing domestic violence and is referred, or self-refers, to domestic violence support service(s) (in a broad construal) or women's refuge at some point between conception and one year post-pregnancy. The study inclusion criteria allows for women whose pregnancy ended in a live birth, miscarriage or termination (abortion) to participate: nevertheless, all women who were interviewed had pregnancies that resulted in live births. Thematic analysis of data was used to identify common themes as they related to and with the study Conceptual Framework.

Results

Women interviewed reported multiple, serious physical and mental health problems during and after their pregnancies, which they related to living in an abusive relationship. Findings suggest that a lack of screening for domestic violence and poor continuity of care and trust building opportunities between health care professionals and women erodes potential for disclosure prospects and reduces opportunities for help and safety seeking. Women stated that time pressured medical appointments, before and after the birth, in busy maternity hospitals lacking a sense of privacy created barriers to disclosing domestic violence. Women self-referred in most cases to specialist domestic violence services, but time spent finding an appropriate service may have increased the risk women were exposed to regarding their abuse. Women's children acted as stimulants with regard to their help seeking, yet fear of removal of children by social workers became a deterrent to this process. Migrant women experienced specific barriers to seeking help, often related to their unfamiliarity with services in Ireland, together with isolation and language barriers. However, each positive professional or service contact women had seemed to re-enforce and support moving forward and more help and safety seeking by women. Once women found, or were referred to, and accessed specialist domestic violence services, including refuges, they were very satisfied with the supports provided, especially migrant women.

Conclusions

Clear signposting and visible resources indicating how to access specialist supports for domestic violence in health and maternity care settings are a strong recommendation emerging from the study. Search engine optimisation for all domestic violence services' websites using a very wide range or terms and phrases to allow women, especially for those who do not speak English as their first language, to easily and quickly find suitable services online and locally is needed. A wide range of organisations need to be sensitised to domestic violence amongst their service users, such as homelessness services, Citizen's Information Centres, charities, addiction services and other organisations providing outreach and fixed supports to women. This sensitisation could ensure women have opportunities beyond the health and maternity sectors to encounter information and experience referrals to relevant services, and could act as a potential gateway and soft entry point into specialist services. Disclosure of miscarriages and/or terminations in the context of a violent relationship were not revealed by women interviewed for the study. Nevertheless these women appear to be invisible in health, maternity and domestic violence service settings but may be at considerable risk within their relationships. Continuing professional development and

ongoing training on domestic violence for key professionals is urgently required, especially for the Garda Síochána, nurses, midwives, doctors, social workers and other health and social care professionals in Ireland. Aspects of this training must include the risks and health ramifications of domestic violence during and after pregnancy. Domestic violence needs an enhanced curricular role and in the education of these professionals at all levels. Stigma and shame remain significant barriers to help and safety seeking for women in relation to domestic violence and pregnancy, especially for Irish women interviewed, overcoming this crucial inhibitor will require concerted efforts at multiple levels and in a range of settings in Ireland.

Prologue

Why research domestic violence and pregnancy in Ireland? These are two phenomena I've never experienced personally. It's a topic that seems too hard to begin to comprehend and nobody really wants to talk about or think that it is happening in their community, county or family. Is it just about "foreign women"? I was asked repeatedly when I began my PhD, "abuse during pregnancy, it can't possibly happen in Ireland, to Irish women" I was told. My research is to begin a response to a question that has been percolating in my head for a long time, since there appeared to be no answers forthcoming I decided that I better start to find some myself. I began to think about domestic violence and pregnancy from 1998 onwards. I was surprised there was so little research on it in Ireland, given high Irish birth and domestic violence prevalence rates. I met women, through my work, for whom it was an issue, but I never heard their voices in the research I was reading. No one appeared to think it was important to listen to what these women had to say about their experiences and what might have best supported and helped them.

In 1998 as a night, or modular degree, student in University College Dublin (UCD) in Social Policy, I wrote my first ever essay on domestic violence. Later that year I began working part-time in a women's refuge in Dublin which continued until May 2000. On my very first day working in the refuge I met a woman who was pregnant. She had to inform me that she was pregnant as I couldn't tell from looking at her, her pregnancy bump was barely visible. I don't recall her having any other children in the refuge with her, which was unusual. She was very appreciative and grateful to me that first day during my time with her. A few weeks later I met a new resident in the refuge, she was pregnant for the tenth time and had moved into the refuge with most of her children. I often contemplated what stimulated the woman I met on my initial day working in the refuge to seek help, safety and move into the refuge on her first pregnancy, and what took the other woman so long to access safety, support and refuge accommodation.

I really loved my job in the refuge but when I finished my night-time degree in UCD I got a full time job as an outreach worker in the Health Board in addiction and HIV services. I was working from a busy clinic that offered lots of services to drug users, including methadone dispensing, HIV testing, a special clinic for women working in prostitution. I worked as part of a multi-disciplinary team there for two and half years. I loved this job too. I really enjoyed meeting lots of clients in the clinic, in needle exchanges, at workshops I used to deliver and on the mobile clinic, or methadone bus, travelling around Dublin and Wicklow. I also enjoyed doing street-work outreach, especially to women working in prostitution. I met a lot of women in this job, mainly

drug users or with other issues that needed support and referral through the clinic I was based in. Some of the women I worked with were pregnant, many of them disclosed abusive childhood experiences and violent relationships to me. I often wondered why we didn't have more of a focus on domestic violence and abusive relationships within the team and clinic I worked in. It appeared to me that a lot of the women and families I encountered needed supports and information on this topic.

In 2003 I moved to my ideal job, as a Health Promotion and Education Officer in the brand new statutory Crisis Pregnancy Agency. Here I had a substantial budget to work with, great, dynamic colleagues and a remit to address the sexual and reproductive health needs of Irish women and sometimes men. I loved this job and I tried wherever I could to bring in a holistic, sex positive, whole person approach into my work and outputs. I went back to the refuge I used to work in and interviewed staff there as part of a consultation to prepare the first ever national state strategy addressing crisis pregnancy in Ireland. The issue of crisis pregnancies arising within an abusive relationship didn't seem to resonate within the Agency. I didn't have any success in getting answers to the questions I had from my time working in the refuge. The idea that a woman would seek help, or an abortion, due to the violent relationship she was in with the unborn baby's father appeared far-fetched to some. After working on multiple award-winning campaigns and developing the role as far as I could I moved jobs again.

I then began work in an African and Migrant women's network in Dublin, I mainly worked on issues of gender-based violence (GBV) and in particular on female genital mutilation (FGM) with a health and policy change focus. In this role I met lots of women who had experienced many forms of GBV; many of whom were marginalised. When this work role ended in late 2010 I began to apply for PhD scholarships in Ireland. I still had questions about domestic violence and pregnancy circulating in my mind but I had no answers to them. I applied for five years for PhD funding but with little success. Domestic violence and pregnancy was a topic that had no potential to make money for any academic institutions, there was no patent or intellectual property breakthrough possible. At best any research I would undertake could only improve or save women's lives and reduce miscarriages, but this appeared not to be a priority in relation to limited and competitive research funding allocation. The issue still had no traction or interest to anyone, it seemed, except me.

Finally, in June 2015, I was offered two funded PhD opportunities. I could at last, 13 years later, start to ask women the question that had begun to form for me during 1998 while working in a refuge:

‘In Ireland, many women experience domestic violence when they are pregnant or after having a baby, we don’t know exactly what process enables and supports some women to seek safety and help. What can you tell me about your experiences?’

My PhD research study is an opportunity to pose this question, listen to women’s answers and suggestions, document, collate and analyse what they told me. This is to ensure that their voices and responses get heard by as many people as possible, in order to make this hidden issue in Ireland more visible. For me social policy is fundamentally based on amelioration and change, as Beatrice and Sidney Webb originally perceived it to be in the 1890s. In my work any research with humans must be situated within Paolo Freire’s reflection and action praxis, defined in *Pedagogy of the Oppressed* as "reflection and action directed at the structures to be transformed” (1970), in addition to respecting core feminist methodological principles of commitment to change for women. Therefore, my research needs to respond to what research participants have identified and shared with me, as researcher, about their needs, requirements and desires. Consequently, my research has action, stimulus, change, impact and amelioration at its heart, as an essential core outcome. This is the aim of my PhD research study on domestic violence and pregnancy in Ireland.

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Glossary and Acronyms

CEDAW: United Nations Committee on the Elimination of Discrimination against Women.

CORU: Ireland's multi-profession health regulator for social care and social work professionals.

Cosc: National Office for the Prevention of Domestic, Sexual and Gender-based Violence based in the Department of Justice and Equality.

CSO: Central Statistics Office, Ireland's national statistical office.

EIGE: European Institute for Gender Equality, an agency of the European Union.

EPDS: Edinburgh postnatal depression scale.

ESRI: Economic and Social Research Institute.

EU: European Union.

FGM: Female Genital Mutilation.

FRA: European Union Agency for Fundamental Rights, an agency of the European Union.

Garda Síochána: Ireland's national police force, Gardaí (plural) or Garda (singular).

GDPR: General Data Protection Regulation.

GP: General Practitioner or family doctor.

HIQA: Health Information and Quality Authority, an independent authority with the national role of developing standards and inspecting and reviewing health and social care services in Ireland.

HSE: Health Service Executive, the national statutory health service agency.

IASW: Irish Association of Social Workers, the national professional body for social workers in Ireland.

ICGP: Irish College of General Practitioners, the national professional body for general practice training in Ireland.

IOG: Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland.

IPV: Intimate Partner Violence.

Istanbul Convention: Council of Europe Convention on preventing and combating violence against women and domestic violence.

MAMMI: Maternal health And Maternal Morbidity in Ireland, research study.

MBRRACCE: Confidential Enquiry into Maternal Deaths the programme investigating maternal deaths in the UK and Ireland.

MDE: Maternal Death Enquiry Ireland, conducts confidential reviews into maternal deaths.

NMHCR: National Maternity Health Care Record.

PHN: Public Health Nurse.

RCT: Randomised controlled trial.

REC: Research Ethics Committee.

SAFE Ireland: National Irish network of women's domestic violence services and refuges.

SAVI: Sexual Abuse and Violence in Ireland.

SDG: United Nations Sustainable Development Goals.

TCD: Trinity College Dublin.

TPFR: Total period fertility rate.

Tusla: Child and Family Agency, state agency responsible for child protection and family support services in Ireland.

WHC: Women's Health Council, Ireland.

WHO: World Health Organization.

Chapter 1 Domestic Violence and Pregnancy

Introduction

Domestic violence is the term used to describe violence between intimate partners which encompasses physical, emotional, psychological, financial and other forms of abusive and controlling behaviours. Domestic violence emerges as a complex social issue in the spheres of justice and policing, child protection and family law, housing and homelessness, gender equality and usually most critically in health, health care provision, injury treatment and psychological and emotional care. There are a multitude of harms documented that impact on health and wellbeing directly related to domestic violence, the most severe of which is murder. These harms can become especially pronounced during pregnancy, where physical violence can result in chronic detrimental pregnancy and health complications, including but not limited to, maternal and infant morbidity and mortality (World Health Organization, 2012a). Pregnancy does not appear to have any protective capacity in relation to domestic violence, especially physical violence. The Task Force Report acknowledges that "Pregnancy can be a time of high risk for women in that violence may begin, or escalate, during this period." (Office of the Tánaiste, 1997 p.29). World Health Organization (WHO) research states that domestic violence may go unrecognised as directly causing maternal mortality (2012b). However, since domestic violence can occur prior to, during and post-pregnancy it is important to examine and consider its presentation and features. This chapter aims to provide a comprehensive background to the topics of domestic violence, in particular in relation to pregnancy and domestic violence, maternity and pregnancy care and domestic violence services and supports, and to situate all these areas within the context of Irish legislation, policy and service provision structures. Domestic violence is a complex issue to research and comprehend, as are the circumstances which women find themselves in while pregnant or with a young baby and with an abusive partner: as Harwin states "The reasons women stay in an abusive relationship include both love and terror." (1997 p. 65).

Definition(s) of domestic violence

There are many terms used to describe domestic violence, the choice of terms often relates to a national legislation and policy context. Globally the terms used include violence against women and gender-based violence (GBV), these terms include domestic violence as well as other forms of violence such as sexual violence, femicide and honour based violence (World Health Organization, 2012c). Locating domestic

violence in a gendered context acknowledges that globally women are disproportionately impacted by violence in their intimate relationships and that at the root of much of this form of violence is gender inequality (Women's Health Council, 2007). The term intimate partner violence (IPV) has become common parlance internationally and is used to describe violence that occurs in an intimate relationship between adults and causes "physical, psychological or sexual harm to those in the relationship" (World Health Organization, 2012b). EIGE's proposed common European Union definition of IPV is: "Any act of physical, sexual, psychological or economic violence that occurs between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim." (European Institute for Gender Equality, 2017p. 44). The Council of Europe in the Istanbul Convention text comprehensively define domestic violence as; "Domestic violence is defined as 'all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit, or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim'." (European Institute for Gender Equality, 2017p.29). However, the term and definition of domestic violence informing this research study will be that which is outlined in the Irish 1997 Report of the Task Force on Violence Against Women:

> '…the use of physical or emotional force or threat of physical force, including sexual violence in close adult relationships. This includes violence perpetrated by a spouse, partner, son or daughter or any other person who has a close or blood relationship with the victim. The term 'domestic violence' goes beyond actual physical violence. It can also involve emotional abuse; the destruction of property; isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone' (Office of the Tánaiste, 1997 p.27)

This definition is utilised in relevant Irish policy and strategy documents and is widely recognised by pertinent service providers as encompassing the range of acts present in domestic violence scenarios. The Task Force definition also forms the basis for relevant Irish legislation, including the Domestic Violence Act 1996, subsequent Act amendments and the Domestic Violence Act 2018 through which victims of domestic violence can seek legal protection and safety Orders from violent spouses and

partners. Although the Task Force definition refers to violence in a broader context than what is understood by intimate partner violence, such as violence perpetrated by family members including by children and/or parents to related adults, this research study will focus on violence perpetrated by a spouse, partner or ex-partner within the environment of a close relationship such as marriage, civil partnership, parenting and co-habitation. The term domestic abuse is often used interchangeably with domestic violence and similarly refers to violence perpetrated within close and intimate relationships. Watson and Parsons define severe domestic abuse as "a pattern of physical, emotional or sexual behaviour between partners in an intimate relationship that causes, or risks causing, significant negative consequences for the person affected" (2005 p.23). The terms domestic violence and abuse will be used interchangeably in this research study.

This Irish Task Force definition recognises the multiple manifestations of domestic violence including physical, emotional and sexual abuse. It also acknowledges that domestic violence is demonstrated by frequent and persistent violent attacks and is rarely a once only event in a relationship (Office of the Tánaiste, 1997). The use of the term "force" in the Task Force definition is pertinent, as domestic violence is not characterised by minor or ineffectual physical or emotional displays, instead as described by Watson and Parsons it is a recurrent and ongoing "*pattern* of behaviour" (italics are authors') which results in significant negative impacts to the victim regardless if the abuse is physical, sexual and/or emotional (2005 p.23). Domestic violence can be characterised by its continuous, detrimental and ongoing nature which can directly and indirectly lead to chronic, as well as acute, health repercussions. WHO notes that the impact of domestic violence on health can be cumulative and negative effects such a poor mental and physical health can linger for years even once the violence has ceased (2012a).

In summary the terminology chosen for this research study, domestic violence, recognises the Irish legal and policy context for this form of violence whilst acknowledging that other, often interchangeable terms, such as domestic abuse and intimate partner violence (IPV), are used to describe the experience of domestic violence. It locates domestic violence within intimate and close relationships where women have strong emotional bonds, potentially financial ties and possibly children and homes in common with the perpetrator of violence against them. The Task Force 1997 definition was utilised for all study documentation including: Research Ethics Committee study application, all information for potential interviewees and service providers who come in contact with potential interviewees in the course of their work.

This study situates domestic violence within a spectrum of gender-based violence that can span the lifetime of a woman and frequently is supported by and mirrors the persistent and deep-seated gender inequalities in the families, societies, countries and cultures where women live.

Legislation and policy in Ireland

The phrase domestic violence in an Irish legal context refers to where, between whom and in what circumstances a crime may have taken place. However, domestic violence itself was not a crime and there was no precise legal definition nor criminal code relating to it in Irish law (SAFE Ireland, 2016a). This Irish legal anomaly changed in 2018 with the introduction of the Domestic Violence Act 2018, however, all the field research for this study occurred while this Act was in the preparation and drafting stages and as a result women interviewed did not have the legal protections offered once the Act is fully commenced. Many of the types of abusive experiences that women have with their violent partners qualified as crimes, principally under the Non-Fatal Offences Against the Person Act 1997, the Criminal Law (Rape) Amendment Act, 1990 and the Criminal Damage Act, 1991 (SAFE Ireland, 2014c). The Domestic Violence Act, 1996 (as amended) offered a number of protection mechanisms for individuals from domestic violence such as; Safety Orders, Barring Orders, Interim Barring Orders and Protection Orders. This Act criminalised the breaching of the terms of any of these Orders, once granted, and is principally concerned with threats to the safety and welfare of those at risk and applying for remedies under the Act due to violence in a domestic relationship (SAFE Ireland, 2016a). The Domestic Violence 1996 Act was gender neutral and can also be utilised in cases of parent to adult child violence and vice versa in addition to intimate partner or spousal violence to seek protection and safety through court mechanisms. The national Garda Síochána (Irish police force) are principally responsible for enforcing Orders granted under the Domestic Violence Act and investigating and responding to breaches of these Orders. The Garda policy on domestic violence proposes the following as a working definition for its members:

> "Domestic violence" includes: physical, sexual, emotional or mental abuse of one partner by the other partner in a relationship which may or may not be one of marriage or cohabitation and includes abuse by any family member against who a Safety Order or a Barring Order may be obtained by another family member." (An Garda Síochána, 2007 p.1).

The Garda Policy emphasises the risk to life inherent in situations of domestic violence and the danger to police responding to these situations and states that “domestic violence crimes are repeated, systematic and dangerous crimes” (2007 p.7). A revised and updated Domestic Abuse Intervention Policy for An Garda Síochána was launched in 2017 and is outlined in the policy subsection later in this chapter. It is important to note the influence of Ireland’s membership in the European Union (EU) in relation to policy development and adoption. EU membership has allowed for comparison (often unfavourable) between Ireland and other EU member states and a number of directives from the EU have supported legislative changes especially in relation to equality and justice and more recently domestic violence (Curry, 2011). It is also important to acknowledge that national policy in Ireland is informed by the targets set under the United Nations Sustainable Development Goals (SDGs). These 17 Goals provide a template to address major global challenges by 2030 (United Nations, 2018). The SDG policy context and target achievement relevant to this research are:

- Goal 3 Good Health and Well-being.
- Goal 5 Gender Equality. Target 2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- Goal 16 Peace, Justice and Strong Institutions. Target 1: Significantly reduce all forms of violence and related death rates everywhere (United Nations, 2018).

Legislation

The new Domestic Violence Bill was introduced by the Minister for Justice and Equality in 2015 proposed modifications and updates to the existing legislation which would align Irish legislation to prepare for the future ratification of the Council of Europe’s Convention on preventing and combating violence against women and domestic violence, or Istanbul Convention (see EU section). The Bill was passed by the Oireachtas (Irish houses of parliament) in May 2018 and as a result the Domestic Violence Act 1996 and the Domestic Violence (Amendment) Act 2002 were repealed and replaced by the new Domestic Violence Act 2018. The 2018 Act contains many new provisions, of particular note is a new criminal offence of coercive control and the eligibility of accessing Safety and Protection Orders via courts has been expanded to allow for partners (or ex-partners) in an intimate and/or dating relationship, and not only those cohabiting or with children in common, to apply for Orders. Significantly courts when deciding to grant or decline an Order under the Act must consider the state of

health of the applicant, including pregnancy, as a relevant factor in relation to seeking protection (Department of Justice and Equality, 2018). The Act also considers the relationship between the parties as a potential aggravating factor for sentencing. This implies that if the victim was or is an intimate partner, spouse, former partner etc. of the offender, the courts can impose a sentence which is greater than that which would have been imposed if there was no prior relationship between the two parties (Department of Justice and Equality, 2018).

Policy and legislation child protection

In relation to domestic violence and pregnancy the issue of child protection and safety emerges as a key theme. In Ireland Tusla, the Child and Family Agency, is the dedicated state agency responsible for child protection and family support services. Tusla was founded by and operates under the Child and Family Agency Act 2013. Tusla merged and absorbed the child and family welfare and protection functions of the Department of Health and the Health Service Executive (HSE) and the Family Support Agency and the National Educational Welfare Board when it was established. Tusla is the principal employer for social workers in Ireland and it has a research unit in addition to funding many of the national services for victims of domestic violence (Tusla, 2015). Tusla's mandate includes: "Support and encourage the effective functioning of families, to include the provision of preventative family support services aimed at promoting the welfare of children; care and protection for victims of domestic, sexual or gender based violence, whether in the context of the family or otherwise; and services relating to the psychological welfare of children and their families." (Tusla, 2015 p.10). The legislative context for Tusla's work is primarily based on the Child Care Act 1991 and the Children First Act 2015, which was fully commenced in 2017. Tusla funds 58 specialist frontline domestic violence and sexual violence services, which includes 42 domestic violence services nationwide (Tusla, 2016). The *Children First: National Guidance for the Protection and Welfare of Children* is a practice resource aimed at social work practitioners in Tusla to support best practice in frontline child protection and welfare work (Tusla, 2017). The Guidance outlines how staff working with women and children in domestic violence services and refuges are mandated to report any child protection concerns to Tusla staff under the remit of the Children First Act 2015 (Tusla, 2017). The Guidance also outlines how children in circumstances with parents in a domestic violence context may be at greater risk of abuse and neglect and as a result social workers and other allied professionals need to be conscious of this vulnerability (Tusla, 2017).

Policy justice

Policy in Ireland relating to domestic violence could be said to have begun in earnest by the appointment of a Task Force on Violence Against Women in 1996 and the subsequent publication of their Report in 1997. The Task Force had been convened following national research commissioned by Women's Aid in 1995 called *Making the Links*, which highlighted the extent, forms and impact of domestic violence experienced by women across Ireland (Kelleher et al., 1995). This was the first attempt at systematic data collection and analysis from a range to sources, including women who had experienced domestic violence, in Ireland. The convening of the Task Force also arose from the consultation process to develop the Department of Health's Policy Document on Women's Health, where domestic violence emerged as a serious concern in relation to women's health (Office of the Tánaiste, 1997). While the *Making the Links* publication framed itself as a precursor to a national strategy on domestic violence for Ireland and the Task Force called for the development of an Irish national strategy to address the issue, it was not until 2010 when an actual strategy was launched. However, the National Women's Strategy 2007-2016 listed a series of objectives to combat and respond to domestic violence in Ireland (Department of Justice, 2007 p.85). Ireland's second National Strategy for Women and Girls 2017-2020, outlines an entire objective within the Strategy to 'Combat Violence Against Women' and lists 16 actions to progress work under this objective within the timeframe of the Strategy (Department of Justice and Equality, 2017). Many of the actions listed in the current Strategy are related to legal reform, implementing legal provisions needed towards the ratification of the Istanbul Convention and the enactment of the European Union (EU) Victims of Crime directive and critically in relation to funding for victim support services:

> 'Ensure adequate funding continues to be allocated to Tusla, the Child and Family Agency, which has statutory responsibility for the care and protection of victims of domestic, sexual and gender-based violence, whether in the context of the family or otherwise.' (Department of Justice and Equality, 2017 p.65)

Ireland's first National Strategy on Domestic, Sexual Gender-based Violence 2010-2016 was launched in 2010 by Cosc. Cosc, is the National Office for the Prevention of Domestic, Sexual Gender-based Violence, founded in 2007 following one of the

recommendations in the National Women's Strategy and the Office, and is located within the Department of Justice and Equality. The establishment of Cosc and launch of a national strategy based on consultation with stakeholders, heralded a whole of government approach to address domestic violence in Ireland. It is important to note the remit in the Cosc Strategy is considerably broader that what was initially envisaged in the Task Force Report, as it also is concerned with elder abuse and sexual violence perpetrated by a stranger (Cosc, 2010). The Task Force that was set up to report on violence against women called for a national strategy that would fundamentally be based on two key principles: one "a total acceptance that violence against women is wrong, it is a criminal offence and there is neither an acceptable nor tolerable level of violence;" and two "neither society nor the judicial system should ever regard violence inflicted on a woman by a man she knows as less serious than violence inflicted by a stranger;" (Office of the Tánaiste, 1997 p.10). The Cosc Strategy has a considerably more gender neutral approach to domestic violence and acknowledges that men are also victims of such crimes (Cosc, 2010). The inter-departmental and inter-agency approach set out in the comprehensive and ambitious first Cosc Strategy was accompanied by numerous objectives actions and activities all framed in the vision and goals contained within it. The first Strategy was reviewed in 2012 and a Second National Strategy on Domestic, Sexual Gender-based Violence 2016–2021, significantly more concise and less comprehensive, was launched in 2016 (Cosc, 2016b). The Second National Strategy is accompanied by a corresponding Action Plan which outlines a range of actions to be implemented and undertaken, many of which correspond to the implementation of the Council of Europe Istanbul Convention. The "living document" nature of the Second National Strategy is also emphasised in the Action Plan stating that actions will be added as required during the term of the new Strategy (Cosc, 2016a).

Fontes and McCloskey state, 'Violence against women does not look the same across cultures,' therefore, research and policies on violence against women with an inclusive scope to fully explore and collect forms of experiences and presentations are needed to accurately capture this multicultural reality (2011 p.151). As the population has transformed and shifted in Ireland, an additional challenge is how to research and understand complex social issues such as domestic violence within altering populations and societies to ensure that data is both representative and robust, and that recommendations and policy measures arising address the needs of the whole population (O'Brien Green, 2018a). The current Irish National Action Plan on Domestic, Sexual and Gender-based Violence acknowledges that communities of particular

vulnerability, including migrants, require specific responses which are evidence based (Cosc, 2016a). This is important given the demographics of the study sample which emerged in this PhD research.

Policy police

The revised Domestic Abuse Intervention Policy of the Garda Síochána was developed in consultation with the Office of the Director of Public Prosecutions and was issued in late 2017. The document states a pro-arrest policy in all cases of suspected breach of domestic violence court Orders; it is cognisant of the patterned and ongoing aspects of domestic violence and highlights the particular needs of ethnic minority communities in interacting with police in relation to domestic violence (An Garda Síochána, 2017). The Policy outlines supports for language and literacy needs of members of the public in relation to Gardaí communications; it gives a time frame for continued liaison between the complainant and Gardaí and outlines the need for a coordinated response to domestic violence which supports referral of complainants to a range of appropriate services. Training for members of An Garda Síochána in relation to the implementation of the policy is mentioned but not elaborated on in the document (An Garda Síochána, 2017).

Policy health

In 2010 the Health Service Executive (HSE) launched its Policy on Domestic, Sexual and Gender-based Violence (DSGBV). The Policy outlines a preventative and multi-agency and multi sectoral approach to responding to DSGBV and highlights the need for training in this area for health care professionals in Ireland (Health Service Executive, 2010 p.15). It sets out a number of goals, actions and indicators for the actions relevant to the health services with a focus on recognising, responding to and referring victims of domestic violence to appropriate services and agencies in a timely manner. The HSE Policy High Level Goal 2 focuses on screening for domestic violence and/or sexual violence in a range of healthcare settings and mentions pregnant women as a specific target group for this screening (2010 p.21). Ensuring an inter-culturally competent approach to meeting the needs of victims of domestic violence by HSE staff is also outlined through resource dissemination and training (2010 p.31). The HSE Policy was followed by a practice Guide in 2012 for all staff working with children and families which acts as a resource for HSE staff in relation to responding to domestic violence in the course of their client/patient work with a focus on child protection (Health Service Executive, 2012). It is important to note that at the time of publication of the HSE Policy and the HSE Practice Guide the majority of state funding for non-

statutory domestic violence services (such as refuges, helplines, support services, etc.) was through the HSE, this has since changed with the establishment of Tusla in 2014. The HSE also produced, in conjunction with the Department of Justice and Equality and Sexual Assault Treatment Units (SATU), national guidelines on rape and sexual assault. The Guidelines are updated on a regular basis and while not strictly a policy resource they do provide the national legal and forensic, as well as health and psychological support, guidance on responding to victims of rape by state and other employees such as Gardaí, medical and legal professionals in compliance with current Irish legislation (Health Service Executive, 2014).

Legislation and policy informed or directed by Europe

Ireland has an obligation to transpose an EU Directive and a Council of Europe Convention into legislation which impact on or are directly related to violence against women. In November 2015 Ireland adopted the EU Victims' Rights Directive, of particular note is Article 22 of this Directive 2012/29/EU, which focusses on individual assessment for specific protection needs, which will establish minimum standards on the rights, supports and protection of victims of crime, including victims of domestic violence (Counihan, 2016a). The Directive will require that all victims of crime have access to free, appropriate support services and it has a particular focus on supporting vulnerable victims. Victims of domestic violence are included in the vulnerable victims category of the Directive. The National Strategy for Women and Girls states as a key action the enactment of the Victims of Crime Bill which will be a step towards providing victims of crime with an individual assessment to identify any special measures and supports required to prevent repeat victimisation and intimidation. Information and support will also be available to victims during their dealings with criminal justice agencies and systems under the new legislation (Department of Justice and Equality, 2017). The Criminal Justice (Victims of Crime) Act 2017 translating this Directive into law was enacted in November 2017 but it has not yet been fully commenced (Office of the Attorney General, 2018).

The Council of Europe Convention on preventing and combating violence against women and domestic violence (commonly referred to as the Istanbul Convention) obliges states that have ratified it in relation to actions on all forms of gender-based violence (GBV) including domestic violence. The Cosc Action Plan contains a number of actions necessary prior to ratification of the Convention, including protocols for referring victims to services, training for key state professionals, (police, social workers, health staff, etc.), supports for child victims of domestic violence and extended judiciary

powers in cases of perpetrators of domestic violence (Cosc, 2016a). Ratification of the Convention requires a number of legislative changes in Ireland, some of which are contained in the recent Domestic Violence Act 2018 and the Criminal Justice (Victims of Crime) Act 2017. States are also required under the Istanbul Convention to support research and conduct population-based surveys at regular intervals to assess the prevalence levels of GBV and ensure that research undertaken is accessible to the public (European Institute for Gender Equality, 2015c). As a result, research in Ireland and in other Council of Europe member states on GBV is likely to increase as more countries ratify the Istanbul Convention, with comparable data within and between countries becoming available.

Domestic violence service provision and supports in Ireland

Development of services for victims/survivors of domestic violence in Ireland has followed an international pattern of grass roots service responses, in the context of feminist and women's liberation movements, when the first women's refuges opened in the UK in 1972, the USA in 1973 and then in Dublin in 1974 and Limerick in 1976. By 1985 the first custom built refuge in Europe opened in Rathmines in Dublin and in 1992 the Women's Aid domestic violence helpline was set up (Fennell, 2009). The range and reach of services currently offered to women victims of domestic violence include, but is not limited to: helplines, face to face support and advocacy, outreach, legal advice and court accompaniment; counselling and support groups; children's services; and accommodation, including refuges, supported or transitional housing and safe house accommodation (Tusla, 2016).

The 1997 Task Force report reported on the predominance of voluntary agencies providing services for victims/survivors of domestic violence in Ireland and the need for greater co-operation between statutory and voluntary bodies in relation to service development, delivery and inter-agency referrals (Office of the Tánaiste, 1997). Morton notes that these services have often developed in a sporadic manner and have been under resourced by the state (Morton, 2003). The Cosc Strategy also noted a need for co-ordination between domestic violence support services and the competitive environment that securing funding had created between organisations (Cosc, 2010). The Strategy remarked on the complexity of finding appropriate services by victims. A review was undertaken in 2008 to inform the HSE of direction and approaches in relation to providing and funding services for victims/survivors of domestic and sexual violence. The review outlined the significant role that non-governmental organisations play in relation to providing the majority of services across Ireland (Kearns et al., 2008).

The Kearns report commented on a number of training gaps for key professionals such as medical staff including nurses, psychologists and physicians (Kearns et al., 2008). The Council of Europe published minimum standards for domestic, sexual and gender-based violence services for all member states in 2008 (Kelly and Dubois, 2008). By 2014 SAFE Ireland had calculated that Ireland was meeting just over one third of the Council recommend number of family units for cases of emergency accommodation in relation to domestic violence (SAFE Ireland, 2014c). SAFE Ireland has collated data on the increasing demand on domestic violence services since 2008 in the context of the economic crisis and decreasing funding for these services during this time (SAFE Ireland, 2014c). It states that in the period 2009 to 2013 the domestic violence service sector experienced overall cuts to core HSE funding of on average 11%, despite continued or increasing demand on the services being provided (SAFE Ireland, 2014c).

In summary, there is a wide range of services and supports available to victims of domestic violence across Ireland. These services are generally provided by voluntary agencies, many of whom form the SAFE Ireland network and are funded by state bodies, previously the HSE and currently Tusla but which operate in an environment of demand outstripping supply and precarious funding.

Domestic violence and pregnancy

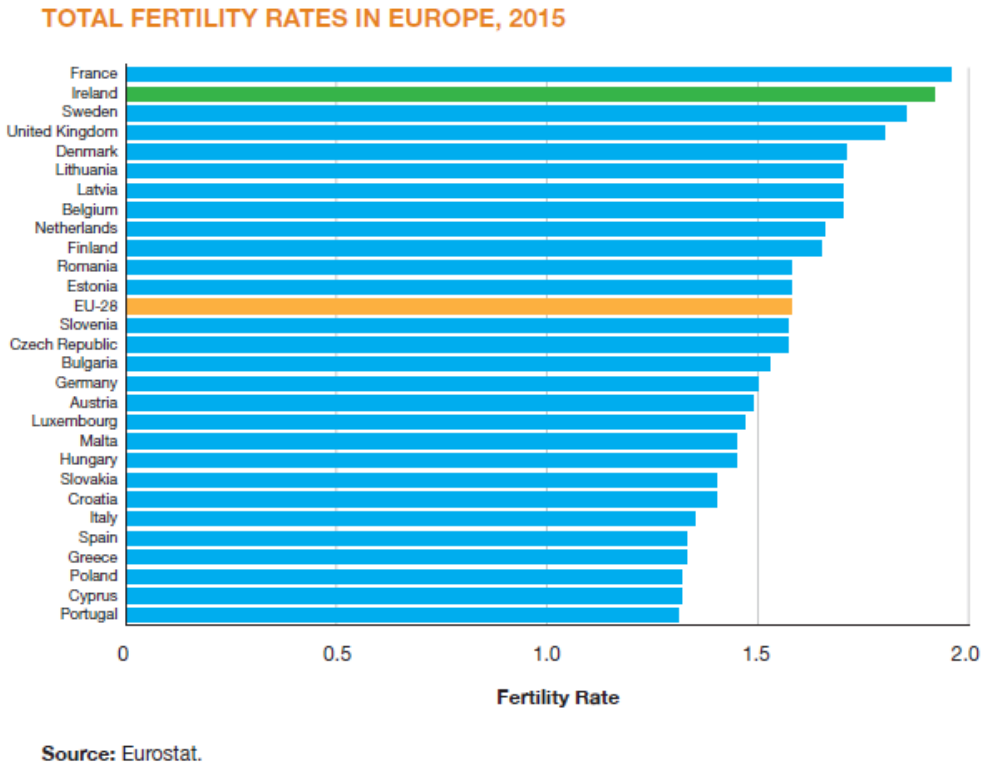
The outcomes of domestic violence during pregnancy for both mother and baby or foetus can lead to multiple poor morbidities and long-term consequences (Kenny et al. 2014, p. 6). Domestic violence during pregnancy may lead to death, miscarriage, low birth weight, pre-term labour, anxiety, depression as well as severe physical injuries and high risk pregnancies (Women's Health Council, 2007). The year prior to conception and the year after childbirth is a particularly vulnerable time of heightened risk of domestic violence (Van Parys et al., 2014). Pregnant women are considered at a higher risk for domestic violence requiring selected interventions acknowledging this risk (Kearns et al., 2008 p.42). The Cosc National Strategy and the HSE Policy both acknowledge pregnant women as a vulnerable group in relation to partner violence. However, there is limited research on the factors that enable women to disclose and seek support when experiencing domestic violence during pregnancy and what interventions are effective at reducing risk and/or domestic violence for the woman (MBRRACE-UK et al. 2015, p. 63). Addressing this gap is the essence of this PhD study. The repercussions of domestic violence and pregnancy and health impacts are outlined and discussed in greater detail in Chapter 2.

Births, pregnancy and maternity care in Ireland

Births in Ireland

Ireland consistently has fertility rates which are higher than most EU 28 countries (Department of Health, 2016b). In addition the population in Ireland is expected to increase and grow to 2050 (Fahey and Field, 2008). In 2017 the total period fertility rate (TPFR) in Ireland which the Central Statistics Office (CSO) defines as "the projected number of children a woman would have if she experienced current age specific fertility rates while progressing from age 15 to 49 years" was 1.8 (Central Statistics Office, 2018c p.2). Although this rate is below replacement rate of 2.1 the level is still comparatively high in relation to other EU member states. Despite declining birth and fertility rates in recent years, the Irish population is expected to rise in the future leading to continued demand for maternity services (Department of Health, 2016a). In 2017 there were 62,053 births, 1,844 fewer births compared with 2016, which gives a birth rate of 12.9 per 1,000 population (Central Statistics Office, 2018c p.1). See Figure 1 below for most recent comparable EU data on TPFR in Europe (Department of Health, 2017 p.11).

Figure 1 Total Fertility Rates in Europe 2015



As migration patterns and trends have changed in Ireland with inward and outward migration demonstrating considerable fluctuations since 2000, the nationality of women giving birth in Ireland is also important to consider (Lyons et al., 2008). The changes in inward migration patterns to Ireland, through EU expansion, asylum seekers and refugees, international students and workers coming to Ireland, have also created a more ethnically diverse population presenting for maternity care and giving birth. According to the Perinatal Statistics Report, by the Healthcare Pricing Office (HPO) and HSE 23% of births in Ireland in 2015 were to non-Irish women, which is the year this PhD study commenced (2017). In 2017 there were 62,053 births in Ireland. Of these births there were 47,991 babies (77.3%) born to mothers of Irish nationality, similar to the 2015 figures. Of the remaining births 11.5% were births to mothers of EU 28 nationalities. Mothers of nationalities other than Ireland, UK and the remaining EU countries accounted for 7.1% of total births registered in 2017 (Central Statistics Office, 2018c p.2). The National Intercultural Health Strategy outlines some of the challenges for migrant women living in Ireland in relation to optimal access to and utilisation of maternity care services and mobility in relation to follow up after birth (Health Service Executive, 2008). The additional needs within maternity hospital caring for multinational patients are also outlined in the National Maternity Strategy (Department of Health, 2016a).

Pregnancy and maternity care in Ireland

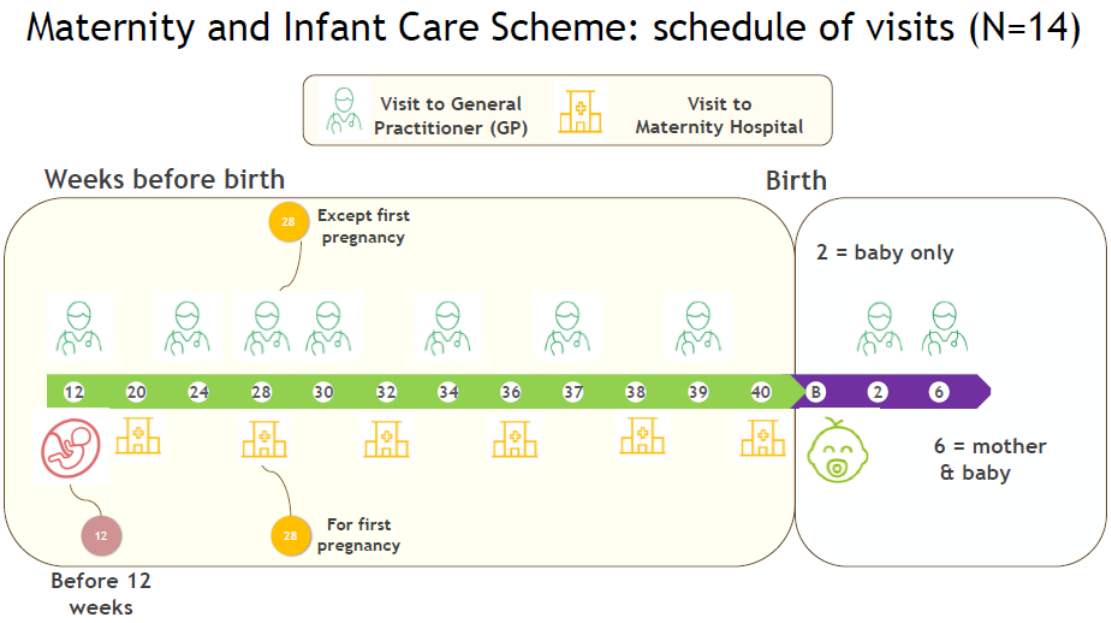
Maternity services in Ireland are predominantly hospital based, with over 99% of births occurring within a hospital setting. Pregnancy is the largest single reason for admission to hospital in Ireland as four out of five women use maternity services in their lifetime (Kennedy, 2010). There are 19 maternity hospitals or units throughout the country, four of which are standalone hospitals, the remaining 15 are co-located within general hospitals. Women can opt for public or private health care, which is paid for by health insurance schemes and tends to guarantee continuity of medical care and private accommodation post-birth (Kennedy, 2015). In 2007 KPMG was commissioned by the HSE to undertake an independent review of maternity and gynaecology services in the Greater Dublin Area. The review undertaken provided a “detailed analysis of current service delivery”, including national and international literature reviews and consultation with key stakeholders (KPMG, 2008 p.5). The review found overcrowding in hospital wards using a “Nightingale-style” layout, or multiple beds in a ward, and that this compromised the privacy and dignity of individual patients and increased the likelihood of spread of infections within maternity hospitals (KPMG, 2008 p.8). It also noted challenges in relation to staffing levels, facilities, inconsistencies in care, a

shared case load model resulting in lack of continuity of care, all located within a hybrid duplicate model of public and private health care (KPMG, 2008, Kennedy and Kodate, 2015, Kennedy, 2015). The review stated that maternity care is generally delivered in a safe and cost-effective way, being led by midwives in many other jurisdictions, but in Dublin (and Ireland);

> "Mother and Infant Scheme has defined this model, assuming that antenatal care is to be delivered by GPs and Obstetricians. It does not provide an option for midwifery led care. This has resulted in relatively under developed services led by and/or delivered by midwives." (KPMG, 2008 p.8)

The Maternity and Infant Care Scheme, or combined care, is a government funded medical care scheme developed since 1954, which provides for free health care for a pregnant woman during her pregnancy, birth and postnatally. Care is delivered between a woman's GP or family doctor (if the GP is a member of the scheme) and the maternity hospital through 14 funded medical visits (Kennedy, 2015). See Figure 2 below.

Figure 2 Maternity and Infant Care Scheme in Ireland



Many of the recent challenges for Irish maternity services are described in the National Maternity Strategy text, including staff shortages especially in relation to rising numbers of births:

> "It is acknowledged that, in recent years, maternity services have experienced particular service pressures in terms of the increase in numbers of births; staff recruitment and retention; relatively low levels of obstetricians and midwives; rising costs of services; insurance coverage and litigation; adverse incident investigations, increasing levels of clinical interventions and significant infrastructural deficits." (Department of Health, 2016a p.19)

Recently the UN Committee on the Elimination of Discrimination against Women (CEDAW) in their concluding observations section on health in the combined sixth and seventh periodic reports of Ireland 2017 stated that:

> "The Committee is concerned at some reports that child delivery is highly medicalized and dependent on the use of artificial methods to accelerate the process such that women are made to deliver babies within 8 hours of hospitalization, owing to a lack of resources in hospitals." (2017 p. 12) and "The Committee recommends that the State party ensure that women can have access to maternity and delivery services without time pressure or being exposed to artificial methods of accelerating births." (Committee on the Elimination of Discrimination against Women, 2017 p.14).

In summary, births in Ireland overwhelming occur in a maternity hospital with medical care during the pregnancy being provided by a woman's GP and maternity hospital staff, there is a lack of continuity of care in most cases in maternity hospital unless a woman opts for private maternity care, paid for by health insurance, and maternity services are under pressure with staff shortages and inadequate and dated infrastructures and buildings.

Maternity legislation

Irish legislation relevant to maternity and health care includes the 1953 Health Act which legislated for the introduction of the 1954 Maternity and Infant Care Scheme providing free medical care during pregnancy and after birth to the mother and limited

care for the baby up to six weeks after birth (Kennedy, 2015). The Health Act in 1970 extended hospital care to women in relation to birth and the 1991 Health Amendment Act extended free hospital maternity care to all women in Ireland regardless of income (Kennedy, 2012). Currently women under the 1993 Amendment Act are entitled to free in-patient, out-patient and accident and emergency health services in public hospitals in respect of their pregnancy and birth, however, this free health care does not cover illnesses not related to their pregnancy. Free maternity medical care in public hospitals extends to all pregnant women resident in Ireland, it is not dependent on the basis of citizenship, social insurance payments or social protection entitlements (Kennedy, 2015).

Maternity policy

The first Irish National Maternity Strategy was launched in January 2016 by the Department of Health and covers the time period in the actions outlined in the document from 2016 to 2026. The Strategy development occurred against the background of statutory maternity service shortcomings, high profile maternal deaths in Ireland and a need for standardisation of care in all 19 maternity hospitals (Department of Health, 2016a). The Strategy highlights violence during pregnancy as an area requiring support from professionals engaged in the provision of maternity services and care (Department of Health, 2016a). It notes the opportunity that pregnancy and birth can provide in relation to accessing support for social problems, such as domestic violence, and the unique role that maternity service staff have in relation to assisting women to access relevant support and services (2016a p.5). A specific action contained in the Strategy directs midwives, obstetricians and GPs to ask women (or screen) about domestic violence during and after pregnancy. The implementation of this Strategy action will require training for staff interacting with patients to allow for the competent handling of disclosures of domestic violence in addition to clear patient referral pathways (2016a p.65). The Strategy is accompanied by a corresponding implementation plan which outlines responsibilities and time frames for action implementation and indicators. Training for midwives, screening for women, development of a referral pathway and social worker staff appointments are some of the actions contained in the implementation plan in relation to domestic violence: however, they have not yet been realised (Health Service Executive, 2016b). The first National Standards for Safer Better Maternity Services were launched by the Health Information and Quality Authority (HIQA) in December 2016. HIQA is an independent Irish authority tasked with developing national standards, inspection and review of health services and was established under the Health Act 2007, reporting to the

Minister for Health and the Minister for Children and Youth Affairs (Health Information and Quality Authority, 2016). The HIQA Standards are designed to support and complement the implementation of the National Maternity Strategy and emerged as a result of serious deficits in maternity care and services being identified through HIQA reports leading to a loss of public confidence in the services (2016 p. 6). The HIQA Standards are intended to "cover pre-pregnancy, pregnancy, labour, birth and postnatal care for both the mother and baby (up to six weeks after the birth), and are designed to apply to all maternity services." (Health Information and Quality Authority, 2016 p. 13).

The HIQA Standards recognise that pregnancy and birth can provide an opportunity for women experiencing domestic violence to access support to enhance their safety and wellbeing and that training is needed for health care staff to "…recognize the signs of domestic violence, either physical or psychological. They are trained in screening, rating and how to make appropriate referrals in line with the national clinical programme guideline." (2016 p.136). It is important to note that the term used in the HIQA Standards, 'rating', is not defined and is presumably referring to carrying out some level of risk assessment related to domestic violence experienced by patients. Universal screening of all women using maternity services in relation to domestic violence is proposed by HIQA in the Standards during antenatal appointments and that the responses to this screening are documented in health records and patient referrals are made where appropriate (2016 p.59).

Prior to the launch of the Irish maternity Standards and Strategy a new National Maternity Healthcare Record (NMHCR) began development in 2007 and was circulated to all 19 maternity hospitals in 2011. The introduction of an identical and standardised patient chart is potentially a factor in improving maternity care nationally by the utilisation of a uniform chart by staff in all hospitals. The HSE Healthcare Records Management states that the NMHCR will assist in the collection of standardised data in maternity hospitals, enabling future research; the Record supports continuity of care for patients and facilitates communication between all members of a hospital multidisciplinary team (Health Service Executive, 2018). The NMHCR is available in hard copy, or electronic versions.

The electronic version of the NMHCR contains two obligatory questions in relation to domestic violence for patients: "Do you feel safe in your current relationship?" and "Have you ever been emotionally, physically, sexually abused by your current partner or someone in your current home?" (Greene, 2016). The paper version contains a space where maternity staff can discreetly enter an agreed code to the Record under the Risk Factors Assessment section, which identifies the patient having disclosed

experience of domestic violence; follow up referrals can be noted in the Social History section of the NMHCR. According to the Maternity Strategy, the Maternal and Newborn Clinical Management System Project is working on the design and implementation of an electronic health record for all women and babies in maternity services in Ireland. This record plans to allow for the sharing of patient information for all key health care providers until patient discharge (2016a p.15). Unusually neither the National Maternity strategy nor the HIQA National Maternity Standards refer to the NMHCR or its potential key role in standardising patient data collection or domestic violence screening in maternity care. It is not clear, despite communication with the HSE by the author, how the NMHCR and the proposed electronic health record will interact and complement each other in practice. How both patient records will link with data held by a woman's GP in relation to her maternity care is also not clarified, potentially leading to communication gaps between health care professionals.

Miscarriage health care

Three sets of Clinical Practice Guidelines by the Institute of Obstetricians and Gynaecologists in the Royal College of Physicians in Ireland (RCPI) and the HSE cover the medical management of early pregnancy loss, second trimester miscarriage and ultrasound diagnosis of early pregnancy loss (IOG and HSE, 2012, IOG and HSE, 2014). There is no acknowledgement in any of the Irish clinical practice Guidelines that miscarriage and domestic violence may be connected. The National Maternity Strategy frames much of miscarriage care in the context of bereavement and palliative care. It does recommend that: "Women with recurrent miscarriage should be offered a follow-up appointment for further investigations to help identify possible preventable causes of miscarriage." (Department of Health, 2016a p.96). The Strategy states that miscarriage can be a physical impact of domestic violence but does not recommend screening for domestic violence in miscarriage or early pregnancy loss in medical settings or exploring this issue in cases of recurrent miscarriage.

Abortion and post-abortion care

Abortion was not legally provided in Ireland until 2013, when the Protection of Life During Pregnancy Act was commenced: it is important to note that the current Irish abortion regime is exceptionally restrictive and most women access medical abortion services in the UK. However, free crisis pregnancy counselling prior to an abortion and free post-abortion medical check-ups and counselling are available to all women in Ireland and are funded by the HSE (ní Riain et al., 2013). The Irish College of General Practitioners Guide to crisis pregnancy management urges GPs to consider issues

which may make a woman more vulnerable to a crisis pregnancy: including domestic abuse and the Guide highlights the importance of appropriate and timely referral to support services in these cases (ní Riain et al., 2013).

Chapter summary

The legal, policy, demographic, health and service provision contexts in relation to domestic violence and maternity and pregnancy care have been outlined in this chapter. This study aims to examine the intersections of these contexts and concurrent support seeking by women in relation to their experiences of domestic violence during pregnancy in Ireland. These overlapping and intersecting contexts, in particular those relevant to health and domestic violence services, form a core part of the unique study Conceptual Framework, which was developed to visualise these networks and relations and how women traverse and negotiate them while seeking help and support. Women in Ireland give birth at overall higher lifetime rates than the great majority of their European neighbours and use health care settings such as GP care and maternity hospitals or units during their pregnancies and births. Given the acknowledged risk in relation to domestic violence during pregnancy and the post-natal period: screening, information provision, referral to specialised services and other supports for women would appear to be obvious recommended interventions for women in Ireland in these settings. However, challenges in relation to the delivery of maternity care imply that these services may be lacking. Kearns and colleagues suggest that pregnant women are part of a high risk group who are susceptible to domestic violence and as a result require targeted interventions (2008).

Chapter 2 Research on Domestic Violence and Pregnancy

Introduction

Domestic violence is a complex social issue which is acutely gendered and intersects the core traditional pillars of social policy; health, welfare, housing, education and personal social services, as well as having implications for child protection and policing. This chapter provides an overview of literature relevant to the research study principally, where available, in relation to domestic violence and pregnancy. The health impacts of violence, in particular during and after pregnancy, are outlined. Help and safety seeking will be discussed in relation to domestic violence and additional barriers for certain female population groups will be addressed. As domestic violence is a preventable risk to life and health, which can have severe health morbidity ramifications, research on targeted interventions in health settings are outlined, as well as the challenges to implementing these interventions, where known. Chapter 3 will discuss prevalence rates of domestic violence and the data sources utilised to inform these rates. Chapter 3 also discusses the first ever data mining and extrapolation of the FRA EU Violence Against Women survey data set to generate up to date nationally representative data on domestic violence prevalence during pregnancy for Ireland for this PhD research study by the researcher.

The headings in this chapter contain research and data from international sources and Irish sources, where these exist. Irish data and research is exceptionally limited on this topic and as MBRRACE note "…evidence about potential interventions to prevent or reduce domestic abuse against pregnant women is lacking" (2015 p.63). This chapter summarises available, relevant and, where possible, recent research, and, given the focussed nature of the study, all research included was required to be relevant to the research question. Additionally as the Irish health care system does not offer universal health care in the primary care setting, unlike all other EU countries, and consists of a hybrid public and private maternity and health system, relatively unique in comparative health policy studies, interventions in countries with differing health systems to Ireland may be difficult to relate and apply into the Irish context (Kennedy, 2010).

The approaches to ensure that all relevant Irish policy, strategy and legislation was captured within the literature review included: searches of the electronic Irish Statute Book; review of Irish government Departmental (including Health, Justice, Foreign Affairs Departments) websites; reviewing bibliographies of all sourced strategies and reports to utilise the snowball referencing method for seeking relevant additional policy reports by the HSE, HIQA, Tusla, EIGE, FRA, Cosc, Women's Health Council and the

National Women's Council of Ireland. The university course reading lists for modules taught by the researcher in UCD and Trinity since 2011 on domestic violence were also reviewed to source relevant reports and documentation in addition to the reading lists for the London School of Hygiene & Tropical Medicine Researching Gender-Based Violence course that the researcher attended in February 2017. References for the three SAFE Ireland studies on domestic violence that the researcher participated in 2013, 2014 and 2016 were reviewed to ensure all relevant Irish policy and strategies were included in the literature review. In addition all relevant reports from Women's Aid Ireland, SAFE Ireland and Sonas Domestic Abuse Service on these organisation's websites were reviewed to assess research relevant to this study and the organisations were contacted to ensure any unpublished reports were also reviewed. Lenus, the Irish Health Repository library hosted by the HSE, was also searched for relevant reports, guidelines, policies and research. Google Scholar was utilised to search for any outstanding Irish policy and strategy reports as part of review process. The International Expert Advisory Group convened for the PhD study were requested to forward relevant national policies and guidelines in relation to domestic violence and pregnancy to the researcher. The Portuguese *Programa Nacional para a Vigilância da Gravidez de Baixo Risco* (2015) and *Violência Interpessoal - Abordagem, Diagnóstico e Intervenção nos Serviços de Saúde* (2014) both by the Director General for Health in Portugal were both read and reviewed by the researcher, but as English versions of the reports were not available they are not included in this chapter. The Norwegian national guidelines for screening for domestic violence during pregnancy, *Nasjonal faglig retningslinje for svangerskapsomsorgen - hvordan avdekke vold* (2014) were also accessed but are not available in English translation for inclusion in this chapter.

The literature search time frame for the study was from 1996 to 2015, as the first Irish domestic violence legislation was enacted in 1996. However, this was time period was monitored and updated as the PhD study progressed to ensure that all legislative and policy changes required subsequent to Ireland signing the Istanbul Convention in November 2015 were also captured and included. As university teaching, conference presentations, training Irish health and social work professionals and writing publications were an important aspect of the PhD process for the researcher pertinent academic publications post-2015 were sourced when possible to ensure the most up to date data was presented and is included in this chapter where relevant. Except for the documents noted above the literature review only included articles and reports published in English. Articles were sought that focussed on domestic violence and pregnancy and help, support and safety seeking by women. Studies and articles

included in the literature review related to Ireland, Europe (EU countries and Norway were included), Canada, USA, Australia and New Zealand. Studies from other countries were excluded due to a lack of comparability between maternity, health and domestic violence services and the Irish context. Search terms were developed by the researcher in consultation with the TCD Subject Librarian. Databases searched included: Heinonline, ProQuest Social Science, PubMed, Cochrane Library, RIAN and Lenus in addition to the policy and grey literature searches described above. Keywords used to source literature consisted of, but were not limited to: domestic violence, domestic abuse, intimate partner violence, pregnancy, support, help seeking, disclosure and screening. The absence of relevant literature and recent research on this topic stated in the 2015 MBRRACCE report, particularly in the Irish context was particularly notable.

Domestic violence and health

Potter and Feder state that: “Domestic violence and abuse is bad for health and a challenge to health systems” (2017 p.293). They list the many repercussions of domestic violence on the physical and mental health of female survivors and note the chronic and costly effects of partner violence on health (Potter and Feder, 2017). The health impacts as a result of abuse can be fatal and non-fatal and represent a significant, but often unrecognised, impact on health systems, as well as on individual women, families and communities.

International research

Analysis of the data collected from the WHO multi-country study on women’s health and violence against women clearly show a significant association between mental and physical health problems and ever having experienced sexual and/or physical violence by a male partner (Ellsberg et al., 2008). The WHO study could not prove a causal link between partner violence and self-reported health problems for women despite the study design and findings meeting many criteria in relation to inference of causality. The Lancet article based on the WHO study data and results determines that intimate partner violence is a crucial health concern, not only due to the direct injuries and murders it causes, but that it is a risk factor for many other serious physical and mental-health problems and suicidality (Ellsberg et al., 2008).

The FRA survey of women in 28 EU countries collected data on the consequences resulting from the most serious incident of physical and sexual violence by a partner as reported by women interviewed. The long-term psychological consequences reported

by women included depression, anxiety, difficulty sleeping and panic attacks (European Union Agency for Fundamental Rights, 2014 p.57). Physical injuries reported as a result of the most serious incident by a partner included; bruises, burns, fractures, concussion and internal injuries (European Union Agency for Fundamental Rights, 2014 p.58). In addition multiple different types of injuries received during the same violent attack, following the most serious incident of violence were reported.

Irish research

The Women's Health Council (WHC), a statutory agency of the Department of Health produced a report entitled *Violence Against Women and Health* (2007). This was the first state report on the topic in Ireland and it emphasised the health burden, both physical and mental, of violence against women and potential responses by the health sector. The report discusses the dual role of health systems in responding to domestic violence injuries and presentations, but also acting as a possible conduit for women to find supports without medicalisation of the issue. The report notes the many physical and mental health repercussions of violence against women and states that no comprehensive Irish analysis of these health consequences has yet occurred (WHC, 2007). Pregnancy is briefly mentioned in this report. The Watson and Parsons study identified a clear link between poorer health and those interviewed who had experienced abuse within the past five years. It also established that severe abuse is associated with poor health and ongoing physical or mental health problems, illnesses or disabilities for women, but not for men (2005). In the study severe abuse was defined as follows:

> "a pattern of physical, emotional or sexual behaviour between partners in an intimate relationship that causes, or risks causing, significant negative consequences for the person affected." (Watson and Parsons, 2005 p.52)

This study also noted that due to the outcomes of abuse, such as disability and poor health, may make it more challenging to leave an abusive relationship (2005).

Health service utilisation as a result of domestic violence

Given the severe and ongoing impact of domestic violence on health, it is to be expected that women experiencing it may have higher rates of presentation to, and utilisation of, health services than those without experience of partner abuse. A study in the United States indicates that women who have been physically abused used more emergency, hospital outpatient, primary care, pharmacy, and specialty health services

than non-abused women (Bonomi et al., 2009). European data from the FRA Survey stated that women are most likely to contact some type of health care service (hospital, doctor, clinic, etc.) following experience of physical and/or sexual violence. Contact with health services was ranked above contacting all other forms of help, support and legal services in the Survey (2014). In situations of partner physical violence almost one in five women (19%) presented to health services as a result of the violence, this rose to 27% of women victims of partner sexual violence (European Union Agency for Fundamental Rights, 2014).

As health care systems, funding and services offered differ from country to country it is difficult to apply international research on this topic in an Irish health care context and, as noted by the WHC report, there is very limited data on this topic pertaining to Ireland (2007). The Bradley and colleagues study gathered data from 22 Irish GP practices using a cross sectional, self-administered, anonymous survey study design with patients attending their GP (2002). The study ascertained that women who experience domestic violence are over-represented among patients using Irish GP services (2002). Watson and Parsons found in their survey that most women reporting physical injuries as a result of severe abuse, required medical treatment or care (59%), with 10% needing an in-patient stay in hospital due to the severity of their injuries (2005).

Domestic violence and health: pregnancy, childbirth and the post-natal period

Pregnancy and the postpartum period are recognised as intervals of higher risk of domestic abuse, representing a threat to both maternal and child health and life (MBRRACE-UK et al., 2015). Goodman states: “When considering IPV during pregnancy, it is important to remember that both the mother and the fetus are at risk” and as a result there are at least two potential victims, and more with multiple pregnancies, e.g. twins (2009 p.253). Violence and abuse within intimate relationships does not cease during pregnancy and may instead intensify, initiate, decrease and then increase again. Therefore it represents a chronic, ongoing risk to the health and wellbeing of the mother and potentially baby, as the violence generally continues after birth (MBRRACE-UK et al., 2015).

International research

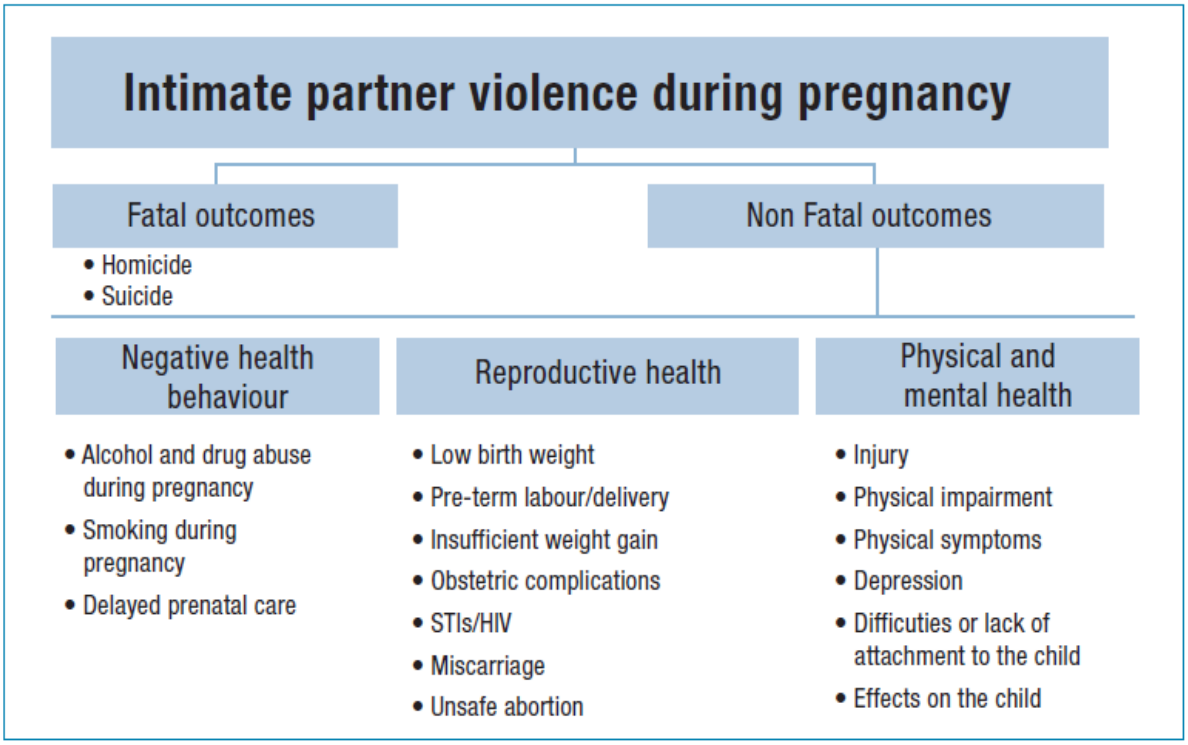
The Cochrane Library database was searched for this study and two relevant reviews are noted in this chapter by Jahanfar and O’Doherty. The WHO recognise that the results of intimate partner violence during pregnancy can lead to fatal and non-fatal

outcomes, refer to Figure 3 below (World Health Organization, 2011 p.2). A number of negative maternal health outcomes have been documented as a result of domestic violence, including: death, fetomaternal haemorrhage, poor weight gain and miscarriage (Jahanfar et al., 2014). Targeted assaults aimed at the abdomen and/or sexual violence as part of domestic violence during pregnancy may increase the risk of spontaneous miscarriage, placental damage and/or abruption, uterine contractions, premature rupture of membranes, preterm delivery and neonatal death (Donovan et al., 2016). A number of negative birth outcomes have been documented as a result of domestic violence and include: low birth weight, premature birth, drug withdrawal symptoms in baby and miscarriage (Goodman, 2009). A systematic review and meta-analysis conducted by Donovan and colleagues concluded that women who experienced domestic violence during their pregnancy are at increased risk of having a preterm birth, a low-birthweight baby and/or small-for-gestational-age baby. The review also noted that some of negative birth outcomes could be indirectly facilitated by the poorer overall health of the mother, such as consuming insufficient nutritious food and living with increased stress due to violence (Donovan et al., 2016).

A number of negative post-natal outcomes have been documented as a result of domestic violence and include: postpartum depression, coping with the effects of a complicated or pre-term delivery, ongoing negative health behaviours such as drug and alcohol use and the potential to have short time periods between pregnancies, or rapid repeat pregnancies (Goodman, 2009, Jahanfar et al., 2014, Jasinski, 2004). Goodman notes that the postpartum time is especially dangerous due to the potential for abuse and violence to continue or escalate, combined with the stress and responsibility of caring for a new baby (2009). A systematic review of observational studies in relation to breastfeeding and intimate partner violence (IPV) concluded that it is associated with lower rates of intention to breastfeed, initiation of breastfeeding, exclusive breastfeeding during the first six months of baby's life and a greater likelihood of stopping exclusive breastfeeding (Mezzavilla et al., 2018). Mezzavilla and colleagues review considered physical violence, emotional violence and sexual violence, or a combination of these types of abuse in their analysis. Kendall-Tackett notes that both past and/or current abuse can lead to stopping breastfeeding and that women who are currently in an abusive relationship can face significant challenges to breastfeeding their infant related to their abuse (2007). A large, prospective cohort Norwegian study, on past and recent emotional, sexual or physical abuse and breastfeeding surmised that abuse is strongly associated with termination of breastfeeding prior to the infant reaching four months of age (Sørbø et al., 2015). It is important to note that in Norway

approximately 99% of mothers breastfeed which is supported by paid maternity leave for one year post-birth, this is not the case in Ireland where breastfeeding rates are approximately 53% at time of maternity hospital discharge (Sørbø et al., 2015, Department of Health, 2016a).

Figure 3 Health outcomes of intimate partner violence during pregnancy



Research suggests that pregnant women in abusive relationships may present late to, or delay attending antenatal care, potentially because they are prevented from attending their appointments by their controlling partner (Jahanfar et al., 2014, National Institute for Health and Care Excellence, 2010). This poor or late attendance may be associated with other maternal morbidity outcomes, such as low birth weight babies and premature labour (Jasinski, 2004).

Irish research

Watson and Parsons note that significant risk factors arising from their Irish study for experiencing domestic abuse include: being female, being a young adult (aged between 18 and 30) and ever having had children, in addition to other risk factors including having parents who were abusive to each other and being isolated from close family and neighbourhood supports (2005). Irish data on negative health outcomes as a result of violence during pregnancy are only available in relation to self-reported miscarriage which is discussed in Chapter 3. The absence of literature and research on

this topic in Ireland is a core reason why this PhD study was commenced by the researcher.

Domestic violence, mental health and pregnancy

Many of the documented consequences of experiencing domestic violence impact on mental health with subsequent presentations including; depression, anxiety, self-harm, alcohol and substance use, post-traumatic stress disorder (PTSD) and suicide (Women's Health Council, 2007, Ellsberg et al., 2008). Stark and Flitcraft established associations between experiencing domestic violence and women's suicide attempts, which were often not acknowledged by the health professionals caring for these women (1996). The mental health repercussions related to previous or ongoing abuse and may also occur during and after pregnancy, but data are limited on the impact of abuse on women's perinatal health (Kendall-Tackett, 2007). Goodman notes that postpartum depression has not been well researched, specifically in relation to domestic violence (2009). The absence of such studies is notable, as much research reviewed for this study either focussed on maternal physical health or mental health but does not address the two issues in combination with domestic violence.

International research

A systematic review and meta-analysis of longitudinal studies examining the association of depression and suicide attempts with partner abuse experience in both women and men determined that experience of IPV increases the odds of incident depressive symptoms and of suicide attempts amongst women (Devries et al., 2013). The review findings indicate that women who are exposed to IPV are at increased risk of subsequent depression and that women who are depressed are more likely to be at risk of experiencing domestic violence. The authors recommend that health care professionals should be alert to risk of abuse when treating women with symptoms of depression; pregnancy is not mentioned in this review (Devries et al., 2013). A systemic review of adult mental health outcomes as a result of IPV found that it can have an adverse impact on the mental health of victims of IPV (Lagdon et al., 2014). The review confirms that the severity and length of time experiencing IPV can increase mental health symptoms, such as depression, PTSD and anxiety. However, this review excluded research studies that focussed on IPV during pregnancy (Lagdon et al., 2014). A recent study in the UK using data from a cross-section of 260 women seeking help from two domestic violence services found high levels of mental health morbidity in the study sample. The authors recommend that women presenting with mental health issues to all medical professionals should be questioned about current or past

domestic violence; maternity services or pregnancy are not mentioned in this review (Ferrari et al., 2016). One study that did look at both obstetric complications and postnatal depression in a cohort of patients using a maternity unit in a London hospital, used semi-structured interviews with 200 women. The Abuse Assessment Screen assessed participants for domestic violence and depression was measured by utilising the Edinburgh Postnatal Depression Scale (EPDS). Results of the study found that higher EPDS scores were significantly associated with a history of domestic violence for women and that having both a history of abuse and an increased EPDS score were significantly associated with obstetric complications, after controlling for other known risk factors. The researchers hypothesised that the long-term impact of domestic violence may predispose women to a range of physical and psychological health problems, including obstetric complications (Bacchus et al., 2004). Researchers in the UK reported findings from their study interviews suggesting that women's usual coping strategies may be compromised during pregnancy, due to being increasingly vulnerable to physical abuse and because they may also be suffering from depression (Bacchus et al., 2010).

Irish research

There are no research studies in Ireland specifically on domestic violence, pregnancy and mental health. The SAFE Ireland INASC study, investigating risk assessment in cases of domestic violence in Ireland, recorded that 29% of study participants self-reported suffering from mental health issues, principally depression. Women interviewed for the INASC study also reported physical abuse while pregnant in 62% of cases, but there is no analysis of the intersection of both these reported experiences in the study (SAFE Ireland, 2016a). A recent systematic review noted that no domestic violence screening tools are in use in Ireland and the UK as part of mental health risk assessment and management; perinatal maternity settings were not mentioned in the review (Arkins et al., 2016). The *National Maternity Strategy 2016-2026* states that prevalence rates of postnatal depression in Ireland range from 11% to 29%, with variances in reported rates depending on length of time since birth (2016). However, domestic violence is not listed as one of the risk factors for postnatal depression in the National Strategy (Department of Health, 2016a). The Irish Mind Mothers Project notes “Childhood or current sexual, emotional or physical abuse or intimate partner violence” is a risk factor for poor perinatal mental health, but does not elaborate on the interconnection nor reference Irish research (Higgins et al., 2017 p.21).

Interventions in maternity and health care settings

Given the severe, documented consequences and repercussions of domestic violence on women's health, addressing the issue in health care settings by health care professionals, especially during pregnancy, is an area that has generated research, investigation and recommendations. The potential for increased interactions between healthcare staff and women experiencing domestic violence during pregnancy for ante-natal care exists, which could lead to an increased number of opportunities for interventions, referrals and support provision to women (Goodman, 2009). The WHO suggests that:

> "Antenatal care provides a window of opportunity for identifying women who experience intimate partner violence. Not only is it often the only point of contact for women within a health-care setting, but also provision of health services and support through the duration of a pregnancy, and the possibility for follow-up, make antenatal care a suitable setting for addressing issues of abuse." (World Health Organization, 2011 p.3).

Campbell proposes that health care systems and settings can act as empowerment enhancing settings for women in relation to disclosure of abuse and finding supports (1998). However, unlike many other health care setting interventions, it is important to note that the patient may still be living with the threat of repeated abuse and as a result this requires holistic and robust interventions that have women's own choices and safety at the heart of them (Arroyo et al., 2017).

Information provision

The National Institute for Health and Care Excellence (NICE) *Domestic violence and abuse: multiagency working Guideline* recommends making health care settings an environment conducive to disclosing domestic violence (2014). This can be achieved, according to the Guideline, by making information on supports, services and contact details of local and national helplines available to those impacted by domestic violence. NICE recommends that information should be available in a range of formats and in languages used by the patients accessing the health services. The environment itself should maximise privacy of patients so that they can disclose abuse without being overheard by other patients, staff or their partners (National Institute for Health and Care Excellence, 2014). In relation to maternity health care settings the MBRACCE report recommends that information on supports for abuse is clearly displayed in

waiting areas, the backs of toilet doors and other suitable locations (2015). This information should also be provided to patients as part of their booking visit information (first appointment in maternity hospital), where safe to do (MBRRACE-UK et al., 2015).

Screening

Improving detection of severe partner violence within health systems, particularly during pregnancy, has been suggested as a means of reducing the risk of femicide (Campbell et al., 2003). Asking or questioning women about domestic violence in health care settings is referred to as screening. A Cochrane Review defines it as: "Screening aims to identify women who have experienced, or are experiencing, IPV from a partner or ex-partner in order to offer interventions leading to beneficial outcomes." (O'Doherty et al., 2015 p.7). Screening can be universal, where every patient in a health care setting is asked about abuse using a standard question or questions. Screening can also be selective, when only patients who are suspected to be high-risk or have specific risk factor for abuse (such as being pregnant) are asked about domestic violence. Routine enquiry is when all patients are asked about abuse but the questions posed may vary depending on the health care setting or patient's presentation or issues (O'Doherty et al., 2015, Kenny et al., 2014, Stöckl et al., 2013). The WHO do not recommend universal screening in all health care settings or appointments for IPV, but do recommend routine enquiry takes place during ante-natal care due to the "dual vulnerability" during pregnancy for abuse, presumably referring to both mother and foetus (World Health Organization, 2013 p.19).

The Cochrane review on *Screening women for intimate partner violence in healthcare settings* aimed to assess the effectiveness of screening within health care settings and to assess if screening causes any harms (O'Doherty et al., 2015). The review concluded that screening does increase the identification of women with experience of IPV within health settings and that pregnant women are more likely to disclose abuse when they are screened. The Cochrane review notes that groups that are high risk for experiencing domestic violence should be screened, such as pregnant women and those attending abortion clinics (2015). Routine screening can inform patients that a health care professional or service is ready and willing to discuss domestic violence (Renzetti et al., 2017). Screening also shifts the onus of responsibility on the woman to disclose by incorporating questions about domestic violence into routine ante-natal or health care. Renzetti et al suggest that this shift could reduce barriers to disclosure of abuse such as stigma and lack of awareness of supports available, it also potentially offers patients access to information and support via referrals (2017). A German study

to assess the acceptability of routine screening for IPV in antenatal care by women found that they are highly supportive of routine screening as part of their antenatal care, as long as it is conducted by a trained doctor and in a professional manner (Stöckl et al., 2013). NICE Clinical Guidelines suggest that in order to facilitate discussion of sensitive issues, such as abuse, women need at least one medical appointment or consultation alone without any family members present (2010).

Irish research on screening

Holt states that since women are at increased risk of homicide during and after pregnancy, assessment, or screening, of all women in relation to domestic violence during the antenatal period could be a potentially life-saving intervention (2007). The WHC report recommends screening in health care settings as a route to facilitate disclosure of abuse, suggests that abuse is a concern for the health of women and that screening has the potential to reduce stigma and secrecy in relation to abuse (Women's Health Council, 2007). The report also recommends that screening is not a one-time only activity and women should be asked about abuse on more than one occasion (2007). The *Domestic Violence in Ireland* report notes that screening in health care settings is a starting point towards intervention and referral for victims of abuse (Kearns et al., 2008). The ICGP recommends screening for domestic violence during ante and post-natal GP visits, in the context of screening at-risk groups for abuse (Kenny et al., 2014). The acceptability of screening by women has been ascertained in the Irish context by Bradely and colleagues (2002) and McDonnell and colleagues (2006) studies and within the Irish sample in the European FRA study (European Union Agency for Fundamental Rights, 2014). In one Irish study, most of the women surveyed were in favour of screening for domestic violence by their GP, but few could recall being questioned about it by a GP (Bradley et al., 2002). Almost nine in 10 women (87 %) in the Irish FRA Survey sample responded that they would support the practice whereby doctors routinely ask about violence when they see women with certain injuries in their practice (European Union Agency for Fundamental Rights, 2014). A cross-sectional survey in GP practices with women and men patients in Dublin found that 82% of female respondents found it acceptable for their GP to ask them about violence in their relationships (Paul et al., 2006). The HSE and Institute of Obstetricians and Gynaecologists (IOG) has published clinical practice guidelines on screening for domestic violence during the antenatal period (2012). The guidelines advocate for routine screening in a private setting and provides a list of suggested specific questions that can be used for the purposes of screening. However, since the release of these guidelines there has been no review or update, even in the context of

the National Maternity Strategy and HIQA recommendations and pertinent legislative change in Ireland. There is no guidance in relation to domestic violence from the Nursing and Midwifery Board of Ireland in their current Practice Standards for Midwives (2015).

Referral

The HSE Practice Guide on Domestic, Sexual and Gender Based Violence describes referral as:

> "The term 'refer' in this context is given to mean the intervention whereby a professional provides a survivor with support and information about the resources available to them, listens to them and encourages them to contact those specialist support or state agencies which are in a position to help them." (2012 p.25).

The NICE *Pregnancy and complex social factors Guideline* suggests that clear referral routes known to staff are offered to women disclosing abuse as well as: addresses and phone numbers of domestic violence refuges and support services; police details; safety information; and referral to a domestic violence support worker if agreed on. The NICE Guidelines also propose additional medical appointments for the female patient as part of her follow up care after disclosure of abuse (2010). In maternity care settings, MBRACCE recommends that all health professionals are aware of care and referral pathways for patients that disclose abuse (2015). The report outlines how communication with the woman's GP should occur to ensure coordinated care for the patient takes place. When pregnant women present to accident and emergency departments on a repeated basis, their GP and maternity care team should also be communicated with, to avoid missed opportunities to identity domestic abuse and potentially prevent maternal deaths (MBRRACE-UK et al., 2015). The MBRRACE 2017 report suggests that in cases of maternal deaths in Ireland, Scotland, Northern Ireland, Wales and England for the triennium of 2013 to 2015, data was missing in the field of socio-demographic characteristics of maternal deaths in relation to domestic abuse (prior to/during pregnancy) in 60% of cases (MBRRACE-UK et al., 2017 p.16).The MBRRACE report notes that this figure has increased to 60%, from the 40% reported in the 2016 maternal death report for the triennium 2012 to 2014, suggesting a decline in either screening patients or recording their responses in maternity settings (2017). If a woman discloses domestic violence the manner in which she is referred onto specialist supports can enable future service utilisation. Renzetti and colleagues describe warm referrals as those where the health care professional connects a patient

to services or phones them and thereby facilitates the referral (2017). Further research is required to develop the concept of warm referrals in relation to maternity care settings and ante-natal screening and subsequent referral in relation to domestic violence.

Referral in the Irish context

While the IOG, HSE, and ICGP all outline the role of referral in relation to patients who disclose domestic abuse there is exceptionally limited research on the outcomes of referral for women and the experiences of those doing the referrals. The ICGP survey of GPs in relation to domestic violence and pregnancy reported that over half of respondents had never had a pregnant woman disclose an instance of domestic abuse during a consultation (O'Shea et al., 2016). This survey of GPs also found that many GPs would welcome training on the topic, especially in relation to appropriate referral options for pregnant women who disclose abuse to their GP. An article aimed at midwives working in Ireland states that clear referral pathways should be established in cases of domestic abuse during pregnancy and that midwives should provide information on local supports as well as safety advice for their patients (Aher and O'Connell, 2012).

Barriers to interventions in health care settings for domestic violence

Research, reviews, guidelines, strategies and policies may recommend interventions in maternity care services regarding domestic violence, however, the reality for those providing and using services may be different. Although Velzeboer et al, stress that the key pre-requisites for effective domestic violence screening programmes are privacy, trained and empathetic staff, an ability to listen and offer a patient or client basic counselling, this can be difficult in resource (human and capital) stretched health settings (2003). Barriers to screening are succinctly stated by Renzetti, et al as a lack of training, time, knowledge and confidence (2017). A meta-synthesis to asses why many women are not screened for IPV during their antenatal care from the perspective of health care professionals suggests that a gap exists between the screening recommendations and actual practice for a number of key reasons (LoGiudice, 2015). A key theme arising in this paper is that health care staff felt unprepared and not equipped to respond to positive disclosures of IPV, unaware of local supports for the woman to refer her to and under time pressure. The presence of a woman's partner during ante-natal care was also a perceived barrier to screening. The synthesis

identified two enablers to screening pregnant women for abuse as having a therapeutic relationship with the patient and being able to interpret non-verbal communication or patterns of health issues related to IPV in their patients (LoGiudice, 2015). However, unless a case-load or continuity of care model is used in maternity settings a woman may not repeatedly see the same health care professional on an ongoing basis and potential for developing the required therapeutic relationship may be limited.

Research in the UK in a maternity and sexual health hospital setting describes some of the barriers encountered when implementing universal screening of patients for abuse and onward referral to an onsite domestic advocacy service where indicated. The study results indicate that it is challenging in clinical practice to screen all patients, unintentional harms to patients can result and that continued training is needed for staff, not just once off training (Bacchus et al., 2010). In the study semi-structured interviews were conducted with 34 women after they had accessed support from the domestic violence service. The interviews found that health care staff who made it clear to patients that abusive and violent behaviour was unacceptable seemed to allow for a shift in patient response to their abuse and a potential for change in their lives (Bacchus et al., 2010). Qualitative research in Finland with health professionals investigated why they don't screen for abuse or intervene with patients when domestic violence is evident. The Finnish research suggests four main categories of rationalisation by health care staff in relation to non-intervention: domestic violence is not a medical complaint; they are very busy and a disclosure of abuse could imply more work for them; as it is a private matter they don't want to patronise their patients; and there is a potential to re-traumatise their patients (Virkki et al., 2015). The study suggested that attitudes and beliefs about abuse held by health professionals can also be a barrier to implementing interventions. Research with midwives explored routine antenatal enquiry for domestic abuse in Australia. Midwives felt unprepared for disclosures of abuse, expressed a lack of education on the issue and in some cases a lack of referral options for patients who do disclose abuse, especially in rural areas (Eustace et al., 2016). The research concludes that routine enquiry must be supported by education for midwives on abuse. Qualitative research in Norway using individual semi-structured interviews examining routine enquiry by midwives for domestic violence found that midwives do screen for it, but not necessarily all women, as it is a sensitive topic and as a result challenging to screen for (Henriksen et al., 2017). Lack of time in appointments is also an inhibitor to screening but a midwife's interest in the issue and positive feedback from patients makes it easier to screen for IPV. The study recommends that protocols and referral routes to IPV services should be available in all

antenatal care clinics (Henriksen et al., 2017). Survey research undertaken with midwives by Baird and colleagues in Australia suggests that knowledge gaps and misconceptions about domestic violence may also be inhibitors to screening and responding effectively and compassionately to women living with abuse, in maternity care health settings (2015).

Irish research on barriers

Research on barriers to interventions in the Irish context is exceptionally limited. The principle research is the ICGP survey, a PhD thesis exploring domestic violence disclosure in primary care settings and a master's thesis researching midwives experiences of screening of domestic violence in one Dublin maternity hospital (O'Shea et al., 2016, Webster, 2018, Lawlor, 2014). Lawlor's research found that GP settings are not prepared for disclosures or screening for domestic violence and that there was an absence of posters or information in GP surgeries and waiting rooms. It identified a lack of training on domestic violence for GPs and practice nurses, time pressured medical consultations and non-use of screening tools for domestic abuse, all of which implied it was not a priority for GP practice staff (2014). Webster's research with midwives found that a lack of privacy (in the workplace setting and due to the presence of a woman's partner at appointments) and a hectic work environment, both impacted on time with patients and as a result IPV screening (2018). The research found that midwives require education on an ongoing basis in relation to domestic violence, national audits on screening practices are needed and national guidance and policies on the issue need to be up to date and revised at regular intervals (Webster, 2018).

Training for health care professionals to enhance screening and referral

Training for staff working in health care settings is a fundamental requirement for addressing violence against women in these settings, this is to ensure an appropriate and safe response to women who disclose violence (García-Moreno et al., 2015). This article, based on the review undertaken to inform the WHO clinical and policy guidelines on responding to IPV and sexual violence, states that the topic needs to be integrated into medical curricula with sustained continuing medical education (CME) for staff. Resources, dedicated budgets, leadership and a commitment to respond to and prevent violence against women in health settings with continued monitoring and assessment are all recommended (García-Moreno et al., 2015). A qualitative UK study explored the understanding of domestic abuse and related educational needs of

undergraduate nursing and midwifery students. The research found that that domestic abuse was an important topic, but participants stated they lacked confidence to be able to recognise and respond to it as future clinical practitioners (Bradbury-Jones and Broadhurst, 2015). In addition to ongoing and repeated staff training on domestic violence, support is also required by health service management to release and resource staff to attend the relevant training (Cottrell, 2009).

Training in Ireland

The researcher has contacted a number of professional associations and reviewed their websites to ascertain training offered in relation to domestic violence, and where relevant domestic violence and pregnancy, in Ireland. The result of enquiries, communication and website searches indicate that currently in Ireland (summer 2018) there is no continuing medical education (CME) or continuing professional development (CPD) training offered by the following:

- Irish Nurses and Midwives Organisation (INMO).
- Irish College of General Practitioners (ICGP)
- Centre for Midwifery Education (CME) which offers training to midwives and nurses in the three Dublin maternity hospitals, including the National Maternity Hospital.
- Royal College of Physicians in Ireland and the Institute of Obstetricians and Gynaecologists (IOG).
- An Garda Síochána (Irish police force).
- Irish Association of Social Workers (IASW).

This is regardless of ongoing CPD and CME requirements on a legal or statutory basis for many of these professions in Ireland. It is not possible to ascertain the course content in relation to domestic violence and pregnancy in undergraduate and postgraduate education for relevant professionals, such as midwives, GPs, obstetricians, social workers, etc. within scope of this PhD study. The ICGP survey on domestic violence and pregnancy of its members reported that the majority of survey respondents (84%) had completed no training or education in managing domestic violence at undergraduate level or as part of any CME undertaken (76%) (O'Shea et al., 2016). Despite recommendations for training of relevant health care professionals by organisations such as the IOG, ICGP, HIQA and the HSE, it appears that CPD and CME training is not presently available in Ireland. The HSE and IOG Guidelines specifically recommend a multidisciplinary education programme for professionals on domestic violence, but it appears never to have been commenced (Institute of Obstetrics and Gynaecologists, 2012a).

Supports for health care staff in relation to domestic violence

Staff in the health and maternity services may experience domestic violence in their own personal lives. Encountering women patients or clients who have had or are having similar experiences to themselves in relation to abuse can be re-traumatising and upsetting for staff. As a result, it is important that staff who are screening patients for abuse also have supports available to access themselves, potentially through human resources, occupational health, health and safety and other employee schemes and routes. Local supports for victims of domestic violence outside of the workplace can be highlighted with posters or leaflets in staff rooms, changing rooms or staff toilets. The NICE Guidelines recommend having policies and procedures for all staff who have experienced or been impacted by domestic violence (2014). Issues may emerge for staff due to the impact and demands of working with patients experiencing abuse and specific staff supports may be required in these cases (Women's Health Council, 2007).

Help and safety seeking in relation to domestic violence and pregnancy

What facilitates and enables women to seek help, support and safety in relation to domestic violence and pregnancy in Ireland is the core research question in this study. Little is known about this process and the eventual outcomes for women, especially with regard to pregnant women. A systematic review of short-term interventions for survivors of IPV states that in addition to providing psychotherapeutic interventions, care and supports to overcome the many institutional, monetary and cultural barriers that survivors encounter must also be put in place (Arroyo et al., 2017). The first qualitative study of disclosure and help-seeking by women survivors of domestic violence outside North America occurred in 2014 in the UK. The authors noted that more studies of this phenomena are required, which explore outcomes of the help seeking by women (Evans and Feder, 2015). Barriers identified for women seeking help in the study include feeling shame and denial, fear of repercussions and having a small social network, often as a result of coercive behaviour by the abuser which also limits opportunities for disclosure. Women interviewed in the study expressed fear about their children being taken into care as an additional barrier to help seeking. Help seeking often occurred via disclosure to friends who assisted with emotional support and family members who assisted with financial, housing and childcare supports to the woman. The study noted that in some cases help seeking was crisis driven or due to fortuitous meeting with someone who then became an enabler to the woman seeking

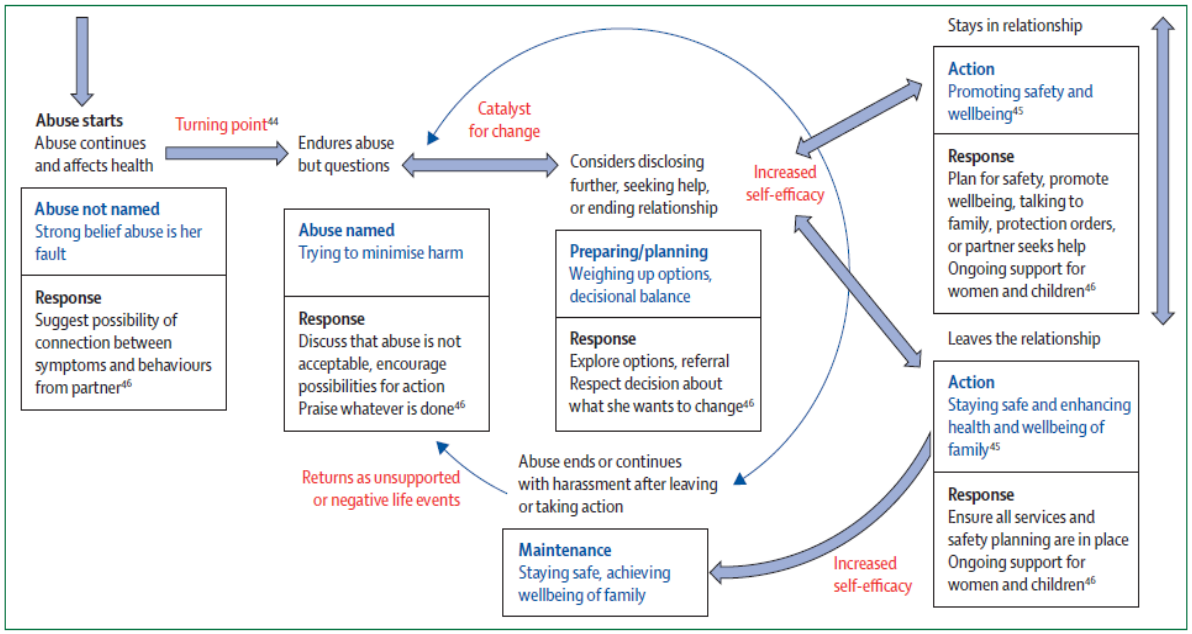
help (Evans and Feder, 2015). The study emphasises that women's routes to help and safety seeking are non-linear and reconfigure due to their abuse, often taking multiple routes and trajectories as part of seeking a life free from violence.

A Swedish study of women who did, and did not, seek help in relation to IPV noted that women with children in common with their perpetrator were more likely to seek help (Dufort et al., 2013). The Swedish study recommends a greater targeting of women attending health care settings, especially maternity care, with information and screening to enable disclosures and offer support to more women than those in contact with specialist abuse support services (Dufort et al., 2013). A New Zealand study on reasons for help seeking and related behaviours by victims of IPV found that shame, embarrassment and fear were barriers to help seeking but that concern for children was a potential trigger for women to seek help (Fanslow and Robinson, 2009). Family and friends were also identified as important supports to women seeking help. Women in the study reported disclosing abuse to a wide range of services, emphasising the importance of information and staff training on IPV in a range of settings that women may use, especially health care.

Bacchus et al note in their study, based in a sexual health and maternity setting in the UK, that the factors assisting pregnant women to disclose partner abuse include: partner's threats to remove the baby, an escalation in the regularity or severity of violence women experienced and a wish to protect their unborn child from physical harm (Bacchus et al., 2010). Women in this study who disclosed abuse were referred to a specialist domestic violence advisor. A survey among 151 women using domestic violence services in Italy explored their help seeking processes. The study found that if violence occurred during pregnancy, or if a woman's children had witnessed or suffered violence by the abuser, women sought help from more sources than women without children and these experiences (Bastiani et al., 2018). The authors describe this exposure to children or violence during pregnancy as a "breaking point" for women in deciding to actively seek help and support. Sources of help accessed by women in the study included; family, friends, medical services (including emergency and GP care), police, lawyers and social workers as well as other services. The study noted higher rates of being described as "an active help seeker", defined as seeking help from four or more sources, amongst women surveyed who were not born in Italy (Bastiani et al., 2018). The study authors also note the numerous and substantial barriers for women to seek help, including fear, shame, isolation, financial restraints and being unaware of services available to victims of IPV.

The WHO systematic review paper outlines the responses that health care professionals can offer women as they seek safety from violence, see Figure 4. Of note is the capacity of health professionals to assist a woman in recognising her experiences as abuse, naming it as such and providing ongoing support to potentially empower women to take action to seek lives free from violence and abuse (García-Moreno et al., 2015 p.6).

Figure 4 Women's (non-linear) trajectory to safety: health professional's response to women's readiness for action



Barriers for specific groups of women to accessing supports and safety

Groups of women may have additional challenges in seeking support and safety in relation to domestic violence, this can include, but is not limited to, migrant women, ethnic minority women and women with no access to welfare payments or financial assistance, often referred to as 'no recourse to public funds'. As the study sample was initially very diverse in relation to nationality and ethnicity and Irish women were very challenging to recruit into study participation, a recalibration of the literature review was required in 2017. Therefore reviewing Irish and relevant international literature on domestic violence and pregnancy and migrant women in relation to help and safety seeking began. The relatively recent nature of inward migration to Ireland, as noted in the HSE *National Intercultural Health Stagey 2007-2012* (2008), implies that the migration patterns for women stated in international research may not be relevant or

applicable to the Irish context. Studies and resource production that the researcher was involved in such as the 2009 Women's Health Council research on minority ethnic women and GBV, numerous AkiDwA resources, EIGE research reports and relevant SAFE Ireland research is drawn on for this section, given the minimal Irish sources available. In additional recent literature that fits with the migration patterns and nationalities moving to live in Ireland reflected in this study and those that are applicable to the model of health care provision and as a result maternity care in Ireland, are included where possible. The 2018 policy paper that the researcher contributed to, *Migrant Women and Gender Based Violence in Ireland: Policy, Research & Practice,* was also utilised to source relevant current literature and policy (Foreman, 2018).

Renzetti and colleagues note that ethnic minority and migrant women can have multiple layers of vulnerability, their disclosure and help seeking can be impacted by levels of integration in their new country, they may be experiencing significant social isolation, have no knowledge of local relevant services and lack language skills (Renzetti et al., 2017). Satyen and colleagues in their study of IPV and help seeking among migrant women in Australia found that the impact of IPV can be more severe for migrant women due to the greater number of challenges they encounter to seek help (2018). Lack of the local language and navigational knowledge of systems such as legal and social welfare and isolation from family who did not migrate along with the woman were all key barriers identified in their survey. Findings from their data indicate that women desired to talk to someone about their circumstances, to leave the situation of IPV and protect their children but that they faced significant social and situation related challenges that prevented them from seeking help (Satyen et al., 2018). The study recommends that support services are aware of the cultural barriers to migrant women seeking help. Services also recognise the intersecting relationships between gender, race and ethnic minority status and how they impact on migrant women's help seeking behaviour. Research interviews with 15 migrant African women survivors of IPV living in the USA examined the barriers to help-seeking and the decision-making process used to leave their abuser (Ting and Panchanadeswaran, 2009). Women in the study reported not recognising their abuse as domestic violence, not being aware of their legal rights (which was utilised by the abuser to isolate the women further), family pressure to reconcile with their abuser and coming from a culture where abuse is not taken seriously or the woman is blamed for marriage breakdown. Barriers to leaving their partner, as recalled by the women interviewed, included a level of acceptance of IPV by the women, financial and housing challenges they would face

alone and a fear of stigmatisation: being Muslim also appeared to be an additional barrier for some women. Their decision to leave was enabled by increased knowledge as to their rights and entitlements and knowing that supports were available to them. However, women's children were noted as acting as both a barrier and incentive to leaving their abuser (Ting and Panchanadeswaran, 2009). The study recommends screening for IPV when women access health care services for themselves and their children, having referral information available to domestic violence services and further research to explore the services migrant women found helpful. A study on Nigerian women living in the UK interviewed 16 women who had experience of IPV (Femi-Ajao, 2018). The research found that often the first person the women had sought help and advice from in relation to IPV was a religious or community leader. Many of the women interviewed were dependant on their husband for their immigration status and had no recourse to public funds so therefore were dependant on him financially too. These factors and the women's acculturation process into the UK were deemed as impacting help seeking regarding IPV. The study proposed collaborative working with community and religious groups to act as a bridge for women facilitating their utilisation of existing UK domestic violence support organisations (Femi-Ajao, 2018).

Research in Norway with migrant and ethnic minority women examined communication about IPV during ante-natal care by midwives. None of the eight women interviewed were asked about IPV during their pregnancies yet most of them thought that antenatal care was a good setting in which to disclose IPV (Garnweidner-Holme et al., 2017). Women stated that a good, trusting relationship with the midwife was key to enabling them to discus IPV. Barriers to disclosing IPV noted were: fear of child protection service, constant accompaniment by their husbands at antenatal appointments, the unacceptability of talking about IPV within the woman's culture and fear that no one would believe them. Despite these barriers, women were keen to talk with the midwives about IPV, but trust in the midwife, and time to build the trust, was an essential pre-requisite to disclosure (Garnweidner-Holme et al., 2017).

Research in Ireland

There is no research with women in Ireland on barriers to help and safety seeking in relation to pregnancy and domestic violence for specific sub-populations of women. The Watson and Parson survey found that there is a higher risk of having experienced domestic abuse for those born outside of Ireland, this finding is most evident for women who have experienced severe partner abuse: 14% of women born in Ireland had ever experienced severe abuse compared to 24% of women born outside of Ireland (2005).

The WHC research suggests an over representation of Traveller women and certain categories of non-indigenous minority ethnic women (asylum seekers, refugees, on a spouse dependent visa or a migrant worker visa) among services users of GBV organisations (Women's Health Council, 2009a p.86). These findings were also reported by Tusla more recently, noting an over-representation of migrant women in face-to-face DV services in Ireland, with asylum seekers, refugees, Roma and African born people over-reported in domestic and sexual violence services use relevant to their population size in Ireland. It is important to note that the Tusla data includes men and women service users (Tusla, 2016). Women's Aid Ireland in its annual service user statistics report for 2017 noted that 26% of new clients in their one to one support service were migrant women (from EU and non-EU countries) and 36% of their clients in their Dolphin House support service (in the Dublin District Family Court) were migrant women (2018). The Women's Aid 2015 annual report lists additional barriers faced by these women as language barriers, legal status in Ireland linked to the perpetrator, not being eligible for social protection payments and benefits and limited access to emergency accommodation (Women's Aid, 2016b). These data sources indicate that migrant and ethnic minority women are experiencing domestic violence and accessing domestic violence services in Ireland to a greater extent than are indigenous women.

The first major research study on violence against women and minority ethnic women in Ireland was undertaken by the Women's Health Council (WHC), the researcher being a member of the Steering Committee for this study (2009a). The study used a mixed methods approach and examined service provision in relation to gender-based violence (GBV) through surveys with GPs, migrant organisations and domestic and sexual violence service providers in order to identify how services in Ireland can best respond to the needs of minority ethnic women and to identify barriers to delivery of services. The study defined GBV as any type of violence that targets individuals or groups on the basis of their gender and recognises that domestic violence is the most common type of GBV (Women's Health Council, 2009b p.8). Qualitative interviews were undertaken with 26 minority ethnic women in Ireland and trained peer interviewers were available to overcome any language barriers to study participation. The study found an increased risk, or vulnerability, to GBV by minority ethnic women coupled with increased service use, and that cultural issues acted often as barriers to disclosing violence. Social isolation by the perpetrator was a feature of DV experiences and a woman's migrant status and lack of income were used as tools of violence and intimidation by the perpetrator. Traveller women noted experience of discrimination as

an inhibitor to help seeking, but this was not reported by any migrant women interviewed: they had very positive experiences when they accessed GBV support services. Barriers to accessing services for women seeking asylum and living in direct provision centres were childcare and transportation costs to services. Migrant women in the study reported pre-migration experiences of various forms of GBV (FGM, conflict-based rape, trafficking for sexual exploitation, etc.) and that violence continued in women's lives in Ireland due to their abusive partners. An important study finding was that training and resources were needed by service providers in Ireland to provide support to women in a culturally competent, sensitive and informed way (Women's Health Council, 2009a).

Research by AkiDwA, a migrant women's organisation for African women living in Ireland, in relation to domestic abuse, noted that a perpetrator may use culture and tradition as an excuse for violence and may also use witchcraft, or voodoo to enhance their control of the victim (Ncube, 2009). The woman may not be allowed to learn English and her migration status in Ireland may be used as a tool for control by threatening deportation or non-renewal of visas. Women in the focus groups undertaken as part of this study articulated their fears regarding repercussions from their church community and pastor if they left their husband and marriage, even as a result of domestic violence (Ncube, 2009).

Travellers, a minority ethnic group, indigenous to Ireland, face significant barriers in accessing safety and supports for domestic violence according to Pavee Point (an NGO working with and for Travellers and Roma). Traveller women may not have financial independence from their husband, so even the transport costs of getting to a refuge can be prohibitive. They may have literacy issues and not know how and where to access helpline and support services. Traveller women often use refuge accommodation as a temporary respite from abuse and may never leave their husband permanently, this can be due to stigma and shame within the Traveller community in relation to domestic violence (Pavee point, N.D.). Allen notes the close and connected family lifestyle of Travellers, many of whom hold tradition Catholic values of marriage for life, despite domestic violence, which can act as a barrier to seeking help and safety (2013).

Chapter summary

This chapter has presented an overview of relevant research on domestic violence and pregnancy. In summary, domestic violence is implicated in poorer maternity and perinatal outcomes, poorer mental and physical health outcomes, including death by

murder, suicide and miscarriage; there is conclusive global evidence that it harms women. Health care professionals have an important role in screening for and responding to domestic violence. Interventions in medical and maternity care settings to support women in disclosing abuse and seeking help include screening, creating a disclosure friendly environment by the visibility and availability of information and resources and by offering patients 'warm' referrals. Research evidence indicates that women are receptive to and positive about being screened in health care settings. Some groups of women, including migrant, minority ethnic, and those with no local language skills, may require additional provisions to support disclosure and seek help and safety.

Training at various education and career stages, on a continuing basis, of health care professionals is recommended in numerous research studies to enhance interventions such as screening and onward referral. Health care professionals need repeated training opportunities, support and supervision, referral routes, protocols and links to specialist services to be able to offer effective interventions to their patients experiencing domestic violence. This should be supported by dedicated budgets for training and the importance of the issue recognised by management in health work places. Given the acknowledged health risk in relation to domestic violence during pregnancy and the post-natal period; screening, information provision, referral to specialised services and other relevant supports to women would appear basic recommended and necessary interventions for women in maternity care settings in Ireland.

Chapter 3 Prevalence, Incidence, Research and Data Sources: Domestic Violence and Domestic Violence During Pregnancy

Introduction

Measuring and quantifying the scale of domestic violence in a country, society or group is inherently challenging. Discovering the extent of violence in intimate relationships requires sensitive research methods which take into consideration the risk of violence any study participants may have currently in their lives and the trauma and abuse they may have previously experienced. In relation to domestic violence, data tends to be collected in three forms:

1. Prevalence, which aims to measure how frequently domestic violence occurs in a specific population such as women aged between 18 and 65 during a specific time period such as lifetime/ever, last year, last month;
2. Incidence, where the number of individual cases presenting to services such as refuges, courts, hospitals, police, etc. are documented during a specific time period such as a year; month or week; and
3. Reported service use figures from helplines, refuges and support agencies that indicates the demand or use of services in response to domestic violence at a local, regional and/or national level. These figures may represent the same individual contacting or seeking support from a specific service on more than one occasion during a certain time period or may be collated as unique individuals. Data from these services is also referred to as administrative data.

Prevalence figures and data on domestic violence are an important tool to guide and inform service providers, policy makers and governments on the lived and ongoing experiences many of their clients and citizens survive and which are highly preventable. The incidence of domestic violence is particularly challenging to assess as many incidents are not reported to police despite their illegality; filling this gap is service-based data arising from the utilisation of domestic violence services at a regional or national level which assists in the development of more comprehensive data figures and allows a fuller picture of the scale of domestic violence in countries and regions (European Commission, 2010).

Ascertaining domestic violence prevalence

Data collection methods on domestic violence include postal surveys, anonymous self-completion surveys in settings such a hospitals or family doctor practices, phone surveys and individual and group interviews to garner more specific details on the experience of research participants. Any interview or survey tends to ask women about their lifetime exposure to domestic violence by asking if they have ever experienced it

with any partner and also any recent experience of violence with a current partner or during the past year and/or month (World Health Organization et al., 2013).This type of questioning acknowledges that women may leave or remain in violent intimate relationships and that the violence may be frequent and ongoing or have been an earlier lifetime experience. The approach, sensitivity and skill of the interviewer and the safety considerations in any study design and execution are paramount to ensure frank and honest responses from research participants and that their safety, and that of the researchers, is not endangered in any way. In many cases, such as the Watson and Parsons 2005 Irish study or the World Health Organization (WHO) 2005 multi-country study, the interviewer may be the first person that a woman has ever disclosed her lived experience of domestic violence to, and as a result researchers must be equipped to refer study participants to appropriate, free and local services (World Health Organization, 2005b). The language and phrases used, the fluency in the language that the survey is conducted in and/or the literacy levels of participants if there is a reading/written element to the study will all impact on response rate, accuracy and validity of the study findings. The language and terms used in a survey or questionnaire to elicit accurate responses are very important and the WHO recommends the following:

> "Gold standard methods to estimate the prevalence of any form of violence are obtained by asking respondents direct questions about their experience of specific acts of violence over a defined period of time, rather than using more generic questions about whether the respondent has been "abused" or has experienced "domestic violence" or "rape" or "sexual abuse", which tends to yield less disclosure." (World Health Organization et al., 2013 p.9)

Many countries add questions into nationally representative surveys on topics such as crime, for example the Canadian General Social Survey (GSS) on Victimization, the European Union (EU) International Crime Survey (EU ICS), the Crime Survey for England and Wales or health surveys such as the multi-country Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). These surveys tend to be repeated at frequent intervals, generally every five years, and therefore offer the possibility of assessing longitudinal trends. It is important to note that in Ireland the Central Statistics Office (CSO) include a crime and victimisation module in their Quarterly National Household Survey (QNHS) however, this module does not include questions relating to domestic and/or sexual violence for stated reasons of sensitivity (Central Statistics Office, 2018a). Other studies specifically focus only on violence,

such as the European Union Agency for Fundamental Rights (FRA) Violence against women survey or the 2005 Irish Watson and Parsons study. These “once off” surveys tend to offer richer data on the types, intensity and outcomes of intimate partner violence experiences but may not be repeated at regular intervals and therefore do not allow for trends or changes in prevalence to be assessed.

There exists, for many reasons, a distinct possibility of underreporting domestic violence in a survey or interview context (Kelleher et al., 1995). A woman may be afraid to honestly disclose her experiences or may not trust the interviewer, the survey commissioning agency or other national or state agencies, such as the police, who are referenced in a survey. This propensity for underreporting needs to be kept in mind in the discussion of international and national violence against women prevalence studies and emerging data and figures.

Global prevalence studies on domestic violence

One of the largest multi-country studies on violence against women to be undertaken interviewed women in 15 locations, both rural and urban, across 10 countries by interviewing 24,000 women in cross-sectional, household face to face surveys. The study was co-ordinated by the WHO with research experts from the London School of Hygiene and Tropical Medicine, however, there were no European Union countries included in the study. The countries chosen to participate in the study represented a mixture of economic development stages and some post-conflict regions. One of the core aims of the study was to estimate the prevalence of violence experienced by women perpetrated by their male intimate partners (World Health Organization, 2005b). Although there are substantial country variations in the prevalence data emerging from this study, key findings indicate that women who have had an intimate partner and ever experienced violence in this relationship (including physical and sexual) ranged between 15% to 71% of the sample (World Health Organization, 2005a).The study found that women are more at risk of experienced violence within their intimate relationships than in any other setting and that the violence they experienced tended to be ongoing, escalating, repetitive and with severe health impacts. This study also questioned interviewees on their experiences of domestic violence during pregnancy, these findings are discussed later in this chapter.

A review of global studies using primary data from population surveys, and a systematic review of literature on violence against women, concluded that the global lifetime prevalence of intimate partner violence (IPV) for women who have ever been in an intimate relationship is 30% (World Health Organization et al., 2013). For Europe

this figure was lower at 25%, with most EU countries falling into a high income country category with a regional IPV rate of 23% (2013 p.18). The WHO study also reviewed data on homicides as a result of IPV, findings reported indicate that 38% of all murdered women were killed by an intimate partner (2013 p. 26).

European prevalence studies on domestic violence

In response to a request for comparable, up to date and wide-ranging data on violence against women in the European Union (EU), the European Union Agency for Fundamental Rights (FRA) undertook a survey in all 28 EU member states in 2012. The final survey report was published in early 2014 entitled “Violence against women an EU wide survey”. The report is based on findings from 42,000 face to face interviews with women in the EU via a random, representative sample of women aged between 18 and 73 years of age in each country (European Union Agency for Fundamental Rights, 2014). Survey interviewees were asked about their lifetime experiences of physical, sexual and psychological violence, including experience of domestic violence by current and previous partners, by female interviewers in the interviewee’s homes. The survey aimed to interview at least 1,500 in each EU country however, some sample size variations occurred with 908 women interviewed in Luxembourg and 1,620 in Czech Republic (2014 p.16). The FRA survey findings provide nationally representative, recent and robust prevalence figures for the EU and indicate that 22% of women in the EU have experienced physical and/or sexual violence by a partner since the age of 15 and estimates 13 million women in the EU experienced physical violence by a partner or non-partner in the 12 months prior to the survey interviews in 2012. Forms of physical and sexual violence experienced by interviewees were also probed for in the survey and categorised by relationship with perpetrator (i.e. partner, non-partner or ex-partner). The FRA survey findings indicate that 22% of women in the EU have experienced physical and/or sexual violence perpetrated by a partner (either current or previous) from the age of 15. Results indicate 8% of women in the EU (which equates to approximately 16.7 million women) have experienced physical and/or sexual violence by a partner or non-partner in the 12 months preceding their survey interview (2014 p.21). The survey also asked women about their experiences of psychological violence by a partner (current or ex), with results indicating that 43% of women have suffered some form of psychological violence including verbal abuse, economic abuse, controlling and threatening behaviour in their intimate relationships. The FRA survey report notes that its survey findings are similar to other national survey findings on domestic and sexual violence in relation to prevalence. The FRA survey also explored contact with police or other

support or medical service by women as a result of violence. Survey findings indicate that in 66% of cases the most serious incident of partner violence, which resulted in injuries such as fractures, burns, broken teeth, concussion etc., was not disclosed or reported to any service or organisation, including the police (2014 p.60).

The FRA study also questioned interviewees on their experiences of domestic violence during pregnancy with current or ex partners, these findings are discussed later in the chapter.

Prevalence studies in Ireland on domestic violence

There have been two national studies undertaken in Ireland since 1995 to assess the prevalence of domestic violence in the population. The first survey was undertaken as part of a Women's Aid study entitled 'Making the Links' and field research for the study was administered by the Economic and Social Research Institute (ESRI) in the form of self-completion questionnaires that were hand delivered to a national random selection of households with women over age 18 living in them (Kelleher et al., 1995). Surveys were delivered to 1,483 women and 679, or 46% of the surveys disseminated, were returned completed with survey findings which were weighted for age and education (Kelleher et al., 1995). The survey found that 18% of women respondents (or 101 women) had experienced domestic violence with the perpetrator being either a current or former partner, there were no variations in the survey findings related to the respondent's level of education (Kelleher et al., 1995). Women reported experiencing physical, sexual, and emotional violence, in addition to threats of violence and damage to pets and property and they outlined the forms of physical violence and injuries they had as a result of the violence (Kelleher et al., 1995). This important study provided much of the impetus for the Irish Government Task Force on Violence Against Women to be created in 1996: it subsequently reported on its recommendations and conclusions in 1997 referencing much of the data emerging from Making the Links study.

The Sexual Abuse and Violence in Ireland (SAVI) report, provided the first national survey on childhood and adult sexual abuse experiences of men and women in Ireland; it was commissioned by the Dublin Rape Crisis Centre and published in 2002. The survey used a nationally representative sample of 3,118 randomly selected phone interview participants from the adult general population in Ireland (McGee et al., 2002). Although the study focussed on non-partner and childhood experiences of sexual violence, it did include questions on partner sexual violence: 24% of female survey respondents reported sexual abuse by their partner or ex-partner. In a study finding

that would be echoed in the ESRI and FRA studies, 42% of those women reporting any form of sexual abuse in the SAVI research had never told anybody prior to their survey phone interview about their abuse (2002 p. 120).

In 2003 the National Crime Council commissioned the ESRI to administer the first national study of domestic abuse of men and women by telephone survey in Ireland. The study interviewed 3,077 men and women aged over 18 in a nationally representative random sample and there was a particular focus on the impact on the victim of the experience of domestic abuse in the study (Watson and Parsons, 2005). The study findings concluded that 15% of women respondents had experienced severely abusive behaviour from a partner of a physical, emotional and/or sexual nature in their lifetime. This finding indicated a prevalence rate of domestic abuse of 15% of the female population in Ireland which in 2003 would equate to 213,000 women, who at some time in their lives, had experienced severe abuse by a partner (Watson and Parsons, 2005). The study defines severe abuse as "a pattern of physical, emotional or sexual behaviour between partners in an intimate relationship that causes, or risks causing, significant negative consequences for the person affected." (2005 p.52). The study also noted that 33% of survey respondents (both men and women) had told no one about the severe abuse they had experienced prior to taking part in the survey (Watson and Parsons, 2005 p. 76). Focus groups with immigrant and Traveller women also took place as part of the study to explore experiences of women who may not have access to a fixed phone line and therefore would not have taken part in the national phone survey. The study report was launched in 2005 and contained a series of policy suggestions based on the research findings.

Analysing the European Union Agency for Fundamental Rights (FRA) Violence Against Women Survey findings for Ireland

The FRA survey undertaken across the European Union (EU) in 2012 and published in 2014 allows for EU members' state data to be analysed at a country level in relation to survey responses. In relation to Ireland, 15% of women reported experiencing physical and/or sexual violence by a partner (current or ex) since the age of 15 (European Union Agency for Fundamental Rights, 2014 p.28). Three percent of women in Ireland disclosed experiencing violence (sexual and/or physical) by a partner in the 12 months prior to their survey interview and 31% of respondents had experienced psychological violence in a current or previous intimate relationship. Seventy nine per cent of Irish women respondents did not contact any service or organisation, including the police, following the most serious incidence of violence they experienced by current or ex-

partner (SAFE Ireland, 2015c). Of those who did contact a service following the most serious incident of violence by a partner, women reported contacting the police (21%), a hospital (20%), a doctor or health service other than a hospital (24%) with smaller numbers contacting a women's refuge (8%) or a victim support service (5%) (SAFE Ireland, 2015b p.8). Reasons given by survey respondents for not contacting supports or services (other than police) following the most serious incident of violence stated include: shame, embarrassment, privacy, fear of offender and/or reprisal, or women simply dealt with the violence themselves or told a friend or family member (SAFE Ireland, 2015c). A number of FRA survey respondents in Ireland stated that they had ended a relationship due to violence; for 6% of women it was the main reason for ending their relationship, while for 2.5% of women it was given as a reason, but not the principle one, for ending the relationship (FRA data set analysis by researcher).

Additional relevant Irish research studies

An area-based survey was undertaken as part of the Making the Links study by Women's Aid in 1995. This consisted of questionnaires being distributed in waiting rooms in general practices (GP or family doctor) surgeries in North Dublin. Women patients were asked to complete the questionnaires anonymously while waiting to see their GP and in the study sample consisted of 211 women all of whom had been in intimate relationships (Kelleher et al., 1995). Of the 211 women, 36% or 77 women reported that they had experienced domestic violence, of these, 53 had experienced physical violence. There were higher reported rates of domestic violence in the area-based portion of the study when compared with findings from the national survey within the same study, 18% as compared with 36% in the area-based survey (Kelleher et al., 1995).

Bradley and colleagues collected data from 22 general practice clinics across Ireland via a self-administered, anonymous survey during March 1996 to May 1997 to assess reported frequency of domestic violence amongst GP female patients (2002). A selection of general practices were used in the study to account for diversity and location of practices (or clinics) in Ireland. In total 1,692 valid surveys were collated with respondents aged between 16 to 84 years. Thirty nine percent of respondents had experienced at least one form of domestic violence, with reported violent incidents including punches, kicks, rape and choking. Twenty eight percent of the sample reported being afraid of their current or ex-partner (Bradley et al., 2002). The study authors suggest that the higher rates of domestic violence emerging in their study may be due to an over-representation of women who experience domestic violence in

primary care medical settings, potentially due to higher incidence of physical and mental health issues linked to domestic abuse (Bradley et al., 2002).

Data from domestic violence services in Ireland

Annual statistics are collected by the services responding to domestic violence across Ireland and these national figures are collated by SAFE Ireland, the national network of domestic violence services in Ireland, and are published regularly. While service use and client figures do not indicate national prevalence, they do point to demand and usage of domestic violence supports such as helplines, court accompaniment, counselling and refuge or emergency crisis accommodation. Significant increases in utilisation of domestic violence services have been documented since 2008 in Ireland in addition to unmet need such as lack of capacity for women in refuges. In 2008 1,647 requests for refuge accommodation were not met due to lack of capacity and by 2014 4,831 requests went unmet (SAFE Ireland, 2015b). In 2008 27,774 helpline calls were answered by domestic violence services and by 2014 48,888 calls were answered indicating a significant growth in use of helplines in Ireland (SAFE Ireland, 2014c). Women's Aid, who operate the national free-phone helpline reported 16,375 disclosures of domestic violence in 2014 via their helpline and support appointments (Women's Aid, 2016b). The most recent annual national service data available from 2016 reports 8,549 individual women and 2,602 accessing face to face support (SAFE Ireland, 2017). In 2016 1,460 individual women and 2,190 individual children were accommodated in a refuges, however, 3,981 requests for refuge accommodation were turned down as the refuges were full. Of the 3,685 individual children who received supports from domestic violence services (face to face and accommodation) in 2016, 1,165 children were less than five years old, which is important for this study inclusion criteria (SAFE Ireland, 2017).

In 2008 SAFE Ireland began to undertake annual one day counts, or censuses, to document the number of women and children receiving support and accommodation within a 24-hour period in domestic violence services (residential and non-residential) across Ireland. One day census are utilised by agencies in other sectors working with dynamic, or rapidly changing, social issues such as homelessness. They provide an insight in to the reality of service demand and provision nationally as a result of domestic violence on a daily basis. The SAFE Ireland annual Irish census has been carried out on a weekday in early November every year since 2008 until 2014 (SAFE Ireland, 2015c). The 2014 one day count figures show 475 women receiving support in a 24 hour period and 120 women living in a refuge, in addition to 301 children receiving

support and/or accommodation with their mothers (SAFE Ireland, 2015c). Women receiving support were aged from 16 to above 65, the majority of women were Irish but 36 other nationalities accessing services were noted and seven ethnicities were self-described by women. Services received 137 helpline calls in the 24 hour period and 18 women who presented seeking crisis accommodation could not be accommodated in refuges due to capacity issues (SAFE Ireland, 2015c). The one day counts provide more in depth data on client demography, service utilisation and onward referral than annual statistical reports from service providers and as such provide an insight into the diversity of women seeking support on any given day in Ireland as a result of domestic violence. This information is significant given the diversity of the sample for this study in relation to women interviewed. Data on the number of pregnant women presenting in the SAFE Ireland annual censuses is discussed below.

Tusla data

In 2015 domestic, sexual and gender based violence services in Ireland were under the remit of the Health Service Executive (HSE) but moved to the government Child and Family Agency or Tusla. In 2016 data on service activity from the 58 specialist frontline domestic violence and sexual violence services funded by Tusla, including 42 domestic violence services (22 providing refuge or crisis accommodation services), was requested to produce a report (Tusla Child and Family Agency, 2016). The report considered data from services for the year 2015 and was collected via an online survey tool. It is important to note that the domestic violence services that Tusla funds also include service for men, which are not included in the SAFE Ireland figures and data. The Tusla report notes that 2,000 women and over 2,500 children were accommodated in 2015 in a range of residential options in relation to domestic violence (Tusla Child and Family Agency, 2016). Of the 39 services funded by Tusla providing services to children in relation to domestic violence, data from 25 services (where data is available, data is missing from the remaining 14 services) indicated that nearly half of the children availing of face-to-face services were aged under five years of age, which is noteworthy for this study given its inclusion criteria.

Data from the courts

Data from the Courts Service of Ireland provides annual statistics on the number of Safety Orders, Barring Orders, Protection Orders and Interim Barring Orders applied for, granted and declined across Ireland. These Orders are mostly made at a District Court level and allow adults (men and women) in certain types of relationships (married, co-habiting, parents with a child in common, family members, civil partners,

etc.) to seek protection from violence and threats of violence through a court ordered protection mechanism under the aegis of the Domestic Violence Act 1996 Amended (SAFE Ireland, 2014a). The Courts Service publishes annual collated figures for the numbers of Orders applied for and granted and the relationship between the applicant and the respondent (the person against whom the Order is being taken) is documented in some cases up to the year 2012. No demographic information on applicants is available from the Courts Service, as a result these figures do not tell us the sex or ethnicity of the applicant, and neither if the applicant was pregnant or had children under the age of one, but they do outline the national demand for court-mandated protection as a result of domestic violence. Due to the in-camera rule in family law cases in Ireland information available publicly is very limited. However, when the Civil Liability and Courts Act 2004 was introduced it allowed for an easing of the in-camera rule with restricted and anonymous media reporting on family law cases (SAFE Ireland, 2016b). During 2017 15, 962 number of Orders were applied for and 8,927 were granted by Irish courts at the District Court level. Orders may not be granted for a number of reasons including being struck out by the judge or being withdrawn by the applicant (Courts Service Ireland, 2018b). At the Circuit Court level 51 Orders were granted in 2017, down from a peak of 203 in 2011 (Courts Service Ireland, 2018a). Breach of an Order constitutes a criminal offence with a prison sentence or a fine possible. Data on breaches of domestic violence Orders, how many were prosecuted, withdrawn or struck out is not publicly available in 2017 and is not recorded by the Central Statistics Office Crime and Justice section nor published annually by the Courts Services (SAFE Ireland, 2016b).

It is important to note that given the range of applicants permissible under the Domestic Violence Act 1996 (Amended) that it is impossible to infer that all Orders applied for were from applicants seeking protection from intimate partner violence. It is expected that under the powers of the new Domestic Violence Act 2018, which extends the eligibility and circumstances of Order applicants legally, that the annual number of Orders granted will increase when the new Act is fully commenced which is expected in late 2018.

Data from national crime statistics

An Garda Síochána (Irish police force) crime statistics are collected via the PULSE (Police Using Leading Systems Effectively) system and are collated and published by the Central Statistics Office (CSO) Crime and Justice section utilising codes from the Irish Crime Classification System (ICCS). As domestic violence itself is not a criminal

offence, even though the acts which constitute domestic violence are almost always criminal acts, it is not possible to examine An Garda Síochána crime statistics to determine domestic violence incidence and prevalence in Ireland. The acts which form domestic violence may be prosecuted under a range of criminal statues such as: the Non-Fatal Offences Against the Person Act 1997, the Criminal Law (Rape) (Amendment) Act 1990, etc. The most relevant data arising from these statistics are breaches of domestic violence court issued Orders, where a victim has sought protection through court-mandated Orders and this protection has been breached which is a criminal offence and Gardaí have powers to arrest without warrant where there is a breach of such a court Order. In 2015, the most recent year where statistics are available, there were 1,532 number of breaches of domestic violence court Orders recorded by An Garda Síochána and 357 convictions for these breaches of the court Orders. It is not possible to ascertain further details on the victims in these Order breach cases and if they female and were or were not pregnant (SAFE Ireland, 2016b). As a result of these data limitations and with the caveats from the CSO related to ongoing quality issues for crime data from the PULSE system it is not possible to disaggregate data to assess the relationship between the victim and perpetrator of crimes which may be acts of domestic violence (Central Statistics Office, 2018b). The Domestic Violence Act 2018 does contain new criminal offences of coercive control and forced marriage but how convictions will be recorded and reported under this Act when it is fully commenced is not yet known.

Data from homicides and/or femicides in Ireland

As some cases of domestic violence end in fatal outcomes such as homicide data resulting from homicides could be utilised to assess fatal prevalence of domestic violence in Ireland (Women's Health Council, 2007). The European Institute for Gender Equality (EIGE) have a proposed definition of femicide for EU Member States as follows:

> "The killing of a woman by an intimate partner and the death of a woman as a result of a practice that is harmful to women. Intimate partner is understood as a former or current spouse or partner, whether or not the perpetrator shares or has shared the same residence with the victim." (European Institute for Gender Equality, 2017 p.28)

Data from annual and quarterly homicide offences, or murders, are collated and published by the Central Statistics Office (CSO) Crime and Justice section utilising

codes from the Irish Crime Classification System (ICCS) and can be dis-aggregated by sex of victim. Currently homicide data cannot be disaggregated by sex of perpetrator and relationship of homicide victim to perpetrator and as a result women murdered by their partners cannot be ascertained by data in the public domain (O'Brien Green, 2018b). In all cases of homicide an inquest is held by the relevant coroner. Data on numbers of deaths reported, post mortems and inquests held by coroners are reported on an annual basis by each coroner's office in Ireland, and these are collated into national statistics by the Coroner Service Implementation Team. These statistics are not dis-aggregated by sex of the deceased nor relationship of the deceased to anyone involved in the homicide. As a result data in relation to pregnant women killed by a partner (current or ex) is not available through national Coroners statistics. Murder legal cases in Ireland are held in the Central Criminal Court. A review of relevant murder trial proceedings and sentencing is possible to determine cases of femicide through information on the Courts Service website however, this data is not collated as annual femicide or homicide statistics (O'Brien Green, 2018b).

Women's Aid have monitored media coverage of murders in Ireland and publish regularly their Female Homicide Media Watch. Figures since Women's Aid began this Watch in 1996 to March 2016 state that 211 women have been murdered in Ireland, of which 62% were murdered in their own home and 55% were killed by their partners or ex-partners (Women's Aid, 2016b). In 2016 the name of the Watch changed to the Women's Aid Femicide Monitoring Project. The Femicide Monitoring Project also reports on the location of the murder, the sex of perpetrator and relationship of the victim to the perpetrator, where it is known. Additional data, such as the victim's age, method of killing, case status (awaiting trial, case resolved, etc.) and whether the case was a murder suicide are also reported if known (Women's Aid, 2016a). Currently there is a review of all homicide cases in Ireland from 2003 to 2017 occurring by a team in An Garda Síochána to assess correct classification of homicides in relation to murder, manslaughter, etc. (O'Brien Green, 2018b).

Domestic violence and pregnancy prevalence

Global research studies

The World Health Organization's (WHO) multi-country study on violence against women identified that women are more at risk of experiencing violence in intimate relationships than anywhere else and that there is a correlation between domestic violence and physical and mental ill-health. The study examined the rates of violence during at least one pregnancy amongst the 24,000 interviewees and found that they

exceeded 5% in 11 of the 15 countries involved in the study with figures ranging between 1% and 28% (World Health Organization, 2005b). Amongst women who had reported domestic abuse and had been pregnant rates of physical violence during pregnancy ranged from 11% to 44% of respondents in the WHO study with substantial numbers in some study sites stating that the physical violence began during pregnancy (between 13% to 50%) (2005a p.16). The study also found that women who experienced physical abuse were more likely to report having had a miscarriage than women who had never experienced partner violence (World Health Organization, 2005a p.17).

A later study examined the prevalence of intimate partner violence (IPV) during pregnancy was assessed using data from Demographic and Health Surveys and International Violence Against Women Surveys administered between 1998 and 2007 in 19 countries (Devries et al., 2010). This secondary analysis of relevant data from the Surveys concluded that prevalence rates of physical violence by a partner during pregnancy ranged from 2% in Australia to 13.5% in Uganda, with most of the 19 countries' estimates ranging between 4% and 9% (Devries et al., 2010 p.162). The only EU country to be included in this analysis was Denmark with an IPV during pregnancy prevalence rate of 1.8% (p. 164). However, the authors suggest that these rates may be underestimates given the documented challenges to disclosing partner violence to survey interviewers.

European research studies

The European survey on violence against women commissioned by FRA asked women surveyed who had experienced violence with a current or previous partner if they had ever been pregnant with this partner and if they experience physical and/or sexual violence during their pregnancy (European Union Agency for Fundamental Rights, 2014). Twenty percent of women who had experienced violence with a current partner and who had been pregnant stated they had experienced violence during pregnancy, while 42% of women experienced violence while pregnant with a previous violent partner (2014 p. 46). Women reported that the most serious incident of sexual and physical violence since the age of 15 that they experienced had resulted in a miscarriage for 6% of the victims related to both partner and non-partner violence (2014 p.58).

A multi-country European study undertaken in Belgium, Iceland, Denmark, Estonia, Norway, and Sweden administered self-completed questionnaires to 7,174 pregnant women attending routine antenatal care in order to estimate the prevalence of physical,

emotional and sexual violence abuse experienced as a child, adult and currently while pregnant (Lukasse et al., 2014). Response rates to the invitation to complete the questionnaire ranged from 50% to 90% depending on the country (2014 p. 671). Almost half, 49.2% of the respondents reported some form of physical, sexual, emotional abuse in their lifetime, when mild physical abuse was excluded the lifetime prevalence rate for abuse was 35% (2014 p.672). Physical abuse during the past 12 months, possibly including during pregnancy, was reported by 2% of the study respondents however, the perpetrator of the physical violence was not elaborated on in the study findings and therefore it cannot be stated that it is domestic violence exclusively being reported (Lukasse et al., 2014).

Ireland research studies

In the 1995 Making the Links survey, 59 women from a sample of 679 experienced physical violence from a current or previous partner, 20 of the women or 34% were pregnant at the time of the physical violence and 6 women or 10% of the sample miscarried as a result of the violence (Kelleher et al., 1995 p.19). An area-based survey was undertaken as part of the Making the Links study by Women's Aid in 1995, this consisted of questionnaires being distributed in waiting rooms in GP surgeries in North Dublin. Of the sample size of 211 women, 36% or 77 women, reported that they had experienced domestic violence, of these 53 had experienced physical violence. Physical violence while pregnant was reported by 29 women or 55% of the women who survived physical violence, 14 of these women had a miscarriage as a result of the violence and in five reported cases there were adverse effects due to the violence on the woman and/or foetus (Kelleher et al., 1995 p.32).

A study to determine the incidence and type of abuse occurring in a pregnant Irish population was carried out in 1995 in a maternity hospital setting in Dublin. The study used an anonymous self-completion questionnaire disseminated to private, semi-private and public patients in antenatal clinics, antenatal and postnatal wards over a three month period (O'Donnell et al., 2000). Of the 400 questionnaires disseminated 290 were returned and analysed, 35 women or 12% of respondents reported experiencing domestic violence during a pregnancy (2000 p.229). In this cohort 71 of the 35 women were currently experiencing abuse, 24 of whom described physical abuse but most reported a combination of physical, sexual and emotional abuse. Four of the women who had experienced abuse while pregnant reported having had a miscarriage in the past and eight women stated that they only ever experienced domestic abuse while pregnant. Twenty-one percent of the overall study population

reported knowing a friend who had experienced domestic abuse while pregnant. The study found that none of the women who had been victims of domestic violence while pregnant disclosed this fact to maternity hospital medical staff (2000 p.229).

Violence during pregnancy was not specifically probed for in the 2005 Domestic Abuse of Women and Men in Ireland study, however, pregnancy was stated as a trigger factor for domestic violence by 7% of survey respondents, including both men and women (Watson and Parsons, 2005). Miscarriage was reported by women in the context of severity and type of injury as a result of domestic abuse, 5% of women (from a sub-sample of 116 women who had experienced severe abuse) reported a miscarriage as a direct result of physical abuse (Watson and Parsons, 2005). The study also noted that women who had children had a higher risk for experiencing severe domestic abuse when compared with those women who had no children (Watson & Parsons 2005, p.108).

A study to assess the acceptability of routine screening of pregnant women with regard to domestic violence took place in a Dublin City maternity hospital in 2003. A non-anonymised, questionnaire was administered to women at their first ante-natal appointment and 478 women participated in the study. Part of the questionnaire consisted of direct questions to the woman by a doctor in a private setting on her experience of partner violence (physical, sexual, emotional and verbal) in the past year. Thirteen per cent of study participants (or 61 women) reported partner violence in the past year, which may or may not have been during their current pregnancy (McDonnell et al., 2006). Although this study had a different focus than to establish domestic violence prevalence during pregnancy it is notable the level of disclosure in a study setting of recent (past 12 months) partner violence by pregnant women in the study sample.

INASC research project

In 2014 SAFE Ireland began work on project INASC – Improving Needs Assessment and Victims Support in domestic violence-related criminal proceedings. The project was co-financed by the Criminal Justice Programme of the European Commission and involved field research in five EU countries: Austria, Germany, Ireland, Portugal and the Netherlands. The author was part of the INASC research project team for Ireland and assisted in study design, undertook pilot and study interviews nationwide and supported data triangulation. The project in Ireland had a specific focus on capturing information on risk assessment and experiences from women who had reported domestic violence to the Gardaí (police) between 2010 and 2013. Part of the focus of

the research was to identify supportive mechanisms available to domestic violence victims within the criminal justice system in order to inform the implementation of the EU Victims' Rights Directive in Ireland (SAFE Ireland, 2016a). Forty women across Ireland were interviewed as part of the INASC research in 2015, and research participants had to meet the following criteria to be interviewed: "Experienced domestic violence at the hands of an intimate male partner; reported at least one incident of domestic violence to the Gardaí between 2010 and 2013; was aged 18 at the time of that report; and, had sufficient understanding of the English language to be able to answer the survey questions" (SAFE Ireland, 2016a p.13). Physical violence during pregnancy was probed for as part of the assessment of acute risk factors for women during interviews, 62% of respondents or 23 women reported that their partner had physically abused them while pregnant (2016a p.27). Forty-five percent of the women who had experienced physical domestic abuse when pregnant reported it to the Gardaí. Although the INASC project did not specifically set out to capture information on domestic abuse and pregnancy and the interview requirements were focussed on reporting domestic violence to the police, the high reported level of prevalence of physical abuse while pregnant in this study is alarming.

SNaP research project

The research project SNaP (Specific Needs and Protection Orders) began in 2014, concluded in 2016 and was co-funded by the DAPHNE Programme of the EU. SNaP was a multi-country study with research project partners in Austria, Germany, Ireland, Poland and Portugal. The author was part of the Irish SNaP research project team, led by SAFE Ireland, and assisted with study design and undertook study interviews and edited the final study report. The project focused on the protection needs through legal mechanisms, such as court mandated safety and barring Orders, for especially vulnerable women victims of domestic violence. The project aimed to inform the implementation of the EU Victims' Rights Directive, especially Article 22 of the Directive which states that all victims of crime should have an individual assessment to determine any particular protection needs required or recommended. Research focussed on anonymised case file analysis from domestic violence services nationwide (n=50), interviews with women deemed to require additional support in relation to domestic violence and legal protection access (n=10) and interviews with legal practitioners (n=13) in order to understand the effectiveness and appropriateness of legal measures being utilised (or not) by especially vulnerable women (Counihan, 2016). The study sought to include women who were pregnant at the time of the domestic violence or when seeking a legal protection mechanism in the data collection

as this was deemed a time of particular vulnerability and increased risk. The case file analysis study sample included 50 women, using a purposeful sampling technique from client case files in 10 domestic violence support services across Ireland. Where data was available (i.e. in 46 out of the 50 files) just above 20% of women were documented on their files as pregnant the time of abuse or of seeking an Order (SAFE Ireland, 2016).

National one day counts

Since 2011, SAFE Ireland has included the category of pregnant in their national one day counts of women and children accessing SAFE Ireland member domestic violence support and accommodation services. These one day counts or censuses compile the number of women and children receiving support and accommodation within a 24-hour period. Data from their one day count on November 2011 indicate that ten women receiving support were known to be pregnant or 2% of total number of women accessing services on that date (SAFE Ireland, 2012). Within one year this number had doubled to 22 pregnant women availing of services or 4% of the total number of women accessing services on that date (SAFE Ireland, 2013). In 2013 the numbers were similar with 24 pregnant women accessing services equating to 5% of the total number of women accessing services (SAFE Ireland, 2014b). In 2014 18 pregnant women were accessing either a domestic violence service or accommodation which represented 4% of the total number of women in the one day census (SAFE Ireland, 2015c).

Homicide/Femicide data

Data from annual and quarterly homicide offences, collated and published by the Central Statistics Office (CSO) Crime and Justice Section utilising codes from the Irish Crime Classification System (ICCS) do not report on pregnancy in their published data on homicides. The Women's Aid collation of media coverage of murders in Ireland and published in their Female Homicide Media Watch reported two cases of women being pregnant at the time of their murder in all cases collated between 1996 and 2016 (Women's Aid, 2016a). A child, aged five months, is also reported as murdered along with their mother in the same report.

Analysing the European Union Agency for Fundamental Rights (FRA) Violence Against Women Survey findings for Ireland

The data arising from the 2012 Violence Against Women survey across the EU provides the most recent, nationally representative research on this topic for Ireland.

The survey interviewed 42, 000 across the EU with 1,569 women in Ireland interviewed face to face by a female researcher. The survey results were published by European Union Agency for Fundamental Rights (FRA) in 2014. The researcher applied for access to the FRA data set in early February 2016 and in July 2017 she was granted access to the entire questionnaire response data set for 28 countries in the EU. The author was the first person in Ireland to be granted access to this survey dataset. Analysis took place using SPSS over the summer of 2016 on the Irish data set. The results are discussed in the following section and refer to the Irish data, except where noted or compared with the EU data set.

Of the 1,569 women interviewed in Ireland, 77% or 1,208 women had children. Questions on violence during pregnancy were included in interviews: interviewers asked women who had disclosed experiencing violence in a current or previous relationship and had been pregnant with this partner if physical or sexual violence ever took place while she was pregnant (European Union Agency for Fundamental Rights, 2012). Interviewees were presented with a list of forms of physical and sexual violence by the interviewer and could respond if any, or all, of the forms of violence had occurred. Examples of forms of violence on the list or show card, which women were asked to read and identify included; being pushed, slapped, beaten, kicked, burned, cut, forced to have sex and suffocated. Women did not have to identify which forms of violence they had experienced, only if any form had occurred while they were pregnant.

The survey found across the EU that of the women who had been pregnant with a violent previous partner, 42% experienced violence during a pregnancy. For women who reported violence with a current partner and had been pregnant, 20% of them also reported violence during pregnancy (European Union Agency for Fundamental Rights, 2014 p.46). In Ireland 26 women stated they had experienced violence with a current partner and had also been pregnant with this partner. Of these 26 women, 6 or 23%, had also experienced violence whilst pregnant. This figure is slightly above the EU average noted in the survey of 20%. Women who had a previous partner who was violent towards them and who had been pregnant with him numbered 98 in Ireland. Of this cohort 48 or 49% of these women also experienced violence while pregnant, again this figure is higher than the EU average of 42%. However, given the low numbers these differences cannot be stated to be statistically significant. Overall almost 4% of the Irish survey sample had experienced violence during a pregnancy with either a current or previous partner.

Establishing the reported consequences of physical and sexual violence were a core part of the FRA survey, therefore women were asked about physical injuries resulting

from the most serious incident of violence by a partner. Six percent of the total European survey sample reported a miscarriage as a result of either physical or sexual violence by a current or previous partner (2014 p.58). In Ireland 6 women, or 0.6% of the total survey sample reported as miscarriage as a result of the most serious incident of violence by a partner. However, when only women who experienced violence by a partner when pregnant (current or ex) and who experienced a miscarriage as a result of partner violence are calculated, 11% of this cohort of women or approximately one in ten suffered a miscarriage as a result of partner violence. This figure is similar to EU figures reported by women in the survey. There were no questions in relation to abortion in the FRA survey.

Irish College of General Practitioners (ICGP) survey data

Many women in Ireland receive “combined care” as part of their overall maternity care from their GP (general practitioner) or family doctor as part of the state funded Maternity and Infant Care Scheme. This Scheme funds up to nine free GP visits during pregnancy and the post-natal period, in addition to a number of maternity hospital appointments, refer to Figure 2 (Kennedy, 2015). GPs therefore, have an important role in terms of identifying domestic abuse in their practices, providing forensic evidence when requested and supporting and referring their patients to specialist domestic violence services and/or the Gardaí/police. As a result, data arising from GP care of pregnant women and post-natal care constitute a potentially important source of prevalence data and information. In 2015 a project began by the Irish College of General Practitioners (ICGP) the aim of which was to raise awareness and increase the recognition of domestic violence against women during pregnancy at primary care level, part of the project included a quantitative postal survey of GPs in Ireland. The survey consisted of 19 questions on topics such as GP experience in asking pregnant women about domestic violence, on actions taken following a disclosure of violence and awareness of support, demographic information pertaining to the GP and their practice was also gathered via the survey questionnaires (O'Shea et al., 2016). Over 3,000 postal surveys were disseminated with 530 completed questionnaire being analysed, giving a response rate of 18% (O'Shea et al., 2016).

The postal survey results found that almost 97% of the GPs who responded had provided antenatal care for pregnant patients in the 12 months prior to the survey; however, 99% of respondents stated that they never routinely ask pregnant women in their practice about domestic violence and in the previous 12 months 70% of respondents had not asked any pregnant female patient about domestic abuse (2016

p.8). Despite this low level of routine enquiry, almost 20% of GPs surveyed had treated between one and five women who disclosed experience of domestic abuse during their pregnancy, this disclosure was either spontaneous or as a result of GP questioning.

Since starting to work as a GP, forty-three percent of GPs had a woman disclose domestic violence. Although establishing prevalence figures is not possible as a result of analysis of the survey's findings, the results do indicate that even without routine questioning/screening women are reporting abuse during pregnancy to their GP. The survey also identified the main barrier to GPs routinely asking women about domestic violence as GP discomfort: time restrictions in GP consultations was also noted as a barrier to asking women by 20% of respondents (O'Shea et al., 2016 p.12). A final pertinent finding from the ICGP survey research was that approximately 65% of respondents were unaware of any guidance document for GPs on the subject of domestic violence, despite the ICGP releasing a second updated edition of their resource *Domestic Violence: A guide for general practice* in 2014 (Kenny et al., 2014).

National Maternity Healthcare Record

In 2012 the National Maternity Healthcare Record (NMHCR) began use in all Health Service Executive (HSE) funded maternity hospitals and units in Ireland. The aim of the NMHCR is to provide a standardised chart for patients during pregnancy and birth and to allow for the collection of data to inform research from maternity settings (Health Service Executive, 2016a). It is currently used in paper chart and electronic versions with full electronic roll out of the NMHCR anticipated by 2018 across Ireland. There is space on the paper record to document with a code domestic violence. The electronic NMHCR version will have two specific patient questions regarding domestic violence. Currently data from the NMHCR is not being centrally anonymised, collated and published so data arising from screening pregnant women for domestic violence in Irish maternity care settings cannot yet be ascertained (European Institute for Gender Equality, 2015b).

Maternal deaths in Ireland

In 2009 Ireland joined the UK Confidential Maternal Death Enquiry. The aim of the Enquiry is to investigate why women die during or in the year post-pregnancy and how to prevent such deaths with the overall purpose to improve care for pregnant women in maternity and health settings (O'Hare et al., 2015a). Data from Irish maternal deaths (including up to one year post pregnancy) is collated, anonymised and assessed as part of a larger number of death reviews in order to protect confidentiality and maintain anonymity (O'Hare et al., 2015a). The Enquiry utilises the WHO definition of maternal

death which is: “Deaths of women while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” and includes data arising from giving birth, ectopic pregnancy, miscarriage or termination of pregnancy (MBRRACE-UK et al., 2015). Both annual and triannual reports are produced by MDE (Maternal Death Enquiry) Ireland and MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) and the data presented allows for the calculation of national maternal mortality rates. The 2015 MBRRACE report, analysed data from 2011 to 2013 from both the UK and Irish maternal death reviews and contained a specific chapter on homicides and domestic abuse. The chapter analysed the data arising from 36 women who were murdered during and up to one year after their pregnancy, of which 86% (or 31 women), were murdered by a current or former partner (MBRRACE-UK et al., 2015). Thirteen of the women were murdered during pregnancy or up to six weeks after pregnancy and the remaining 23 women were murdered between six weeks and one year after pregnancy, which gives an overall homicide rate of 0.97per 100,000 maternities for women murdered during and up to one year after pregnancy (2015 p.63). Assessment of data from all women who died during or up to six weeks post-pregnancy, indicates that 5% had documented histories of domestic abuse, worryingly 76% of women (or 356 women) who died appear to not have been screened or asked in relation to domestic abuse (2015 p.65).

The deaths of 101 pregnant women who committed suicide during or up to one year after pregnancy are also analysed in the 2015 MBRRACE report. Seventeen percent of women who died by suicide had a documented history of domestic abuse in their files or patient notes, however, in 51% of these cases it is not clear whether domestic abuse was a factor as it was not recorded on patient files nor was elicited from the women as patients (2015 p.23). The report makes a number of recommendations in relation to care for pregnant women who disclose domestic violence, indicators of abuse in relation to medical presentations, ways to better enable disclosure of abuse and pathways for referral and support. It is important to note that the cases contained in the chapter of the MBRRACE report on women murdered do not appear to contain any cases of women murdered in Ireland. However, the report findings are pertinent to Ireland and highlight the potential for preventing similar murders in the future and the importance of undertaking on-going risk assessment during and after pregnancy in cases where domestic violence is identified (2015, p. 77). In recognition of the direct links between pregnancy and suicide in 2016 The MDE followed WHO and MBRRACE UK recommendations to change the classification of suicides from indirect to direct

deaths (O'Hare et al., 2016). The MDE report notes that in relation to maternal deaths from 2012 to 2014 in Ireland suicide was the most common cause of direct maternal death and the most common cause of late maternal deaths happening between 42 days and one year of pregnancy end (O'Hare et al., 2016).

Miscarriage data

Miscarriage as a direct result of domestic abuse is reported in surveys and research by women in Ireland. However, data on miscarriage prevalence and experience in Ireland is limited. The HSE and Institute of Obstetricians and Gynaecologists (IOG) Clinical Practice Guideline on the Management of Early Pregnancy Miscarriage state that approximately one in five pregnancies ends in miscarriage with annual estimates of miscarriage in Ireland of 14,000 (IOG and HSE, 2012 p.4). Annual statistics based on maternity hospital metrics are published in the Irish Maternity Indicator System (IMIS) National Reports, established in 2014. The IMIS Reports use the definition of: "stillbirth refers to death of a fetus weighing ≥500g, irrespective of duration of pregnancy" (Irish Maternity Indicator System, 2016 p.8). Much of miscarriage care and management occurs on an outpatient basis and many women may not present to health services at all in relation to their miscarriage. Currently there exists no potential to correlate experience or disclosure in ante-natal care of domestic violence and subsequent miscarriage or early pregnancy loss.

Abortion data

Abortion data for terminations of pregnancy carried out in Ireland under the Protection of Life During Pregnancy Act 2013 are reported annually by the Department of Health. The information published is very limited to reduce the risk of identification of women, in 2017, the year for which most recent data is available 15 terminations were carried out in Ireland (Department of Health, 2018). The UK Department of Health and Social Care releases statistics on the number of women and girls giving addresses in the Republic of Ireland who accessed services at abortion clinics in England and Wales annually. In 2017, 3,092 women and girls from Ireland were documented as having an abortion in England or Wales (Department of Health & Social Care UK, 2018 p.20). These figures from the Department of Health and the UK Department of Health and Social Care do not include women who self-medicate with abortifacient drugs nor those who travel to other jurisdictions, such as the Netherlands or Spain, to access abortions. There is no data collected on a woman's relationship status or if there is any connection between a woman requesting an abortion and her experience of domestic violence in relation to women living in Ireland.

Chapter summary

Women globally, in Europe and in Ireland experience domestic violence. This violence can take various forms. Data on domestic violence is gathered from a range of sources including surveys, administrative data, research studies and data from legal sources. Domestic violence is an underreported crime and as such all prevalence data should be considered an underestimation of the true extent of violence against women by their intimate partners. Domestic violence does not stop during pregnancy, it can begin at this time and can result in miscarriage. There are considerable gaps in data in Ireland in relation to domestic violence and pregnancy. However, examining the data collated from a range of research studies, surveys, administrative sources, etc. in this chapter the issue of domestic abuse during pregnancy in Ireland requires further investigation given the substantial number of women who have survived it.

Chapter 4 Study Aim, Objectives and Conceptual Framework

Introduction

This research study explores the factors associated with the disclosure of domestic violence and subsequent positive service utilisation during and after pregnancy by women in Ireland. The study aimed to address a research gap by interviewing women who have direct personal experience of DV during pregnancy and who had sought help. This was in order to understand and identify supports and enablers, in addition to barriers and inhibitors, which enhance and allow for, or detract from, safety and help seeking by women. During the study a unique Conceptual Framework was developed and refined to inform the research process and guide the data analysis.

Study aim and objectives

There is limited research on the factors that enable women to disclose and seek support when experiencing domestic violence during pregnancy and what interventions are effective at reducing risk and/or domestic violence for these woman (MBRRACE-UK et al., 2015). This study aims to address this research gap by interviewing women who have direct personal experience of the phenomenon and who have sought help and safety in order to determine key supports and enablers including individuals and professionals, structures, responses, and referrals which enhance and allow for safety and help seeking by women. The study has been undertaken to gain a greater understanding of the processes and routes of help and safety seeking by women. The overall aim of the study is to examine the processes and paths of women disclosing they are experiencing domestic violence during pregnancy and their seeking information, support, safety and help. The primary objectives of the study are to explore the factors that enable, empower and support women to disclose they are experiencing domestic violence during pregnancy and then seek help and safety, and consequently the factors that act as barriers and challenges to a woman's help seeking. The secondary objective is to explore women's experiences of the interactions with clinicians and staff engaged in the provision of maternity care in Ireland to determine if these interactions have any influence on the woman's decision to disclose and any supports and referrals women received after their disclosure occurs. The final, but relatively minor, study objective is to explore the experiences of key workers (domestic violence services staff) engaged in the provision of support services for pregnant women experiencing domestic violence to identify the facilitators and challenges encountered when supporting such women. The study aims and objectives are summarised and listed as follows:

Study aim: to explore the factors associated with the disclosure of domestic violence and subsequent positive service utilisation during and after pregnancy by women in Ireland.

Study objectives:

1. Determine the factors that enable, empower and support women to disclose they are experiencing domestic violence during pregnancy and seek supports, help and safety;
2. Determine the factors that act as barriers and challenges to disclosure and help seeking by women in relation to domestic violence and pregnancy;
3. Investigate women's experiences with health care professionals during and after pregnancy, and their influence, if any, on deciding to disclose and seek support; and
4. Explore experiences of a small sample of domestic violence services' staff supporting pregnant women experiencing domestic violence.

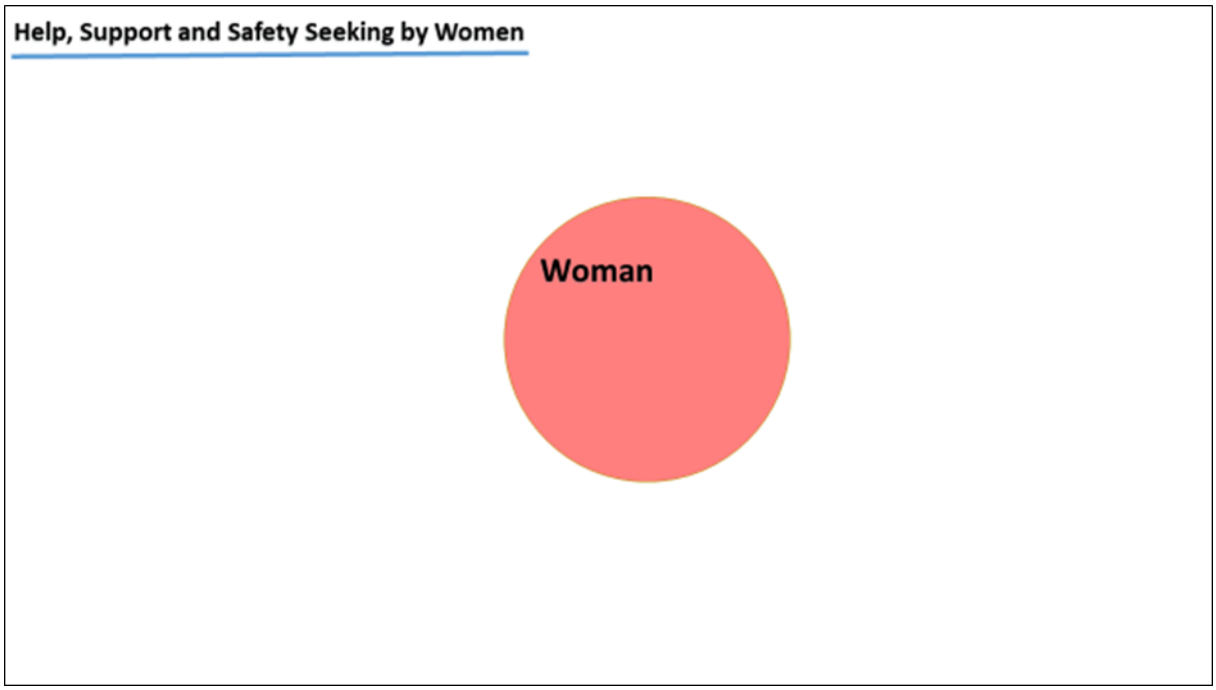
Study Conceptual Framework

A Conceptual Framework for the study began to emerge following the author attending the Researching Gender-Based Violence short course in the London School of Hygiene and Tropical Medicine in February 2017, where developing individual study frameworks was a core aspect of the course work. A conceptual framework is a useful tool for visualising and framing the research study within the context, environments and settings within which women are/were living and seeking help and support. The study Framework is a consolidation of literature engaged with, planned study design and the concepts and ideas used to underpin the study in addition to providing a visualisation of interconnected aspects of women's routes to help and safety seeking. It was developed in March 2017 and refined during 2017 as further study interviews and reading took place. Utilising a conceptual framework as part of the research design is useful in assisting in the description of why, how and where things are occurring for research participants and expands on what could potentially be a unitary or restricted focus on what is happening, or has happened to them (Zimmerman, 2015). A conceptual framework therefore can illuminate the inter-relationships between topics emerging in the study and the intersectional nature of women's lives. The study Framework development also drew on the work of Heise in terms of locating violence against women in an ecological, intersecting and inter-related framework (Women's Health Council, 2007; Heise, 2011). Creating the Conceptual Framework allowed the researcher to see the shifts occurring within the study as interviews began, from an

initial greater focus on the individual response to the phenomenon of domestic violence during pregnancy, to incorporating key external factors into the frame of research. These key factors included; resources (especially financial and housing), relationships, family and friends, health and maternity care and knowledge of and navigation into relevant services and supports, all of which may be crucial in the help and safety seeking process. The elements of the study Conceptual Framework are discussed and outlined below.

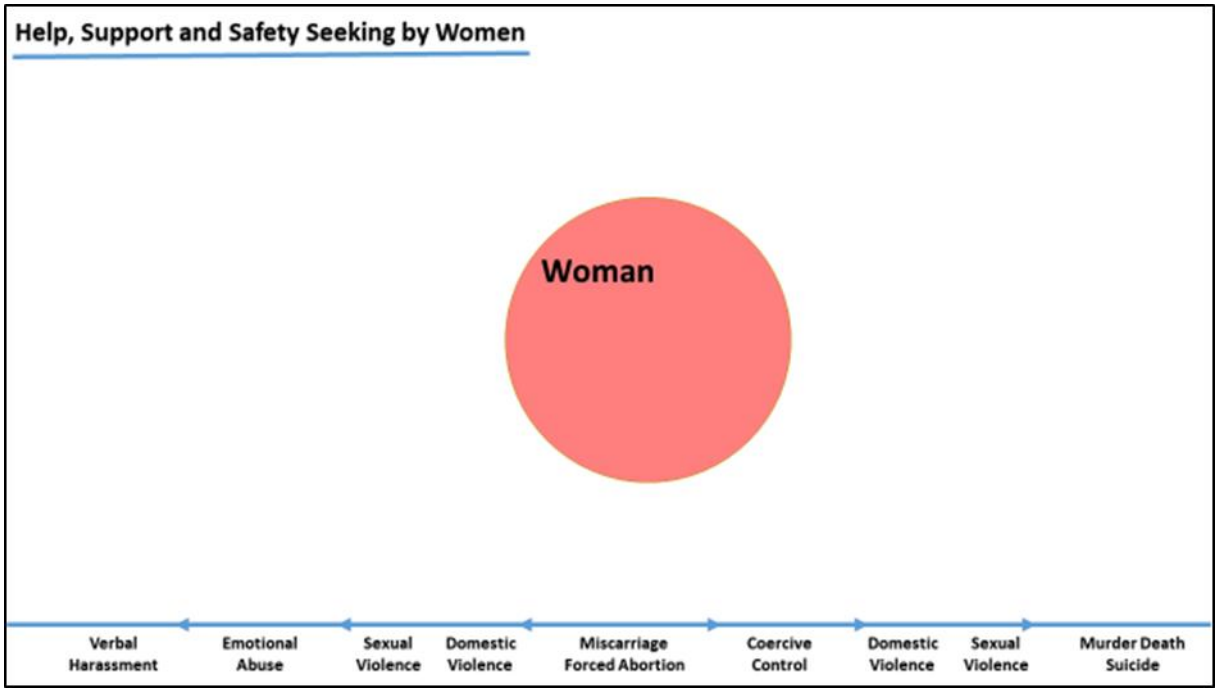
Figure 5 (1) places the woman at the epicentre of the research study in understanding and identifying what helped women, and what did not, in seeking support, safety and appropriate services. As qualitative research in Ireland, specifically on domestic violence and pregnancy, is absent, the voices and experiences, collected through interviews with women, needed to be central to all aspects of the study design and approach. Therefore the woman herself, as the expert on her lived experiences and resultant reflections, opinions and understandings, is the foundation and centre of the Conceptual Framework and of the study design, being congruent with feminist research approaches.

Figure 5 Study Conceptual Framework 1



The forms of abuse experienced by women while pregnant are outlined in Figure 6 (2) as well as potential outcomes of abuse such as miscarriage, suicide and death. The escalation, de-escalation, re-escalation and ongoing nature of domestic violence is indicated by the small arrows, in different directions, along the base of the framework. This is used in order to visualise the patterned and continued aspects of domestic violence.

Figure 6 Study Conceptual Framework 2



The next figure 7 (3) superimposes the three potential outcomes for a pregnant woman in the study, noting that a pregnancy may end in a live birth, termination or miscarriage. Arrows on the trajectories indicate a women's route or journey moving forward and seeking help and safety, regardless of the outcome of her pregnancy. With the pregnancy outcome of live birth, baby is also added as this may impact on woman's choices and help seeking post-pregnancy. The image also visualises domestic violence occurring during and continuing post-pregnancy.

Figure 7 Study Conceptual Framework 3

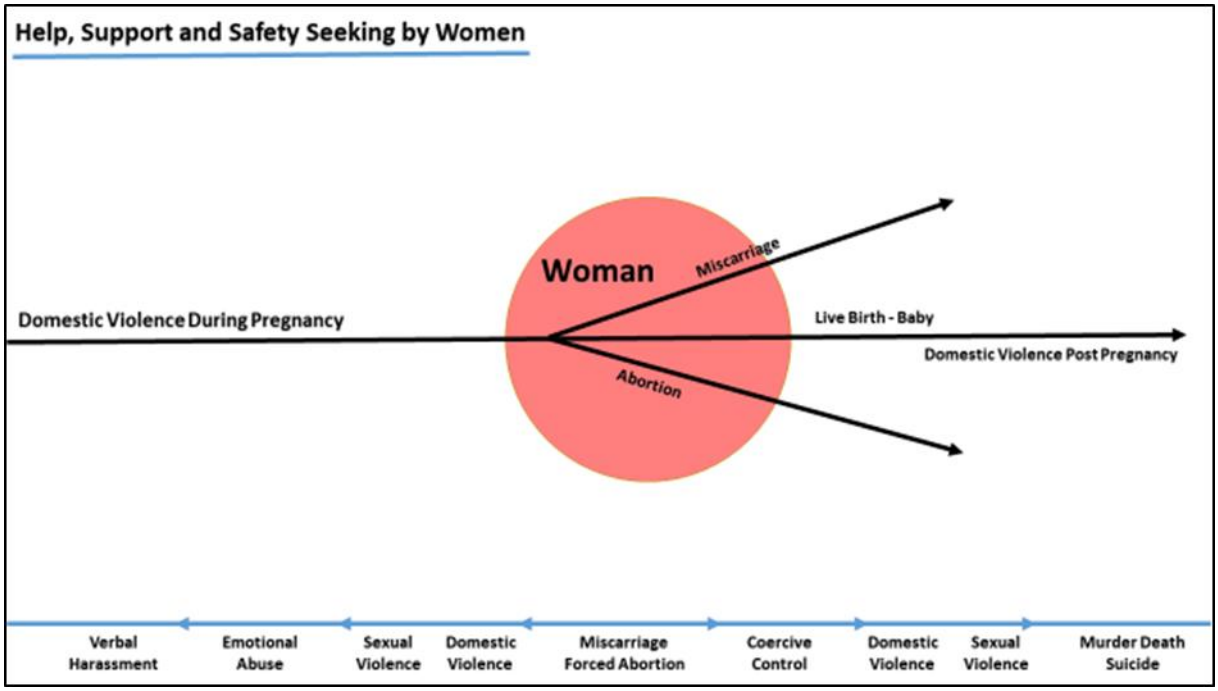


Figure 8 (4) locates the woman's partner within the framework by superimposing him (all perpetrators in this study were male) around the woman. Her partner may have been a current or ex, partner, boyfriend or husband, at the time of the birth. The woman may have left him prior to the end of pregnancy or he may have left her prior to the birth. However, this relationship with the perpetrator, ongoing or ceased, and his geographical proximity to her, has implications for the woman in relation to her help and safely seeking. As a result the visualised image of the partner is located around the central representation of the woman and includes the 'live birth' text too. Women were asked in their interviews "When you sought help what was your relationship with the perpetrator?" to gather data on this aspect of women's experiences. However, this question addition occurred after the Conceptual Framework was developed and after five study interviews had taken place when the potential importance of the relationship status was noted.

Figure 8 Study Conceptual Framework 4

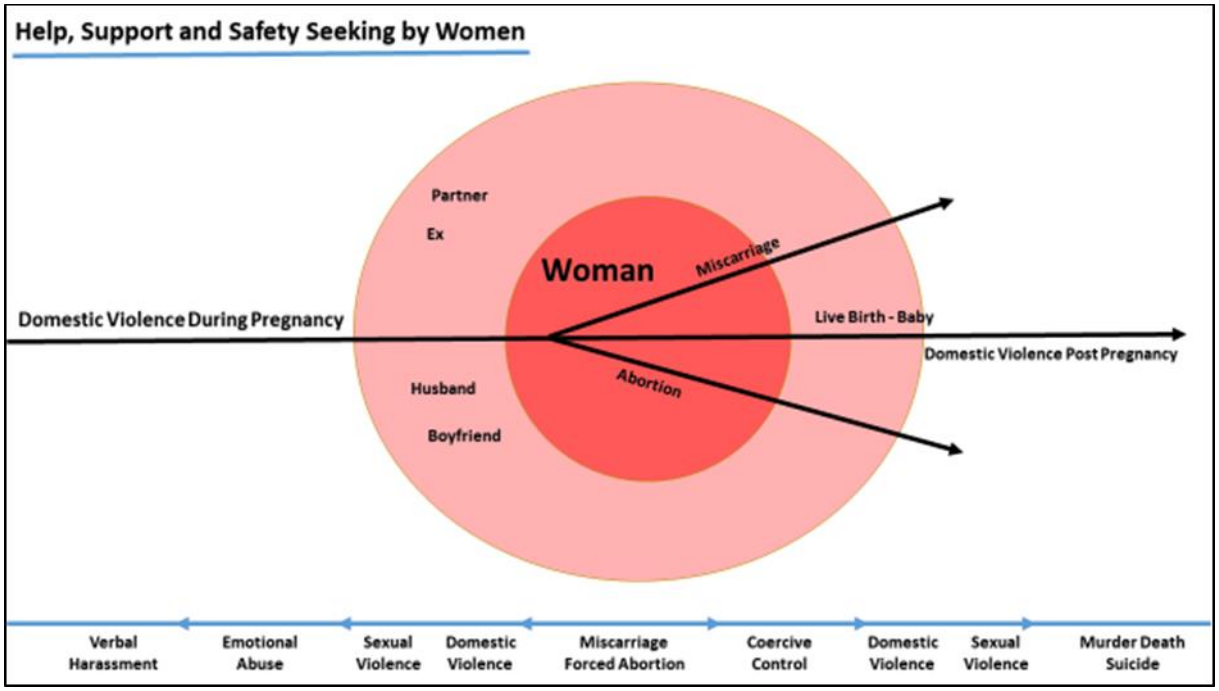


Figure 9 (5) includes the woman's family, children and friends in the framework. As multiple research studies in Ireland have indicated (Watson and Parsons, 2005, European Union Agency for Fundamental Rights, 2014) women very often seek advice and support from family members and friends prior to any disclosure to police, health, social, and/or domestic violence services. Women in Ireland have reported lower rates of disclosure to formal services and higher rates of managing domestic violence themselves and/or with the help of friends or family (Tusla, 2016). Women may also consider the impact of domestic violence on their children, if they have other children prior to their pregnancy. As a result family, children and friends make up a large image in the study framework and overlap with the live birth and domestic violence post pregnancy text.

Figure 9 Study Conceptual Framework 5

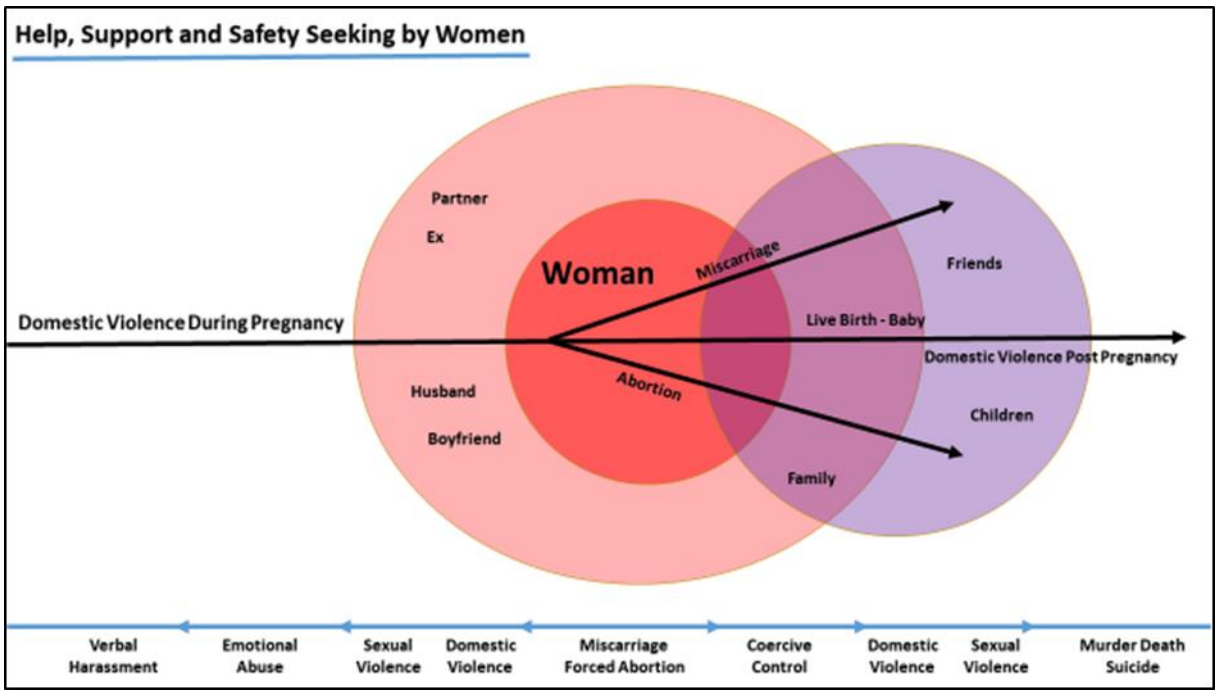
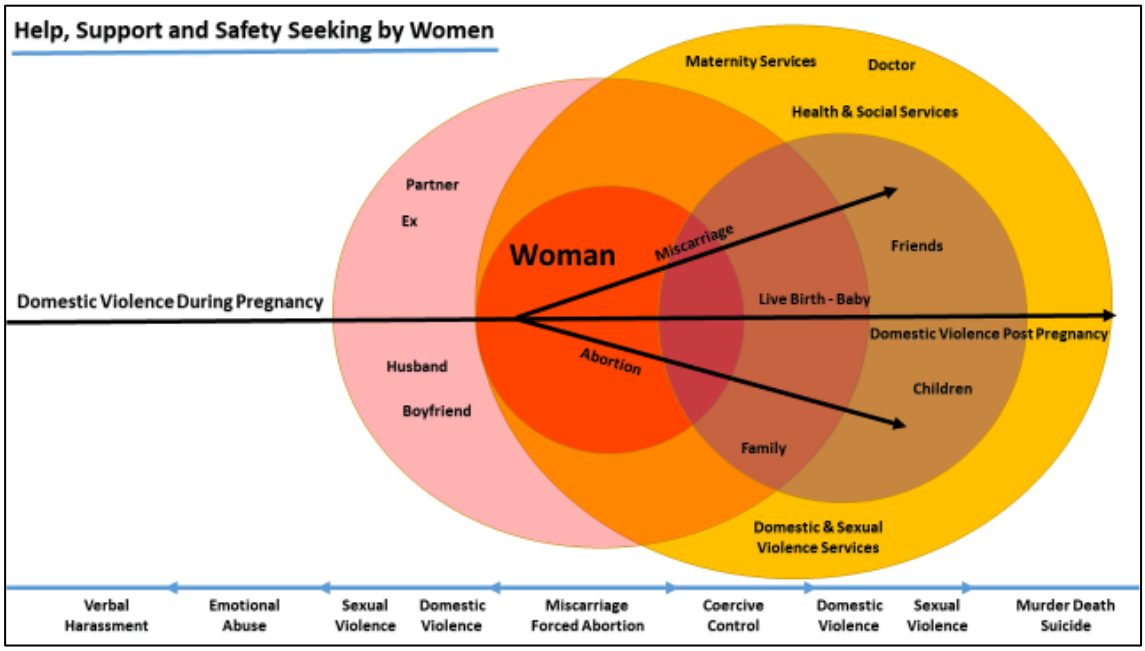


Figure 10 (6) includes the services that women are accessing in relation to their pregnancy, birth and health such as maternity hospital services, doctor (or general practitioner, GP), public health nurse (PHN), child health services, etc. Health services also include addiction, both drug and alcohol, services. Social services and child protection staff, such as family support workers and social workers, are also incorporated here. As recruitment for the study interviews occurred via domestic violence services across Ireland and contact with such services was an element of study inclusion criteria they are included in this large image which envelopes the woman and covers all three potential pregnancy outcomes. Sexual violence services are also included in this element of the framework as women may have accessed these services or may be pregnant as a result of rape within their relationship.

Figure 10 Study Conceptual Framework 6



The figure 11 (7) adds to the framework relevant services in relation to: justice, crime and the police (Gardaí); welfare, as providers of social protection, welfare payments and child benefit and advice; housing, which is not specifically domestic violence refuge and crisis accommodation services; and other community based services such as citizen's information centres, information services for migrant women and local charity organisations who do not have an explicit remit in relation to domestic violence.

Figure 11 Study Conceptual Framework 7

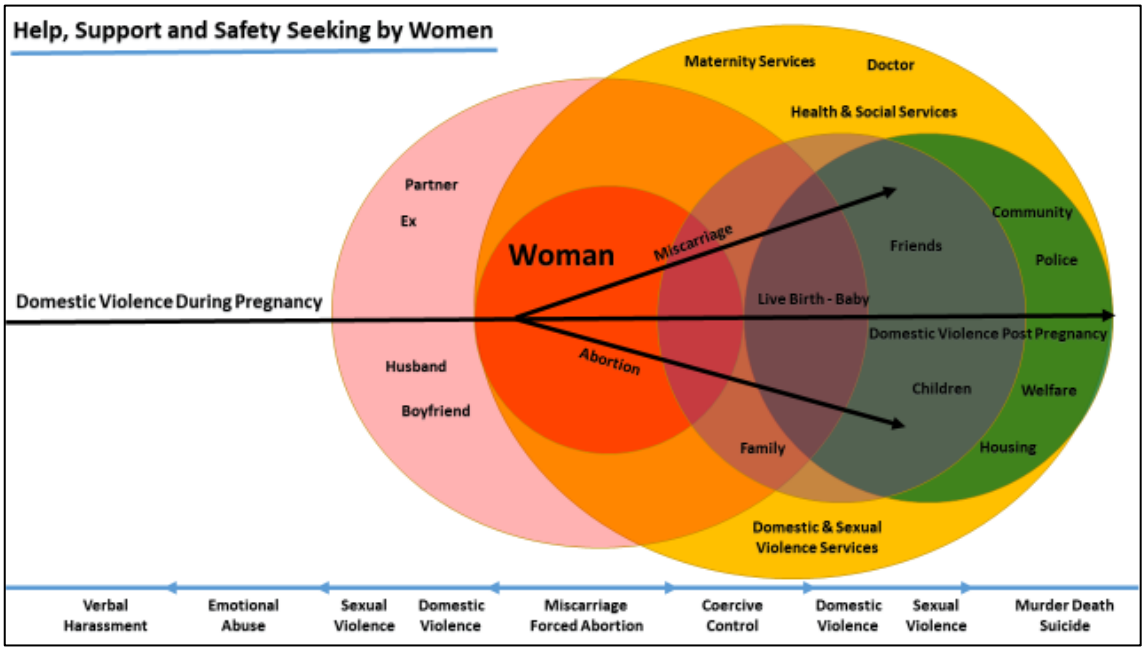
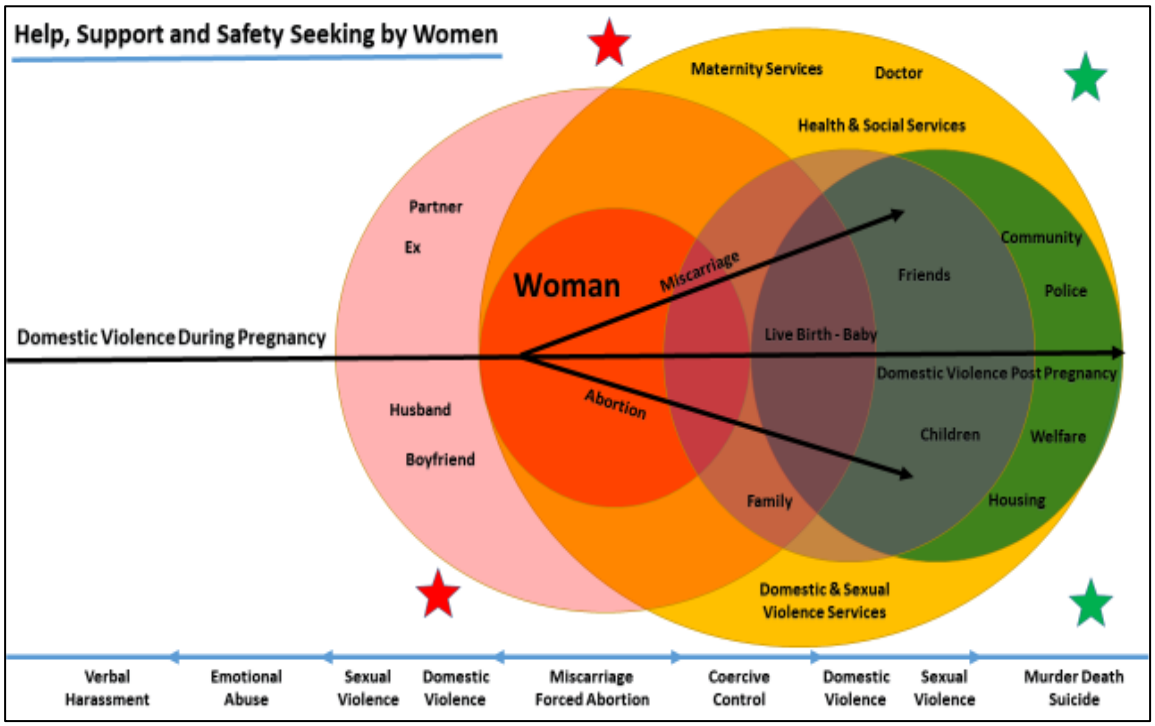


Figure 12 presents the final complete study Conceptual Framework with all the framework elements interrelated and interconnected. The images of green stars hovering over the front of framework symbolise enablers, or positive catalysts and experiences which stimulate, enable or support a woman in her help seeking trajectory. The red stars, further back in the image of the framework represent inhibitors or negative catalysts: the events, responses and experiences which discourage, hold back and inhibit a woman from seeking help, support and safety. These enabling and inhibiting elements of women's experiences are often unpredictable, random and may not be directly related to services she is linked in with or attempting to access. However, the nature and timing of the enablers and inhibitors that women encounter have repercussions in relation to women's experiences and can act as powerful stimulants or deterrents on routes to help, support and safely seeking.

Figure 12 Study Conceptual Framework Final



The study Conceptual Framework has been utilised in presentations on the preliminary study findings at conferences and to research colleagues. It was employed to open interviews and contextualise the study with key informants once data collection with women, the primary study participants, was complete and it has acted as a reference point for the synthesis and discussion of relating variables and aspects of women's experiences. The Conceptual Framework provided the structure and conduit for coding and systematic analysis of study data. Feedback on the framework from peers and colleagues and international experts on domestic violence, including during pregnancy,

has been exceptionally positive. The Conceptual Framework relates to the study epistemological and methodological approaches of feminism and intersectionality by locating the woman at the centre or core of the study and by acknowledging the interconnected, overlapping, interrelated personal characteristics as well as the influences and contexts that women live with and in and move between while seeking help, support and safety.

Study International Expert Advisory Group

An international advisory group to provide guidance and practical support to the researcher was established in spring 2016. The aim of the Group was to advise on the successful and timely implementation of research study aims and objectives by drawing on member's knowledge and expertise to provide guidance and insights on the topic, research process and area of domestic violence. Potential Group members were contacted by the researcher and asked if they would be able to respond to email, phone/Skype or in person to requests for guidance, support and suggestions during the PhD study in a timely manner. By May 2016 four experts based in Australia, Belgium, Norway and Portugal had agreed to be in the Group. The Group members were sent updates on the study progress and information on challenges and any issues arising approximately three times a year. Recommendations and suggestions from the Group provided vital support to the researcher, especially during the challenges in finding interviewees early on in the study. The researcher was invited by one of the Group members to present on her study design and preliminary findings in OsloMet University and at a conference celebrating 200 years of midwifery education in Norway, hosted by OsloMet University, in February 2018. Membership of the Group is detailed in Appendix 1.

Chapter summary

The research study aims to explore the factors associated with the disclosure of domestic violence and subsequent positive service utilisation during and after pregnancy by women in Ireland. The development of the study Conceptual Framework allowed the visualisation of the complexity and interconnected nature of women's paths to safety and help seeking and the multiplicity of potential enablers and challenges during this process. The Framework presented the numerous services and professionals who may interact and care for a woman during pregnancy but also to breadth of people and agencies women may seek support, protection and information from in relation to pregnancy and domestic violence. The study Conceptual Framework assisted with study data collection by ensuring that prompts and probes for the

broadest range of supports and services were utilised in study interviews. It also informed the methodology utilised and the data analysis by creating categories in which to interpret and visualise study themes. Seeking advice, suggestions and feedback from a range of professionals, service providers, research colleagues and instigating an International Expert Advisory Group for the PhD study, was imperative to commence and continue the research study despite issues and challenges emerging that will be described in the next chapter.

Chapter 5 Methodology, Methods, Ethics and Study Design

Introduction

This chapter outlines the methodology chosen to undertake the study. It discusses the methodological decisions undertaken, the philosophical underpinning of the study, the study ethical and safety considerations and REC application, the methods associated with the study and it details the analytical method utilised with the subsequent collected study data. The rationale for decisions taken in relation to the study methodology and data collection approaches are presented and researcher standpoint and reflexivity are also discussed.

Qualitative research

Quantitative research findings in Ireland, and globally, demonstrate that women experience domestic violence during and after pregnancy and that it is strongly associated to poor health outcomes for mother, foetus and child, see Chapters 2 and 3. Prior research conducted in Ireland in maternity hospitals on domestic violence, pregnancy and screening had been by self-completion questionnaires (O'Donnell et al., 2000, McDonnell et al., 2006). The national study on domestic abuse utilised quantitative telephone surveys to gather data (Watson and Parsons, 2005). The FRA Survey, using a quantitative nationally representative sample with face to face survey questionnaires, provides the most recent data on violence against women in Ireland (European Union Agency for Fundamental Rights, 2014). Administrative data from domestic violence services, refuges, helplines, etc. report that women are accessing their services while pregnant or shortly after birth, across Ireland. However, these studies are lacking the insights and lived experiences that are present in qualitative data. Missing from these studies are the voices, experiences and opinions of women that can only be gathered from qualitative in-depth interviews, especially in relation to pregnancy and domestic violence. If there is truly to be policy and practice recommendations arising from this research study that articulate the needs of women, their voices and experiences must be listened to, collated, analysed and reported. This missing Irish data relates to the lived realities of women in these situations and what they find supportive, useful and accessible in relation to help and safety seeking. Qualitative research approaches are the ideal route to gather this data as they are concerned with meaning, context and lived experiences. How these experiences are interpreted and understood by the research participants themselves, together with elements of reflexivity and subjectivity on the part of the researcher are core to

qualitative research (Guest et al., 2013). As recounting the experience of living with domestic violence during pregnancy is potentially traumatic and distressing, one to one in depth interviews were deemed the most appropriate for data collection given the privacy they offer the interviewee, especially in an often busy and full refuge setting (Guest et al., 2013). In addition, the safety of study participants was a constant core consideration of the research design and would necessitate sensitive recruitment with confidentiality and risk assessment procedures very robustly in place.

Population to research

Deciding on the exact population to research for a PhD study means focussing on the sample who will be best in a position to provide data and insights relevant to the research question. Although research on this topic with relevant health care professionals in Ireland was extremely limited, including this cohort as a part of the study sample was ruled out at the start of the PhD. This was for logistical reasons related to the potential challenges of finding participants for the study and the complexity of recruiting midwives, general practitioners (GPs) or obstetricians which would require multiple research ethics committees' applications to professional bodies, as well as to hospitals. Two relevant research studies in Ireland on the topic emerged during this study: a postal survey conducted by the Irish College of General Practitioners on its members (O'Shea et al., 2016) and a master's thesis examining midwives views of screening patients for domestic violence in a Dublin maternity hospital, utilising qualitative interviews (Webster, 2018). In addition, a PhD thesis published in December 2015 had interviewed general practitioners, practice nurses and administrative staff in GP practices in Ireland in relation to domestic violence, but not specifically in relation to pregnancy (Lawlor, 2014). These three studies all focused on the experiences of health care professionals in Ireland, with the women at the centre of this topic still not being researched. As a consequence, the sample for this study were women with relevant experiences (domestic violence during pregnancy and help and support seeking) as they were underrepresented in research in Ireland. A small purposive sample of highly experienced staff in key services would be interviewed at a later stage in the study to discuss preliminary study findings and their related work experiences.

Methodologies chosen and rejected

According to some researchers there is an absence of current theory that provides an integrated research framework for investigating domestic violence and pregnancy: therefore a theoretical framework to guide current and future research is needed in

order to progress research on the issue (Van Parys et al., 2014). Given the researcher's prior experience working on five studies on violence against women, (both national and multi-country), safety concerns related to the sample and the study time constraint of three years, some methodologies were discounted early in the study: such as action research, (auto)ethnography and heuristics as being un-workable or not suited to the topic. The study began utilising a classical Grounded Theory methodology; readings were undertaken, as well as lectures, workshops and training attended on the methodology during the initial year of the PhD. This methodology was vigorously promoted by two of the author's first PhD supervisors to the exclusion of all other methodological options. This promotion was without guidance, or reflection, on how well it might suit the topic being researched, including the logistics of recruitment and interviewing and the diversity and safety needs of the population agreeing to be interviewed. Issues with the classical Grounded Theory methodology became very apparent in the second year of the study. A potential for incomplete theoretical saturation given the wide variations in the study interviewees' demographics such as nationality, parity, age, etc. and their experiences, the immense challenges of study interviewee recruitment leading to potentially incomplete theoretical sampling and the possibility of multiple or repeated interviews for theory testing with the same study population/women becoming highly unlikely for many reasons, including women's safety and mobility. The time pressure for PhD completion can also limit the time that comprehensive theory-building calls for in Grounded Theory (Timonen et al., 2018). The impossibility of undertaking back to back interviews, while being fully consistent with Glaser's requirement for constant comparative analysis, which dictates that data collection occurs then immediate analysis, became a further impediment to working with classical Grounded Theory for the study (Glaser, 1978, Sullivan and Cain, 2004).

Many of these challenges have been outlined by researchers such as in work by Timonen and colleagues (2018) and Thomas and James (2006). Taylor argues that Glaser is unable to take into account the subjective nature of knowledge gathered through qualitative research by humans, leading to a reliance on description and not conceptualisation, in his ongoing defence of the form of Grounded Theory he developed (2013). A key issue in utilising the classical Grounded Theory was also the requirement of the researcher to be a blank slate and avoid any in-depth reading of relevant literature until data collection is complete (Glaser and Strauss, 1967). This was particularly challenging when I began lecturing midwifery students on domestic violence and pregnancy in Trinity College Dublin one month after starting the PhD study and continued teaching until the end of the study (Autumn 2018). Years of prior

work and research experience in relation to violence against women accrued by the author would be impossible to conceal, forget or deny. Many of the interviewees began their interactions at the start of the interview process by asking about my previous research and work experience in the field. This particular requirement of classical Grounded Theory has been dismissed by some academics (Bryant and Charmaz, 2010, Timonen et al., 2018). The final disenchantment with classical Grounded Theory and its subsequent rejection by the researcher, occurred when I was explicitly told on numerous occasions by my first PhD supervisor to plan to attend a workshop led by Barney Glaser in the USA and that he would identify the themes in the study data by reviewing an interview transcript. Due to these experiences and considerations the initial study methodology was deemed unsuitable and unworkable for the study and needed to be changed. However, some core methodological concepts from Grounded Theory were useful including; being and/or remaining open to data sources, flexibility and intensely listening to and probing for the main concern of the study participants, which were utilised throughout the all data collection phase of the study (Timonen et al., 2018).

Action research is concerned with participants' empowerment and integral involvement in the doing of the research, both of which are especially pertinent in researching domestic violence. But the ongoing engagement needed with the same participants over time was deemed unrealistic given many women's need for mobility in seeking help and safety and the potential for rapid changes in their circumstances. Case study research was also considered and training attended on this type of research method. But as the primary data would be interview recordings, notes and transcripts and as case study research would optimally require patient medical notes as well as other forms of client or patient data, it was also rejected. Domestic violence during pregnancy is an exceptionally gendered topic, it requires conceptualisation and a methodology that considers power, gender inequality, including gender pay gaps, social and cultural norms and the additional vulnerabilities women can experience during pregnancy. As a result an exploratory study, utilising feminist and intersectionality epistemology and methodologies, qualitative in-depth semi-structured interviews and inductive thematic analysis, all informed by and located in a unique study Conceptual Framework, were chosen and utilised by the researcher.

Researcher standpoint, reflection and flexibility

Where a research question starts from, and expands to, are highly influenced by a researcher's prior experiences and standpoint. Work experience, research roles and

volunteer work gave me insights into the complex intersections of issues that vulnerable women live and cope with, including poverty, violence, addiction, sex work and a life changing/ending viral infection. Working in a woman's refuge for two years gave me considerable insights to on how the study needed to be designed and implemented. Training and teaching health care professionals in relation to gender based-violence (GBV) since 2008 allowed me to comprehend the pressures and challenges in health care provision to women experiencing complex social issues while still delivering culturally competent patient or client centred care. In addition to a very strong feminist upbringing these experiences informed how, where, with whom and why the study was taking place and the design and approaches to it. Feminist methodology emphasises the potential for exploitation through research but highlights the need for researcher reflexivity to assist in mitigating against this risk (Ward and Wylie, 2014).

Given attention in national guidelines and policies on screening for domestic violence in health care settings, my initial expectations were to interview women and hear about their experiences of being screened (questioned or asked) during their maternity care. I expected that these questions on women's marriages or intimate relationships and safety, would be an ongoing and integral part of ante and post-natal care for women, both in GP and maternity hospital settings. I expected that accessing domestic violence services while pregnant would be relatively straightforward for women and that it would be easy to encounter or locate details of local services for women to engage with and utilise. Finally, I anticipated that much of the shame and the concealed and hidden nature of domestic violence observed while working in a women's refuge and with Women's Aid in Dublin from 1998 to 2000, would have been replaced with more openness about the issue. Within the study interviews I expected I would encounter a definitive shift towards responsibility being placed upon the perpetrator for violence. Women recalling a pro-active and safety focused response by the health care professionals that they encountered was also anticipated, in advance of field work.

Reflexivity on the researcher's part also includes positioning themselves within the wider arena in which they are researching, being cognisant of this setting and policy changes (Ward and Wylie, 2014). Throughout the study I met with domestic violence service staff and other key professionals to promote recruitment for the study and to hear their thoughts on the issue of domestic violence and pregnancy. Feedback, comments and insights from these meetings greatly assisted with study design and provided information and observations arising from years of work supporting women and children in relation to domestic violence. I took part in seminars, training and

conferences in Ireland on domestic violence which allowed for the promotion of study participant recruitment to gatekeepers. Challenges in relation to interviewee recruitment were overcome by listening and responding to gatekeeper concerns and amending the study documentation and inclusion criteria and revising the Research Ethics Committee application, in order to respond to their concerns. During my PhD I lectured student midwives from October 2015 to September 2018 in the School of Nursing and Midwifery in TCD specifically on domestic violence and pregnancy. These lectures provided more insights as to the working conditions, privacy concerns, time pressures and other challenges for midwives in relation to screening, through feedback and comments the students provided. These lectures also confirmed the exceptionally brief and limited teaching and training that midwives receive in relation to domestic abuse: approximately four hours over a four year undergraduate degree or one year higher diploma in midwifery.

The policy and legislative terrain in Ireland changed during the study, as well as my academic location, from the School of Nursing and Midwifery to TRiCC and the School of Social Work and Social Policy. Eighteen months into the PhD study a new supervisor was allocated when I moved Schools within TCD. Ongoing international/national training, conference presentations, expert meeting attendance and participation occurred throughout the PhD. Presentations on the topic and preliminary study findings at conferences in Ireland, Portugal and Norway occurred. Feedback and comments on the study design, preliminary findings, study recommendations and sample demographics were gathered at these presentations. Ongoing communication with the study Expert International Advisory Group in relation to overcoming research and recruitment challenges and to seek advice and support took place, the expertise and guidance received from the Group was very important. Researcher reflection and flexibility encompassed responding to the challenges arising during the study through incorporating knowledge gained from multiple sources into the design, approach, actual undertaking the study and re-orientating aspects of the study as required and necessary.

Feminist research methodology

The development and establishment of philosophical and epistemological underpinnings began with symbolic interactionism (used in classical Grounded Theory) and reading Foucault to address issues such as power and his conceptualisation of the medical gaze (Foucault, 1982, Agamben, 2014). Classical Grounded Theory became less feasible to utilise once study interviews began. More reading critiques of Foucault

occurred, which highlighted his neglect of gender and lack of emphasis on economic or financial power dynamics which made employing his postmodern discourse analysis unsuitable, given the highly gendered nature of study topic (Walby, 1990). This led me (back) to feminist methodology as the methodological approach to be utilised, being guided by the research question, the study sample and the envisaged outputs that research findings can be applied to. Critical social theory suited the aim of undertaking a research study in order to assess uncontested beliefs on domestic violence and pregnancy and related power structures, but as women are centre to the research design, feminist methodology is more suited to the study than critical social theory approaches (Welch, 2014).

Feminist research methodology is embedded in the concept that feminism is primarily a movement for social change, thus the research methodology is the route to find out what requires change and how change can potentially occur (Westmarland, 2001). Two key questions need to be posed to ensure that feminist methodology is suited to the research topic: 1) is the research primary concerned with women? and 2) is the aim or focus of the study bringing into public awareness the topic or issues being researched? (Welch, 2014). The responses to both these questions reaffirmed the potential to use feminist methodology to the researcher. The study sample proposed is relevant to utilising feminist research methodologies, which are designed to centre stage women's lived experiences. As women, not their health care providers, were planned to be interviewed for the study the sample also fits with feminist methodology. Qualitative methods are usually the primary preferences in feminist research as they are perceived to be closer to discovering women's own experiences and as a result their own standpoints (Walby et al., 2017). The core aim of feminist qualitative research to listen to women's voices and validate their experiences, it is well oriented towards in-depth interviews which are a key method utilised by feminist researchers (Kitzinger, 2004). Feminist epistemology fundamentally relies on women's knowledge and experiences, it uses thoughtful study design which is not potentially harmful or exploitative to research study participants and it works towards liberation and equity for women (Crotty, 1998). It recognises women's beliefs, opinions and experiences as genuine and authoritative sources of knowledge and explores how gender inequality can be addressed and rectified (Welch, 2014).

For feminist researchers participants talking about their lived experiences is evidence that it has happened, there is no need to correlate interviewee data with other data sources to ensure that it is valid and true. This resonates with the research topic of domestic violence as one of the key issues women articulate as needed when they

seek help or support is belief in their disclosures of abuse (Health Service Executive and Sonas Domestic Violence Charity, 2018). Feminist research aims to produce meaningful research outputs that can be used for creating or lobbying for change and women's empowerment, as a result there is political and dynamic core to it as a research methodology (Lentin and Byrne, 2000). As a result building networks and coalitions as part of the research process is fundamental to feminist methodology in order to leverage potential change identified via the research (Ward and Wylie, 2014). Challenges to utilising feminist research methodology are the diverse and contested opinions as to what exactly constitutes feminist methodologies (Lentin and Byrne, 2000) and the obligation on the researcher to represent and report on the breadth of data that women articulated and divulged during interviews or data collection (Kitzinger, 2004). Feminist researchers try to involve the participant in the research process as much as is possible and are cautious to avoid conducting interviews in any way that could possibly coerce or exploit interviewees (Westmarland, 2001). Recognising the importance of women's lives and experiences as a legitimate study topic and contextualising this within the location of women's position in social structures is a core element of feminist research (Baird and Mitchell, 2014). Baird identifies that there are varying perspectives challenging what constitutes feminist research but highlights that it should: recognise the relationship and interface between researcher and study participant; identify that gender and gender inequality are key factors influencing the lived experiences of women; and promote a commitment to openness, explanation and understanding (2012). Feminist research can be utilised with a range of research methods, as Kelly, Regan and Burton point out "what makes feminist research feminist is less the method used, and more how it is used and what it is used for" (1992 p.150).

Feminist research methodology: pregnancy and birth

A core feminist principle is that gender is considered a key determinant of social status. As pregnancy and giving birth are gendered activities that pertain to women only there is potential to harness feminist methodologies and use them for research studies on pregnancy. Feminist research should be undertaken in order to lobby for change in areas that impact on women's lives: pregnancy and birth in relation to domestic violence is such a field (Baird and Mitchell, 2014). According to Walsh, midwives themselves should self-declare as feminists and adopt a feminist lens to view midwifery practice through (Walsh, 2016). Walsh proposes that respecting women's choices and facilitating their agency in relation to birth is a core aspect of being a midwife but also core to being a feminist. Walsh describes feminist values as: listening to and valuing women's voices and versions of events; believing in the primacy of women's

experiences; recognising gender equality and woman centred care; and taking action for empowerment and emancipation- all of which are as relevant for research in addition to supporting women during birth. Walsh suggests that midwifery research, which is relevant to this study, should adopt feminist research methods (2016). This study although not with midwives, does investigate a topic that is at the heart of midwifery, care of women through pregnancy and during and after birth.

How is this study utilising feminist methodology demonstrated?

The research question and topic, the study sample, a focus on researcher reflexivity, which are core to this study design, are all appropriate for feminist methodology utilisation. A commitment to feminist principles, acknowledging the potential for power differentials between those doing the research and those sharing their lives and experiences with the researcher and attempting to mitigate against them and comprehending that women are the experts of their own worlds, are core to feminist research and are embedded in the study design and approach (Lentin and Byrne, 2000).

Intersectionality

Intersectionality, according to Hancock, is a research paradigm and an approach to undertaking research that emphasises interactions between categories of individuals, such as ethnicity, class, gender, sexual orientation, in addition to other categories and characteristics (2007). By its nature intersectionality is interdisciplinary and contemplates the dynamic interaction of individual characteristics, or social categories, with social structures and institutions to assess how they enable or detract from equality, potential for justice and political access (Hancock, 2007, Collins, 2015). As a result the concept can be utilised to assess where and how policy and state (or other) service provision is meeting, or failing to meet, the needs of those on the periphery of society. Lockhart and Mitchell define intersectionality as:

> "..a conceptual framework, a methodology for practice and research, and a catalyst for social and economic justice agendas to address social issues, .." (2010 p. 17).

Intimate partner violence is one of the social issues to which, they suggest, intersectionality can be applied for research purposes. Intersectionality is also a theory which examines how individual characteristics and hierarchies of power and oppression interact, construct and re-reinforce each other, fundamentally it is located in praxis and commitment to social justice (Withaeckx, 2017). Intersectionality can be

described as a research paradigm that explores and acknowledges multiple axis of difference (Hankivsky et al., 2014). The concept of intersectionality was primarily introduced into academic use and broader acceptance with the work of Crenshaw, who used it to discuss the multiple oppressions that women in abusive relationships may be experiencing (1991). Crenshaw outlined how violence experienced by women is influenced by various elements or aspects of their identities, in particular by race, and by not acknowledging these differences, both within and between groups of women, it can inadvertently reduce or hinder broader attempts to address violence against women at multiple levels (1991). Crenshaw's analysis of intersectionality hinges on structural intersectionality and political intersectionality, whereas Hancock, another key intersectional theorist, focusses on the potential fluidity between categories and how such categories have the potential to be dominant or equal to each other (Walby et al., 2012). As a result of the emergence and discussion of intersectionality, feminist analysis began to embrace this new theory and apply more focus on the intersection of multiple inequalities when researching women's lives (Walby et al., 2012). By failing to address and consider intersections for women, barriers can be exacerbated, or created for women seeking a life free from violence and can even be implemented by those in help providing settings, thereby reproducing what Crenshaw describes as intersectional subordination (1991). Hancock recognises that the multiple forms of marginalisation or oppressions that women experience may create policy challenges that are greater than the sum of their parts and become a form of "interlocking prison" with serious repercussions for women (2007 p.65). This model of interlocking interconnectedness is utilised to describe intersectionality, as the interlocking patterns of gender, race, ethnicity, class, disability, etc. all impacting upon women (Nixon and Humphreys, 2010). Baird and Mitchell frame intersectionality as a methodology with which to consider how hierarchies of power exist with and, influence class, gender, race, etc. (2014).

There are challenges with utilising intersectionality as a methodology: Carbin and Edenheim discuss a theoretical vagueness to intersectionality and propose, given its flexibility and application, that it can be utilised by almost anyone in multiple settings as it resonates so widely (2013). They comment that power has more than one dimension and link intersectionality to Foucault and his perspectives on the subject (Carbin and Edenheim, 2013). In a response to this universality and vagueness McKibbin and colleagues acknowledge that there is confusion as to the exact definition of intersectionality, but see it as a useful and worthwhile tool to progress feminist theory and practice (2015). They present intersectionality as a feminist discourse, which

acknowledges diversity and explains how different groups of women live with, and experience, disadvantage (McKibbin et al., 2015).

This form of discourse is helpful to enable the experiences of marginalised women to be heard and also allows for researchers and policy makers to dialogue together on this diverse range of experiences of women and outline future responses to them (McKibbin et al., 2015). Walby proposes that a challenge of the simultaneous theorisation of multiple and complex disadvantages or categories is that they cannot be simply added up to assess their impact, as they can modify and change one and another (2007). The actual point of intersection can re-enforce or create, in some situations, new categories of disadvantage for women (Walby, 2007). Walby suggests that we centre the inequalities experienced by women rather than relegate them to the periphery of social theory when utilising intersectionality (2007).

However, a lack of research utilising an intersectional methodology and the underdevelopment of intersectional research methods and study design do pose practical challenges to researchers wishing to utilise it (Hankivsky et al., 2014). Intersectionality is a research paradigm useful for researching, understanding and addressing the ways in which gender intersects with other identities or categories, but there still exists potential for even more methodological development and advancement (Hankivsky et al., 2014)

Intersectional research is distinguished by the inclusion of marginalised perspectives and making the lives and experiences of marginalised groups visible (Withaeckx, 2017). The core assumptions of intersectionality methodology according to Hankivsky et al, are to; recognise that all members of a social group don't necessarily have the same experiences (i.e. lesbians, migrant women, Travellers, etc.), therefore humans cannot be separated into elements or an essentialist approach taken, with intersectionality adopting a context specific approach. Intersectionality attempts to comprehend what happens at the intersection of two and/or more forms of oppression experienced by an individual or group. It is proposed that researchers undertaking intersectional studies must be committed to social change and social justice and be engaging with a range of stakeholders. This is required both to do the research and to inform and leverage subsequent change (2014). Researchers, Withaeckx suggests, need to be cognisant of the following when adopting an intersectional methodology; that their research is not overly descriptive and must attempt to unpack systems and power dynamics that enable oppression (2017). Any research findings must empower the individuals that participated and not reproduce or reinforce the inequalities they live with. If there is a limited focus on only certain categories or structures then this could

reduce the insights generated via the research; and finally the researcher must reflect on and acknowledge their privileged position as they undertake research on marginalised groups (Withaeckx, 2017).

Intersectionality methodology and domestic violence

The contribution intersectionality makes to a traditional feminist framework on violence against women is to explore the role of culture, expand definitions of abuse, look at the structural causes of partner violence and shift from disempowering presentations of vulnerable and marginalised female victims to resourceful, active survivors of violence (Sokoloff and Dupont, 2005). The social contexts that humans live in are formed and maintained by intersecting systems of power and of oppression, which modify and interact with each other to frame what safety from and responses to domestic violence consist of or imply for individual women (Sokoloff and Dupont, 2005). The reality is that women's experiences of abuse are qualitatively different and that patriarchy manifests itself differently in different contexts and cultures, therefore research must be informed by these differences (Sokoloff and Dupont, 2005, Montoya and Rolandsen Agustín, 2013). Barriers to leaving an abusive partner can be highly specific and impacted by intersecting oppressions. Crenshaw highlighted the particular vulnerabilities of migrant women such as those who are dependent on their spouses for legal migrant status and for information on their migration status which act as a structural barriers to service engagement (1991). Migrant women can have very precarious legal and housing situations, they may not have citizenship status and subsequent entitlement to services in the country they are living in and may be more dependent on their violent partner due to poverty and isolation; as a result their resources to leave their abuser may be minimal, or substantially reduced (Montoya and Rolandsen Agustín, 2013). Lockhart and Mitchell maintain that any failure to understand the lived experiences of survivors of violence from a holistic contextual framework can result in significant consequences for women who are already marginalised. This is especially relevant in understanding the support and help seeking patterns and routes of migrant women from abusive relationships (2010). Minority ethnic and migrant women may take differing routes for seeking help regarding abuse, or have reduced knowledge or access to routes, due to their isolation and language barriers: this needs to be addressed in research (Nixon and Humphreys, 2010). Women living in very remote, rural settings, women with disabilities, women living in poverty and migrant women all need to be included in research on violence against women. By giving attention to diversity in study sampling and acknowledging the greater risks and vulnerabilities that these women can experience through culturally competent intersectional research the voices of women

traditionally excluded from, or on the margins of, social research can be heard and can contribute meaningfully to research focussed on policy change (Collins, 2015, Nixon and Humphreys, 2010, Sokoloff and Dupont, 2005, Crenshaw, 1991).

How is this study utilising intersectionality methodology demonstrated?

Intersectional research begins with the researcher themselves; it is essential for the researcher to demonstrate reflection and undertake critical and responsible enquiry into complex social issues (Hankivsky et al., 2014, Mattsson, 2013). The dynamic, altering relationship between categories or identities located in individual, group and institution settings need to be recognised by the researcher at the study design phase. An inclusionary approach needs to be taken to hear and incorporate differing experiences, this is essential to ensure the most vulnerable women can participate in research (Montoya and Rolandsen Agustín, 2013, O'Brien Green, 2018a). By extensive national study recruitment and amending the initial study inclusion criteria this was attempted, within the study constraints of limited time and resources. Hankvisky and colleagues noted that an intersectionality methodology has key defining features, based on their approaches to health and health policy research projects in Canada, which are summarised in Table 1 below with corresponding actions and approaches adopted in this study (2014). However, when utilising intersectionality researchers can only address as many characteristics that are presented, or disclosed, by the research participants themselves, they cannot be alluded to or assigned. For many reasons study participants may not wish to reveal or discuss certain aspects of their selves/categories in an interview. For this study the principal inclusion characteristic was an experience of domestic violence during pregnancy and seeking help and support. Elements often considered in intersectional research, for example sexual orientation, did not emerge within this study sample and could relate to the study inclusion criteria or that interviewees did not sense their sexuality was core to the research question. It could also indicate that there are hidden intersections occurring. Socio-economic demographics were not collected during interviews and as a result cannot be factored into study data collation and analysis. Place of residence, while not a stated diversity characteristic, does influence access to services such as refuges, counselling, police and courts: as a result the urban, rural and geographical spread of interviewees in the study is relevant to consider. Working status, length of time living in in Ireland, visa and legal residency entitlements and religion are additional elements that impact on socio-economic status and potential help seeking paths in relation to domestic violence (Collins, 2015 Black and Stone, 2005).

Table 1 Intersectionality Methodological Features and Response by Researcher

Intersectionality methodological feature	**Response by researcher**
Creation of coalitions on social exclusion and marginalisation.	Extensive consultation with domestic violence service providers and other relevant stakeholders took place before and during data collection to ensure study findings could be progressed and utilised post-research.
Meaningful participation of diverse participants in the research.	The study sample was diverse with women reporting 10 nationalities, five ethnicities, at least four religions and having given birth in all four Provinces in Ireland. One study participant had a congenital disability and two others were receiving Disability Allowance state welfare payments. Migrant women's length of time living in Ireland varied considerably in the sample as well as the number of children women had.
Analysis is rooted in the lived experiences of the study participants.	Thematic analysis offered the flexibility to incorporate both feminist and intersectionality methodologies and adapt to the language needs of interviewees.
Role power recognised in creating and perpetuating discrimination, marginalisation and oppression.	Researcher was cognisant of potential power and control dynamics in the sample recruitment and context of interviews and worked to mitigate against them.
Recognise that agency and resistance are identified in the research to avoid over-victimisation of participants.	Identifying the barriers and enablers to seeking help, support and safety by women was the core research question and as a result their resourcefulness, creativity and resilience are highlighted in study findings.

Walby and colleagues reported a lack of inclusion of intersecting inequality in their analyses of gender based-violence policy in Ireland (2012). This suggests a need for culturally competent research on domestic violence in Ireland that is mindful of the potential for major and unique differentials between women's lived experiences of seeking help in relation to domestic violence during pregnancy: the aim of this research study. However, this study was not initially intended/designed as an intersectional study as this would have required deeper initial demographic and other study sample characteristics collection and would have also required a deeper initial assessment of how participants self-define their identity and how their identity shapes their experiences, interactions, perspectives and their lives. As stated above, this study aimed at understanding experiences of help-seeking rather than identify processes in help seeking experiences. Given the diversity of the sample, the inclusion of intersectionality was considered important and as an additional methodological tool/frame. This implied using and including an intersectional lens in the interpretation of findings. Thus, intersectionality was not used at the initial study design phase, only at a later mid-study point and in particular during the analysis phase, therefore extensive characteristics of women were not gathered, nor probed for during their interviews.

Ethics, safety and study design

Research ethics: considerations, application and process

Research with human subjects requires ethical consideration and approval prior to field research, or study interviews in this case, occurring. Work on completing the application for the Faculty of Health Sciences Research Ethics Committee began in October 2015. The researcher attended training on ethical research and child protection, undertook focussed reading, consulted with gatekeepers and experts on domestic violence research and carefully considered the study cohort, research topic and context for the study in order to comprehensively address the ethical considerations of the research planned. Application to the Faculty of Health Sciences Research Ethics Committee (REC) for ethical approval for the study was submitted on 31st December 2015. The researcher was very mindful that the study needed to convince the REC and domestic violence support and accommodation services, who would be the key recruiters or gatekeepers for the study interviews, that the safety of women participating was the primary concern at all times of the researcher. In addition, the study must comply with Irish legal requirements, especially child protection legislation as many of the women interviewees would have young children who could

potentially be in danger. The REC application contained details of study background, aim, proposed sample, recruitment methods planned, together with the details of consent, confidentiality and data protection. The REC requires a seven day time period between initially providing information on the study to potential interviewees and giving consent to participate and this was included in the REC application. As the European Union (EU) General Data Protection Regulation (GDPR) preparation for legal implementation was occurring during the study data collection period, all data from the study would be handled and stored in accordance with the Data Protection Act 1998 and the Data Protection (Amendment) Act 2003 but would be cognisant of maintaining standards relative to the GDPR and its legal transposition in May 2018. Additionally protocols for researching a potentially vulnerable group (pregnant women) were devised and included in the REC application with a focus on risk and harm mitigation throughout the research process. Withdrawal from the study up to the point of data analysis without consequence for an interviewee was highlighted in the application. The protocols devised for the study are discussed in detail later in this chapter.

Potential to reimburse any travel costs to the interviewees as result of participation in the study was included in the application, but no specific payments or incentives were detailed. All study documents and a letter of support from the national network on domestic violence services, SAFE Ireland, endorsing the researcher and the study, were included in the REC application (see Appendix 2). The REC application was also informed by the Trinity College Dublin Policy on Good Research Practice (2009), the Declaration of Helsinki for the protection of human research subjects, especially in relation to vulnerable individuals and informed consent (World Medical Association, 2013) and followed the protocols devised by Sullivan and Cain in relation to research with battered women (2004). Adherence to the Faculty of Health Sciences 'Lone Worker Guidelines' was outlined in the REC application. Correspondence from the REC required some minor clarifications and revisions in the initial application which were amended and re-submitted to the Committee. The changes which were required included those in relation to gatekeepers for the study recruitment who were not recommended to be in direct care or authority positions with women approached to participate in the study. Final approval from the REC was granted on 23 February 2016 and recruitment for interviewees commenced immediately. There appeared to be limited understanding of how domestic violence services are structured and operate in Ireland and the staffing structures and limitations and demands that many of the services operate under by the REC based on the amendments requested to the researcher.

Safety and ethical considerations

Domestic violence is a challenging and sensitive topic to research according to Fraga (2016). The ethical considerations in relation to researching domestic violence are also intricate and have entailed much discussion and debate. There are two main dimensions to any qualitative research study: the researcher and the participants from the cohort chosen to investigate. In relation to research with humans who have experienced domestic violence both participant and researcher safety become of heightened importance. Effectively preparing field researchers or interviewers on how to respond to and process what they are hearing in interviews is also necessary (Fraga, 2016). How women are engaged with and accessed to participate in research; heard and listened to by researchers; have their histories documented and where the research and reports are published in the context of potentially life threatening past and future experiences places much responsibility on the researcher in relation to safety, confidentiality, re-victimisation and vicarious trauma (O'Brien Green, 2018a). Additionally the dimension of experiencing a recent pregnancy by participants in the study adds another layer of potential safety concerns and heightened vulnerability. The inclusion of women of childbearing potential in research studies may intensify the sensitivity of research ethics committees to potential harms and as a result they may opt for additional safety measures or the exclusion of this population cohort in research studies (Faculty of Health Sciences Research Ethics Committee, 2008). The absence of qualitative research on pregnancy and domestic violence in Ireland and the potential of research on this topic to inform professional guidelines, service delivery, screening and legislation also creates an ethical dilemma in relation to policy making in a research vacuum without adequate and recent research to guide and inform. Downes and colleagues state that the challenges in gaining ethical approval to undertake research on domestic violence may lead to a diminishment of research occurring and policy making taking place without evidence (2014). Halse and Honey emphasise “hearing the voices and silences smothered by the conversations of others.” in relation to the moral dilemmas that researchers face in undertaking research on challenging topics ethically and bringing the experiences of women into the public domain (2005 p.2154). Kvale outlines the ethical issues of seven research stages and how they might be incorporated into the design of research projects utilising interviews, these are; thematising; designing; interview situation; transcription; analysis; verification and reporting as all requiring input and reflection in relation to ethical issues (2007 p.24). Not all seven will be fully addressed however, they will inform the ethical and safety considerations utilised and applied within the study.

The challenges and risks associated with researching violence against women, while great, must also be compared with the absence of survivor voices to correctly and comprehensively inform policy, service provision and legislation. As Ellsberg and Heise state;

> "In the case of gender-based violence research, the risks are potentially large, but so too are the risks of ignorance, silence and inaction." (2005 p.45)

By not including women who have histories to tell that can shape and enlighten responses to violence against women, and in particular in relation to pregnancy, the absence of their inputs can lead to an absence of evidence informed services. Although pregnant women and women who have experienced domestic violence are generally classified as vulnerable populations in research settings, given the prevalence of both experiences in the adult female Irish population (refer to Chapters 1 and 3) neither experience can be considered rare or infrequent in Ireland. Downes and colleagues suggest that the bio-medical model of vulnerable research populations is not entirely suited to social science research on the topic of violence against women and that more, not less, research is required in the area to adequately address and support considerable numbers of women in any given country or society who have experienced domestic violence (2014).

There exists the possibility of re-victimisation of study participants in research on domestic abuse, in particular if women are asked to recount incidences of forms of violence they have experienced. Avoiding this re-victimisation was part of the study design by consciously not including any questions on the actual types and/or frequency of violence women interviewed had experienced. Some literature suggests that participation in qualitative research studies on domestic violence enables victims to use their experiences to help others, as they may find the interview a cathartic and meaningful experience and feel valued and listened to as they recount their own personal history and opinions to a researcher (Downes et al., 2014). That the researcher had an established track record of using research findings to leverage and inform policies, legislation, government strategies and public information campaigns at a national and European level. This fact was emphasised to reassure participants that the findings and data emerging from the study will be utilised to their fullest capacity to ameliorate supports for pregnant women experiencing domestic violence in the future in Ireland and to influence policy and service provision for women with similar experiences. It was also required to emphasise that the researcher had experience of working with and researching vulnerable populations on difficult and hidden subjects

such as: HIV, drug use, female genital mutilation (FGM), domestic violence and sexual health. Drawing on this expertise and prior experiences would prove necessary to drive participant recruitment for this study and to appropriately and sensitively interact with women before, during and after their study interviews and to promote recruitment with study sample gatekeepers.

As nationally representative quantitative surveys and smaller scale self-completion questionnaires had been conducted in Ireland on the topics of domestic abuse, one of which specifically focused on pregnancy (Watson and Parsons, 2005, European Union Agency for Fundamental Rights, 2014, O'Donnell et al., 2000), there was a gap in qualitative research on these topics with women living in Ireland. Quantitative research can state numbers, prevalence, concentrations of an issue in a population and provides much of the rationale for this study however, it does not provide a nuanced and insightful description of the issue of interest from the perspective of those who have lived through it and experienced it. Centre staging the voice of women, their lived experiences and their retrospective observations on seeking help, support and safety in relation to domestic violence and their pregnancy or pregnancies was the key focus of the study.

This study benefits from previous researcher experience in researching sensitive, hidden, taboo and challenging topics with hard to reach populations where the safety and ethical dimensions of the research are given substantial consideration. This included previous research studies using mixed methods interviewer administered survey, semi-structured phone interviews, focus groups, case file analysis, key informant interviews and statistical extrapolations (SAFE Ireland, 2016a, European Institute for Gender Equality, 2013, Leye et al., 2014, European Institute for Gender Equality, 2015a, SAFE Ireland, 2016b, O'Brien Green, 2013). Focus groups, given the potential risk profile of the study sample and the geographical spread of participant recruitment (nationwide across Ireland), were not considered for this study despite the researcher's previous experience in conducting them on sensitive topics (O'Brien Green, 2017). Semi-structured interviews with women were deemed the most conducive to gathering data and for creating a private and trusting space where women were able to discuss their experiences in a confidential setting (Guest et al., 2013). As quantitative survey research had previously been undertaken in Ireland on the topic of domestic abuse and pregnancy through self-completion questionnaires (O'Donnell et al., 2000), telephone survey (Watson and Parsons, 2005), face to face survey questionnaires (European Union Agency for Fundamental Rights, 2014) and mixed

methods questionnaires (SAFE Ireland, 2016a), an obvious gap in Irish research was one to one qualitative interviews.

Study definitions were drafted to allow for targeted participant recruitment and the development of study documentation. A working definition of disclosure for the study was developed by the researcher and was defined as:

> 'Disclosure will be defined as: when a woman discloses that she is experiencing domestic violence and is referred, or self-refers, to a domestic violence support service or refuge at some point between conception and one year post-pregnancy, regardless of outcome of her pregnancy (i.e. the pregnancy may end in termination or miscarriage).'

Domestic violence support services were outlined as incorporating different types of services, in a broad sense, as some services may offer supports for domestic violence in addition to other types of supports and services. Women were invited to participate in interviews (if they met the study inclusion criteria) regardless of the outcome of their pregnancy. This allowed for women whose pregnancy, or pregnancies, did not result in a live birth to participate and included women whose pregnancies ended in termination or abortion or with miscarriage to participate in the research study. The concept of a pregnancy ending prematurely in miscarriage due to domestic violence was challenging to explain to midwives and maternity hospital staff consulted on the study design, but given the prevalence of this experience, as documented in a range of Irish studies (see Chapter 3), it would be limiting to not include it in the study definitions. Domestic violence service providers acknowledged that miscarriage does occur within their clients' lives and crisis pregnancy counsellors also discussed meeting women in violent relationships who terminated their pregnancies, during meetings with the researcher held to inform the study design.

Safety aspects of study design

The safety of research participants and of the researchers is of paramount importance in this study: this emphasis is necessary according to numerous researchers on the topic (Fraga, 2016, Sullivan and Cain, 2004, Ellsberg and Heise, 2005). The WHO state that research interventions with women who have experienced partner violence while pregnant require special ethical considerations and referral routes for interviewees given the increased risk of pregnancy loss due to violence (World Health Organization, 2016). Based on research conducted by Campbell and colleagues violence during pregnancy indicates an increased risk of a woman being killed by her

partner and therefore heightened risk of murder or femicide, although a rare research study safety challenge is one that needs to be considered and responded to in this study design (2003). Many of the risk studies in relation to domestic violence, pregnancy and homicide risk have occurred in countries where personal gun ownership patterns and population prevalence are different to those in Ireland, as a result risk levels for women of murder in an Irish context may possibly be overestimated (McPhedran, 2017). There are, however, still substantial risks to women's physical health and safety as a result of domestic violence during pregnancy (Women's Health Council, 2007). The study design is cognisant of safety issues for interviewees through the following: participant recruitment processes; gatekeeper risk assessment of potential interviewees; researcher contact with potential interviewees prior and after interviews; location of interviews; and referral routes and supports identified in case of risks or needs changing in the course of the research study or during the interview. Research by Sullivan and Cain was used to guide the study design development and centre staging their supposition:

> "When conducting research with women who have been abused, the presumption should always be that each woman could be in danger." (2004 p. 609)

In all aspects of the study participant safety has been a focus of the overall study design. The Trinity Policy on Good Research Practice was drawn upon for the study design and REC application, in particular the prominence placed in the Policy on respect for the interviewee and the research cohort and the aim of research to endeavour to provide the maximum benefit with minimal harm (Trinity College Dublin, 2009).

Study recruitment

Recruitment of potential interviewees for the study via maternity services and hospitals was dismissed for this study due to complexities and time required for individual ethical applications to each hospital to interview staff and women. It was also deemed unsafe to contact women during their pregnancy via their health care providers who may, or may not, be in a position to assess any level of participant safety or risk prior to interview. The maternity care setting might not offer sufficient privacy for women to be recruited discreetly for the study. As domestic violence service providers throughout Ireland were they key study recruitment route, a strong focus was on meeting them at every possible event, seminar, conference, meeting, launch, etc. for the duration of the study to seek to engage them in supporting the study by recruiting women for study

interviews. National Irish networks such as SAFE Ireland, the national network of domestic violence services and the National Observatory on Violence Against Women were used to inform services about the study both in-person and by email. Meetings with domestic violence service managers, staff teams, outreach staff and other relevant services were organised and took place from January 2016 to May 2018. The purpose of the meetings were to inform services, who would act as study gatekeepers and recruiters, about the study, describe the ethical and safety features of the study design and to re-assure services of the researcher's credentials, experience and capacity to undertake interviews on the topic with potentially vulnerable women. The meetings also allowed for discussion of an interview approach and study questions in the interviews. This was essential to build trust with gatekeepers and to re-assure them that the interviewer was cognisant of potential for re-traumatisation of women during interviews and that steps would be taken to avoid this happening. Creating time to thoroughly outline the study to relevant services also allowed for the study design to be adapted to the needs of domestic violence services and their clients and to inform the researcher's approach. Not all meetings in services resulted in study interviews, nonetheless they greatly informed the research design.

Interview location

Location of study interviews is a key feature of safety considerations in the study. Cain and Sullivan recognise the immediate safety needs of women are usually met when research interviews are conducted in domestic violence refuges but also acknowledge that study interviews may take place in other locations which women interviewees themselves deem as safe and comfortable (2004 p.604-608). Study interviews were planned to occur in refuges or in domestic violence support services. This was for a number of reasons including the availability of private spaces to conduct interviews in, as services tend to have counselling or assessment rooms that are ideal for study interviews. The availability of staff trained in responding to child protection and self-harm issues on-site in these services make them ideal should these issues emerge during an interview. Domestic violence refuges services also have pre-established professional links with local medical services and police should these services be needed during or after a study interview. Some of the interviews were with women who were currently living in refuge accommodation and as a result child care supports were available to them onsite to assist with participating in the interviews and they had no travel costs. Many of the women interviewed noted a feeling of safety and ease once they initially arrived in a refuge. By having their interview in a refuge setting this ease allowed them to potentially feel more comfortable during the interview. There are

potential confidentiality issues that arise when being interviewed in a refuge where a woman has lived but has subsequently moved out of. Study participants were offered a choice of location for their interview should they wish it to take place in a domestic violence refuge or service where they were not known and where they had not lived in, this was in order to offer increased levels of confidentiality to interviewees. Having experienced staff in close proximity with expertise on domestic violence was also re-assuring for the researcher should serious issues of safety and risk or extreme distress emerge in the interviews. No attempts in the study design were made to interview women in their homes, unless they were living in supported second stage (i.e. non-refuge or emergency housing) accommodation provided by domestic violence services with potential referral routes and supports in the immediate vicinity. One interview took place in a community setting that the interviewee suggested and where she had previously met her social worker and felt safe in, all 17 others study interviews took place in domestic violence refuges, services or second stage supported housing.

Study inclusion and exclusion criteria

The study inclusion and exclusion criteria were drafted to ensure that women who participated were at a point where imminent risk was reduced, as determined by gatekeeper risk assessment procedures utilised in domestic violence services; women were considered adults in Irish law (i.e. aged 18 years and over); had support services available to them and contacts in these services to connect with should it be required post-interview; and, were able to consent to and participate in an interview conducted in English. These criteria were outlined as follows in documentation for women and domestic violence services circulated to recruit interviewees, including the participant information leaflet and the study summary document. See also Appendix 3. Study inclusion criteria was defined as follows:

Women over 18 years of age living in Ireland who;

1) Experienced domestic violence during a pregnancy or pregnancies;

2) Are currently accessing and/or in contact with domestic violence support services or made initial contact while pregnant or in the first year after pregnancy (regardless of how the pregnancy ended);

3) Are willing to take part/participate in the study and to be interviewed;

4) Are deemed not to be in immediate or current danger from a violent (ex) partner(s); and

5) Can read, speak and understand English at a level that allows for written informed consent to be understood and obtained and for a spoken research interview in English to take place.

Women who were aged 18 and under, who could not communicate in English at a sufficient level to give informed consent and answer study questions; women who were assessed by gatekeepers to be in current danger from violent partners or ex-partners and women who have no pre-established link to support services in relation to domestic violence in Ireland were excluded from participating in study interviews. There was some flexibility needed in relation to when initial contact or a referral was made to a support service. This emerged as some women made enquires or sought information about domestic violence supports during pregnancy or the year after pregnancy but did not engage with the services until a later time. For some women, given the level of abuse and trauma they had lived through, exact time frame and dates were hard to recall precisely. The inclusion criteria were re-iterated to women when and if contact was made with the researcher, when organising a place and time for the interview. It was also repeated when reading through the informed consent form just prior to the interview and women were asked if any clarifications were needed.

Time period for study participation

The time frame to participate in the study was initially stated in the REC application and on study documentation as during pregnancy and up to one year post-birth. Studies suggest that both the time of pregnancy and post-partum are heighted risk periods for women in relation to partner violence (Kendall-Tackett, 2007). According to Van Parys and colleagues the year prior to conception and the year after childbirth is a particularly vulnerable time of heighted risk of domestic violence (2014). This time period correlates with Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) and Maternal Death Enquiry Ireland time limits for maternal death reviews in Ireland and the UK, which are during pregnancy and up to one year post-pregnancy for late maternal deaths and include deaths by homicide and suicide (O'Hare et al., 2015a). One year post-pregnancy is also listed in the WHO International Classification of Disease (ICD) reporting standards for late maternal death (World Health Organization, 2018). However, the initial time period proposed for interviewees emerged to be confusing for gatekeepers and hugely limiting for study recruitment and for women to participate. This time period in the first year post-pregnancy women are exceptionally busy, usually with a new baby, and may not be in a safe place to participate and be interviewed. It needed to be extended to ease recruitment

challenges for gatekeepers and to respect the pressures that women were under not only in relation to having a young baby but also to seeking safety and accommodation. As a result a re-application to the REC was made in September 2016 and the study time frame was re-defined as:

> 'Women taking part in the study may be interviewed up to three times, if they wish, including during pregnancy and up to five (5) years after birth/pregnancy, regardless of the outcome of their pregnancy.'

Again some level of flexibility was needed for the five year time limitation. The five years was initially designed to reflect that policy changes had occurred in the five years prior to the study commencing (i.e. since 2010). This was especially in relation to the use of a standardised maternal health care record that included space for queries on domestic abuse which has been rolled out nationally to maternity hospitals since 2010. The first guidelines for GPs in Ireland on domestic violence were launched in 2008 and were subsequently revised and updated in 2014 (Kenny et al., 2014). In 2010 the Health Service Executive (HSE) launched its national Policy on Domestic, Sexual and Gender Based Violence to inform and guide all HSE staff in their interactions with these issues. In 2012 the Institute of Obstetricians and Gynaecologists in Ireland, in conjunction with the HSE, released their *Clinical Practice Guideline for Antenatal Routine enquiry Regarding Violence in the Home*, which recommends that enquiry about a history of violence should be included routinely in antenatal social history for all women (2012). Given all these developments in relation to health care, maternity care and domestic violence, especially since 2010, it seemed prudent to focus on women who would have had interactions with maternity and health services since then and who would expect to have their dealings with health care professionals directed by recent guidelines and policies in relation to domestic violence.

Multiple interviews with the same woman were initially stated in the REC application as during pregnancy, at 6-12 weeks post pregnancy and at 6-12 months post pregnancy, and was approved by the TCD REC. However, the prospect of interviewing a woman more than once became highly improbable, in particular during and soon after pregnancy. The multiple data collection episodes of three interviews, were planned to assist in data saturation and theory development but became highly impracticable and potentially unsafe to contact women over time who may be fleeing very dangerous personal situations. As there is an element of mobility attached to seeking safety and protection from a violent partner and as women's personal situation of risk may escalate and de-escalate rapidly (with a perpetrator being released from prison, for example), it became clear that undertaking one interview with a woman who met the

study criteria would be challenging and three interviews with the same woman practically impossible (Sullivan and Cain, 2004). This was due to women moving between refuges, changing phone and contact details for safety reasons, women leaving Ireland and/or potentially due to women returning to their abusive partner. As a result the recruitment aim and study documentation changed to state that women could be interviewed up to three times, but only if they wished to do so. At the end of data collection no women were interviewed more than once.

Communication and contacting women for study participation

Initial contact with potential interviewees was through domestic violence services, except for two women who were recruited through snowball sampling. In most cases the time, date and location for the interview was confirmed by the service and the researcher arrived to meet the woman at the service or in the refuge with no prior contact with her before the interview. In some cases the researcher was given contact details for a woman who expressed interest in taking part in the study and she phoned or emailed the woman. However, pre-defined study protocols to ensure the safety and confidentiality of all potential participants were in place when women were contacted, they were outlined to gatekeepers in study documents and are as follows;

- Women will only be contacted at phone numbers that they have self-identified and deemed to be safe and confidential.
- The researcher will ask for the participant by name when they call and not identify themselves to anyone else who might answer the phone.
- Each time contact is made, the researcher begins the phone call by asking "Is this an okay time to talk?". If the participant says no, the researcher will end the call immediately.

Some women needed numerous SMS messages and phone calls to arrange a time to talk about the study with the researcher and the researcher was aware of time pressures, childcare demands and the privacy needs of women so phone calls were also made at evening time if that is what suited the woman best. Information on contact details for national domestic violence services were given to all participants before and after their interviews in case their needs or situations changed in relation to supports required.

Once a woman had received details of the study from a gatekeeper or the researcher (whichever was earlier) there was a seven day time lapse before seeking consent and interviewing. This is a requirement of the TCD REC and ensures that a woman is not recruited and pressurised into an interview on the same day. It also allows her time to change her mind and withdraw from an interview should she change her mind and not

wish to participate or to request more information on the study or researcher. This seven day period allowed the researcher time to arrange a safe, secure, accessible and appropriate interview venue and to respond to any queries that a woman might have about the study based on the information and documentation she had been given. This seven day time for reflection also permitted communication between the researcher and interviewee to occur and queries on the study to be addressed and a potential rapport develop. However, it also meant that a woman's circumstances could change in the seven day period, in particular in relation to housing and a woman's wish to "move on" physically, geographically as well as psychosocially and consequently decide not to participate once she has started a new phase of her life possibly in a new location. This requirement did have implications for interviewing women who wished to participate in the study on meeting the researcher but who had moved out of the refuge in the seven day time period and were then no longer interested in participating.

Legal aspects of study design

Data management and storage

Researchers have legal responsibilities, in addition to ethical ones, in relation to certain disclosures or issues which may emerge in the course of a research study and/or interview. The Data Protection Act 1998, the Data Protection (Amendment) Act 2003 and the EU General Data Protection Regulation on the protection of individuals with regard to the processing of personal data and on the free movement of such data, or GDPR, which became legally binding in Ireland in May 2018, all require legal compliance with how data arising from research is gathered, stored, destroyed and moved. The researcher attended training on the GDPR twice in order to orientate the storage of data arising from the study (such as interview recordings and transcripts) prior to and after the adoption of the GDPR into Irish law. In compliance with the Directive all study data will be securely retained for a maximum of five years and then destroyed. However, all non-anonymised data and study documents will be destroyed as soon as is viably possible into the study and prior to five years where feasible. Hardcopy records of transcripts have been stored in a secure location in a locked filing cabinet in a locked office in the Trinity Research in Childhood Centre (TRiCC) in Trinity College Dublin, where there is no public access and a range of security elements (alarms, security personnel, security cameras) in situ. The transcripts are stored separately from other research documentation, data and forms such as consent forms and participant demographic data forms, both of which are also stored in a separate locked filing cabinet in a locked office in the TRiCC, Trinity College Dublin. Participants

are offered copies of their interview transcripts should they wish to receive one after their interview, this is stated clearly on the study informed consent form.

Transcription services were utilised for recordings of interviews with women where all identifying details were not present in the recording. Prior to an interview the researcher explained to the woman being interviewed that names, locations and all identifying details would not be used during the recording of the interview, and that the woman would be addressed as “you” and the location of the interview (usually a refuge or domestic violence service) called “here”. Women understood that this was to protect their identity and to assure their confidentiality. The transcription service used was not located in Ireland, to enhance confidentiality, and the transcription service was required to sign a confidentially agreement (or client non-disclosure agreement) prior to data transcription. In addition once transcriptions were received from the service by the researcher, all audio files and related documents (i.e. the transcription draft) were deleted at the researcher’s request. The audio files from the interviews were stored on a password protected computer in a location that did not have public access. The audio files were assigned a code directly after the recording and were deleted as soon as possible from the researcher’s portable digital voice recorder.

Protocols for use during study and interviews

Protocols for dealing with issues that could arise in interviews were devised and formed part of the REC application for study. The protocols devised and used were mindful of national mandatory, legal reporting and disclosure requirements, especially in the case of an ongoing risk of child abuse or disclosure related to potential self-harm or suicide. The protocols included appropriate referral routes and contact details for services, including out-of-hours/weekend services, to which to refer interviewees should these issues arise. If an interviewee disclosed child abuse or an intent to harm another person then there are specific obligations on the part of the researcher which must be adhered to. This is legally in relation to the Child Care Act (1991) Revised, the Children First Act 2015, the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act (2012) and the Children First National Guidance for the Protection and Welfare of Children by Tusla. The researcher was also guided by the Protection of Persons Reporting Child Abuse Act (1998) and Trinity College Dublin Policy on Good Research Practice (2009). It is important to note that all domestic violence service providers, housing and refuges in Ireland have child protection procedures, reporting mechanisms and protocols in place as required by Tusla, the statutory Child and Family Agency should the researcher have needed to report any

child abuse issues that were disclosed during an interview. In addition all SAFE Ireland members are committed to adhering, promoting and protecting the principles detailed in A Framework, Principles and Standards for Specialist Domestic Violence Services in Ireland (SAFE Ireland, 2015a). Of particular relevance for this study are Principle One which refers to safety of women and children and Principle Two which refers to the promotion and protection of confidentiality.

In the cases of child protection concerns or child abuse, that have never been disclosed previously to child protection staff, and emerge during an interview the study protocol was as follows:

- The researcher will stop the interview, reiterate the text of the informed consent form and participant information leaflet and inform the participant that in accordance with Irish legislation, in particular the Child Care Act (1991) Revised, the Children First Act 2015, the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act (2012) and the Children First National Guidance for the Protection and Welfare of Children, the researcher is required to inform a Designated Child Protection Officer of the concerns or abuse that have been disclosed during the interview.
- Prior to all interviews Designated Child Protection Officers will be identified in each of the study sites where interviews take place. If no Designated Child Protection Officer is available at the time of the interview to report to, the local social work duty service will be contacted by the researcher, local contact details will be accessed via the Tusla national website.

In the cases of participant distress during an interview the study protocol was as follows:

- Participants will be informed during the consent procedure that they have the right to stop or pause the interview if at any point they do not feel they can continue.
- The researcher will pause the interview and take the time to listen and empathise with any participant who becomes distressed and will, after a period of time, determine whether the participant feels like she can continue the interview before commencing again.
- If a participant is becoming very distressed, the researcher will put the woman's emotional wellbeing before data collection. She will pause the interview and then assess whether the woman feels she can continue with the interview or not.
- The researcher will be prepared to refer participants to appropriate support services should a need arise during the interview, or after it. Information on contact details for national domestic violence services will be given to all participants after the interview.

In relation to self-harm concerns the study protocol was as follows:

- Should immediate self-harm concerns emerge during the interview the researcher will stop the interview, reiterate the text of the informed consent form and participant information leaflet and inform the participant that in accordance

with good research ethics she is required to inform key support staff where the interview is taking place about the disclosure.
- The researcher will also explore the supports that the participant feels most comfortable accessing at this time and will assist her to do so. This may include contacting emergency medical services if required.

In relation to harm to others concerns the study protocol was as follows:

- Should intent to harm others emerge during the interview, the researcher will stop the interview, reiterate the text of the informed consent form and participant information leaflet and inform participants that in accordance with good research ethics she will need to inform key support staff where the interview is taking place about the disclosure.
- The researcher will also explore the possibility of contacting the Garda Síochána (police), if needed, with the participant.

Having predefined protocols to manage adverse situations in interviews was important in relation to the REC application and to reassure gatekeepers that the researcher was legally compliant and aware of the consequences of certain disclosures in interviews and the necessary legal and ethical responses required of her.

Informed consent form

The researcher has been involved in five national or multi-country research studies which required the design and development of study documentation including informed consent forms. Drawing on this experience and incorporating guidance from the Trinity Policy on Good Research Practice; the WHO Ethical and Safety Recommendations for Research on Domestic Violence Against Women; the WHO Informed Consent Form Template for Qualitative Studies and forms for similar studies on domestic violence (both Irish and European studies) a form was drafted and submitted with the REC application. The Trinity Policy states that clear and accessible information on the study must be provided to potential study participants to allow them to make an informed decision to participate in the study with the maximum information on any potential harms participation may entail clearly outlined (Trinity College Dublin, 2009). The Policy also requires that a consent form is signed prior to agreeing to participate in the research study. The consent form developed was designed to be signed by both researcher and interviewee, two copies are signed prior to the interview starting: one for the researcher to retain and store and one for the interviewee for her reference. The form lists contact details for the researcher should the interviewee need to contact her or request a copy of her interview transcript. An approach to maximise readability of the study documents including the informed consent form based on prior researcher training Crystal Mark Plain English writing course was utilised. This was to ensure that potential study interviewees who do not speak English as a first language or who have

literacy issues were still able to participate. Prior to all interviews the researcher read through the informed consent form with the interviewees and checked for their understanding of the text and any clarifications or explanations which may be required by the woman. As ethical research needs to be a “continual process of collaboration” according to Halse and Honey (2005 p.2159) the researcher was aware that ideally consent should be ongoing and dynamic during the interview and that a “checking in” process might be needed to ensure that all participants, in particular those who do not speak English as a first language, are clear on what consent consists of during their interviews. Refer to copy of the study informed consent form in Appendix 4.

An amendment to the informed consent form took place in January 2017, at the request of researchers in the TCD School of Nursing and Midwifery to avoid duplication in sampling of women for this study and the MAMMI (Maternal health And Maternal Morbidity in Ireland) study. All study participants were asked if they had taken part in the MAMMI study or not prior to interview, either response did not preclude them from being interviewed. No women in this study had also taken part in the MAMMI survey.

Research Ethics Committee re-application

Domestic violence services were consulted during the initial study design phase but further meetings with them and listening and adapting aspects of the study and related documents according to their suggestions were evidently required a number of months into unsuccessful study participant recruitment. Sullivan and Cain suggest that this type of dialogue and consultation should lead to more valuable, relevant and timely research that is useful to practitioners and produced in a collaborative spirit (2004). Based on feedback from multiple meetings with domestic violence service providers and requests for clarification on aspects of the study inclusion criteria and a lack of interviews, amendments to the initial design were submitted to the REC for approval in early September 2016. Following queries from gatekeepers on the nature of questions in the interviews for the study, text amendments were needed to re-assure potential study participants (and gatekeepers) that the interviews would not seek information on the experience, intensity, levels and types of violence that women have survived: only their experience of help, support and safety seeking. Although this data was not being sought in the study interviews, it was not explicitly stated that women would not be questioned on these aspects of their experiences and therefore this information gap was acting as a deterrent for gatekeepers to inform women about the study due to their concerns about re-traumatisation of women. As a result, clear information on the nature of questions in the interviews was included in the study documents, both to potential

interviewees and to gatekeepers, to re-assure potential study participants that the interviews would not seek information on their experiences of domestic violence.

The time frames for participation in the study were firstly stated as; ‘during pregnancy, early motherhood at 6-12 weeks post birth and late motherhood at 6-12 months post birth’ with the intent to complete multiple interviews with the same woman. These definitions and time frames became unworkable in the context in interviewing new mothers in relation to domestic violence. Women might be in a very vulnerable situation soon after birth and gatekeepers found it challenging to safety recruit women for interviews with these time constraints. As part of the REC re-application in September 2016 extending the time frame for interviewees, from one year post-pregnancy to five years post-pregnancy, was requested in order to allow women to participate in interviews for a longer time frame post-pregnancy/birth (up to five years rather than one year). It was expected to allow for increased interviewee recruitment for the study and to ensure participant safety during what could be an increased time of vulnerability for women directly after birth. The revised text also emphasis taking part in one interview, rather than three interviews which was originally stated. Finally, a one page, plain English study outline document was also requested by gatekeepers to easily disseminate information on the study within their services to staff and to women who may wish to participate in the study. This document was drafted and included in the REC re-application. The sought amendments to the initial ethics application were approved in late September 2016 by the REC and all relevant study documents were edited and changed to conform with the changes and revisions requested by the researcher.

Monitoring Reports were submitted by the researcher to the REC to update the Committee on research progress and to potentially report on ethical issues arising in the course of the study interviews. Reports were submitted September 2016, December 2017 and June 2018: no adverse incidents were reported to the REC.

Study design challenges and amendments

While a study can be designed to incorporate the most current and comprehensive advice in relation to ethics and participant safety the issue can arise that the study participation restrictions and criteria are such that study recruitment is limited or interviewees are non-existent. The initial main challenge to the study was a lack of interviewees. Discussion with domestic violence service providers pointed to a number of issues in the study design that needed to be addressed to initiate and boost study participant recruitment. There needed to be a clear emphasis on the study focus which

was what enabled help, support and safety seeking by women and not probing for their experiences of and the frequency or intensity of types of domestic violence in their relationships. This meant a modification in the terms used in the study recruitment documents, which were changed following REC re-application and approval in September 2016. The time for an interview was initially estimated to be two hours and multiple interviews occurring with the same woman, gatekeepers stated that this was too long for busy women and too much of a commitment. The study documents were amended (as above) and gatekeepers were informed that one interview is all that is needed and that it would be the time length that suits the woman. The documents drafted in line with TCD REC requirements to recruit interviewees were long and the language was not “plain English” and could be challenging to fully comprehend for women whose first language was not English. At the request of gatekeepers a one page, brief outline of the study was drafted and circulated. This research summary was circulated in domestic violence services amongst staff to assist with recruitment and was also given to women in advance of committing to an interview (see Appendix 5).

Recruitment challenges

There were a number of research studies occurring in Ireland on domestic violence by SAFE Ireland during the same time as this PhD study; including SNaP (Specific Needs and Protection), which examined trauma and help seeking by women and the economic cost of domestic violence. In addition to these research projects, which interviewed similar cohorts as this study, funding for front line domestic and sexual violence services shifted from the HSE to Tusla. This meant more administration for services and less capacity to assist with study recruitment. A major data collection exercise on service delivery and statistics was undertaken by Tusla which required time and effort on behalf of services to collate and report their data in new formats and using new categories. There was a level of research fatigue amongst domestic violence services in Ireland and asking them to consider becoming involved with an additional piece of research by assisting with study recruitment was simply too laborious for some of them. However, ongoing meetings and informing services of the study still continued by the researcher but no interviews were planned over summer time or during school holidays when refuges tend to have staff on holidays and children are not in school and therefore present in the refuge. There were also a number of external factors which affected interview recruitment, in March 2017 a pregnant woman and three children died in fire at domestic violence supported housing building in Clondalkin, west Dublin. As a result, many other women and children needed to be moved out of the building to alternative accommodation and neighbouring refuges were

under extreme pressure. It would have been inappropriate and highly insensitive to continue recruiting for this study while the community and services were in shock and grieving, as a result study recruitment was paused for a number of weeks. After the fire in Clondalkin, the oldest custom-built refuge in Ireland, also in Dublin, closed for renovations due to electrical issues in November 2017. All the residents needed to be moved to other refuges before it could shut down, again putting pressure on services. The refuge has not re-opened to date (August 2018). This closure was particularity disappointing for study recruitment as the researcher had worked in the refuge previously and hoped that her connection with the staff and service would enhance study interview possibilities.

Childcare

For migrant women, who made up the majority of the study interviews, a lack of extended family and strong informal networks may mean that childcare supports are absent, and the only way that women can participate in research is with their babies or infants. This can present challenges for the researcher, as time will need to be allocated for baby feeds and breaks and noise from the child can be an issue for the transcription of interviews (O'Brien Green, 2017). Children should not be present in interviews if they are verbal, for any research related to GBV. This is for two principal reasons: the content can be upsetting to the child, and there exists a possibility of children being later quizzed (for example, by the perpetrator of violence) as to what their mother has told others, potentially exacerbating risks and compromising participant safety (Zimmerman and Watts, 2003). Some interviews needed to be re-scheduled to accommodate women's childcare needs and most took place during school or pre-school hours to allow for privacy in the interview. The childcare facilities in refuges were also used by women to allow them to take part in study interviews without their children.

Participant selection by gatekeepers

Gatekeepers from relevant services were utilised to access the study population, promote participation in the study and assess potential risk related to participation of interviewees. However, this may lead to power and control dynamics being exerted and a subsequent sample selection bias (O'Brien Green, 2018a). Gatekeepers are highly unlikely to select clients who might be critical of the services offered or managed by the gatekeepers to take part in interviews. There may be efforts to present services positively, so only certain clients are informed about the research by the gatekeepers and subsequently take part (Vearey et al., 2017). Acknowledging that there was both a

level of self-selection by participants and an additional layer of participant recruitment by gatekeepers, which ultimately influences the study findings despite as broad recruitment measures and efforts as possible, is inevitable.

Participant compensation

Compensation given to interviewees is a complex issue in research ethics, budgets and design. The REC application included compensation of cash refunds of public transport tickets to interviewees if this emerged as a barrier to participant recruitment. Sullivan and Cain state in relation to providing adequate compensation to women participating in research interviews:

> "Compensation for participating in any research should be high enough to show respect for women's time and expertise but not so high that is might coerce women into participating when they would rather not." (2004 p.615)

Initial study documentation to gatekeepers and potential interviewees did not contain any reference to compensation upon participation except in the case of travel expenses for attending the interview. However, given the challenges in study recruitment, acknowledging that a qualitative research study is futile without research participants and valuing their time and experiences led to compensation being considered for women upon completing interviews. It was suggested at the PhD Confirmation Review that the researcher consider amending the REC application and study documents to include compensation as a recruitment incentive. This was discussed with some domestic violence service providers who felt it could assist with interviewee recruitment but would not be a fundamental requirement for women. Following discussions with study gatekeepers a shopping voucher usable in a range of shops nationwide at a value of 50 euros was suggested to be given to women upon completion of their interview as a token of appreciation, but it was not advertised nor promoted in study documentation. Some women who participated in interviews prior to Christmas received the token along with the usual thank you card and box of chocolates that all women interviewed for the study received.

While compensation can be seen as incentivising potential interviewees to participate by means of monetary pressure and, therefore, possibly biased study samples, it can also mitigate against interviewees' travel and childcare expenses and lost earnings when giving their time to participate in a study (O'Brien Green, 2018a). Globally, women earn less than men, they may have experienced financial hardship as a result of leaving a violent relationship, and they may have been victims of economic abuse

(Watson and Parsons, 2005, European Institute for Gender Equality, 2014). Awareness of these facts and support for the expenses incurred to participate in research studies should be part of every gender-based violence (GBV) research study design. To truly value the time that women take to travel, arrange childcare, and not work in order to attend interviews, there is a strong argument for adequate compensation upon completing a study interview that is offered in a manner that women can utilise discretely and easily (O'Brien Green, 2017). Adequate and appropriate compensation should have been a key part of the initial study design, REC application and budgeting and may have boosted interview participation, even if it jars with bio-medical ethics committees concerns about over-incentivising research participation.

After the interview(s)

At the end of the interview the researcher can leave, both physically and psychologically, the topics or issues being investigated and the place of the interview. This option may not be available to the research participant, due to her current living circumstances, such as living in a women's refuge and/or ongoing contact with, or living in proximity to, her abuser (Montoya and Rolandsen Agustín, 2013, Women's Health Council, 2009a). Being sensitised to this reality and acknowledging that the options and choices that researchers have, or can exercise, at the end of an interview are not the same as those of their participants is humbling. It can also be upsetting for the participant, as the circumstances that have led to her current living situation will usually have been revisited via the interview (O'Brien Green, 2018a). Being cognisant of this reality at the end of each interview, the researcher asked women about their long-term visions and goals that they have for their lives, future and children. Their current situation was noted as temporary and would potentially change with time and support. The woman's strengths were emphasised and interviews were ended with a positive and grateful tone, this was also to signify the benefit of participating in research as an empowering process, and not necessarily an extractive one (Ellsberg and Heise, 2005). All women were personally thanked via SMS, email or WhatsApp by the researcher after their interview (if there had been contact through these communication means prior to the interview).

Despite not questioning women in interviews about the type, duration, intensity and frequency of the violent abuse they experienced perpetrated by their partner, many women shared this information during their interviews. Some felt compelled to show the researcher their physical scars and describe the deep negative emotional legacy they now had as a result of violence they had lived through. They also spoke about the

accommodation and financial challenges they lived with and the impact of seeing their perpetrator on court mandated child access visits. All these items are not easy to listen to and process, no matter how much experience a researcher had on investigating challenging topics. Vicarious trauma to interviewers can occur during the interview and while revising the data by listening to interview recordings and reviewing interview transcripts and notes over and over. Vicarious trauma for the researcher is an often overlooked issue when researching complex and distressing issues with participants who are exceptionally stigmatised and marginalised. Building in support, debriefing, and other processes into the research design, as well as opportunities to discuss the study challenges, is crucial to retaining researcher objectivity and completing the study in a timely manner (Medical Research Council, 2015). Supports for researchers to avoid burnout, resultant poor data collection and analysis due to distress associated with the topic being researched needed to be built into the study design, researcher supervision processes established and potential researcher supports identified in relation to vicarious trauma needs. Prior to starting study interviews a former colleague of the researcher in Ireland who provides both counselling to women impacted by domestic violence and supervision to staff working in domestic violence services was contacted and requested to provide emergency de-briefing or phone support to the researcher should it be required. The colleague agreed to this request and in addition the researcher investigated supports to Trinity students available via the Student Counselling Services should they also be required by her and psychologist supports available through Trinity if necessary. The researcher also acknowledged vicarious trauma, and it's opposite trait vicarious resilience, in her conference and seminar presentations on her research to begin discussions on researcher supports required while working on GBV to peers and colleagues.

Thematic analysis of study data

As the methodological orientation of the study shifted a suitable analytical method that could confidently be utilised for analysis of study data was required. Once Grounded Theory had been rejected for the study other analytical approaches were assessed for suitability. Both discourse and content analysis were deemed unsuitable given the number of interviewees who did not speak English as a first language in the study sample. Inductive data-driven thematic analysis became the most appropriate and flexible method for analysis. Thematic analysis acknowledges the researcher's role in the process of analysis and the themes could be presented within the study Conceptual Framework elements or fields. Researcher training on thematic analysis that was based on Braun and Clarke's guidelines for the phases of thematic analysis formed a

core aspect of my understanding of this analytic approach and processes (2006). Braun and Clarke present thematic analysis as a method for identifying, analysing and documenting themes in data, they emphasise the active, searching role of the researcher in data analysis and the ways thematic analysis can be utilised with different research questions or theoretical frameworks (2006). All study data, interview transcripts and interview notes, were imported into NVivo Version 12 to organise, store and assist with coding and analysis of data. Attending training on NVivo and accessed ongoing technical support for troubleshooting with the software during data analysis also occurred. The six phases of thematic analysis describe by Braun and Clarke were followed methodically to arrive at the study themes, each step is described in detail below (2006). During this process the study Conceptual Framework was constantly visible and re-visited to ensure fidelity to the intersectional aspects of the study methodology and study design.

Phase one

Phase one began with the first study interview in November 2016. All interviews (except for one) were digitally recorded. All interviews had extensive notes taken during the interviews which were transcribed within 48 hours of the interview, along with observations and remarks by the interviewer and comments or further contributions from the interviewee after the recording of the interview had stopped. Interviews were transcribed using a transcription service with a rapid turnaround time which meant usually within 36 hours post-interview of submitting the recording file being reviewed the transcript in detail to refine the document and ensure absolute fidelity to the interview and recording. This final transcription file was then compared with the interview notes to allow for preliminary observations and thoughts on the interview to be documented. Ongoing familiarisation with the data occurred as early and initial study findings began to be presented at meetings in Trinity and at conferences in Ireland and Europe. Being alert to the potential for certain issues or topics to appear in the data, based on other related research on the topic, but remaining open to all accounts by women of their experiences and opinions in response to the interview questions was part of the analytical process (see Appendix 6 for interview questions and prompt schedule).

Phase two

Phase two consisted of all interview documents being read and re-read repeatedly for in-depth content familiarisation and imported into NVivo for storage, coding and analysis. Codes were sought that were descriptive and data driven in the text utilising

terms or words that the study participants used themselves for code names where appropriate. Inductive and line by line coding of all interview notes and transcripts took place. This phase of generating initial codes resulted in 275 initial codes, which were reviewed and merged in cases of duplication. A code for interview comments by women was created to collate their feedback on their feedback on being interviewed, where the interview took place and any other comments they had on the study. Codes were studied repeatedly to ensure fidelity to the transcript text and some data extracts were assigned to multiple codes in cases of especially rich and significant content.

Phase three

Phase three of thematic analysis involved searching for themes by grouping, collating and reviewing codes. Codes that were similar or related to the same issues or topics in the interviews were grouped under draft theme headings. A miscellaneous code group was created to house codes that didn't fit well at this point in the analysis with the preliminary themes devised, as suggested by Braun and Clarke (2006). Codes in each theme were checked again for content that resonated strongly with the theme title and how the themes related to the research question, study Conceptual Framework and methodology were also contemplated and assessed. The final draft themes at the end of phase three were:

1. Barriers to help seeking.
2. Children.
3. Domestic violence.
4. Enablers to help seeking.
5. Finding domestic violence services and/or referral.
6. Migrant women.
7. Woman's health.
8. Women's suggestions.
9. Miscellaneous.

Phase four

Phase four began by micro, or level one, analysis of theme content by re-reading and reviewing each code within a theme to ensure a good fit with the code and that it related to the theme it was housed under (Braun and Clarke, 2006). Subsequently all the data extracts and coded content within each theme were examined to ensure they related to the theme title. At this point some code content was moved into other codes or other themes. Codes were deleted when empty as data extracts were moved to another code or theme which better matched the data. Aspects of the Miscellaneous theme content were re-housed under other themes and codes with only one piece of corresponding data, or data extract, rigorously reviewed to see where they might fit

under another theme. There were 273 codes at the start of phase four which were reduced to 216 over the reviewing processes. The second stage of analysis, macro or level two analysis, occurred, with the aim of this phase being to revisit and re-read all the study interview notes and transcripts in the context of the themes to asses if the draft themes seemed valid, representative and captured the meaning of the study data (Braun and Clarke, 2006). This entailed a line by line review of the documents to cross check that the themes developed resonated with the original study data. Each study transcript and notes document was ticked off on a customised table as it was reviewed in order to ensure no relevant documents were omitted from this stage. Notes were taken of key quotes of interest and very minor additional coding occurred with no new codes being created. Remaining fully cognisant of the study's Conceptual Framework during this phase, to ensure that the themes being refined and reviewed related to it was a core part of this analytical phase

At the end of phase four of thematic analysis the draft themes were refined and renamed as follows with a number of sub-themes also identified:

1. Domestic violence.
2. Woman's health.
3. Finding domestic violence services and/or referral and a sub-theme of support services used.
4. Children with one sub theme; social workers and child protection.
5. Inhibiters to help, support and safety seeking with one sub-theme migrant women.
6. Enablers to help, support and safety seeking with one sub-theme; experiences of using refuge and domestic violence services.
7. Women's suggestions with one sub-theme on interview participation and comments from the women.

At this point a thematic map of the analysis began to be visualised and created drawing heavily on the study Conceptual Framework.

Phase five

Phase five of thematic analysis involved further analysis to refine the boundaries within and between themes and to generate clear definitions and names for each study theme. It entailed a detailed review of all the themes' titles, the codes each theme contained, and an identification of the essence or core of each theme was defined in a brief one sentence summary. The scope and content of each theme was outlined to ensure that it was faithful to the data and subsequent codes and internally homogenous (all the codes relate to a topic or issues) and externally heterogeneous. This is to ensure that while a theme might be linked or connected to other themes each one is unique and differs to the other themes due to its content, as outlined by Braun

and Clarke (2006).The theme titles were further refined and contracted. Early study themes, domestic violence and women's suggestions, were removed. This is because although women spoke about the types, intensity and forms of domestic violence that they experienced during their interviews the study inclusion criteria stated that a woman needed this experience to participate in the research. As a result it was to be anticipated that women would describe their experiences in some way in the context of the study interviews, therefore domestic violence was not an inductive data driven study theme. In a similar way the suggestions, recommendations and comments women articulated as part of their interviews deserve consideration and assessment and are discussed in the thesis but do not constitute a core study theme.

The final study themes at the end of phase five were as follows.

1. Finding Services
2. Woman's Health.
3. Children, with one sub-theme; Social Workers.
4. Inhibitors, with one sub-theme; migrant women.
5. Enablers, with one sub-theme; using domestic violence services.

The thematic map arising from the study data analysis is presented and discussed in Chapter 7 Discussion of Study Themes and Thematic Map.

Chapter summary

The methodological decisions for this study were challenging and changed as the study fieldwork and data collection commenced. Given the primacy of women and their unique and personal experiences, the choice of feminist methodology was appropriate. The study Conceptual Framework leant itself to intersectionality as an appropriate methodological option for the study. Ethics and study design in relation to researching violence against women, in the context of pregnancy, requires considerable thought and ongoing reflection in relation to the safety of the interviewee and the researcher. This is because issues can arise during and after data collection and there exists the potential of re-traumatisation of the interviewee and vicarious trauma for the interviewer. In addition, given the challenges in relation to recruitment for the study, a degree of flexibility was required on the part of the researcher: to modify and adapt to gatekeeper requests, emerging issues in the field and the needs of the study participants, all the time being cognisant of the REC, legal and ethical research requirements. Seeking advice, suggestions and feedback from a range of professionals, service providers, research colleagues and the International Expert Advisory Group, formed to advise the study, was imperative to continue the research study despite issues and challenges emerging and initial exceptionally slow interviewee

recruitment. Thematic analysis provided a suitable method for data analysis that complemented the methodology and the study Conceptual Framework. As with any research study there are limitations, with more time and human and financial resources there could have been potential for more study interviews and more data collection. However, the breadth and richness of the data collected is discussed in the subsequent chapter and provides illuminating insights into the help and safety seeking of women in Ireland as a result of domestic violence during pregnancy.

Chapter 6 Research Findings

Study sample: inclusion criteria, demographics and features

Introduction

Study recruitment began in February 2016 and interviews occurred from November 2016 to February 2018 with 18 women. Despite the initial study design and ethical approval for up to three interviews per participant, no woman was interviewed more than once. All interviews, except one, were conducted in a domestic violence service or refuge. Women were interviewed from counties in all four Provinces in the Republic of Ireland and the researcher travelled to meet women at a time, date and location that suited them. One interview was with two women who wished to be interviewed together, all other interviews were with the researcher and woman and occasionally their baby, only. No children who were able to talk were present in any interviews for the safety reasons previously outlined. Often interviews took place during school hours or when childcare at the refuge was available for the women's children. All women, except for two, were recruited through domestic violence services, meaning that they had been assessed for safety by staff to participate and met the study inclusion criteria. The two women who were recruited by snowball sampling were interviewed in a refuge where one of them had stayed previously and were very keen to participate in the study. A brief risk assessment was undertaken by the researcher in advance of this interview with the two participants.

Limitations and challenges of study inclusion criteria

Although the time frame for participation in the study had been changed in 2016 from one year to five years post-pregnancy, based on feedback from the numerous meetings held nationwide and the study interview recruitment challenges, the time frame was still problematic. Domestic violence services were not always able to recruit precisely in the time frame requested, women were not always able to recall dates or when exactly events in their relationship and help seeking occurred. This is to be expected for a number of reasons. Leaving an abusive relationship is not a once off event, it is a process (Kenny et al., 2014), therefore contact with domestic violence supports was also often a process and not a singular event, as women may contact services many times before leaving an abusive partner (Health Service Executive, 2012). As a result women were not always precisely clear when events in relation to seeking help and safety took place, although they could often recall the age(s) of their child or children when they moved into a refuge. The researcher had to flexible,

especially considering that study recruitment had been so drawn out and challenging. As long as women were not perceived to be in any danger and were willing and comfortable with being interviewed and they met the key study criteria in order to respond to the research question: they could participate. Therefore, all women interviewed in the study had: experienced domestic violence during a pregnancy or pregnancies; were aged over 18; all women had accessed domestic violence support services at some point in Ireland; all women (expect one) gave birth in Ireland and therefore had interactions with Irish maternity care; all women had interactions with Irish health care systems (for example: GP, Public Health Nurse, hospital, ambulance, etc.) for themselves and their children and all the women interviewed were eager to participate and had a level of English which allowed them to give informed consent and speak with the researcher. The one woman interviewed who gave birth outside Ireland did access domestic violence services in Ireland when her children were very young, as well as health services and was very keen to participate in the study. As giving birth in Ireland had been anticipated, but not clearly stated, in the study criteria this did not preclude the woman from being interviewed.

Women recruited and/or contacted who did not participate in the study

Five women were referred to the researcher through domestic violence services and one through snowball recruitment for study interviews. These six women had verbal contact with the researcher and in three cases a time and place for an interview had been arranged, the women were both Irish and migrant. For a variety of reasons the women did not participate in the study: one became ill, one woman's child became ill and had to be hospitalised, two women moved out of temporary safe accommodation into more permanent housing and were so busy with moving homes that being interviewed was not a priority for them. The final two women the researcher communicated with were unable meet for interview, this might have been due to returning to their partner or for other issues in their lives which meant that the study was, naturally, not their immediate priority. It would have been inappropriate and insensitive for the researcher to continue to try to contact the women after a few phone calls and/or text/SMS messages were not responded to by the women in question.

Study interviews

All 18 interviews, apart from one, were digitally recorded and transcribed verbatim. Interview notes were taken by the researcher during and after the interview and were typed as soon as possible and included observations by the researcher such as tone of voice, woman's body language, comments before and after the recording, etc. The

study demographic form was completed at the end of the interviews and many women gave other comments or insights at this point which the researcher noted. Women interviewed often wanted to add or state something prior to or after the recorder was switched off and this was also noted. During the one interview that was not recorded (as the interview took place in a café at the request of the woman and it would have been conspicuous to record the interview) extensive notes were taken which were typed up later the same day. Study interviews recording length ranged from 19 minutes to 85 minutes. The dyad interview recording was just over two hours. However, the actual interview time was often considerably longer with time spent completing the consent and demographic forms, talking about the research and the researcher's experience, talking about women's lives and their children or asking for information from the researcher pertinent to their current situation. These conversations usually continued after the interview too. Some women were under child care, school or medical appointment time pressures and as a result their interviews were shorter. Copies of the interview transcripts were offered to all women interviewed but none were requested from the researcher.

Demographics of study sample

The women recruited for this study are characterised by their diversity in many forms. Women's ages ranged from 26 to 46 with a mean age of 34. Ten nationalities were reported with the majority of interviewees being Irish (seven), six women were born in or were nationals of African countries and five women were European Union nationals. The term migrant women is used in this study, opposed to immigrants, minority ethnic women or non-Irish nationals. This reflects the reality of migrating to Ireland for the women interviewed and potentially their transient presence in Ireland given a need for legal status regularisation. Women's legal status was not probed for in the interviews however, some women disclosed their Stamp Four status (giving the bearer legal right to work and live in Ireland) or ongoing legal processes to access this status. All of the European women interviewed were entitled to live and work in Ireland. Some of the migrant women stated their ethnicity as White, which is the same as all the Irish women interviewed, and therefore does not denote a minority ethnic status despite their migrant status, they are listed as Other White Background in the study demographic table. Women's ethnicity was asked for based on the ethnic identifier categories utilised by the Central Statistics Office in the census of Ireland the Health Service Executive in patient health care records (Health Service Executive, 2008). Five ethnicities were documented in the study participants: White Irish, Other White Background, Mixed, Black African, non-Chinese Asian and Traveller. The term migrant reflects that women

may chose to leave Ireland in the future and return to their country of origin, as was expressed by two women interviewed. The term migrant also denotes that women voluntarily came to Ireland, no women in the study reported being forced or coerced to live in Ireland, although the study interviews did not specifically probe for this. Migrant women, at the time of their interview had lived in Ireland for between two and 16 years. Migrant women's partners or husbands were a mixture of Irish and migrant men.

Women interviewed had between one and five children and two women were pregnant when they were interviewed. One woman had given birth to twins. The age ranges of their children were from four months to 19 years. Women's relationship status was asked for later in the study field work and a question was added into the study interview guide in April 2017 by asking women; "When you sought help what was your relationship with the perpetrator?". Women stated that they were either married to, or cohabiting with, their partners. For 17 of the women interviewed they had separated from their partner and their relationship was over. Some were in the process of applying for a legal separation when interviewed, if they had been married. One woman, although interviewed while living in a refuge, was still in a relationship with her abusive partner and planned to reconcile and be together with him once their fourth baby was born. However, given his violent past and addiction issues this was potentially unlikely. Women's relationship status is not differentiated in the discussion of the data analysis and study findings and the term partner or husband or ex-partner is used throughout, except where specifically referenced for legal or other details. Some women interviewed had children with more than one partner, this was not probed for as part of the demographic questions but arose in the course of interviews.

Women reported living in both urban and rural settings: women were living in a big city, in a town or small city and two reported living in a rural setting or country village. The education level of participants varied from leaving secondary school early to completing third level education to master's degree. Some women were still in education or participating in adult education or job training schemes. Women's work status consisted of full time or part time work, job hunting, on maternity leave from work or being a full-time mother. One woman reported a disability and two women were in receipt of disability state welfare payments. Although not part of the demographic questionnaire women also mentioned their religion in some cases, which was noted as: Catholic, Christian, Hindu and Muslim.

At the end of the interview, if it had not emerged during the interview, women were asked where they had given birth. The 17 participants who gave birth in Ireland had utilised ten of the 19 maternity hospitals across Ireland for their maternity care and

births, covering all four Provinces in the Republic of Ireland and all three maternity hospitals in Dublin. One woman had given birth to her two children in two different hospitals as she had moved with her new partner to a different county in Ireland. Women also talked in their interviews about having given birth abroad prior to migrating to Ireland, in total five women gave birth in other countries, as well as Ireland. These countries were not probed for and are of interest only when women compared their maternity care in Ireland with other countries in the context of seeking help or support for domestic violence. Women were not asked the nature of their maternity care (private, semi-private or public) in their interviews, however, women described the Irish public health care system, and none discussed using private or semi-private birth or post-natal facilities in the hospitals they used. This could be considered an omission in the interview question guide, not to ask regarding their health insurance or maternity and birth care options, but it did not emerge in the interviews. It can be assumed (based on their interview data) that all the women accessed free of charge public maternity care and the Maternity and Infant Care Scheme consisting of GP and hospital medical care.

A summary of the study demographics is presented below in Table 2. The study ethnicity categories correlate to the categories utilised by the Irish Central Statistics Office in the census of Ireland since 2006 and those used by the HSE Social Inclusion Office (Health Service Executive, 2008). The area living categories correlated with those used in the EU FRA Violence Against Women Survey (European Union Agency for Fundamental Rights, 2012).

Table 2 Demographic Characteristics of Study Sample

Demographic indicator (at time of interview, where relevant)	**Reported by study participants (numbers of women in parentheses)**
Nationalities:	10 reported including; Irish (7), European Union (5), African (6).
Ethnicities (CSO categories used):	White Irish (6), Traveller (1), Other White Background (3), Black (6), Mixed (1) and non-Chinese Asian (1).
Age of woman:	Range from 26 to 46 years, mean age of women 34.
Number of children:	One (5), two (5), three (3), four (3) and five (2) children. Two women were pregnant at the time of interview.
Ages of children:	Children's ages ranged from 4 months to 19 years.
How long lived in Ireland:	Between 2 to 16 years (Irish women excluded), mean 7.2 years.
Education, highest level achieved:	Secondary school to Junior Certificate or equivalent (3) Secondary school to Leaving Certificate or equivalent (7) College or post-Leaving Certificate education or equivalent (4) University undergraduate degree (3) University postgraduate degree (1)
Working status:	Maternity leave (4), full time work (2), part time work (2), student/CE Scheme (2), unemployed (1), caring for children full time (5), receiving Disability Allowance (2).
Area Living (FRA Survey categories utilised):	Country village (1), town or small city (10), farm or home in the countryside (1) and big city (6).
Hospital for ante-natal care and birth:	10 out of 19 maternity hospitals in Ireland utilised by 17 women.
Disability:	One woman reported a congenital disability. Two women in receipt of Disability Allowance.

Discussion of study sample demographics

The most striking feature of the study demographics is the range of nationalities and ethnicities present. Irish women (seven) are the minority of women interviewed compared with migrant women (11). However, it is not possible to draw the interpretation that as the majority of women interviewed were migrant they experienced higher rates of domestic abuse during pregnancy. This "over-representation" is commented on in the Key Informant Interviews section of the thesis. Seven women interviewed stated that their first language was not English. There was no research

budget foreseen for interview translation and although the researcher spoke to two women in languages other than English (French and Spanish) all interviews were conducted in English. Potentially more women who do not speak English as a first language might have participated in the study if translation services were available. The researcher made significant attempts by contacting, meeting with and attending relevant events throughout Ireland to ensure that the study sample was as broad and varied as possible. A particular focus was to ensure that women living outside of Dublin (where the researcher is based) were interviewed to ascertain as wide a range of experiences from women around Ireland as possible. This is evident in that only six of the eighteen interviews took place with women in the greater Dublin area and the remainder in other counties. The second noticeable feature of the sample is the range of women who were primiparous, or who had only one child (five women) and the greater number who were multiparous, who had more than one child at the time of their interview including twins (13 women), in addition to two of the interviewees being pregnant at the time of their interviews. This implies that women in the study sample often had repeated and ongoing interactions with health and maternity services on multiple pregnancies and therefore could have experienced multiple domestic violence interventions and help seeking opportunities.

The limitations of the study sample are that as a qualitative study it is not seeking to be representational and that study findings cannot be scaled up to be interpreted as nationally representative. The study data comes from eighteen women who agreed to participate and share their experiences by being interviewed. The time period for the study meant that sample recruitment, despite begin slow and challenging, had to cease at a certain point in order to complete the PhD in three years. The final sample limitation is that no women presented to participate whose pregnancy did not result in a live birth as all of the interviewees had children, therefore women's help seeking experiences in the context of abortion or miscarriage cannot be commented on in this research, only this absence noted. The study design was not a case study one and did not include review or analysis of any files or documents related to the women interviewed (maternity health records, GP records, Tusla or social work case files, domestic violence service files, etc.). As a result, women's own descriptions of their experiences are utilised for analysis and discussion, as is keeping with feminist research methodology, and they were not corroborated with other potential data sources or documents. All the women interviewed have been assigned pseudonyms and direct quotes from their interviews appear in quotation marks.

Study analysis and findings outline

The study findings chapter present the results of thematic analysis of the study data through the elements of the study Conceptual Framework. The next section outlines the types and forms of domestic violence that women interviewed experienced and described. This analysis relates to the Conceptual Framework areas of Woman, her Partner/Ex/Husband/Boyfriend and the continuum of domestic and sexual violence presented as the lower border to the intersecting Framework. Domestic violence as both an inhibitor and an enabler to help and safely seeking is discussed, referring to the green and red stars in the study Conceptual Framework. Finding Services links with the Conceptual Framework sections of Woman; Maternity Services, Doctor, Health & Social Services, Domestic & Sexual Violence Services; and in addition the Framework aspect of Community, Police, Welfare and Housing. This section explores how women accessed and found help, support and relevant services in relation to domestic violence discusses and outlines the services they utilised as part of their help and safety seeking. This area relates to two major aspects of the study Conceptual Framework and how they interact with Woman at the centre of the Framework. However, the important role of friends and family in supporting women is also examined and this aligns with the Friends, Family and Children area of the study Conceptual Framework. Women's health aligns with the Woman and Maternity Services, Doctor, Health & Social Services section of the Conceptual Framework and discusses women's self-reported health, including mental health, in relation to their pregnancies, births and domestic violence. Baby and Children examines the presence of a new baby and/or other children in relation to their impact on women's experiences of help and support seeking. It correlates to the Conceptual Framework sections of Woman Live Birth - Baby and Friends, Family and Children. This study analysis sections contain a sub-theme of Social Workers which outlines women's experiences of child protection services as being both positive and negative. The subsequent theme discussed is Enablers to help, support and safety seeking women encountered. This theme also has a sub-theme of women's experiences of using domestic violence services, including refuge and other safe accommodation as an overwhelmingly positive factor in their journey to safety and support seeking. The final study theme Inhibitors to help, support and safety seeking that women identified is then discussed. A sub-theme of this section is the experiences of migrant women in the study, which describes the specific challenges and experiences of seeking help and support in Ireland,

Feedback from four key informant service provider interviews and their comments on the study preliminary findings and study sample composition provide insights from experienced professionals based on many years of working in domestic violence and/or pregnancy support services. Finally women during their interviews were asked for their suggestions and ideas on how to improve maternity, health and other relevant services in relation to pregnancy and domestic violence in Ireland. This important and insightful data brings the study findings and analysis back to women at the centre of the study Conceptual Framework and design and also presents the comments women gave in relation to participating in the study and their interview experiences. Quotes from the women interviewed appear indented, in inverted commas and with pseudonyms used for each of the 18 women throughout the thesis. Details that have been removed for the purposes of anonymization of data such as; partner's name, child's name, city or town location, etc. appear in brackets with a brief description to allow the reader to comprehend the woman's statement or comment and what it exactly refers to.

Section 1 Woman and Domestic Violence

Introduction

As a result of consultation with gatekeepers the study design and all the study documentation specifically indicated that there would be no questions in relation to women's experiences of domestic violence in any interview. There was sufficient prior research in existence that demonstrated that women globally, and in Ireland, experience domestic violence before, during and after a pregnancy and that the injuries and harms as a result of the violence are severe (refer to Chapters 2 and 3). As women for the study were primarily recruited via domestic violence services, all would have had to be assessed for domestic violence and risk levels prior to admission to a refuge or receiving support and advocacy from the service they accessed. Therefore there was no need to ask women to substantiate or prove if they had experienced domestic violence to participate in the study and no questions were posed in any interview. However, all the women interviewed talked about their experiences of domestic violence. Their experiences are discussed below.

Types or forms of domestic violence reported

Women interviewed reported experiencing all types of domestic violence in their relationship with the father of their child or children. Emotional, verbal, physical, sexual, financial and physical abuse were all recounted. Women spoke of fear of their partner

and described being coercively controlled, being blamed for everything, being accused of infidelity and feeling broken and helpless. One women described the abuse as:

> Angela: “So no matter what I did, say, or do, it was not good enough.”

Three women spoke about growing up in a family in which domestic violence occurred and one woman had spent time in a refuge as a child with her mother. One woman also mentioned that her previous relationship with the father of her first child was also violent. One women described how growing up with domestic abuse in her home made her view it as routine or normal.

> April: “And you see there would've been like a bit of violence when I was growing up as well, you know? So I just seen that as normal.”

Women recollected a lack of food and clothing for themselves and their children as a result of their partner keeping all the money in the relationship, including Child Benefit payments, and not giving the woman money to purchase anything. Women recalled domestic violence that according to many risk assessment tools would be considered high risk such as; attempted strangulation, attempted suffocation, stalking, breaking into their house, physical beatings in public spaces, rape and fear for their lives (Health Service Executive and Sonas Domestic Violence Charity, 2018, An Garda Síochána, 2017).

> Sheila: “I had a huge fight with [ex-partner’s name]. And he put me against the wall and he was trying to make me like choking and strangling me.”

Two women spoke about how their last pregnancy was a result of rape by their partner and the impact this had on them. Women (five) also spoke about their partner having affairs with other women, for some they found out about the affairs when they left the relationship but for others they were a fact of life with their abusive partner and seemed to be leveraged as part of the abuse. One woman felt that her partner’s abuse had a profound impact on her and her child.

> Ava: “..[ex-partner] psychologically destroyed me and my son.”

Commencement or escalation of violence while pregnant

For some women in the study domestic violence had been present prior to becoming pregnant, for others it began or escalated when she became pregnant. Two women commented that pregnancy is a time of increased vulnerability for women in abusive relationships, especially coupled with physical changes during and after pregnancy.

Women recalled verbal and physical abuse while pregnant and the long term impact it had on them. The physical violence during pregnancy in some cases was strategically located so that bruises would not be visible on the woman's abdominal area or face, for other women they were beaten in a targeted manner on their abdomen or pregnancy bump. Women were concerned for harm to their foetus and in two cases went to their GP or hospital to ensure their unborn baby was not impacted by the physical abuse. Women discussed how the violence intensified or escalated during their pregnancies and although they had presumed that it would de-escalate this was not reported by any women.

> Sophia: "I thought, okay, because I was pregnant I thought maybe it's going to tone things a bit down because I'm pregnant, and we have the other kids, but no it was just getting worse."

Women reported that their abuse in some cases began during pregnancy, for one woman it escalated on her fourth pregnancy, for other women their abuse simply continued, as usual, during their pregnancies.

Continuation of violence after pregnancy

Once their baby was born women hoped that the violence would de-escalate or stop. This was not the case for the women interviewed and once they returned home from hospital to their partner the violence continued. One women described how she didn't get to enjoy her initial few weeks with her new first baby due to the abuse. For women who had experienced abuse for many years and with many pregnancies it was an expected return to abuse after the birth and was ongoing between pregnancies.

> Olivia: "But it was happening so long to me it was normal."

No woman interviewed reported domestic violence ending once their baby was born.

Woman trying to manage the abuse herself

Women reported feeling that something was wrong, or sensing that something was not right, in their relationships but not being able to accurately name it as domestic violence. For some women, particularly those pregnant for the first time, coping with the physical changes in their body and feeling emotional, coupled with their abusive relationship all appeared to be interconnected and it was hard for them to actually define the abuse they were experiencing as domestic violence. Women spoke about trying to manage or deal with the situation themselves and to keep things looking normal, especially if they had other children. Other women thought that things would change if they could manage to cope for a while. One woman focused on keeping busy

and another spoke about trying to hide or disregard the violence. For women with other children it was a matter of keeping going and trying their best.

> Nina: “So I was trying to, not control, but manage the situation because I had two other children as well.”

However, for all the women interviewed the violence at some point became unmanageable, a hope for change in their partner’s behaviour dissipated and it became evident that she needed to move on and seek help and safety. Managing the abuse herself was no longer an option.

> Brenda: “So that was what was holding me back, and being managing it was not helpful for me, hanging in there, thinking it's going to be fine, it wasn't helpful for me.”

Recognising this point, where women can no longer cope with or endure domestic violence from their partner and are seeking change, could be crucial in recognising and responding to women in maternity and other health care settings.

Impact of domestic violence on women

Women spoke about the longer term impact that experiencing domestic violence has had on them. Some of the women couldn’t understand how they had ended up in an abusive relationship and sought answers as to why this had happened to her. Women also spoke about feeling as though they were the problem or that there was something wrong with them. Women felt that they were to blame when in the relationship and accepted that their partner would consider that everything was their fault. As a result, women blamed themselves for the abuse as well. This strong sense by women that they themselves were the problem in the relationship or that they deserved the violence led to a form of acceptance of the violence by some women.

> April: “..I would have been like, going, every time he hit I'd be like, I deserved it. Or, if I hadn't have done this he wouldn't have hit me. You know, I blamed myself.”

Women reported feeling that they had no self-confidence and that their self-esteem was very low.

> Angela: “..I lost my confidence, I lost my identity. I was isolated and you know..”

Women modified their behaviour to try to keep the peace in their home and avoid abuse and conflict. They became more isolated and avoided contact with friends or family in order not to feel that they might provoke their partner.

> Sheila: "..to see my friends or whatever, but then when I did that, that used to be a problem. So we might start a huge fight or whatever, so I tried not to do that."

For one woman the abuse was not perceived as her main issue due to her concurrent drug addiction and because she viewed the violence as normal or routine. However, she also described the impact of the abuse and her and her partner's addiction on her as very severe.

> April: "I hated myself, I hated who I was. Couldn't look in the mirror. No respect for myself, no self-esteem, no confidence, so I was broken completely. Completely broken."

Women interviewed described the impact that domestic violence had on them and the behaviours they employed to try to manage, reduce or mitigate their abuse.

Partner/Ex/Husband/Boyfriend: Abusive partners' responses to domestic violence

Women outlined how their partners acted in their relationships regarding the abuse and how they responded when she left the relationship. One woman reported her husband was apologising and promising to change his behaviour when she went to a refuge for the first time. She felt pressure from him, and her family, to return to him so she left the refuge after a few days there. She later sought safety in a different refuge as the violence continued on her return to the family home. Another woman reported that her partner stated that the new baby was not his child and told the woman to leave his house with no further contact with her since then. One man left his partner, another left Ireland and was later imprisoned due to the violent assault inflicted on his partner. For three women there has been no contact with their partner since she left him or he left her. In one case this meant that the woman's husband has never seen his baby after it was born.

> Sophia: "Never made contact. Never seen the baby. I think there's something seriously wrong, maybe."

Women reported that their ex-partners had addiction issues in seven of the eighteen cases. For six women they reported that their partners had alcohol abuse and for one woman her ex-partner was addicted to illegal drugs. In three cases women interviewed also spoke about their own addiction issues.

Inhibitors and domestic violence

Domestic violence as an inhibiting factor to help seeking

As domestic violence is strongly associated with control (Stark, 2009) and isolation from friends, family and colleagues is often part of the pattern of control by an abuser it is not surprising that the actual experience of domestic violence acts as an inhibitor to help seeking (Watson and Parsons, 2005). Women reported feeling controlled and intimidated by their ex-partner in their interviews. Women were scared of their partner and living in fear.

> Rachel: “I was just terrified, it was not normal to feel this way.”

As women were so isolated, controlled and fearful due to the ongoing abuse, their partners appeared beyond the law, or as one woman stated “invincible” to them.

> Emma: “..this was my world, my lonely, isolated world. I had no information. I didn't know about this, you understand? I didn't know, this man to me, because this was the way they make themselves invincible,..”

When women confronted their partners, or were assertive they reported that their partner accused them of being crazy or imagining the abuse. Women were often reminded of the consequences if they did not conform to their partners’ demands and as a result lived in heightened states of fear.

> Angela: “I knew there was something wrong, but I didn't know, because I was so brainwashed and so afraid, that, it's fear. I was so afraid. And to this day, I'm not as afraid as I am because I've got my control back. But the fear, is so strong of, if I didn't actually act the way that he wanted me to act..”

Three women talked about how their partners would threaten them with removal of their children by social workers, this was very frightening for the women. It was also used as a tool by the abuser to ensure that the woman complied with his demands, as one woman recounts being told.

> Emma: “If you don't do what I ask of you, you'll never see your children again.”

In one case the woman’s ex-partner reported her to social workers and her children were placed in foster care. She had had no contact with child protection or social services until that point despite having three children, living with a violent abuser and addition issues.

> April: “I wasn't even dealing with social workers then. Which I should have been, you know when I was an active user. They only got involved when my ex-partner rang them on me.”

Given the threats, accusations, fear, isolation, control and the ongoing patterned nature of domestic violence that women were experiencing, seeking help and safety seemed impossible to many of the women. As a result the actual lived experience of the abuse, before, during and after pregnancy, can be considered an inhibiting factor to seeking support as one woman describes below.

> Emma: “Already there was a point, this man broke me, broke me in a way that was it that, I couldn't take it anymore, talk about strength, that I couldn't take it anymore, I wanted to end life.”

For some women interviewed it was very hard to see any routes out of their violent relationship.

Enablers and domestic violence

Domestic violence as an enabling factor to help seeking

Despite the circumstances that women articulated they were living with as part of their abuse for some women in the study when the violence shifted or escalated, that was their trigger to seek safety. For two women interviewed, when their abuse shifted during pregnancy from verbal, emotional and/or coercive control to the real threat of physical violence this was the shift, or moment, that instigated their seeking help and safety. For these women it marked a line, or boundary, in their relationship that they felt had been crossed and they greatly feared for their safety.

> Olivia: “..he raised his hand to hit me, and he didn't hit me, but the threat was there, and I knew then, this is kind of getting out of hand now. 'Cause this is going to be the next thing..”

One of the women moved into a refuge soon after the incident and the other began to research and look for help and supports online for herself.

> Olivia: “..I just knew at that stage, go now, or it's going to get worse.”

Other women reported fearing for their safety and that of the foetus as the violence intensified acted as the trigger to seeking help.

> Sophia: “My own safety and my unborn child as well, and that's what really made me just decide to give it up and just take myself out of the situation, as well…”

For one woman discovering her partner having an affair with her friend was a trigger for her to leave their relationship.

> April: “So I actually found him cheating on me. That's why I left. He actually left me for my friend. I actually walked in and caught them when I was four and a half months pregnant with my last son…… when I was pregnant he seemed to be cheating on me more…”

The range of enabling factors that allowed women to seek safety and help will be fully discussed later in the thesis. Yet it is important to note that these incidents that acted as precursors to help seeking could be issues that could be probed for in ante-natal medical appointments or could be highlighted in communications (posters, leaflets, etc.) aimed at pregnant women experiencing domestic violence.

Discussion Woman: domestic violence during and post pregnancy and Partner

Women who had experienced domestic violence, of any form, while pregnant were the study sample and therefore it is not surprising that women interviewed discussed the abuse that they had lived with during their interviews. Yet women were not asked about their experiences of domestic violence in any of the interviews, as this had been specifically requested by gatekeepers consulted, and was clearly stated on all study documentation that women read prior to their interviews. However, all 18 women spoke, to a greater or lesser extent, about their lived experiences of domestic abuse. This points to three very important conclusions. Once women felt safe, comfortable and in a private setting during their interviews and were confident in talking with the researcher they spoke about very difficult, and what some described as very traumatic events, in their intimate relationships. Secondly the types of violence, including high risk, escalating and very perilous physical abuse that women recounted indicates that women were in very dangerous situations during their pregnancies. This would imply that greater attention to a range of presenting factors related to the violence in maternity settings is needed and a range of issues that can be asked about as part of ante and post-natal screening for domestic violence. Finally, the women interviewed may benefit from ongoing, longer term therapeutic supports such as counselling and group work to come to terms with the trauma and abuse they have lived through.

Section 2 Finding Services: Woman; Maternity Services, Doctor, Health & Social Services, Domestic & Sexual Violence Services; and Community, Police, Welfare and Housing

Introduction

The fundamental research question for this study is how women were enabled and supported to access help and appropriate services in relation to domestic violence during and after their pregnancies. As part of this help and support seeking women needed to find, or be referred to, appropriate services. Therefore, discovering how women found services and their subsequent referral routes or paths to accessing them is a core aspect of the study data analysis. Prior research through quantitative nationally representative surveys indicated that many female victims in Ireland never accessed services for domestic and/or sexual violence (McGee et al., 2002, Watson and Parsons, 2005, European Union Agency for Fundamental Rights, 2014). This phenomena was outlined in more detail in Chapter 2 of the thesis.

Woman self-referred and/or friends referred her

In interviews women were asked how they located and found the services they accessed in relation to domestic violence. Predominantly women had made initial contact and self-referred into specialist domestic violence support and housing services. Twelve women made contact themselves after finding information online or seeing a poster for a helpline or a leaflet. Five women reported browsing the internet and using search terms that they felt were suitable to try to find help. This was somewhat challenging as some migrant women were not always familiar with terms used in Ireland for the services they were seeking. One woman spoke about how she thought that Ireland must have some kind of supports as they were available in her country of origin. For another woman accessing services took longer due to confusion between the meaning of the terms hostel, shelter and refuge. This woman was in contact with numerous housing and homeless services before being told to search for a refuge and call the Women's Aid national helpline. This delayed her accessing services when she was in a potentially very risky abusive situation.

> Rachel: "They said they don't take mother and children, just single people, and it wouldn't be appropriate. They said a women's shelter, so I looked for a women's shelter. Then the women's shelter said to look for a refuge."

For some women space was available in their local refuge when they phoned which allowed them to leave rapidly with their children. The next most frequently stated

source of finding information on domestic violence services were the woman's friends. For five women, their contact was initiated by a friend suggesting that they contact a service or bring them to a service.

> Nina: "My experience was that my friends helped me with support. And they led me to the Women's Refuge."

One migrant woman who did not have a strong command of English, was brought to the local social welfare office and then subsequently to a local domestic violence service by a friend who spoke and understood English well. In one case a woman's friend called her GP, as she was concerned about her and a potential diagnosis of post-natal depression, which the friend felt was inaccurate. For this woman both the public health nurse and the GP supported the woman and referred her to the local domestic violence service following on from the initial contact her friend had instigated.

Other sources of information and referral

Four women were in contact with homelessness services. For two of them this was their route into refuge accommodation. One woman was in phone and email contact with numerous housing services before being told to contact a refuge and given the Women's Aid helpline details. The other woman was referred to homeless hostel accommodation as there was no room in a refuge for her and her four children. She noted a lack of information in the hostel and finally accessed appropriate supports when she saw the Women's Aid helpline details in the office where she met a Community Welfare Officer.

> Susan: "Even in the homeless unit, I didn't get any referral for help around domestic violence, no information, I didn't know what a Barring Order is, I didn't know anything. I wasn't told anything in this place."

Two women were referred to a refuge by social workers, one was a medical social worker in a hospital as the baby had been unwell and was hospitalised. She had also had contact with the social worker in her maternity hospital before and after her birth in as a result of her abusive relationship. In the other case the Gardaí were not able to find and apprehend the woman's violent partner so they arranged for her to live in a refuge with her two very young children. Due to her severe physical injuries she had been referred to social workers by her GP and the hospital. One woman disclosed the violence she was living with at home to her manager at work and he found contact details of the local domestic violence service for her. He then let her make the initial phone call to the service at work. For one woman, every person that she disclosed to and spoke about her abusive husband to resulted in being advised to contact her local

domestic violence women's refuge. She was given the same contact information by her GP, practice nurse during ante-natal care, a female Garda officer, the principal of her children's school in addition to her looking online for information and contacting the Women's Aid helpline. This meant that she felt confident in contacting the refuge as it had been suggested to her by numerous people. Another woman had ongoing contact with the St. Vincent de Paul charity, which was suggested to her by a friend in her church, due to the financial hardship she was experiencing while living in an abusive relationship. This interaction with a charity was her route into a refuge and safety. From her initial contact with them and subsequent ongoing financial support she was ultimately brought by St. Vincent de Paul volunteers to medical services and then to a women's refuge.

> Ava: "The St. Vincent de Paul I tell you they are fabulous you know. They rang different places and see, so they said they want that they should get a suitable one for me. Then the suitable one was the [refuge name], it was very good."

For one woman her children's school did a home visit due to concerns about her welfare, they then contacted her GP and asked him to do a home visit as they were so worried about her mental health. This later prompted the woman to get information about the local refuge, where she lived once she left her violent partner. Most of the women in this study, 12 out of 18, self-referred into specialist domestic violence services with five of them using the internet to find and locate these services.

Support services women used in addition to domestic violence services

Women interviewed also spoke about the range of support and information services they accessed and used either before, during or after contact with domestic violence services. For some women these services were accessed for the first time when they came into contact with specialist domestic violence services and for other women they used them due to issues in their lives connected with their abuse or their childhood. Some of the women noted that the positive response by the services that they initially accessed led them to later on seek support from other services. Women reported utilising the following:

- Addiction treatment services, including alcohol services and drug rehabilitation programmes.
- Citizen's Information Centres (CICs).
- Community Welfare Officers, as part of Department of Social Protection welfare payments, benefits and allowances.
- Counselling and psychotherapy (including couple counselling in one case).
- Family Support Worker.

- Legal supports including; Legal Aid, for marital separation and child custody advice, a solicitor for visa and migration queries and Domestic Violence Act Orders for protection and safety.
- Rape crisis centre.
- St. Vincent de Paul.
- The Probation Service.

One woman also spoke about seeking support from her foster care family who she was still in contact with and she specifically asked to be moved into a refuge close to where they lived to maintain the ongoing support from them. Another woman stated that her landlord was very helpful when she moved home from the refuge, as she took the woman's husband off the lease and replaced him with the woman's name on the lease. What is significant is the wide range of services utilised by women, some of which could have potential for highlighting and promoting local domestic violence services both in private advice settings and in public waiting areas with posters, leaflet, helpline numbers, etc.

Discussion finding services

As the majority of women interviewed self-referred into specialist domestic violence services women needed to be pro-active and seek the information and service contact details themselves. Women's friends also played a substantial role in accessing services and were able to suggest where to go or even accompany their friend into services. This finding does point to the random and arbitrary nature of finding help for a population that is in regular contact with free to access Irish health services: pregnant women and women with babies. All the women in the study, except one, were accessing maternity care services and health services for themselves or their children on regular basis, yet only two referrals for women came from their combined maternity care of GP and maternity hospital. So despite ongoing medical appointments during and after their pregnancies and spending time in a maternity hospital to give birth (except for one woman) when they were experiencing abuse, health care services appeared to have a very marginal role for women finding domestic violence service. The implications of this study finding, including potential means to assist women finding services and the important role of online information, will be further discussed in Chapter 7.

Section 3 Woman's Health: Woman and Maternity Services, Doctor, Health & Social Services

Introduction

Domestic violence is strongly associated with poorer health for women, encompassing both mental and physical health and including health harming habits. Domestic violence during pregnancy is strongly associated with pre-term birth, low birth weight babies, miscarriage and increased maternal morbidity amongst other adverse health outcomes. Women who have experienced domestic abuse are known to access health services more frequently than women who have not. The health repercussions of partner violence were outlined in the first Irish national study on the topic *Making the Links* and included depression, head injuries, broken bones and miscarriage (Kelleher et al.,1995). Similar findings emerged in the Watson and Parsons study where women reported bruises, cuts, broken bones and teeth and miscarriages as a result of partner abuse in their survey interviews (2005). An advisory body to the Department of Health in Ireland published their report in 2008 entitled *Violence and Health* outlining the negative impact of abuse on women's health and the role of health care professionals in identifying and supporting women victims (Women's Health Council, 2007). Poor health outcomes are not only aligned with the mother as international research indicates (Lukasse et al., 2014, Donovan et al., 2016). However, the WHO describe health care during pregnancy as a crucial time for identifying and responding to domestic violence: "Antenatal care provides a window of opportunity for identifying women who experience intimate partner violence." (World Health Organization, 2011 p.3).

As a result of the national and international research and evidence on this topic it is not surprising that women interviewed for this study spoke about their health during and after their pregnancy/pregnancies and the health of their new babies. In early October 2017, after six interviews had been conducted for the study, a further question was added into the study interview guide. This was because many of the six women interviewed had spoken in considerable detail about their health being impacted negatively because of the violence they lived with and experiencing complications during their pregnancies and births which they directly connected to their abuse. The issue of women's health began to emerge as a research theme and therefore all women subsequently interviewed from this point on in study interviews were asked: "How was your health during and after your pregnancy? And the birth?". Women's medical files were not reviewed or accessed as part of this study and therefore the

words used to describe women's health and pregnancy complications are their own and not necessarily formal medical diagnostic terms or diagnosis. There was no data-triangulation or case file analysis of women's medical records to substantiate their own health assertions as part of the study design. As one woman in the study did not give birth in Ireland data presented here relates to the 17 women in the sample who did.

Women's physical health during and after pregnancy

Three of the 17 women interviewed reported that their health during their pregnancies was good. The remaining thirteen described a range of health issues. For one woman her pregnancy with twins rapidly followed an ectopic pregnancy and then a further singleton pregnancy a year after giving birth to her twins. Women spoke about having severe morning sickness, which left one woman dehydrated and very weak and required intravenous rehydration in the maternity hospital. The range and severity of health issues women discussed in their interviews was substantial. Women reported having: high blood pressure, gestational diabetes, incompetent cervix, irritable bowel syndrome, recurrent urinary tract infections (UTIs), bruising, repeated hospitalisation during their pregnancy for health issues, poor weight gain during pregnancy or weight loss and ongoing ante-natal bleeding. Two women reported that their pregnancies were as a result of rape by their partner. One woman recounted presenting to an accident and emergency department due to physical injuries as a result of the violence. Women stated that their health was being negatively impacted due to the pressure, control and abuse they were living with. One women spoke about how she broke down and cried in front of a hospital consultant trying to articulate what she felt was the real cause of her health problems during her pregnancy.

> Elizabeth: "I was crying with my dietitian, and my dietitian was so upset once.… No, it's not, is not even listening to what you have to say."

Three women also spoke about their addiction to alcohol or illegal drugs during or after their pregnancies.

> Nina: "My child was born, then from about 15 months I started drinking really bad."

Overall women in the study reported poor health during their pregnancies which they directly associated with their experiences of domestic violence.

Delayed ante-natal care

Two women in the study reported that they delayed or did not attend all their ante-natal appointments. One woman went late for her first ante-natal appointment in the

maternity hospital and was then told she was pregnant with twins, the other woman did not attend all her GP appointments and was drinking alcohol heavily at this time. The NICE *Pregnancy and complex social factors Guideline* notes that women experiencing domestic violence may have particular difficulties using antenatal care and attending their appointments due to a controlling partner or fear that any disclosure of her abuse to midwife or doctor will worsen her circumstances (National Institute for Health and Care Excellence, 2010). Therefore the NICE Guideline suggests that women who present late in pregnancy for ante-natal care require more time and support to determine the issues preventing them from attending their appointments and additional needs they may have. This finding is substantiated in the ICGP *Domestic Violence: A Guide for General Practice* which notes patients in domestic violence situations may have frequently missed medical appointments (Kenny et al., 2014). The ICGP survey of GPs in relation to domestic violence during pregnancy also notes that research suggests that women experiencing abuse may present late for ante-natal medical care (O'Shea et al., 2016).

More, not less, contact with and use of health services

As a result of their health issues described, almost all women interviewed had more frequent and regular contact with health services during their pregnancies than the routine free 14 Maternity and Infant Care Scheme visits.

> Mary: “There was always kind of, every time I went there was an issue….. They always found something wrong with me.”

Despite this more frequent and ongoing contact with health services only two women in the study were referred to specialist domestic violence services by the health care professionals they were in contact with while pregnant. One further woman was referred in the post-natal period by the Public Health Nurse and her GP to appropriate services but with the intervention and support of her friend.

Birth

Seventeen women in the study had given birth in Ireland utilising ten different maternity hospitals across Ireland. Four of the 17 women interviewed reported that their births were good, without complications and straightforward. The remaining 13 women recalled difficult labours, premature delivery in three cases, complications during the birth in eight cases, emergency caesarean sections and longer stays in hospital after the birth for three women due to complications, and two women reported having a post-partum haemorrhage.

Lorraine: "..my last baby, I lost blood and after the labour, I lost a lot of blood.."

In the systematic review and meta-analysis by Donovan and colleagues suggested that women experiencing domestic violence during pregnancy are at increased risk of having a preterm birth, defined in the review as infants born before 37 weeks of gestation (2016). Again women connected their difficult and preterm births with the violence they were experiencing by their partner. Two women interviewed mentioned the good care they received during and after their births in the maternity hospitals they used.

Health of new-born baby

Health of women's babies after birth was a concern: two needed resuscitation after birth, three were born prematurely and one baby required ongoing hospital visits.

> Mary: "it was very, very difficult. She was born, they had to resuscitate her. For three minutes she wasn't responding."

One woman spoke about praying after her birth that her new baby would respond to the attempts to resuscitate him. The baby did respond and recover. Another described how she tried to tell staff in the maternity hospital that there something wrong with the baby.

> Mary: "Like I told them multiple times near the end that I felt there was something wrong."

The systematic review and meta-analysis by Donovan and colleagues also suggests that women who have experienced domestic violence during pregnancy are at increased risk of having a small for gestational age (SGA) weighing <2500 g and/or low birth weight (LBW) with a birthweight below the tenth percentile for a given gestational age, baby (2016). This was the experience of some of the women in the study.

> Nina: "I had to have a lot of scans because of the baby was small."

In two cases the babies required ongoing medical care for the first few months of their lives.

Post-natal health

After giving birth women outlined the health complications they had. For one woman her caesarean section wound failed to heal, she collapsed at home and a neighbour called an ambulance for her. She was then re-admitted to the maternity hospital she had given birth in. Another woman spoke about having a post-partum infection. The Public Health Nurse (PHN), who visits women during the six week time frame after birth

in their homes, was mentioned by some of the women interviewed. However, in one case the PHN couldn't find the house to visit the woman and baby. For one woman the PHN was very supportive and referred the woman to local domestic violence service. Two women reported that their partners were always at home when the PHN visited and as a result they were unable to speak privately with the PHN about the abuse they were living with.

Breastfeeding

For some women given the pre-term birth or infant health complications after the birth breastfeeding was very challenging or impossible. Three women recounted feeling stressed or like a failure due to their difficulties breastfeeding. One woman related this challenge to pressure from her abusive partner.

> Emma: "Do you think I could breastfeed? I got six weeks….. But still you feel like a failure as a woman. The one thing you want to do for your baby you can't do, and you're still pushed into the corner. You're not left alone to rest and things like that. He would always be hovering."

The experiences described in this study are supported by a recent systematic review of breastfeeding and intimate partner violence (IPV). The review found lower breastfeeding initiation and exclusive breastfeeding rates during the first six months of the baby's life and a higher potential of early cessation of exclusive breastfeeding all amongst women living with a violent partner (Mezzavilla et al., 2018).

Women's mental health

One of the strongest elements related to women's health in the Women's Health study was women's poor mental health, which ranged from anxiety to attempted suicide in the study sample. In the sample of 18 women, ten reported experiencing negative or poor mental health symptoms. Findings from a meta-analysis by DeVries and colleagues found that for women who had experienced domestic violence (their inclusion definition was physical and/or sexual violence), this life experience was associated with incident depressive symptoms, and in cases of depressive symptom presentations by women, there was also an association with this experience and suicide attempts (2013). The WHO, NICE guidance and MBRACCE reports all outline the profound impacts that domestic violence can have on a woman's mental health and subsequent mental health morbidity during and after pregnancy (National Institute for Health and Care Excellence, 2010, MBRRACE-UK et al., 2015, World Health Organization, 2013). Women interviewed spoke about feeling emotional and crying a

lot during their pregnancies. Some women were concerned about the impact of the abuse and their mental health on their unborn baby.

> Sophia: "…I was worried about the baby. I kept thinking if I am going through all these emotions, what impact does it have on him? But it turned out all right."

Women spoke about the mental ill health they lived through and how they lacked a positive vision for their future.

> Elizabeth: "I felt depressed, desperate, and had no hope to go for a positive thought at least… I have to talk with somebody what's going on, because I think I will losing my mind."

One woman recognised that she needed to seek safety away from her partner due to the impact the abuse was having on her mental health. Another woman described how she was unable to reach out and seek any support for her depression, although she felt it could have been picked up at her ante-natal appointments.

> Emma: "When you are in depression, you don't even want to bother nobody. Your pain is too heavy for you to put it on somebody else, you don't want to put it on nobody else. You want to take everything on your shoulders, which is the problem, which is what a lot of people, especially the professionals, I'm not going to go there and say, 'Help me'. It's difficult, but the signs are there."

Three women spoke about their suicidal ideation.

> Emma: "Please, my life is over. Please come and take your daughter. I don't want to live anymore. It's over. My life is finished…Already there was a point, this man broke me, broke me in a way that was it that, I couldn't take it anymore, talk about strength, that I couldn't take it anymore, I wanted to end life. This man came and beat me naked outside… I'm thinking, if I take my life what's going to happen to them [woman's three children]?"

One woman spoke about hearing voices and contemplating suicide. Another woman felt that her situation was so beyond hope that suicide was an option. One woman's husband tried to have her admitted to a psychiatric hospital, he persisted in telling her and health care professionals that she was mad.

> Mary: "It was very bad depression afterwards. Even after, after the second to last baby actually. He brought me to the doctors, but he told the doctors I was mad. And the doctor said 'Well, what's going on?' But he used to, he was hitting us and calling us names and telling me I was mad..."

In this case the woman's GP saw her, diagnosed post-natal depression, prescribed anti-depressants and referred her to a psychiatric clinic. At the psychiatric clinic the woman tried to speak about the abuse she was living with at home with her husband but was dismissed. She eventually gave up going to her psychiatric appointments as she was being given higher amounts of medication with no exploration of the issue which she felt was causing her depression, her abuse.

> Mary: "I had loads of appointments with them [outpatient psychiatric unit], I think I went twice, which was the most but I didn't go back. They would just give me stronger tablets every time,…"

The woman also spoke with the PHN when she did a home visit to her and to check on the new baby, but with no recommendations apart from attending yoga classes.

> Mary: "..she'd ask 'How are you feeling?' And I was really depressed, and she said [PHN] it was post-natal depression. You can do yoga classes and this and I said 'I don't have time'.."

One woman attempted suicide after experiencing abuse during her three pregnancies and being raped by a man other than her partner, in addition to her ongoing drug addiction and self-harming behaviours. Her suicide attempt was unsuccessful and it became a turning point for her seeking help and support, she reached out to her father to bring her to addiction treatment services. For one woman it was an intervention by St. Vincent de Paul volunteers who brought her to her GP and then a physiatrist, which led to her moving to a refuge and getting appropriate medical support. Despite the fact that *Maternal Death Enquiry Ireland* report noted that suicide was the most common cause of direct maternal death for the triennium 2012-2014 and in the 2013-2015 time period maternal suicide was the leading cause of direct maternal deaths occurring between six weeks and one year after pregnancy end, there appeared to be minimal exploration of women's presentations of depression, anxiety and suicide ideation during and after pregnancy by health care professionals caring for women in the study sample (O'Hare et al., 2015).

Discussion woman's health: Woman and Maternity Services, Doctor, Health & Social Services

According to the WHO research physical and sexual violence are associated with psychiatric problems, including depression, anxiety, suicidality and alcohol and drug abuse, all of which women in this study spoke about experiencing (Ellsberg et al., 2008). Therefore it is not surprising that women articulated a range of issues related to

their health both during and after pregnancy, they outlined births with complications and health issues their new babies experienced. Women articulated in interviews that their health issues were related to their experience of domestic violence, although for some this connection was as a result of hindsight and reflecting on their relationships. The impact of their poor maternal and mental health was very serious in a number of cases and potentially life threatening in cases of suicidal ideation, attempted suicide, (possible) pre-eclampsia, post-partum haemorrhage and neo-natal resuscitation. In the annual *Irish Maternity Indicator System (IMIS) Report* which examines birth and health outcomes for the approximately 65,000 births in Ireland per year, the figures and/or rates for some of the conditions that women spoke about in their interviews are very low (Irish Maternity Indicator System, 2016). This could potentially indicate that a greater interest in their medical care would arise given the relative rarity of some of the health events and presentations which they described.

However, the absolute minimal connection to domestic violence made by the health professionals caring for and treating women in this study sample is profound. This is despite most of the women reporting attending more than the 14 combined care appointments provided free under the Irish Maternity and Infant Care Scheme for issues such as increased scans and blood tests which meant that women had more, not less, contact with maternal and other health services. Two women recounted crying in medical appointments trying to communicate about the abusive situation they were living in but with no engagement by their health care professionals. The recent guidance by the Royal College of Physicians and Surgeons of Glasgow would appear highly relevant to the women interviewed; “Never make the assumption that symptoms are just caused by pregnancy” and to probe for circumstances around all health, and especially mental health presentations, during and after pregnancy (Royal College of Physicians and Surgeons of Glasgow and the Royal College of Obstetricians and Gynaecologists, 2016). The key exhortation in all health care of treating the patient and not the symptoms appears to have been overlooked for the women in this study. As a result what should have been a route for women to be enabled and supported to seek help and safety from domestic violence via their ongoing appointments with a range of health care professionals, actually became an inhibiter as women were disillusioned with the responses they received from them, if any. This acted as a delay to women seeking safety and help and will be discussed in more detail in the thesis section exploring the Conceptual Framework area and study theme entitled Inhibitors.

Section 4 Children

Introduction

This section discusses children in relation to women seeking help and support. It aligns with the study Conceptual Framework areas of Live Birth-Baby, Children (in Friends, Family and Children) and especially Health & Social Services. All the women in the study had children at the time of their interviews. For five women they were recounting violence during and after their single pregnancy to date and for others they had experienced violence on all or some of their pregnancies; two women were pregnant when they were interviewed. Women in the study interviews spoke about how their children acted as both inhibitors and enablers to seeking help, support and safety in relation to the abuse. Understanding how their new baby and/or children facilitated women to oscillate between two very different potential routes and eventually, in all cases, find and access help is crucial if women are to be better supported to seek safety as a result of this research.

Negative impact of domestic violence on children

Women feared for their own safety as a result of the abuse by their partner, but they also feared for the safety of their children and in some cases the potential risk to the foetus. The potential negative impact of abuse in the family home on children was a concern of many of the women interviewed. One woman described how the abuse she was living with was constantly escalating and as a result she needed to seek safety for herself and her children.

> Sophia: “I felt in danger. My own safety and my unborn child as well, and that's what really made me just decide to give it up and just take myself out of the situation, and take the kids out of the situation..”

Women often tried to protect their children from hearing or witnessing the abuse they experienced, but this was not always possible. Even for women with very young children they acknowledged that there was an impact on them living in an abusive home environment.

> Elizabeth: “She's the only baby, but she's a smart girl. She could pick the stuff around her very easy.”

This was despite women’s efforts to try to conceal the violence from their children.

Women felt others should realise the danger that children could be in and described that it was a turning point for them in seeking safety and leaving their partner.

> Alice: “Get out, because your child doesn't deserve it. That's when I knew. If this man could hurt his own unborn child, or do this with his other child watching..”.

Women interviewed spoke about being afraid that the domestic violence would impact on the baby/child/children in the future and sensing that their children deserved better than the domestic violence situation they were living in.

Women sensing children deserved better

Based on the negative impact of the abuse on their children women decided that the children/child deserved a different type of environment to grow up in, one that would not negatively impact on them, especially as in future as the child grew up.

> Angela: “Why should a child not be given the opportunity of a future because of past experiences? That's something that's been very strong with me.”

For one woman thinking about her children’s future was critical in starting to seek help for the situation she was living in. For another woman she blamed herself at not begin able to provide a safe family home for her children.

> Ava: “I’m angry at myself, despite my efforts I did not give my children a real home.”

This strong sense that women felt that their children deserved safety and a better life was a key initial enabler for a woman to disclose violence and begin to seek help.

Children as enablers

Women described their children becoming a crucial driver to them seeking safety and help, children provided a special kind of strength and motivation to women.

> Emma: “Probably I was not meant to be happy will have to accept it, this is my life. But that is you, that's it, that's just your life, it's over, this is your life, but don't touch my children. My children were my strength.”

Women felt they had to be strong, find safety and seek help because of their children.

> Maria: “The baby pushed me to disclose from day one. I needed her to be safe and that was the reason I did everything.”

Even though it was very challenging for some of the women to keep going while seeking help and safety they felt that their children were driving them forward. All the women in this study had children, therefore for women whose pregnancies do not result in a live birth may not potentially have the same sense of urgency about seeking safety and help and may not be as motivated as the women interviewed for this study

to engage with relevant services. For the women in the study their child/children, and their future and safety, were the key reason to keep seeking safety and help and a life free from violence and abuse.

Foster care

For two of the women interviewed their children were in foster care when their interviews took place, but the women had ongoing contact with their children. Both of them spoke about the impact their children being in care had on them. They also spoke about working towards living with their children in the future. However, when the children were taken into care it was a profoundly negative experience for one woman and she spoke about the hopelessness she felt at that time.

> April: “You know, because when my child was taken, I gave up all hope, you know of getting him back. I never thought I was going to get him back, you know, I just completely gave up.”

In the two cases the women’s parents were fostering some of their children and their remaining children were living with non-family members.

Contact with father of children

In two cases there was no contact with the child’s father after the woman sought safety and/or moved into refuge accommodation. One woman hoped that in the future her children might meet with their father, in this situation he had never seen his youngest child after it was born.

> Sophia: “I do tell the kids, ‘Look, you can pray for your dad. Pray for him, pray for God to bring him back into your lives.’ When you're older you can always go and find him, you can look for him, but right now I don't have any contact.”

For other women in the study, courts directed access to the children with their father which was the main source of contact for them, and in some cases the women, with their ex-partner.

Court utilisation

Women in the study went to court for a variety of reasons; seeking Domestic Violence Act Orders for their safety and protection, for financial support and maintenance for their children and for access between parents to be decided by the courts. For one woman seeking maintenance through the courts for her three children was another opportunity for her ex-husband to exert control over her.

> Nina: “I've been in the courts loads times about the maintenance. I must have been in the court five or six times, maintenance and he's been in front of the judge. I seem to be, it's going on now over 17 months now, it’s going nowhere with him, he’d put in the money and then he'd stop but then, so he's always been controlling even me he's gone. It feels like control there over money.”

For two women they were unable to initially access Domestic Violence Act protection Orders as their partners’ whereabouts or address was unknown. Eventually in both cases the men were served Orders. Some women found the courts process very disappointing when they were threatened in the court by their ex-partner or when he was given unsupervised access to their children. Another woman described how she had to supervise the court ordered access her ex-partner had with their baby, and how distressing this was.

> Sheila: “..but I didn't find it fair at that time. Like my baby was so small, and he could have access. And I have to be there, because somebody has to supervise the access and I was the person supervising it. I was completely broken. My heart was broken…..”

One woman described her court experiences as very frustrating and futile.

> Emma: “What is the point of going through the court if you're not going to protect the women?”

No women reported court intervention or utilisation as positive in relation to seeking help and safety and most women interviewed utilised courts in relation to child access and maintenance.

Health & Social Services: Social Workers

Social workers and Tusla (the Irish statutory Child and Family Agency and principal employer of social workers) were discussed by many of the women in their interviews, predominantly in a negative way. Women spoke about the fear that any engagement with Tusla and child protection services entailed and how this was an inhibiting factor to disclosing domestic violence.

> Alice: “..some of them [social workers] I've met were terrible. Then there's some I met that were brilliant.”

Although women realised that they and their children were in danger because of the violence and that child protection interventions were necessary, the approach and impact of social workers was mainly seen as unsupportive and unhelpful.

Social Workers as enablers

Social workers became involved with women in the study through a variety of routes. For some women their GP or hospital contacted social workers due to child protection concerns, for other women when they linked in with specialist domestic violence services they were referred to Tusla. One migrant woman self-referred to the maternity hospital social worker as her GP had suggested it to her as a route to information. For one woman her ex-partner called child protection services and suggested that they remove the woman's children. For many women they felt that they were problematized as the issue of concern, not the violence they were experiencing.

> Alice: "I felt from the social workers, the way they were kind of attacking me, making me pay for [Ex-partner's name]'s mistakes…I felt you know like everything, it was like the victim was not the victim. I had to pay even more for his mistakes."

One migrant woman was referred to the maternity hospital social worker by the midwife and later linked in with a social worker when her baby was re-admitted to hospital. She found the social workers very caring.

> Maria: "The maternity hospital and the social worker were very helpful. I felt that everybody was trying to help me."

She appreciated that her social worker from the children's hospital came to visit her on Christmas Eve in the refuge and brought gifts for the baby. For this women, she articulated the most positive experience in the study with social workers and found their continued support helpful. Another migrant women self-referred to the maternity hospital social worker and found her supportive. These two migrant women were the exceptions in the study with their very positive interactions with maternity hospital social workers. Another migrant woman did state that the maternity hospital social worker was helpful when she first met her but didn't discuss ongoing contact with child protection services, possibly because she had no contact with her ex-partner since he told her to leave their home and she moved into a refuge in another county and province.

Social Workers as inhibitors

As discussed previously domestic violence perpetrators used the threat of reporting their partner to social workers in order to have their children removed from the woman in a number of cases, in one case this was acted on. Women generally spoke about social workers in a fearful and threatening manner. As a result Tusla, social workers

and child protection became a barrier to seeking help and safety for women due to the dread and fear of them. One woman described social worker involvement with her family as a barrier to moving forward and seeking help.

> Nina: “It was a barrier and the fear of what would happen to my kids and all that. And then it did happen. I had all the social workers involved.”

For one woman even the phrase social worker incited anxiety, but she felt that this needed to change by better communication and a sensitive approach.

> Susan: “Sensitivity instead of a judgment towards us, even with the social workers, this fear of social workers needs to go because there is obviously, as soon as you hear social worker your mind just goes ... the panic is crazy..”

Another women suggested that opening up and being honest with social workers was challenging, given their reputation. This women had lived in foster care and a refuge as a child and possibly may have had negative experiences with social workers growing up too. The fear of social workers and their role was evident in the interviews but could be potentially diffused according to the women interviewed if their remit and job was explained to them and if women were treated with more empathy and in a supportive manner. One woman suggested improved and clearer communication by social workers to women could be helpful.

> Susan: “If they explained, ‘This is what we're doing. We're looking at the best interest of the children, that's our job initially, but we're looking at your best interest. What can we do?’ And then explain to us, that you know we cannot allow your children to be witnessing violence for X, Y. Explain the process, don't just hang us.”

Given this fear, refuge accommodation where women could safely live with their children became even more important to women. Although many women outlined their fear of having their children removed it appeared more pronounced by the Irish women and migrant women from the UK than for other migrant and European women interviewed. No African migrant women in the study articulated concerns about, fear of social workers, or child removal in their interviews. For some women interviewed they felt unsupported by social workers and as though the woman herself was to blame for the situation she was in. Social workers letting women know about options they had, services available that they could access for addiction, domestic violence and other supports would have been appreciated by the women.

> April: “I wasn't given the option, like, you can go to treatment and link in with services. I wasn't told about NA [Narcotics Anonymous] meetings, I knew

> nothing about them. I didn't even know about one to one counselling, or anything like that, you know I wasn't given them options, I was just told, you know, 'You need to hand your son over'. I feel like if they [social workers] give you a bit more of an option."

However, this woman did describe how relations could be improved between women and social workers by offering more supports. One woman described how due to her alcoholism she was seen as the problem in the family and she felt that there was little understanding about the abuse she was living with.

> Nina: "I found the social workers hadn't much compassion."

One woman couldn't understand that despite ongoing appointments with two social workers in the maternity hospital when she was pregnant they never gave her any information about domestic violence services and the local refuge.

> Sheila: "In fact, I couldn't believe, when I went to that office, the domestic violence, I say why they didn't say that to me in the first place, you know?"

In this case the social workers referred the woman and her partner to couple counselling despite the woman having experienced attempted strangulation while she was pregnant and verbal abuse and threats. One woman did speak about the support she was getting from social workers while her three children were in foster care, but she hoped for a future without social workers at some point in her life. Two women noted a lack on follow up and ongoing support by social workers, when they felt they still needed support.

> Nina: "I felt that she should have kept more in touch with me when I was the full year sober and I was still living in that situation. That she should have checked in with me every two or three months."

The requirement of ongoing support was discussed by women after they left refuge accommodation or when they needed to return to court and this role could have been filled by social workers and provided much needed longer term support.

Discussion: Children

Children acted as both a positive and a negative force towards seeking help and support for women: they acted as inhibitors and enablers. In some cases fear for their new baby or children's safety and future wellbeing pushed women to disclose their abuse and seek help. Other women reported the fear they had about contacting any service, in case social workers became involved and their children were removed from them. All the women in the study had children and many of them articulated that the

fear of social workers, the threat of removal of their children by child protection services and the use of this threat by their abusers acted as inhibitors to seeking help and support. This is not unique to Ireland and has been discussed in Chapter 2. It is important to note that not all women in the study had contact with social workers regarding child protection and as a result did not perceive them to be either a barrier or an enabler to seeking help and safety. Seven women in the study sample did not discuss social workers in their interviews. It is also important to note Irish and migrant women from the UK were the demographic group in the study most critical of social workers and their interactions with them, whereas migrant women seemed less cognisant of the possibility of their children being removed by Tusla and were more positive reflecting on their interactions with social workers. For one migrant woman, she discussed in her interview how she found social workers very supportive and helpful and how much she valued her ongoing contact with them. This supportive aspect of social workers will be discussed further in the section examining Enablers.

Section 5 Enablers to help, support and safety seeking by women

Introduction

Women were asked to outline their experiences as to what supported and enabled them to seek safety and help at the outset of their interview. Discovering the enablers that women relied on and utilised was a key aim of the research study. Women spoke about the positive forces both internal and external that assisted in their routes to seeking support. For many of the women interviewed it was an initial combination of repeated positive interactions with different services, not necessarily initially specialist domestic violence services, which enabled them to move forward to a life free from abuse and then seek out more specialist supports. Women discussed their experiences in some detail of utilising domestic violence services and how imperative the information, assistance and for many housing, provided to them was in relation to getting appropriate help and finding safety. As a result, the sub-theme ‘using domestic violence services’ will be discussed later in this chapter. Specific experiences relating to migrant women in the sample that enabled and supported them will also be outlined. The supports or enablers recalled by women, similar to the inhibitors, can be categorised within the overall theme as internal, relating to the woman and her relationship with her partner, and external relating to other aspects of the study Conceptual Framework such as maternity and health care, police, community and welfare services, etc.

Women as their own enablers

Women spoke about the factors they had within them that assisted them or drove them to seek supports and help. For one woman it was the need for stability for her family that helped her to leave her partner and move into a refuge.

> Sophia: “I knew I had to do it, and I felt that the sooner was the better because the sooner we got to a safe place and the stability, because I always felt we needed stability. You have to have stability to bring up a family.”

Women felt they drew on their inner strength to motivate themselves to find help and supports. For some women, despite having health problems, being pregnant or just having given birth they managed to find internal strength to keep going and seek safety. Women felt they had to be strong for their children too.

> Sophia: “It was putting things in motion for us. I think, yeah, what myself I felt I needed to do regardless of the fact that I was pregnant, I had young children and all that, I needed to be strong….. Like they say after hardship things become easier, and then what doesn't break you makes you stronger.”

Women also found strength through their children to motivate them out of an abusive relationship, this helped them to realise how much change they have lived through. Realising the danger they were in acted as a source of strength for one woman to seek support and accept that their partner wouldn’t change.

> Brenda: “The second pregnancy was the worst. That is when I now stood on myself that I can do this better, I can do without him. Because even if I've died, nothing would have happened…. Yes, nothing would have happened. He will continue doing his life and while me I am there in the grave.”

For another woman being pregnant for the fourth time was a new opportunity to parent and that motivated her to continue to seek help and link in with services.

> Lorraine: “I want to look after this baby when it's born, I want to be there. As a mam. Because I didn't get the chance with my other three kids, I still see them, but I think there is another chance in me to be a mam again.”

Women felt it was important to reflect on the changes they had made and how different their lives were now from when they were living in a violent relationship and for some women with addiction issues. Moving forward in their lives, continuing to seek safety and stability were things that women articulated enabled them.

> Sophia: “Go forward, to move on, yeah. The thing is in my mind, I had a plan. I had a vision, and there was nothing to stop me from getting there. My vision was to have a safe home for myself and my kids, and bring them up.”

Two women spoke about their faith (Christian and Muslim) as a source of internal support. For one woman her greatest support was God, who was closely followed by the organisations in Ireland that assisted her, which she prayed to God to give thanks for regularly.

A profound enabler for some of the women interviewed was when each contact they made or disclosed their abuse to was sensitive, helpful and referred the woman onto relevant services appropriate to her needs at that time.

> Maria: “Ever since I asked for help people have helped me in every way possible”

Women noted that this positive response and interaction oriented them in a direction to keeping seeking support and was an enabler in their route to safety. This woman-centred and coherent response seemed to re-enforce and support moving forward and enable more help and safety seeking by her.

> Sophia: “Positive response. Definitely positive and encouraging throughout. Very positive and encouraging, and I just felt, okay this is helpful. I do want to talk again to this person, because they're telling me something that's going to make things better for me and my family.”

The ongoing interaction and support some women encountered in the services was key in starting to recover from the abuse and move forward in their lives.

> Angela: “..but it was the constant reassurance because when I was in that environment, I lost my confidence, I lost my identity”

Women spoke about being determined to move forward in their lives without their partner and they drew on their inner strength, motivation for change and safety and vision for a different life in order to do this. Women interviewed were positive about their futures and felt they had achieved a great deal. This was following on from having sought help, leaving their abusive partners and drawing on their strengths to create change in their lives. Having a safe and peaceful home for themselves and their children was also something that women now drew strength from.

> Nina: “I have peace of mind now…. I have great peace in the house… I turn the key and go where I like.”

Women acknowledged that it was challenging to keep going at times and not rapid nor easy to find safety and help and utilise supports.

> Angela: “Because when you're so afraid and you're so in pattern, you know you're looking at that window and it's so dark. You're just waiting for that light, but you could be looking at the light and you could be looking at that bit of light and it could take a while to actually pull up that blind…. It's a long-term journey with a healthy outcome, yeah.”

Women felt they were still moving forward, had become stronger individuals and had hope for a positive future with their children.

Discussion: Woman as their own enablers

Women spoke about drawing on their inner strength, being motivated by their need to find safety for themselves and their children and how each positive interaction or response drove them forward to seek more support and information. Women also noted how being determined and finding the supports they engaged with helpful in keeping them moving forward to a life free from violence. However, this route from fear and abuse to safety and hope was not easy and women needed to draw on all their resources of internal strength to enable them to keep going at times. Reflecting on their routes to safety and support was also empowering for women in the interviews as it reminded them of the challenges and difficulties that they had overcome.

Enablers external to women

For many women the routes to seeking support and safety were supported and enabled by individuals or interactions beyond their personal or individual sphere. These enablers will be discussed under headings from the study Conceptual Framework areas or fields. In some cases there appears to be duplication between inhibitors and enablers, this is where a woman has encountered a positive response rather than a negative one in relation to her support and safely seeking.

Family and Friends as enablers

Just as many women in the study were referred into specialist domestic violence services by their friends, such friends also played a key role in supporting the women and enabling them to move away from their perpetrator. Support from friends was in addition to support from families for some women. Women who could confide in their siblings or parents about their abuse reported that this was very crucial to them in seeking further help and services. One woman couldn’t fully disclose to her mother

what was happening in her abusive relationship at the time of the abuse, but since leaving her husband she now gets good support from her.

> Nina: “She's great. But I don't tell her too much you know. But she kind of knowing that the violence was going on by my appearance and stuff.”

For another woman her father was the first person she turned to in order to get help for her addiction and the abuse. He was very supportive and met her and drove her to a residential addiction treatment service that day. For migrant women there was a challenge of being far from their parents, even though they were somewhat supportive, and not potentially being able to return to the family home.

> Sheila: “I had support from my family, but I don't think it was enough. 'Cause when I told my mum I was pregnant and all that, what she said is, ‘Well, you take responsibility for that if something happened’. I mean I suppose she mean that if I was with my partner or whatever I couldn't go back home.”

For one migrant woman she felt she couldn’t tell her parents what was happening until she was safe and settled in a new home as it would cause them worry as they were far away. However, she disclosed to her sister and this offered her great support in the meantime until her mother could visit her and the new baby in Ireland. For another migrant woman, who had moved to Ireland recently, she felt her parents were a vital back-up as she had no friends or community support where she lived in rural Ireland. She regularly spoke to her mother by phone.

> Emma: “My mum… We have got close because I haven't got any friends here…I don't have any of that, and family is all you have.”

When women could reach out and disclose to family members the assistance they received was a vital enabler to continued help and safety seeking, unfortunately for some migrant women, this family support was not available to them for reasons outlined in the Inhibitors section.

Discussion external enablers: Family and Friends

Friends not only played a key signposting role for women to initially find and engage with specialist domestic violence services, they also were a source of continued support for some women. In cases where women could talk with their parents or siblings about the abuse they found this very helpful and a key source of support, but this was not possible for all women in the study.

Maternity Services, Doctor, Health & Social Services as enablers

Women spoke about the interactions with health and social work professionals during and after their pregnancy that were constructive and useful to them, in relation to being enabled to access help and safety.

Information on domestic violence visible

Three migrant women interviewed recalled seeing information in the maternity hospital about domestic violence services, either a poster in the toilets or a leaflet in the waiting area.

> Sophia: “In the hospital I noticed in the toilets they had some signs, just advising women if you're having issues talk to somebody. Don't just put up with it. Seek advice.”

Although the women self-referred to the domestic violence services, having the information visible in a location they went to regularly enabled them to seek help quickly when the violence intensified. For one woman it acted as a positive catalyst to speaking with the maternity hospital social worker, for another migrant woman it meant she knew some services might be available to her in Ireland.

> Sheila: “Every time I went to hospital there was a little paper, and it had all the phone numbers of police. It was for abusive things. So I used to have a look to all these numbers and services just to see what else I could..”

One woman was discreetly able to get the details of her local domestic violence service this way. As women interviewed for the study utilised ten maternity hospitals in Ireland it is not reassuring that only three women, who gave birth in three different hospitals, could recall any visible information on domestic violence during their entire maternity care time frame.

Doctor, practice nurse and midwife

Five women who disclosed domestic violence to their GPs received some advice from them. Two women were told to contact Tusla or the maternity hospital social worker, one woman was referred by her GP to the local social work team, another GP suggested to the woman to contact MABS (Money Advice and Budgeting Service), giving her their contact details. Another women was re-assured by her GP that she was not suffering from post-natal depression. Although the women appreciated the responses of their GPs, none were referred to domestic violence supports, nor were offered information on safety planning or emergency helplines or potential legal

interventions as outlined in the ICGP Guide (Kenny et al., 2014). However, being able to talk with their GP about their abuse did seem to have an enabling aspect as these women continued to seek further help and supports. Two women spoke about seeing the same Public Health Nurse or GP Practice Nurse on an ongoing basis as enabling them to develop a trusting relationship with them and to seek further support. However, this continuity of care was absent for most women interviewed.

> Angela: “I wouldn't have opened up otherwise. It was getting the trust in her and the trust with my doctor and the trust with the service.

Three women spoke to midwives about the abuse they were experiencing. One woman broke down crying in her ante-natal appointment and was referred to the hospital social worker.

> Ava: “I cry nonstop. I say I have problem. My partner ... I don't have money. He no give me money, and I have problem. She say next time coming to hospital and you speak woman..”

The two other women were also referred to maternity hospital social workers and in one case the midwife was very supportive to the woman. This woman greatly valued the discreet and sensitive manner in which the midwife supported her and referred her to the maternity hospital social worker, this enabled her to access more services and supports after the birth.

> Maria: “The first time I asked the first time I got help, they helped in every possible way.”

Although the numbers of women who sought help from health care professionals were low and the responses not always in harmony with current professional guidance (Kenny et al., 2014, Institute of Obstetrics and Gynaecologists, 2012a, Health Information and Quality Authority, 2016, National Institute for Health and Care Excellence, 2014) being able to speak to someone about their abuse during their maternity care did seem to act as an enabler to continued help and support seeking by women interviewed. For one woman in the study her interaction with a midwife, the midwife’s concern and subsequent response and referrals was very positive and helpful.

Social Workers

Although many women interviewed perceived any intervention by social workers as a deterrent to seeking support, as outlined in the section entitled Inhibitors, four women found their social worker interactions enabling and helpful. Despite one woman’s

children currently being in foster care she appreciated the support she was getting with her fourth pregnancy from the social worker.

> Lorraine: “In the hospital and my other one as well, she's very good, and just to help you around and get you through. Just to help you out. Support you in a way.”

For two migrant women the interactions and support they received from social workers were exceptionally helpful. For one of the women the help she received towards financial independence and accessing social protection payments with the support of her social worker was vital. For the second migrant woman the initial helpful response from a midwife was further enhanced by constructive support ongoing from hospital social workers.

> Maria: “The maternity hospital and the social worker were very helpful. I felt that everybody was trying to help me.”

Although the perception of social workers and fear of removal of children acted as an inhibitor for many women in seeking help and engaging with services, for a minority of women their engagement and support from social workers was very helpful and an enabler to leaving their partner and finding safety.

Discussion Maternity, Doctor, Health & Social Services as enablers

A low number of women in the study disclosed abuse to their GP and in these cases none received referral to a domestic violence service. However, women did not appear deterred by this and went on to engage with other services and in two cases, as advised by their GP, disclosed to social workers too. Where women had trusted and ongoing contact with the same health care professional or social worker this appeared to be especially enabling and supportive.

Community, Police, Welfare and Housing services as enablers

Women had dealings with a range of agencies and professionals as part of their seeking help and support that correspond to the Study Conceptual Framework areas of Community, Police, Welfare and Housing. This range of professionals and services that women found enabling are discussed below.

Services alert to domestic violence

For one woman the fact that the charity volunteers she was connecting with in relation to financial support were alert and sensitive to the potential for domestic abuse and responded to her situation in a prompt manner with appropriate onward referrals was

crucial. The observations made by the charity volunteers and responses they instigated for the woman were enormously appreciated by her and meant that she didn't have to articulate exactly what she was experiencing, as they could pick up on the signs of abuse. The combination of professional curiosity and insight by the charity volunteers meant that this woman was rapidly linked in with appropriate health and refuge services when her home and health situation was deteriorating. In one case a woman noted the support she received from her parish priest who became aware of the abuse she was living with. As well as offering pastoral support he arranged to buy the woman a new mobile phone as her partner had destroyed her previous one, this was in case she needed to call the police due to a severe beating. The woman appreciated this support as it was not anticipated by her.

> Ava: "Well, he was just kind of the religious kind of thing. You know, 'I'll say a prayer for you' and he just called me on side and he said like you know 'I understand what you're going through and it's not easy, I'll say a prayer for you'. Yeah, but he said 'You know where we are if you ever need us'…. They were helpful as well. Where you least expect it.."

No other women in the study recalled any positive or enabling interactions in relation to their abuse by any religious congregation members. This could be a potential route for information and referral on domestic violence that women could access via churches, temples, mosques or worship buildings or even through parish or congregation newsletters or websites.

Police

The experiences of the study sample in relation to Police, or Gardaí, interactions varied, many women found their interactions to be inhibitors to further help and safety seeking. It is important to note that not all women interviewed had interactions with the Gardaí nor did they all seek Domestic Violence Act Orders. For four women interviewed they found the Gardaí to be very helpful, in particular for two migrant women in the study. One woman valued the sensitive manner they spoke to her with and their rapid response to her phone call.

> Rachel: "They [Gardaí] sat down and they spoke to me. Just as a normal human being, you know. Just talking to them in general, they showed me that the support is there. If I ever need anything to just give them a call. They gave me their number. They are very helpful."

In two cases women's partners went to the Gardaí about them prior to the woman contacting the police. One husband complained to the police about her wife to get her

removed from their home and the Garda asked to meet with the woman separately and in private. The woman described feeling comfortable speaking with the female Garda Officer about what she was going through. She later phoned the Gardaí and was referred to her local refuge.

> Sophia: "I even called the Gardaí at some point, and two officers came and they said to me, 'Look, if you feel unsafe, you can always go to a refuge. There are places where you can be safer. If you don't feel safe you can go out, go and find help'."

For another woman when she moved into a refuge her partner contacted the police to report her missing and to try to find her. The Gardaí told him that she was safe and did not reveal to him where she was living. By maintaining her confidentiality the woman was able to settle into the refuge with her children without his harassment and contact which she really valued.

> Brenda: "They [Gardaí] kept my privacy. And me myself I did for me I barred his number, he was unable to reach me, the phone was on barred till when I'm a little bit relaxed."

Migrant women in the study reported more positive responses and interactions with police than Irish women. Where these positive responses occurred women felt protected and reassured by the Gardaí and went on to engage with other services and supports.

Additional Community enablers

Three women spoke about the support they received in relation to domestic violence from their workplaces, and in particular from their managers. One woman was given time off for her appointments in relation to her alcohol addiction which she found very helpful. For another woman in the study when she moved jobs and had to explain the reason why she was leaving her job, the response from her manager was very supportive. Her manager gave her a good reference which helped the woman in terms of finding a place to live and future work. For another woman going to work was a break from her abuser and she disclosed her abuse to her supervisor, who then immediately referred her into local domestic violence services.

> Mary: "I used to love going to work, I used to love going in, it was just away from him for a while. I got to meet other people… So my supervisor, kind of he actually picked up on it. He said 'Everything's not okay at home?'. And I took to crying. And I said 'No'. And he said, I've cuts and bruises and that. And the

same time my hands were all bruised. And I tried to cover up, I couldn't cover my hands… They were helpful as well. Where you least expect it.."

The woman was very disappointed when she had to leave her work role to go on maternity leave and later when her exceptionally helpful manager was moved to another region. However, her work supervisor was the only person to respond with regard to her abuse and she felt comfortable confiding in him.

Discussion: Community, Police, Welfare and Housing Police as enablers

Women found support and information in relation to domestic violence from a range of services and professionals. Where women received a sensitive and pro-active response from the police this was greatly valued, unfortunately this was in very few cases in the study. For some women the response from their work supervisor or manager was very supportive and enabled contact with other services. Finally, where other services women were engaging with, such as a charity, were alert and able to respond promptly to domestic violence this was a key enabler, especially for one woman.

Migrant women's enabling experiences

In relation to the migrant women interviewed in the study, some felt initially that they would not be entitled to services in Ireland regarding their abuse or that the responses they would receive would not be constructive. As a result when migrant women did disclose their abuse and link in with services they were very grateful for the positive, understanding and supportive responses that they received. The very helpful responses in some cases mitigated the additional inhibitors that these women had experienced, one woman stated that as she was not Irish she didn't think that she would receive help, but that she was mistaken.

Maria: "It's not my country, I didn't think people would help me but I was very wrong"

For another woman she was exceptionally grateful for all the support she had received in Ireland and prayed to give thanks for it every day. This woman also noted the non-discriminatory approach in the services that she used, in particular the Community Welfare Officer she dealt with. Once migrant women located and linked in with domestic violence services they were very positive about their experiences and the help they received, despite initial barriers to finding and accessing the services.

Domestic & Sexual Violence Services: utilisation as an enabler

Once women found, or were referred to, and made contact with specialist domestic violence services their experiences were overwhelmingly positive. The support and information they received enabled them to access and avail of more relevant services. Not all women used refuge accommodation services in the study, for a variety of reasons, and some women used more than one refuge. Most of the data gathered in this study sub-theme were collated from women's responses to the interview question: 'Can you tell me again what supported or helped you at this point in your life/pregnancy?'. Women were interviewed for the study in domestic violence facilities or refuges (except for one woman) and were reassured by the researcher that anything they spoke about in their interviews would not be communicated to the service staff, be it positive or negative. Women spoke about their needs being met in a very comprehensive way while using services through the support, information, childcare, referrals provided and by feeling safe and secure and that relevant information and supports were offered to them. For many of the women interviewed when they came to the service, and especially when they moved into the refuge, they reported feeling safe. Women felt protected and secure in the fact that they and their children were safe.

> Rachel: "First and foremost you feel safe and free"

For one woman simply the knowledge that she could go to a refuge and that there were services to support her enabled her to leave her abusive partner.

> Emma: "After got my first information of the refuge, domestic abuse in all those things, it took me a while, but it stuck with me. It helped me to leave. I had somewhere to go, and I could be safe, and I could be protected."

Women felt they could relax once they moved into a refuge due to this sense of safety.

> Maria: "I was more relaxed when I was in the refuge. There was no tension, no stress.. I was very, very safe."

One woman felt that the domestic violence services available were so vital that they potentially had a life-saving impact on the women and children who utilised them. Once women were accessing domestic violence services and/or living in a refuge and they felt safe, then they felt they could rest and get some mental space which enabled them to start to plan for their future.

> Sophia: "..first of all safety. When you're somewhere safe you can think in an open mind and you can be a lot more positive when you're safe…."

Women described the safety and “head space” the refuge provided as a time to reflect and plan, which had seemed impossible when living with an abusive partner. The safety allowed women to relax and they knew they were meeting professionals who could assist them. One woman felt that as she was able to rest, relax and recover from her abuse, both her health and her baby’s health improved when she was living in the refuge. For this woman the fact that her baby began to thrive after they moved into a refuge was very significant.

> Brenda: “When we moved in, when the baby moved out from the house and moved into the xxx [refuge name]. Then the changes now begun; he begins to sleep well, he feed well, he laughs very well. He does some things that he has not been doing before.”

One woman did note that living in a refuge meant that she was sometimes under a different form of pressure, to make decisions and choices about her future. She felt that she still needed time and space to make the right decisions for her and her family.

> Olivia: “Sometimes you do be so stressed out you can't even think about things. Kind of just give me a break every now and again.”

Another woman noted that she got good advice to turn off her mobile phone when she first moved into a refuge, this was to avoid pressure to return to her abuser and to get the peace of mind she needed to make her own decisions. Women described feeling safe, relaxed and having an opportunity to contemplate and plan their futures when they moved into a refuge. The most frequent terms that women used to describe their experiences with domestic violence services were helpful and supportive. Women spoke about being able to engage with knowledgeable and supportive staff who understood them and what they had lived through and were able to offer them relevant and accurate information.

> Rachel: “that is one thing I found that helped me a lot because I feel like I have been very stuck, and stagnant, like trying to figure things out and I didn't know how to go about it. I have literally had most of the things that I needed done within a week… Very, very helpful.”

Even though for one woman it was hard to begin to trust people after her abusive relationship, she found the staff in the refuge helpful. One woman described the level of high trust and confidence she had in the refuge staff, she emphasised that the fact it was free to access these supports as imperative. One woman stated that she felt she had been offered options and guidance, not been told what to do and was really listened to by the refuge staff.

> Sophia: “I really appreciated that, the fact that they were not only listening to my needs and all that, but also they were there to support me but not tell me, ‘Look, this is what you must do’."

Two women spoke about spending Christmas in a refuge. Despite it being potentially an emotive time living away from home with small children, the women really appreciated the support provide by the staff and gifts provided for themselves and their children.

> Alice: “The refuge was very good. They helped me get a house. Very supportive. They still are, they're very good. They've helped me over Christmas and everything here.”

> Maria: “I moved into the refuge at Christmas time, they made a Christmas dinner, gave gifts to me to the baby.”

Women spoke about having days or times where they felt very sad, down and emotional but that at these moments support was there for them from the staff.

> Sheila: “Not only that, also if I needed to talk and cry one night, they would be there for me. They would be listening.”

Overall women interviewed who were still living in a refuge when interviewed were very happy with the support and help they were receiving. Some women connected with and got peer support from the other residents in the refuge, they found this an additional positive enabling aspect of living in a refuge

> Sophia: “I think I met a few people whilst I was here. Some of them we got on really, really well, and because this is just a temporary thing we had to move on. I meet some of them, and they've moved on, they're doing really well as well.”

Women noted that they met and engaged with the same staff members, sometimes over a number of years and that this continuity of care was important to them and a positive enabler to ongoing connection with the service. Women articulated how much they valued the information that was given to them by staff in domestic violence services. They knew that the staff had up to date, relevant and important material and that they could request and get any information that they needed from them. One woman described it as being in the dark, until she was able to get the information and support from the service which enabled her to see light in front of her.

> Angela: “And that if there was anything, if I was getting stressed or exhausted or needed to talk to someone, that that's who I go to. And to be told, that's who you go to. Very valuable information. Because when you're so afraid and you're

> so in pattern, you know you're looking at that window and it's so dark. You're just waiting for that light, but you could be looking at the light and you could be looking at that bit of light and it could take a while to actually pull up that blind. But to be constantly told, this is who you can go to if you feel, you know…"

For migrant women who were unfamiliar with services in Ireland, or how legal or housing systems operate, the information that they received was especially valuable.

> Elizabeth: "In the end, I receive help from here with the council, explaining what emotional stress I going through. They put me on the house list, and I was so happy."

One woman noted that any information she had requested was made available to her and was often printed out for her to read. For women who were not native English speakers the support to fill in forms and guidance on how to access services was very important to them.

> Sheila: "They say step by step what they have to do. They said you have to court report him for domestic violence, you have to go to the city council and get into the house list. And they even came with me, if I needed…. People working here is part of my family because I didn't know what to do without them. They referred me to the city council for me to have a house, and the social welfare."

Legal advice and access to free legal services provided very valuable information for the women interviewed. Two women participated in the Freedom Program while they were using domestic violence services. They both felt it was very helpful in making sense of what they had lived through and for recognising abusive behaviours and patterns. They appreciated that the Freedom programme had been developed by a woman who lived through domestic violence and so had elements of peer support contained in it.

> Emma: "Now, it starts to make sense because Freedom Program was created out of people who went through the same thing, went through."

Specific, accurate, relevant and practical information provided to women by staff in the domestic violence services they accessed was greatly appreciated. The information provided assisted and enabled the women to avail of other supports and services they needed in relation to domestic violence.

Ongoing support for women and children

For many women the option of continuous and ongoing support and being able to link back in with the domestic violence service whenever they needed to was very important.

> Nina: “I've been coming here since I think 2011. I always knew the support was here… I always knew I could come back.”

This reassurance was a crucial enabler for some women to know they could reconnect as they needed. This was helpful if their circumstances changed or if they needed to renew a Domestic Violence Act Order.

> Mary: “They always told me, the door's always open.”

For women this ongoing support with no time limits or costs was really invaluable for them. For one woman leaving the refuge and going to live by herself with her two young children in secure housing was a big step, as she had felt so supported and welcome in the refuge by the staff there. But she knew she could avail of ongoing outreach and other supports from the staff while in her new home. Women noted the lack of ongoing support as an inhibitor to seeking safety. Where support was provided by specialist domestic violence services, at no cost and with no prescribed time limits this was reassuring to and appreciated by the women interviewed.

That refuges had childcare staff and in some cases a crèche was very important to women. This allowed them to relax more and know that their children were in good, safe care while they used other services offered in the refuge. Women also noted that their children were very happy in the refuge, enjoyed their interactions with childcare staff and living away from the mother’s abuser. One woman felt that as refuge’s had facilities and staff for children and childcare that this could avoid children being removed from women by child protection staff, which was a substantial concern.

> Alice: “It's great to have places like this, and that you can go to a place like this and not get your kids taken off you. Because if there wasn't a place like this they would take your kids off you. They wouldn't give you a chance if they couldn't get the father.”

Onsite, free and accessible childcare in refuges was appreciated and utilised by women in the study. It was also used by some women to participate in the study interviews.

Accessible local refuge

Women noted that once they were in contact with the refuge they were facilitated to move into it rapidly, even in relation to initial transport to get to the refuge.

> Rachel: “It was brilliant response time. They said they had a place for me here…I think I couldn't have made it without their support. From the moment I rang them and they said to me, ‘Look, you can just get on the bus and come. If you don't have money we will pay for your fare, whatever, as long as you can get yourself here. We'll get you sorted somehow’."

Women felt that they were lucky that space was available in their local service for them when they needed it. For one woman being able to move into a refuge in a matter of hours with her new born baby was critical to her. Women also commented that refuges were busy and often under pressure for rooms and space so they were very grateful when they could quickly move into their local refuge. One woman stated that she felt that the doors and locks in her second stage safe housing, where women live after moving on from a refuge, was not very secure. She felt that it could have been safer with more security elements in place such as stronger locks and doors. This was one of the very few (three) minor negative comments about domestic violence services in the study.

The study inclusion criteria stipulated that women in the sample needed to be currently accessing and/or in contact with domestic violence support services. As a result all the women in the study had utilised these services and many were still living in refuge or safe transitional accommodation when they were interviewed. Women were very positive about the support, advice, information and help they received from the services, they often felt that this had enabled them to move forward in their lives and to cope and come to terms with the abuse they had lived through. As a result utilising domestic violence services is an enabler for women in this study to seek further help, support and safety. However, given the study recruitment criteria, and sampling via domestic violence services, there is potential for a positive bias amongst the sample in the study towards the services they utilised.

Discussion of sub-theme: Domestic & Sexual Violence Services utilisation

Once women in the study were accessing and utilising domestic violence services the positive interactions they had with these services enabled and motivated continued safety seeking by them. Women were very keen to emphasise the support (professional and peer), information provision, childcare they engaged with in the

services they used. Women reported feeling safe, looked after, given options and allowed the “head space” to decide what they wanted and needed to do next and this was greatly valued. Women who were able to access their local services in a prompt manner were especially appreciative of this fact. Women also noted that the services were free of charge and could be accessed on an ongoing basis for as long as they needed, which they found supportive and helpful.

Discussion Enablers to help, support and safety seeking for women

Women discussed the enabling factors that assisted their help, support and safety seeking. Although there was substantial diversity in the study sample in relation to parity, nationality, ethnicity, age of women interviewed and where they lived in Ireland, common issues and experiences emerged as recounted by women and formed the data for analysis which contributed to the Enablers theme. This study theme, similar to the Inhibitors theme, also interacts with the study themes such as Children, Women’s Health and Finding Services and echoes in the interconnected aspects of women’s lives and experiences reflected in the Conceptual Framework. The interactions between the study conceptual elements can be potentially either positive or negative (visualised by the red and green stars in the Framework) for women in their route to a life free from violence. Leaving an abusive relationship is a process and not a once off event, as such it may require multiple factors and issues to be in a woman’s control, or at least for her to have knowledge of, prior to her contemplating leaving her abuser (Kenny et al., 2014). Seeking and finding advice and information, not always initially from specialist domestic violence services, and getting a positive and supportive response, was very enabling for the women interviewed. Enablers, represented as green stars, in the Study Conceptual Framework involved women’s interactions with a range of services and professionals that then enabled or led a woman to contact or engage with further services. For most of the women in the study their key enabling turning points were when they found and contacted domestic violence services. Their routes to this point were usually not facilitated by the health, social and police services that they were already interacting with, especially those services in relation to pregnancy. However, when coherent, sensitive, timely supports were offered to women in maternity care settings these were greatly appreciated and utilised by women. Yet this appeared to happen in only four cases in the study sample. An increased visibility of information on domestic violence and services available to women as part of their maternity care would be staring point to allow health care settings to act as disclosure friendly and enabling environments for women.

Section 6 Inhibitors to help, support and safety seeking by women

Introduction

Women were asked in their interviews to describe what supported or enabled them in relation to looking for help and safety and linking with appropriate services in relation to domestic violence and pregnancy. However, many women described significant barriers and challenges to finding and accessing services, safety and help. These barriers, or inhibitors, can be considered within the study Conceptual Framework overall theme as internal: relating to the woman and her relationship with her partner, Ex ,Husband, and/or Boyfriend, and external to the woman relating to other aspects of the study Conceptual Framework such as maternity, doctor, health & social services, police, community, welfare and housing. A subsequent sub-theme became apparent during the data analysis of Migrant women. This sub-theme of the specific barriers to help seeking recounted by migrant women in the study will be discussed later in this chapter. The sub-theme relates to where migrant women articulated specific issues that were problematic for them in Ireland and acted as additional inhibitors. Listening to women describe challenges to availing of, or gaps in or between, services that they encountered is a key feature of this research study. This is important in order to identify what changes can be instigated to better support women during the ante and post-natal periods in seeking support. Many of the internal inhibitors identified in the thematic data analysis coincide with the documented outcomes of coercive control, living with and surviving domestic violence and have been discussed in Chapter 2. Therefore these known inhibitors could be anticipated by the professionals interacting with women as part of their maternity care and probed for or ascertained through routine screening. Unfortunately this was not the case for almost all women who took part in this study

Woman and internal inhibitors

Women spoke about the issues and concerns they had themselves which acted as inhibitors to seeking help or delayed their help seeking. These inhibitors were often beliefs, feelings, emotions, reactions or internal opinions held by the women and in some cases re-enforced by her abusive partner. Interviewees outlined how they didn't recognise what they were living through as domestic violence and therefore were unable to name it as such. For one woman listening to a phone in radio show drove her to begin to search online for the signs of partner abuse and see if they related to her situation. Still she found it hard to acknowledge that domestic violence was what she was experiencing herself. For some women as they had lived with the abuse for so

long and during multiple pregnancies they found it hard to see the changes that had occurred within themselves in order to cope with their abuse.

> Olivia: “You won't even see the difference in yourself, just other people will see that for you it would be normal..”

One women grappled with an assessment of domestic abuse by the Public Health Nurse (PHN), her GP and the local domestic violence support service. When one woman was asked to complete her ante-natal form she didn’t yet believe that she was in an abusive relationship, she described it as lying to herself.

> Sheila: “At that time I couldn't believe everything was so bad, so I didn't want to tell them. I was lying myself saying no, everything's fine. He is very supportive. He wasn't.”

Not recognising domestic violence by the woman was a delay or inhibitor to help seeking. This was because the specialist domestic violence services, that potentiality most suited the woman’s needs at that point in time, were not recognised by her as relevant and/or necessary. One woman spoke about how domestic violence wasn’t the main issue for her and she considered it quite normal, she experienced abuse on all three of her pregnancies.

> April: “Back then, I suppose I thought it was quite normal, you know? I didn't see it as a problem…. I didn't see the need to talk to anybody because I thought it was quite normal.”

She had grown up with domestic violence in her family home and community, and never considered the ongoing violence as abnormal.

Three women felt that the abuse they were experiencing, which varied between physical, verbal, emotional and sexual was not severe enough to access specialist domestic violence services. They also articulated that they might not be believed as victims of domestic violence as they had no visible bruises or recent scars.

> Sheila: “Like I wasn’t covered in blood, too, so I just think domestic violence office is only for this kind of women. If I go there, maybe they are going to say ... You know? So I didn't even think that was a place for me.”

Although all three women had experienced abuse during their pregnancies none of them self-identified as a victim of domestic violence. Some women felt unable to tell their parents or family what was going on in their relationship. Others didn’t feel confident enough to disclose in medical settings the violence they were experiencing. One woman who wasn’t screened for domestic violence during her five pregnancies

hoped that she would be asked about her bruising on her body and what caused it, but felt unable to disclose to medical staff at the time. Women also felt that all the responsibility was on them to disclose their abuse, which wasn't always easy and required a competent and reassuring GP and/or midwife.

> Nina: "So it was all about myself. Why didn't I say something? Or because I was in that situation."

> Alice: "They [women] aren't sure whether they want to tell or open up, and open that can of worms when they're pregnant do they want this? They need someone to be able to spot it and to reassure them."

For women seeking supports other than refuge, telling professionals that they had experienced domestic violence was challenging too. One woman spoke about her interactions with a county council housing officer when she was living in a homeless hostel with her four children. Articulating that they were seeking help as a result of domestic violence, especially while pregnant, was not easy for the women in the study and was an additional inhibitor to seeking supports.

Isolation, loss and loneliness

The decision to seek help was described as a lonely one. Women spoke about loss, isolation, feeling very alone and for one woman coping with the fear that her partner would leave her. Isolation is a known feature of, and risk factor for domestic violence and can be a key aspect of coercive control (Stark, 2009; Walby et al., 2017). Isolation was the most frequently described and reported internal inhibitor for women in this study.

> Angela: "..it's been a very lonely process because the only one, the only one who can really understand is you and professional support. I lost a lot. I lost a lot of friends. I lost family support."

Living in an abusive relationship in a foreign country when pregnant was also very lonely for one woman and was an inhibitor to finding information and support

> Emma: "This was my world, my lonely, isolated world. I had no information."

For one woman the fear of being alone without her partner kept her in the relationship for three pregnancies and tolerating her abuse, she felt this was an issue for many women in similar circumstances. Women spoke about losing contact with their in-laws, family, friends and the more isolated women felt the harder it was, in some cases, to seek help. For one migrant women living in rural Ireland with her abusive partner was very isolating and made it harder to find services and supports.

> Sheila: “Well, first of all, when all the problems started I was living in the village where he's from, and it's a very small place in the countryside. So from the beginning I was very isolated.”

When women moved into refuges, or addiction treatment, sometimes without their children they found the experience very isolating and difficult.

> Lorraine: “The isolation was bad when I was in here. It wasn't a great experience at all.”

For security reasons many refuges limit visitors to the building but for one woman that added to the seclusion she was already feeling.

> Olivia: “You do feel very isolated because you can't even have visitors, so you don't really see much of your family or friends or ... so it's hard.”

For women interviewed the initial fear of being alone, for some living in a rural village in a foreign country, the isolation as part of their abuse and control they experienced and the loss of friends and family was very challenging and hard to overcome. For women whose children were living away from them in foster care, their sense of loss and isolation was even more acute. The sense of isolation, loneliness and loss was a key experience for half of the woman in the study sample. Isolation was a crucial internal inhibitor which delayed help seeking by women in the study.

Pregnancy as a time of hope for women

For many of the women interviewed they felt hope that their partner would change, in particular when they were pregnant or once the new baby was born. Women reported waiting and hoping for change to occur with their abusive partner.

> Maria: “I didn’t leave [partner] then, I was thinking that with the new baby things would work and that everything would be OK.”

For one woman whose abuse escalated on her fourth pregnancy she found it hard to accept that things would not improve between her and her husband.

> Sophia: “..thinking back like I said, perhaps I would have sought help earlier, but again it was a waiting game. I kept thinking it was going to get better..”

One woman linked in with her local domestic violence service and her husband’s behaviour changed for the better. However, it was short-lived, she reconciled with him and the violence re-escalated on her subsequent fifth pregnancy. She eventually separated from him.

> Mary: “I thought right, he's changed, everything's grand, but it wasn't.”

Two women waited until their baby was born as they were sure that their relationships would improve once the first baby arrived in the marriage. This was not the case for both women and both moved into safe refuge accommodation when their babies were approximately one month old. However, women articulated that the decision to move into a refuge was not an easy one. They were unsure about what living in a refuge would be like and if their children would settle into the refuge.

> Grace: “But that time, I was so scared, because it was my first time out. I was just debating. I don't think ... I don't want to go ahead with this [move into a refuge]. I should just go back home. I don't want this… it was very hard. It was very ... It was a tough decision.”

One woman spoke about the fear of the unknown, especially when pregnant, and also the difficulty of admitting to yourself that your relationship is so violent and dangerous that you need to live in secure, safe accommodation, as a key inhibitor.

> Alice: “You're leaving your home. You're leaving everything to go live in a secure building, and you know what it's for as well, and you're kind of denying it to yourself what’s really going...”

Women in the study did not take the decision to move into a refuge lightly and felt it was a substantial move for both them and their children.

Shame, embarrassment and stigma

A significant internal inhibitor to help seeking reported by women in the study was shame and stigma: one third of the sample spoke about feeling these emotions. For Irish women the sense of shame and embarrassment was more significant and reported more frequently than for migrant women interviewed. Women spoke about feeling embarrassed when they first accessed domestic violence services.

> Angela: “I was really embarrassed coming here, at the start, because I had to identify that this is what's going on.”

Part of this feeling was admitting to herself that she was in an abusive relationship but also because of stigma attached to domestic violence, in particular in small towns and in rural Ireland.

> Alice: “There's a stigma to domestic violence still to this day. And embarrassment as well.”

For a women who linked in with services and then returned to their partner it was even more embarrassing to then seek help again for a second time. Two women spoke about this process.

> Mary: “Then I was too embarrassed. Because when he changed, I was too embarrassed to kind of go anywhere, look for help, because I told everyone, everything was grand.”

The sense of shame that her marriage was abusive and having to move into a refuge while pregnant was very profound for one woman.

> Olivia: “You do feel very ashamed. And you do feel embarrassed, because I mean who doesn't want a nice marriage and you kind of pretend that everything's going normally, but it's not. And it’s very, it is shameful, having to get up and leave your own home and bring your kids to a refuge...”

Stigma and shame were also associated with denial that domestic violence during pregnancy exists in Ireland and living in rural communities or small towns by the women in the study. The sense of shame also fed into the isolation and loneliness that women spoke about in their interviews, especially when combined with stigma and embarrassment. Stigma and shame were key inhibitors to seeking help and safety for the Irish women in the study. However, one migrant woman spoke about how gossip in rural Ireland can feed into the stigma and ultimately keep domestic violence hidden. One woman in the study sample had a disability and she felt that this was an additional barrier to her seeking supports, particularly in court where she felt her disability, deafness, left her at a disadvantage. One woman in the study still considered herself in a relationship with her abusive partner of eight years, despite currently living in a refuge and her three children being in foster care. She was hopeful that things would work out for them as a couple when she had her fourth baby with him in the near future. For one woman in the study she felt even more trapped in her abusive relationship when she became pregnant again. Her pregnancy was as a result of rape by her partner.

> Emma: “Being with a man instead of who loved me, who abused me, I couldn't get away from him now because I was pregnant.”

Discussion: Woman and internal inhibitors

Women interviewed discussed a range of factors and feelings that acted as internal inhibitors to them seeking supports for domestic violence during and after their pregnancies. Hoping that things would improve, that the violence would decrease and

stop, finding a way to articulate and disclose their abuse and self-identifying that what she was living with was violence were all challenges articulated. In particular, feeling isolated and loneliness and the sense of stigma, shame and embarrassment still attached to domestic violence in Ireland were critical internal inhibitors for women in the study.

Inhibitors: Family and Friends; Maternity, Health, Social and Domestic Violence Services; and Community, Police, Welfare and Housing

Women discussed barriers to their seeking help that were not in their personal control or within their intimate relationship and which correlate to the study Conceptual Framework fields of; family and friends; maternity, health, social and domestic violence services; and community, police, welfare and housing areas.

Domestic violence and pregnancy: hidden in Ireland

Women outlined how in Ireland domestic violence during pregnancy as hidden. One woman described it as a taboo subject. Women who experienced emotional abuse and coercive control found it even more hidden than physical abuse in Irish society, therefore harder to recognise.

> Angela: "..it's so hidden. Emotional abuse is so hidden. It's a very hard one to actually identify.."

Women spoke about domestic violence not being seen as an issue in maternity care and therefore not screened for.

> Mary: "I suppose there's not many people looking yet to see if there's domestic violence."

For many women their abuse was private and kept behind closed doors at home.

Maternity, Doctor, Health & Social Services as inhibitors

All the women in the study had accessed health services in Ireland. Seventeen women had used the combined care model of GP and maternity hospital visits as part of the Maternity and Infant Care Scheme and gave birth in a hospital therefore, they had multiple experiences to draw on in these settings to speak about in their interviews. Research discussed in Chapters Two and Three outlined how women living in Ireland are receptive and positive about being asked about, or screened for, domestic violence by health care professionals however, this rarely occurred for the women in the study sample.

Maternity Services

Two women recalled being screened in their ante-natal hospital appointments, one woman was unable to remember if she had been screened and the remaining fourteen women were not screened during their pregnancy/pregnancies in the maternity hospital. Women spoke about their interactions with maternity hospital medical staff as brief health checks with no connections made between their health issues and their abuse and no instigation of discussion about these topics.

> Elizabeth: “No question, no connection, just the treatment, and that's it.”

One woman described how there was little rapport between her and the hospital staff which could possibly enable a disclosure of abuse. For most women there were no specific questions about their relationship with the baby’s father or abuse.

> Mary: “Like they’d ask, they'd often ask questions, ‘How are you feeling generally?’. They never ask how are things at home?”

Women interviewed did state that some kind of intervention or information provision during their ante-natal care would have been welcome and helpful. Women recognised that midwives are experienced health care professionals and they had a role to play in relation to identification of domestic violence and subsequent referral and support, but that they were very busy.

> Rachel: “…because nurses and the midwives, they are extremely intelligent people, and they are very well educated, and they have loads and loads of information that they can give women, but I don't think they have enough time…”

For one woman she felt it was a missed opportunity to have provided her with vital information, referral and support during her three pregnancies, one of which was an ectopic pregnancy. In some cases women did attempt to ask about supports or disclose what they were going through to midwives, but this did not result in referral or supports for the woman. One woman also noted a lack of continuity of care, or seeing the same midwife on an ongoing basis, in maternity hospitals as an inhibitor to disclosing abuse. Irish hospital maternity services are not based upon case-load models of care (except for very low numbers of midwifery-led care schemes) despite international research associating them with improved maternal and child health outcomes (Sandall et al., 2016).

Doctor

General Practitioners (GPs) or Family Doctors have a major role in ante and post-natal care due to their participation in Mother and Infant Care Scheme funded by the Irish state. GPs also provide infant and child medical care and are usually a first point of contact with the Irish health services providing care and referrals to specialist services. All of the women in the study had ongoing GP appointments during and after their pregnancies. However, no women reported being screened or asked about domestic violence by their GP, or GP Practice Nurse who may also provide ante-natal medical care to patients. Two women attended their GPs due to physical violence and told the GP that their partner had beaten them, one woman was pregnant at the time, but neither of them were told about domestic violence services available nor were referred to any supports.

> Alice: "Yeah I went down and told her exactly what had happened and she just checked me over and made sure the heartbeat was all right."

One woman felt that as her partner was also a patient at the same GP practice she wasn't referred to any relevant services. One woman was once asked by her GP what caused bruising on her arms, but she didn't feel comfortable disclosing her abuse at that point and said she had fallen at work. In this case again, the GP was also the family doctor for the woman's husband and children. Two women told their GPs that they were experiencing abuse, in one case the GP suggested the woman apply for a barring Order. The woman followed her GP's suggestion but in hindsight both women were astonished that neither of them were given information about local domestic violence services or helplines. Another woman stated that her GP may have noticed that something negative was going on in her relationship, but that the onus was on the woman to disclose and say something to her GP.

> Brenda: "But when the GP sees me he notice that something going on, but definitely the GP will want me to say it myself to him."

Although women had appointments with their GP and the Public Health Nurse (PHN) after their baby was born, apart from one woman interviewed there was no screening or identification of domestic violence. Women noted that the main interest of the PHN during the home visits was their baby's health. Three women also stated that their partner was always in the family home when the PHN visited, making it impossible for the women to speak privately to the PHN about their abuse.

Three women in the study recalled seeing posters or leaflets about domestic violence supports in the maternity hospitals they attended in Ireland. The remaining 14 women

did not remember any such information in their GPs surgeries or the maternity hospitals that they gave birth in. One woman remembered seeing stickers in the toilets in the maternity hospital she gave birth in with her first child in the UK promoting local violence against women support services, so she felt that there must be some similar services in Ireland. Another felt that any information during her pregnancy could have been helpful for her.

> Emma: "If I got that information with the twin's pregnancy, somebody saw the signs and give me this information that would have helped me a great deal."

The lack of visible information such as posters, leaflets, stickers, wallet cards and information that women could take discreetly with them, or take photos of, appeared to substantiate the sense that domestic violence and pregnancy is hidden in Ireland. This absence of information was an inhibitor to women finding appropriate services in a timely manner via maternity and GP services.

Women spoke about a lack of time during their maternity medical appointments as being an inhibitor and the time pressures that staff were under. The women interviewed knew that midwives were skilled and trained professionals but the time pressured conditions that they were working in made it very challenging to spend time with their patients.

> Rachel: "…because nurses and the midwives, they are extremely intelligent people, and they are very well educated, and they have loads and loads of information that they can give women, but I don't think they have enough time…"

Women wanted to speak about what they felt was causing their health issues during pregnancy but the time pressured settings made this impossible. Women also noted that despite their medical appointments being very brief and rushed they would often wait in the hospital to be seen for up to four hours. After giving birth two women spoke about the lack of privacy they had due to being on an open ward with six other women and babies in the ward. This made it very hard to speak discreetly to hospital staff about domestic violence. For women interviewed the lack of privacy and feeling rushed was an inhibitor to help seeking. The 'Florence Nightingale' style hospital wards with multiple beds and patients in each ward were noted in the KPMG Dublin maternity services review as being problematic in relation to infection control and privacy (KPMG, 2008). This lack of privacy appears particularly problematic in relation to disclosure of abuse when a woman is an in-patient in hospital.

Three women spoke about their partner being with them constantly for their medical appointments before and after the pregnancy. This made it very difficult for them to have any time alone with their GP or a midwife to talk about their abuse. One woman spoke about how her partner would observe her carefully during her appointments to ensure she didn't disclose anything in relation to the abuse and used to threaten her.

> Brenda: "He was with me all the time. Because anytime that I want to say something to anybody he would look at my face as if when I get home he is going to kill me. And definitely when I always remember that I have a child, a daughter at home, and I don't want to die, you know, I just keep quiet sometime.."

Research discussed in Chapter Two indicates that midwives do find the constant presence of a woman's partner a challenge to screening women for abuse. It is not impossible to overcome this challenge or to strategically get a woman on her own, for at least one or two ante-natal appointments. In four cases women went to all their medical appointments by themselves, which should have allowed for them to be screened in relation to domestic violence, but this did not occur.

> Ava: "Never go with me a doctor. Never go with me to hospital. Never."

While women noted themselves that the constant presence of their partner with them at medical appointments reduced possibility of disclosures and screening for domestic violence, even if there was no partner present screening did not happen for women in the study.

Maternity Services as potential enablers

Despite women not finding the settings where their maternity care and births took place as conducive to disclosing domestic violence, nor in terms of signposting and highlighting supports and relevant services to them, some women interviewed did sense that there was potential for advice and referral in these locations. Women noted that having a trusting relationship with the GP and/or nurse and sufficient appointment time could make a difference in screening for or disclosing domestic violence in health care settings.

> Angela: "It's getting that bond and trust, one person coming in for a half-an-hour or an hour, just that half an hour might allow, I know nurses have very little time, but I know that half an hour might open up something else and then the nurse could report into their GP as well."

Yet the time pressures and busy maternity hospitals or GP surgery settings detracted from any potential trust building between a woman and her health care professional and reduced opportunities for disclosure and support seeking by women.

Discussion inhibitors: Maternity, Doctor, Health & Social Services

As most of the women in the study did not recall seeing information about domestic abuse in their maternity health care settings and almost all were not screened for domestic violence during their pregnancy/pregnancies, the hidden aspect of domestic violence was reinforced and this then reduced potential disclosure and help seeking opportunities by women and was an inhibitor to seeking help. This lack of screening, conversation and information appeared to re-enforce the idea the domestic violence during pregnancy is concealed and stigmatised in Ireland and is not a topic for discussion. Many of the women in the study presented on a frequent basis to medical services for health complications that they felt were related to living with abuse, as outlined in the Women's Health section. Women attempted to disclose their situation in some cases but their conversation was shut down rapidly by health care professionals. Despite this women felt that there was potential in health care settings for information provision and that with time and trust women would feel more enabled and supported to disclose their experiences of domestic violence.

Domestic & Sexual Violence Services

When women found their way into local refuge services, generally by self-referral, some women noted that there were space or room pressures which meant accommodation was limited. Three women noted the demand refuges are under in relation to providing accommodation for women and children. One woman interviewed had to travel from northern Connaught to a Dublin refuge as there was no space for her and her two children in her closest refuge. She found this experience very isolating and returned to her partner after a few days. The woman later accessed a local refuge and was settled and happy there when interviewed. As there were very few inhibitors reported by women relating to domestic and sexual violence services and as the utilisation of these services is discussed in detail in the section on Enablers, there is no additional discussion in this section.

Community, Police, Welfare and Housing as inhibitors

Police

As a prompt, professional and pro-active response is the Garda Siochána policy in relation to responding to domestic violence, women were entitled to expect such when they contacted the police/Gardaí (An Garda Síochána, 2017, An Garda Síochána, 2010). However, women's experiences were mostly negative in their interactions with members of the Irish police force. Women, in some cases, went themselves to the Garda station to seek advice and protection. For one woman she was deterred as she was told it was a long procedure to get a Domestic Violence Act Order. Her husband was just warned by the Gardaí not to enter the family home but he ignored them and came into the house through a window. The same woman later approached the local Gardaí again seeking advice and protection from her abusive partner, but she was informed that unless there was physical abuse the police would not intervene.

> Nina: "I did go in when I was in a year sober and he was still verbally abusive to me, I'm still living in the house. I went in to the guards and I told them that he's still, that I was in before to them. That I called into them about two years ago and I said he's still being verbally abusive to me. 'Well he's not hitting you, or he's not doing anything to you'. So I said until he has to do something to me then they will do something."

A similar response occurred when another woman went to the Gardaí again seeking support and advice. She was shocked that she needed to be beaten by her husband before they could intervene.

> Olivia: "I'd asked them, 'cause the house is in my name, to move him out of the house, you know, go down and tell him, but they said it was a family matter, unless he's beating me up, there was nothing they could do…do you have to wait 'til it gets to that point for them to do something? Which I thought was ridiculous."

For some women there was a lack of clarity on the time frame for reporting abuse and the relevant Garda procedures, which was confusing for them. One woman was told she had months to report her abuse and when she went to the Garda station to do so she was informed that she couldn't due to a time limit. Another woman was unable to access Domestic Violence Act Orders as she didn't have her ex-partner's current address, as he was homeless but was stalking her and had broken into her house. She phoned the Gardaí once she realised he had broken into her home but they stated they

were unable to pursue the case without an Act Order in place. Even in the case when a woman had a Barring Order and her husband broke the Order the Gardaí did not challenge or arrest him, a response which is explicitly stated as routine in their policy (An Garda Síochána, 2017). The woman's husband was not arrested or cautioned by the Gardaí. Regardless of the unhelpful and unsupportive Gardaí responses women stated they received, one woman articulated that she understood the challenges for Gardaí working in the area of domestic violence.

> Emma: "I can understand when they don't have patience for us, today we open a case, tomorrow withdraw."

Some women interviewed did have positive and helpful interactions with the Police/Garda Siochána and this is discussed in the section on Enablers.

Welfare and lack of financial supports

Women spoke about the financial implications of contemplating leaving their abusive partner as an inhibiting factor and then the subsequent financial worries and pressures they lived with after leaving. One woman articulated her need for financial stability for herself and her children that drove her to very actively look for a job while she was pregnant and soon after moving to Ireland. This placed considerable pressure on her to find a job and work until she gave birth. As she had not worked in Ireland previously she was not entitled to any maternity welfare benefits once she went on maternity leave. As a result the woman went back to work as soon as she could after the birth.

> Sophia: "I hadn't worked in Ireland and I hadn't paid any contributions, so I wasn't entitled to any maternity pay. When the baby was about three months I had used all my savings, I had to go back to work."

Another woman felt that the money she currently makes working is very little to cover her bills and childcare now she is a single parent. She felt there was little financial incentive in Ireland for women to work outside the home.

> Elizabeth: "What I gain, like I give back for bills. Is no help, now I'm in a CE [Community Employment] scheme, is not too much help that you work. Is like here, if you stay home, is better."

She felt trying to work full time with a small child is simply impossible financially and getting sick and not being able to work was a constant fear for her. Trying to navigate and access welfare and financial supports was a delay to this woman leaving her abusive relationship, she felt it was a complicated process.

> Elizabeth: “Because I had no money to move away, and then the service is so hard to get there, the process is too long ...”

One woman stated that the cost of childcare in Ireland meant that returning to work was not realistic for her at this point. Her ex-partner was not working either and so she felt considerable financial pressure.

> Sheila: “I think the crèches. Any place for to leave your children with them when mums go to work. They're much expensive…But I really would like to go back to work and I can't, because the crèche is so expensive.”

For women the financial pressures involved with leaving an abusive partner and becoming a single mother were substantial and a cause of worry and distress to them. These pressures acted as an inhibitor or delaying factor to seeking help and support and appear especially significant for migrant women interviewed in the study. They were not mitigated in the study sample by the range of welfare supports offered in Ireland.

Housing

Many of the women discussed the challenges of finding housing in their interviews. Women spoke about the lack of affordable housing available to rent and the difficulties finding landlords who will rent to recipients of state housing aids such as Rent Supplement or those on the Housing Assistance Payment (HAP) Scheme. For one woman this was a key driver to find employment.

> Sophia: “That was the only thing that drove me to find the job, because there was zero chance of getting a place on rent allowance. Zero, because all landlords are like, we're not renting out..”

For migrant women interviewed, with no family support in Ireland, they articulated even more challenges to finding accommodation, as well as extra financial pressures. Women spoke about their children asking them when they will have their own home and move out of the refuge, but the challenge of finding housing was an ongoing issue for them.

> Ava: “What I do, I don't have a home ... sometimes XXX [woman’s son] ask me, ‘Mummy, when we go new home?’ And I don't know?”

One woman had stayed with her sister for months, so was technically homeless.

> Alice: “I was homeless as well for a long time, sofa surfing on me sister's. …..Nothing, I was homeless for three, four months.”

For many of the women interviewed and living in a refuge their biggest challenge was to find somewhere to live so that they can move out of the refuge with their children.

> Olivia: “Accommodation would be the biggest part now. I have great support with my family, which is great…..like number one the most important one is the housing.”

The challenges of finding suitable housing, especially to move into out of a refuge with children and the fear of homelessness was an inhibitor articulated by women interviewed. Women interviewed spoke about a lack of overall supports for victims of domestic violence in Ireland and the need for ongoing supports, even once links to specialist support services have been established. Women discussed feeling that professionals don’t want to get involved or be pro-active in screening for domestic violence.

> Mary: “I just feel that doctors, nurses, they don't want to get involved in domestic violence. Same with the guards [police]… Everyone seems to want to, like when they hear domestic violence, kind of ... ‘Oh, you'll be fine, you’ll sort it out’. No one seems to want to get involved in it.”

Women felt that given the impact of domestic violence on their children there was a need for specialist child supports too.

> Emma: “There is a big lack of service. There is a big lack of safety for women, for kids. Kids have to see their mum go through this, and they think, ‘I should have protected her’. How do you explain to a child it's not their fault?”

Feeling a lack of support and the challenges of finding the appropriate services in a timely manner that would meet a woman’s needs are a major inhibitor for women to seek help and safety. Women recognised that encountering support, in a range of settings, is crucial to getting the help and services that they need to live a life free of violence. Some women noted a lack of ongoing support for women once they had moved on from living in a refuge.

> Emma: “After refuge there are so many loopholes in services, and gaps, it's untrue. It's disgusting.”

This need for ongoing support was perceived to be crucial in order for a woman to avoid returning to the perpetrator. Overall a lack of support and the need for ongoing support for women experiencing domestic violence in Ireland, especially in relation to pregnancy, was articulated by women in the study interviews. For one woman a lack of

family support made seeking help and support even more challenging, she felt there was no one in her family she could ask advice from about her abusive relationship.

> Alice: “My Mam wasn't really there for me that time you know what I mean. I was on my own with nobody to tell me any different or to help me or to counsel me either.”

The lack of family support as an inhibitor to help seeking was very pronounced for migrant women and will be discussed in later in this chapter under the sub-theme Migrant women. One woman was referred to family, or couple counselling, with her abusive partner by the maternity hospital social worker. They attended three counselling sessions together but she found that it was very unhelpful and they verbally fought in one of the sessions. Couple counselling or mediation is rarely recommended in situations of domestic violence and pregnancy and it appears that no risk assessment was undertaken prior to this referral to couple counselling (Williamson, 2000). Even though the woman, who was pregnant at the time, expressed the view that the couple counselling sessions were not resolving her concerns to the counsellor, there was no onward signposting to any domestic violence services. A lack of immediate family support and referral to inappropriate and unhelpful services were additional inhibitors in relation the help seeking that women recounted.

Discussion inhibitors: Community, Police, Welfare and Housing

Women in the study outlined how their interactions with and the responses they received from members of the Garda Siochána in relation to their abuse were in many cases very negative and unhelpful. Their risk of homelessness and the challenge of finding safe and affordable housing was substantial: some women stated that this was now their greatest challenge. Women felt financial pressures and struggled with the financial circumstances they now found themselves in as a single parent, particularly in relation to child care costs for migrant women. The lack of overall supports for victims of domestic violence in Ireland and the crucial need for ongoing supports were also articulated by the women interviewed.

Inhibitors Sub-theme: Migrant women

As migrant women are a substantial part of the study sample (11 out of 18 women), issues specifically related to their experiences of help and safety seeking emerged in their interviews. Research on migrant women and domestic violence indicates that additional barriers linked to legal and migration status, permission to work or study, language and literacy ability, culture and religion and community pressures all may act

as inhibitors to leaving a violent partner and seeking support (Women's Health Council, 2009, Allen, 2013, O'Brien Green, 2013, AkiDwA, 2010, Ncube, 2009, Mayock et al., 2012, Femi-Ajao, 2018). There is no Irish research on migrant women's experience of help and safety seeking in relation to domestic violence during pregnancy and/or the post-natal period. Migrant women in the study sample came from a diverse range of nine countries in the European Union and from the continent of Africa. The length of time they had lived in Ireland at the point of their interview varied from two years to 16 years. However, this time period did not appear to be a significant factor in terms of reduction of inhibitors to help seeking, although it did impact on women's level of fluency in English and literacy levels. While the barriers to initially finding and accessing specialist domestic violence services may have been greater for migrant women, once they did find and utilise the services they were very positive about their experiences. It is important to note that for three of the migrant women interviewed their husbands or partners were Irish men, while this was not specifically probed for in the interviews it emerged during them. For the remaining eight women their partners were also migrant men, but not necessarily from the same country of origin as their female partner.

Community and culture as an inhibitor

Women spoke about how their culture and religious backgrounds had an impact on her help seeking in relation to the abuse. One woman spoke about her not being able to tell her parents initially that she was leaving her husband due to domestic violence, as they were far away and came from a traditional culture. One woman felt that advice and pressure she received from her community led her to stay longer in the violent relationship. She referred to this as "traditional advice" in her interview.

> Brenda: "Yes advice, like a traditional advice, yes. They're using that like, 'You should not go, you have to stay like if you go do you know it is uncultured'. That when you go where do you want to start from, who is going to be there for you? And those advice was keeping me inside the relationship and it wasn't helpful for me."

Three migrant women spoke about the use of religious input or advice in relation to domestic violence as unhelpful. For one woman the advice from her church members and her pastor was particularly unhelpful as she was made to feel that she was to blame for the abuse. In this case the woman was blamed for her 'wickedness' that was prompting the abuse from her partner according to her pastor.

Unfamiliarity with Irish services

Women who had moved to Ireland were not familiar with how many aspects of Irish services functioned and how to access them. In some cases what services were available, their legal rights and if costs were associated with services were very unclear to migrant women. The processes and routes to help seeking appeared complex and could be inaccessible to women and this delayed their help seeking in some cases as they remained with their violent partner longer.

> Brenda: “I was afraid that if I go out will I find help, so is it not better for me to just stay where I am.”

In particular the legal and family court system in Ireland was challenging for women to navigate.

> Emma: “I don't know the justice system here. I've never set foot in a court, be that here or in xxx [city in her country of origin], or anywhere I've ever lived. I've never had to.”

For women who had recently moved to Ireland navigating all the issues they needed to resolve to live a life free from violence in a new country appeared very daunting. One woman spoke about a lack of trust with Irish police, she wasn’t sure how their systems and protection Orders worked or how they would perceive her.

> Emma: “I had four other children, so I knew to keep a record at this stage even if I couldn't go to guards [Gardaí]. I didn't really trust them. I didn't know how the guards worked. I didn't know how I'd be received.”

Language and literacy barriers

For women who did not speak English as a first language this caused issues in relation to finding and accessing services. One woman who spoke very good English, in addition to other languages, did acknowledge for some migrant women language is a barrier. Even if women spoke good English the terminology associated with domestic violence services, such as the differences between a refuge, hostel and shelter, were not clear and meant they did not know what service was most appropriate for them. Another woman felt that as her partner spoke, read and wrote English very well she was more dependent on him. This was a crucial barrier to her seeking help as she felt she was unable to articulate and explain the abuse she was living with and that she could potentially be in situations where she was unable to complete documents or forms without her English literate partner.

> Brenda: “You know the biggest problem I see some women facing, like maybe if our partner knows how to write and read and is educated while we don't know anything, we will be afraid that how are we going to do it without them [partner]…..”

One woman interviewed was offered and used a translation service in her maternity hospital which she stated she found helpful for her. No other women interviewed spoke about seeing resources or information in their own languages nor were they offered translation or cultural mediation services in the maternity hospitals they used.

Lack of friends and family locally

Although many of the women interviewed discussed the isolation and loneliness they experienced for the migrant women in the study this appeared very acute. Four women spoke about the isolation they felt in a new country with no family around them when they were pregnant. Women spoke about no supports around them and nowhere to go.

> Ava: “I don't have friends. I don't have family. Nothing. I stay nonstop at home.”

Another woman articulated her concerns if anything happened to her due to a lack of support from her partner and her family being far from Ireland as a key form of stress. Being far away from parents, in particular their mothers, was very hard for some migrant women, it amplified their feelings of isolation.

> Emma: “My situation, my two year old, I have nobody. My parents are far away from me. I have nobody. How am I going to deal with this situation?”

Yet they didn’t want to worry their parents by stating the true nature of their abusive relationship. This seemed to create a double bind for the women of no support close by and no disclosure to close family members, who although far away might be able to give some advice or verbal support to their daughter.

> Sheila: “And also I couldn't tell my mum I was pregnant, living in a very isolated place 'cause I didn't want my mum to be so worried, in another country.”

For three of the migrant women interviewed their mothers travelled to Ireland after the birth to help with the baby and this was very much appreciated and seen as vital support by the women. While the Conceptual Framework area of Friends and Family appeared to be a supporting mechanism for Irish women, the lack of these important supports was a feature of migrant women’s experiences in seeking help in Ireland.

Discussion of sub-theme: Migrant women

Migrant women were a larger part of the study sample than Irish women and their experiences in help seeking faced additional challenges related to their ability to communicate in English, a lack of familiarity with services in Ireland, significant isolation and absence of family support. In some cases women were completely reliant on their partner or husband for their legal status and competency in the English language. Despite this once migrant women found and accessed help they were remarkably grateful and appreciative. The migrant women found the services met their needs and exceeded their initial expectations. The overrepresentation of migrant women and ensuing underrepresentation of Irish women in the study sample will be discussed further in the next section Interviews with Key Informants.

Discussion: Inhibitors to help, support and safety seeking for women

The inhibitors women recounted in their interviews, both internal and external, are substantial barriers for women seeking help and support in relation to domestic violence during pregnancy. They act as considerable deterrents to finding safety in a prompt and timely manner for women and for migrant women the inhibitors were even more restricting and acute. Many of the inhibitors women outlined are documented in research and literature on domestic violence internationally (see chapters 2 and 3). In a sense they are predictable and recognisable if the professionals interacting with and caring for pregnant women are alert and sensitised to them. In relation to the barriers women experienced the most significant appears to be that the majority of women in the study were not asked about or screened for domestic violence during their ante and post-natal care. A comprehensive patient history in maternity health care settings is one of the fundamental recommendations in the *Maternal Death Ireland* triennial report which states:

> "It also serves to emphasise the importance of a comprehensive history being documented at the first booking visit to a maternity unit." (O'Hare et al., 2017 p.6)

However, in relation to patient history and partner violence this does not seem to have occurred in the sample interviewed. Screening for domestic violence should occur in a universal, private, professional manner and in a context where resources, helpline details, relevant service information are up to date and visible (National Institute for Health and Care Excellence, 2014). Screening should also be repeated because, as noted by women interviewed in this study, abuse can commence, escalate and de-escalate during and after pregnancy (Van Parys et al., 2014). Given the state funded

combined care model operating in Ireland delivered via GPs and maternity hospitals screening has the potential to occur in at least two medical care settings on at least 14 occasions. Women noted that time pressured ante-natal health consultations in busy maternity hospitals without a sense of privacy were unhelpful to disclosing domestic violence and even if they attempted to disclose the response they were met with was not always supportive. An absence of continuity of care in maternity hospitals lead to a lack of trust building opportunities between health care professionals and women and eroded any potential for disclosure opportunities and therefore further reduces opportunities for help and safety seeking. Women wanted to confide in trusted professionals that they met but often felt that the onus was on them to disclose and they were unsure of the response that they would receive. In addition it was not easy for some women to articulate and speak about their abuse, especially if English was not their first language. The hidden and concealed nature of domestic violence appeared to be perpetuated by a lack of visible materials and information resources on the topic in maternity care settings. Women seeing such information was the exception, not the norm, despite utilisation of ten of the 19 maternity hospitals across Ireland by women in the study.

The inhibitors theme connects with other themes emerging in this research, such as challenges in finding services and a reliance on self-referral by women, fear of children being removed by social services and the physical and mental health repercussions of exposure to domestic violence. The inhibitors encountered by women correlate to the domains and intersecting aspects of the study Conceptual Framework where the red stars visualise the barriers women felt pulling them backwards on their paths to help seeking. Despite women having more and repeated contact with health services (GP, maternity, mental health, ambulances and emergency department) there was limited connections made by health care professionals to the health issues women presented with and the violence they were living with. This lack of identification and connection were a substantial barrier that women faced and need to overcome in order to seeking help and safety. There is a synergetic relationship between the four study themes of Inhibitors, Finding Services, Women's Health and Children: each reinforcing the other to act as obstacles to help and safety seeking for women and each overlapping and interconnecting within the study Conceptual Framework.

Section 7 Interviews with Key Informants

Introduction

The initial study design envisaged interviews with staff in services working with women who experience domestic violence while pregnant. These experienced staff in identified services would be invited to take part in one-to-one interviews to explore the issues relevant to providing support for women accessing the services while pregnant and to explore issues around disclosure. There were no potential ethical issues anticipated for these interviews, and none arose. As the research developed and multiple meetings with gatekeepers took place to inform them about the study two principal issues emerged. The first was the exceptional challenge in recruiting women to be interviewed and the second was for the first 18 months of the study only migrant women agreed to participate and be interviewed. By the end of the data collection period no Irish women based in or currently living in refuge or safe accommodation in Dublin were interviewed. These challenges were overcome eventually (as discussed in earlier Chapters) but questions remained about the study sample composition and study recruitment difficulties. There was an overrepresentation of migrant women in the final sample and no women interviewed reported a miscarriage or termination, despite the study inclusion criteria clearly stating that a live birth was not a pre-requisite for study participation. Exploring these matters with key informants was done in four interviews between April and July 2018. The interviewees were a small purposive sample of experienced staff with many years' experience working in relevant services, who were contacted by the researcher and asked to participate. This was with the aim of generating feedback on the study sample and preliminary study findings and also to hear their comments and insights on domestic violence and pregnancy gained through their substantial and lengthy work experience.

While data triangulation is not a requirement in qualitative research traditions some form of data checking is recommended to seek feedback and comments prior to final data analysis write up. Member checking, or the process through which data, conclusions and interpretations are presented to members of the study sample, in this case women who met the study inclusion criteria and were interviewed, (Ellsberg and Heise, 2002). This was not feasible due to many of the safety and mobility reasons previously outlined. However, by discussing the study with the key informants in interviews, insights were generated on the final sample composition and comments on the preliminary study themes and findings. A meeting also took place with a migrant organisation's staff on the preliminary study findings and study sample composition

which will be referred to, but it was not a formal interview with informed consent granted. The key informant interviews were not digitally recorded, however detailed notes were taken by the researcher during the interviews, which were promptly written up and later reviewed and analysed. The responses to the interview questions are collated and discussed below. Direct quotes from the interviews appear in inverted commas. See Appendix 7 for the interview questions and prompt guide utilised in the interviews, the Participant Information Leaflet to Domestic Violence Service Providers and the letter to Service providers as prospective study participants.

Domestic violence and pregnancy hidden in Ireland

All four key informant interviews began by asking the interviewees about their professional experiences of meeting and supporting women. Participants spoke about how pregnancy and domestic violence is extremely hidden, that there is a perception that a woman being abused during pregnancy should be "off limits" and that this type of abuse would never occur in Ireland. Having children and/or being pregnant are perceived as demonstrating a level of intimacy with a partner, therefore it is a challenge to disclose abuse while pregnant. A woman's pregnancy bump usually tells a story of love, intimacy, partnership and hope to others: changing that perceived narrative to one of fear, abuse and rape is not easy "It is huge pressure to burst the dream" stated one interviewee. In some cases the woman could be blamed for the abuse or be told by family or friends "How could you let this happen?". Embarrassment, regret and shame are internalised by the women in this situation and they may think "what was I doing getting pregnant if he was abusive?". For some women they decide to keep going, with the pregnancy and hope that the new baby will bring change to their abusive partner and in their relationship. This is similar to what women recounted in their interviews and was discussed in their interviews.

One interviewee spoke about the isolation and loneliness women feel, the fear they have of leaving a partner and of being alone with a new baby. The ideal of leaving the family unit, even if it is violent, and becoming a single mother is also very frightening for some women, as a result they might stay in an abusive relationship longer. One interviewee emphasised the mental health impact of domestic violence on pregnant women which results in high anxiety levels. Women utilising services may have experienced very severe domestic violence, they can be young mothers who are coping with both the physical aftermath of birth as well as their own trauma and injuries. Women may have been threatened by their abusive partner that no-one would believe them about the violence and that instead they would be diagnosed with post-

natal depression. Due to their ongoing exposure to abuse these women's tolerance and acceptance levels to violence are skewed and they can appear "glazed" and disconnected to their abusive reality when they first access support services according to one interviewee.

Maternity, Doctor, Health & Social Services: screening for domestic violence

The key informant interviewees noted that women are not always screened for domestic violence as part of their ante-natal care. The prevalence of sexual violence in marriage and intimate relationships is an "undefined area" in Ireland and this means that a very serious form of abuse, which can result in unplanned pregnancy, is being overlooked in health and in domestic violence services. Questions in medical screening situations with women's interest at the heart of them are needed stated one interviewee. The questions could be "Are you happy with this pregnancy? Are you happy with the way your husband treats you?". Busy ante-natal clinics in maternity hospitals were noted as not ideal environments for screening and disclosing domestic violence. According to the interviewees, GPs did not appear to be screening pregnant women and referring women to domestic violence services. But interviewees also felt that time constraints for women in medical appointments with GPs offered no time and no space for a disclosure of abuse. One participant observed that women's ant-natal care can also be impacted by their abuser, as they are prevented from going to medical appointments or are avoiding pre-natal appointments and being vigilant at their appointments not to disclose domestic violence to anyone.

Examples of practices to support women in a maternity hospital were discussed by one interviewee. She described how her work setting offers creative ways to get support to women: for example workers from the local refuge attend ante-natal appointments in the hospital, if needed and if the woman agrees. She also described now a consultant obstetrician will post out a "fake" ante-natal appointment letter to a patient to allow her to attend a supposed medical hospital appointment, but instead it is a guise to meet with a domestic violence support worker from the local refuge in the hospital. For these interventions to be offered the woman must give her full consent and having an established and good working relationship with the local woman's refuge (or domestic violence services) is very important. This interviewee noted that linking women into services that are local to them and using creative ways to meet women via their ante-natal appointments is effective and that the primary aim of these interventions is "about keeping the woman safe and keeping the baby safe". However, to be able to offer these creative routes to support for women, staff supports in maternity hospitals in

relation to domestic violence screening are key: staff need to be confident doing screening, be using up to date and current guidelines and have an established care pathway for women who do disclose abuse to them. If a woman doesn't engage with services offered to her after a disclosure of domestic violence then the Public Health Nurse (PHN) is informed so that they are aware of the woman's history and/or situation for the post-natal follow up home visits. Women are also linked with social workers in relation to abuse in this service. This interviewee spoke about the importance of women being able to disclose to maternity staff a previous violent relationship or pregnancy, even though they are now is a safe, stable and good relationship with a subsequent pregnancy. This is because women might still need support to deal with her previous experiences and trauma.

Child protection and social workers

Interviewees spoke about the fear the women they work with have in relation to Tusla, social worker involvement and potential subsequent consequences. Women worry "What will happen? Will the children be taken?". One interviewee spoke about the "large caseloads….best intentions…and huge expectations" that social workers have in cases of domestic violence. She described that in these cases the social worker's approach can be focussed on protecting children, making the woman get a Domestic Violence Act Order and moving the abusive partner out of the family home, all very rapidly. The mother, or pregnant women, is the most vulnerable individual in this situation, but has to do the most and often has to move out of the family home with her children instead of the abuser. In these type of cases it was noted that social workers create upheaval, but then move on to their next case and in essence "..they're gone". For some women this implies no follow-up and with few things put in place for her ongoing support.

Study sample composition and demographics

The study nationality demographics and the challenges to recruit Irish women to be interviewed for the study were described to the key informants and their comments and perceptions sought. Some interviewees thought that as the recruitment occurred via refuges and domestic violence services that staff could be deciding if a woman could "handle" meeting a researcher. In this case women would not be told about participating in the study to protect them from further trauma or distress, but this approach was noted to feed into silence about issues such as domestic violence and pregnancy. However, they did acknowledge that for many women discussing rape and abuse while pregnant is a hugely distressing topic.

The challenges in recruiting Irish women into the study were assessed by the key informants. They surmised that Irish women could feel that as Ireland is small, they might know the researcher or that she might know their family. As a result they might not wish to participate and be interviewed. Irish women might not seek help, or are hopeful for a change, with their pregnancy and new baby in relation to domestic violence. This could mean that there are less Irish women that fit the study sample criteria. One interviewee noted "In Ireland it takes a lot of strength to put yourself out there [to seek support, disclose, get legal protection against domestic violence]" as a result women might not want to discuss this topic in an interview setting. Interviewees also referred to the shame and embarrassment about disclosure of abuse during pregnancy, women might feel "I should have known better, I have an education, I'll be judged..". This culture of fear, stigma and blame could have impacted on Irish women opting to participate in the study.

More migrant women (eleven) than Irish women (seven) took part in the study. This overrepresentation of migrant women was discussed by the key informants. The fact that migrant women appear to have less concerns about speaking with an Irish researcher than Irish women could mean that they perceive more freedom to share their experiences in an interview. In general, one key informant interviewee noted, migrant women are keener to engage with anything on offer in refuges. They are generally very grateful and are open to assisting staff in order to demonstrate their gratitude. This could result because of being in a foreign country with not only the threat of domestic violence but also the fear of deportation being over them. This could lead to migrant women being seen as "very pliable" and assisting with anything that will allow them to stay in a refuge and as a result they are eager to please refuge staff. This interviewee observed: "Migrant women are vulnerable and are doubly impacted by domestic violence and are doubly grateful [for help, support, services, etc.]".

Interviewees thought that migrant women may sense the precarious and risky situation they are in and then access any available opportunities and supports in relation to their abuse on offer in Ireland. There could be a sense amongst migrant women that "I'm coming to Ireland for change, doing this for change" and as part of this change they are open to engaging with services and participating in research. Another interviewee noted that migrant women will often call the Gardaí faster than Irish women, as they're not afraid of what their neighbours will say. She also noted they will engage with other services, like citizen's information centres, as they are "ready for change" as part of their new life in Ireland. The key informants had valid explanations on the demographic features of the study sample arising from their work experience which assists in

illuminating the reasons for the challenges in recruiting Irish women and the more enthusiastic response from migrant women in participating the study.

Abortion and/or miscarriage: conspicuous absence

Key informants were asked to comment on the absence of women in the study sample who had experienced and disclosed either miscarriage or abortion in the context of an abusive relationship. Interviewees noted that miscarriage is an issue for women that is also hidden, in the past it could be considered invisible. Only with time can women begin to acknowledge, reveal and recall their miscarriage(s). For women using domestic violence services, miscarriage is rarely disclosed on a first appointment or session and for some women they may never want to talk about their miscarriage(s) or disclose them. According to the interviewees women, who they had worked with, responses to their miscarriage recounted to them were “I never thought about it, I just kept going..” and as a result it was never disclosed to others. For some women neither the grief nor loss of a miscarriage, nor its violent circumstances, have been acknowledged and only with substantial time can women speak about miscarriage in the context of their violent relationship. Those interviewed had all met women through their work, who had spoken about “lost children” as a result of domestic violence and subsequent miscarriage and women who had reported direct physical violence targeting their stomachs during pregnancy to induce a miscarriage. Many of these women who spoke about their miscarriage(s) to key informants were older, had time to reflect on and process their abuse and had done something about it i.e. by accessing support services. Given the study sample recruitment focussed on women who had been pregnant in the past five years (from 2010 to 2015) there might not have been sufficient time for women to have come to terms with their experiences and feel able to discuss them with a researcher. One key informant suggested that miscarriage is not recognised as the same as the loss of a full term baby, as a result it could depend on the gestational age of the foetus in relation to the perceived loss by women and their willingness to talk about it.

Interviewees spoke about child welfare and protection mechanisms in Ireland as a possible deterrent to disclosing abuse with children and how in cases of miscarriage it could be construed that a woman had failed to protect her unborn child. When women are beaten to the point of miscarriage they feel shame and responsibility and a sense of “How could I let that happen?” according to one interviewee. As a result these feelings contribute to silencing women about miscarriage. Those interviewed also explained that the reality of women experiencing miscarriage as a result of abuse

implies that women are not protected when they are pregnant from severe violence and abuse. The hidden nature of miscarriage was described as similar to the hidden nature of sexual violence in marriages or intimate relationships by those interviewed.

In relation to women who have terminated a pregnancy in an abusive relationship, either due to coercion or as their own personal decision, the key informant interviewees had pertinent observations to make. It is important to note that for much of the data collection period there was considerable public debate in Ireland on constitutional and legislative change in relation to abortion, which culminated in a constitutional referendum in May 2018. This may have acted as a deterrent to women consenting to be interviewed in relation to their own abortion history and their experience of domestic violence. One key informant felt that the legal issues in relation to abortion in Ireland stop women from speaking about it. She felt that for some women in abusive relationships, who may want to avail of an abortion, their circumstances in a controlling relationship and/or being a victim of financial abuse, could mean that they don't have the money or freedom to travel. For migrant women in the study sample their legal or visa status could mean that it is very challenging for them to leave Ireland to access a clinical abortion in a different country. Another interviewee noted that abortion very rarely emerges or is disclosed with women accessing domestic violence services.

The one key informant interviewed, who worked in a service that has clients presenting who have had abortions, had many insights as to why these women did not participate in the study. In her professional experience these women may not go to a refuge or access any non-residential domestic violence services. By terminating their pregnancy they are moving away from an abusive partner, as they feel if they continue with their pregnancy they will always have the abuser in their life due to having a child in common. These women report feeling that if their pregnancy is over, then they can move on in their own lives and are unlikely to access domestic violence support services, as they have dealt with the issue themselves. However, they may with time, access counselling services in relation to their abortion. The informant referred to this cohort as "non-visible women" as they are rarely acknowledged or rarely present to any services in Ireland.

Discussion: Key Informant interviews

Key informants interviewed gave pertinent and insightful comments on the study sample composition and the challenges encountered by the researcher for study recruitment. Their explanations, based on many years of professional work experience with women who met the study inclusion criteria, offered valid explanations as to why

more migrant women and less Irish women participated in study interviews and why no women disclosed abortion or miscarriage in their interviews. They noted the misperception in Irish society that domestic violence does not occur during pregnancy and stated that this contributes to the shame and embarrassment women reported feeling due to the hidden and concealed nature of the phenomenon. They also suggested that a much longer period of recruitment, possibly with women who had completed their families or were post-menopausal was needed to research the issue of miscarriage as a result of domestic violence in Ireland. In relation to abortion those interviewed noted that the legal climate surrounding it also kept the issue hidden in Ireland and that women who have terminated a pregnancy due to abuse rarely engage with specialist domestic violence services. The chronological order of the research study meant that the key informant interviews occurred at the end of study data collection. These additional interviews offered an opportunity to reflect on the study recruitment challenges and sample diversity and explore with experienced professionals subsequent questions with the researcher in relation to the study. In additional they assisted with reflection on the absence of women reporting abortion and miscarriage within the study interviews and pointed to potential ways to include these experiences in future research studies. They offered insights into the study sample composition from varied viewpoints and provided suggestions for future areas of research.

Section 8 Women's Suggestions and Recommendations

Introduction

Towards the end of each interview women were asked during their interviews three questions to elicit their suggestions and recommendations in relation to domestic violence and pregnancy in Ireland. The questions were:

- Based on what you have told me so far what would you say to others about your experiences?
- What else could health and maternity services do?
- What could health and maternity services do better?

This section collates and analyses their responses and although not a core finding or theme in itself, the resulting data assists in creating the policy recommendations and conclusions arising from this study. This section also allows women to give voice to what they would recommend and what they want to see changed in relation to responding to domestic violence in Ireland, this being a key aspect of feminist research. Given the questions posed to women many of their responses and

recommendations relate to the study Conceptual Framework area of Maternity Services, Doctor, Health & Social Services. The recommendations they proposed for women in similar situations to themselves are more connected to the Conceptual Framework area of Woman.

Maternity Services, Doctor and Health Services

Women drew on their own experiences of ante-natal care by their GP, Practice Nurse and in maternity hospitals to suggest what could have been more helpful and supportive for them. Women noted that the ante-natal time period was very important for accessing information and services and for seeking safety. They suggested that more information on domestic violence services, including stickers in hospital toilets, helpline details, needed to be visible in these settings. Women also needed appointment time alone, away from their partner, where they could confide with a health care professional about the abuse they were experiencing. For women who had been accompanied by their controlling partner at every ante-natal appointment they recommended that women must be seen alone at medical appointments and that health care professionals needed to ensure this occurred. Women felt that health care staff needed to be assertive to ensure they saw women alone.

> Brenda: “Me I would have think if the midwives or the GP noticed things like this, if they can say, ‘Sorry, can you allow me to see this woman alone’."

One woman suggested that a special session as part of ante-natal classes for women only, which would cover domestic violence and how to recognise it, would be helpful.

> Emma: “You know if you do mother and baby class or something like that, it needs to be brought up there, every type of abuse, and men should not be allowed in.”

The women suggested that a man-only session could be held for the partners of the women simultaneously to avoid any suspicion by men. By having more and visible information on the issue during medical appointments, women stated that this would be a start to letting other women know what types of supports and services are available to them.

> Rachel: “Linking in is the main thing, that wasn’t there, what services you can avail of when you are pregnant needs to be clear. They [maternity hospital staff] need to be upfront about what supports are available..”

Two women also suggested that it could be useful to have staff from domestic violence services or relevant counselling services present in maternity hospitals during the ante-

natal clinics and appointments for women to be referred to or to link in with. This model is referred to in the NICE Guideline *Domestic violence and abuse: multiagency working* and has been instigated in some maternity hospitals in the UK by having independent domestic violence advocates, or IDVAs, present to support and assist women in health care settings in relation to their abuse (National Institute for Health and Care Excellence, 2014).

Screening for domestic violence in Maternity Services

Interviewees were very articulate in relation to their recommendation for screening women for domestic violence during the ante-natal period. Most of the women in the study were not screened during their pregnancy/pregnancies, despite strongly stating that they wished they had been questioned. Women interviewed were in favour of routine and repeated screening throughout and after pregnancy. Women spoke about their own experiences and how they wished they had been different.

> Mary: " Well, I suppose there's not many people looking yet to see if there's domestic violence…In, especially pregnant women. I have often been for check-ups with bruises and stuff like that…Like they just say 'Oh, do you bruise easy?'. Kinda hoping that someone kind of catch on to what's happening. I was terrified to say it."

One woman recalled being asked only once and in not clear enough terminology about her relationship. She recommended multiple screenings of women and utilising much clearer and more specific language in the questions posed to women in relation to abuse.

> Rachel: "Basically the only thing I was really asked in the beginning like for my first visit to the hospital was, 'Do you feel safe in your home?' And that was it. They never like elaborated and asked, Has it ever happened to you? Or in recent times, or has your partner been violent to you during your pregnancy? Or anything like that. They just ask you, 'Do you feel safe in your home?'."

Women felt that there should be no exceptions to screening for domestic violence, it needed to be a mandatory and universal aspect of Irish ante-natal care.

> Emma: "I think every pregnant woman no matter how old she is or how young should be screened for domestic violence, especially psychological, because like me they may not be aware it's happening."

Women stated that all health care professionals should be alert to and ready to respond to domestic violence. Health care staff also needed to be alert to patterns of behaviour which could assist in identifying domestic violence in their patients.

> Angela: “So I feel that it's pattern is what's going to identify issues, from my experience.”

One woman spoke about how warmth and understanding was needed by medical staff to encourage disclosure. In addition to being able to recognise and connect health problems a woman might present with as being linked to the abuse she is experiencing. Medical staff also needed to be alert to non-verbal communication and body language which could indicate cases of domestic violence.

> Mary: “Sometimes you want them to pick up on a vibe. I'm still afraid to say it kind of.”

Yet women also felt that there was no substitute to verbal communication between staff and patients and that being given leaflets alone was not sufficient.

> Rachel: “Maternity services need to ask more often, I was given leaflets all the time but not enough time to talk, no sit-down time.”

One woman noted that sensitivity to the situation was needed as well as care and interest in another human being.

> Nina: “I think if I had seen somebody.. that was pregnant and with bruises on them that I would go to them and I would ask them is everything all right.”

Overall women interviewed were strongly in favour of repeated and universal screening for domestic violence during the ante-natal period, using a range of direct terms and clear questions in a private setting without partners or husbands present. They also recommended that maternity health care staff be cognisant of, and alert to, any indicators of abuse in their patients and be ready and able to respond to them. Information on domestic violence supports and services available needed to be clearly visible in GP care settings and maternity hospitals. For many of the women in the study post-natal care provided by their GP and the Public Health Nurse (PHN) was a missed opportunity in relation to responding to their abuse. For some women they were never alone when the PHN came to visit so it was not possible to disclose domestic violence. Despite this women recognised the important role that both GPs and PHNs have in relation to identifying abuse, but that more appointments and more time might be needed by them in order to support disclosures and identify abuse in their patients.

Training on domestic violence and pregnancy

There was strong consensus from women in the study that training was needed for a range of professionals including: Gardaí, social workers, PHNs, GPs, midwives, nurses, family support workers, counsellors and doctors. One woman noted that the reaction she got from an untrained counsellor was off-putting.

> Emma: “She made me feel worse just by her reaction because she didn't have the training. They don't have the training. You need specific training in domestic violence because you don't understand.”

Women felt that without specific training the professionals that they were interacting with were unable to recognise domestic violence. In particular one woman noted the training needs of the Gardaí she had dealings with.

> Nina: “They had no kind of training, I found, to deal with the situation.”

Her main recommendation for social workers and police was with regard to accessing training and acting with compassion. As part of the training proposed by women they also suggested that links between services that women could access would need to be established. This would be to ensure an informed and coherent response to victims and clear referral routes for women into relevant services.

Advice to other women

During the interviews participants were very direct about advice and suggestions they had for women in similar situations to themselves in relation to domestic violence and pregnancy. Most of the interviewees felt that talking about the situation was the first step to seeking support.

> Sophia: “I think talking is the beginning. If you’re able to talk, especially if you ask the right questions you'll get the right answers.”

Even though it is not easy to talk about abuse women felt it was the important initial step. Women felt that talking, articulating their situation and opening up was a primary issue. The next step was to leave the violent relationship. Women spoke about their partners not changing and that if a man was capable of violence during pregnancy then he was a very dangerous person, therefore leaving promptly was in a woman’s own best interest.

> Alice: “Get out. The best thing I can say is take a step back away from it, and tell somebody you trust.”

Women interviewed also wanted to warn other women that the violence will potentially escalate, as a result leaving was their best and safest option.

> Olivia: “To leave. At the first signs. To not wait around, and to leave and get out of this because it'll get worse. Do you know, a man like that can never change, as much as you’d want him to. Or as much as you hope.”

Interviewees wanted women in similar situations to know that they were not alone and that support is available to them.

> Lorraine: “You're not alone and there's people out there, just go, don't be afraid to talk to anyone….If you feel you need to talk, talk, and get it out and it will help you. It helps me and I’ve been through it.”

Women also spoke about becoming strong together through realising that they were not alone. Women suggested that others could draw strength by focusing on their future and being positive for their children.

> Brenda: “The overall thing is that I want to say for a woman who is going through abuse, violence, it is we should be strong and come out of our shell. Come out and be strong, be firm, be positive and look up to your children..”

Finally interviewees also suggested that women need to trust their instincts and to accept support that is offered to them.

> Angela: “If you ever have that gut feeling that something isn't right, and you get offered support, give it a try and see what happens. Because if you don't try ... You might have to try a few times, because the damage is so, the wound is so deep.”

Being able to speak about their abuse and telling someone about it were the first steps interviewees recommended to other women. Following these initial steps by realising a violent partner will not change, drawing strength from the fact that the woman was not alone in this experience and being positive for her children were also recommended by interviewees. Women interviewed had further suggestions and some noted that additional domestic violence services were needed nationwide. School programmes for children on relationships and domestic violence were recommended by two women. One woman also suggested that the Freedom Program could be taught in schools to make children aware of the signs of abuse. One migrant woman felt that as Ireland was a predominantly Catholic country there could be a potential greater support role for Catholic Church in relation to outreach to women in parishes who were impacted by domestic violence.

Women's interview and study comments

Women's comments on the study and being interviewed were collated and are presented here. Most women were very keen to talk and eager to share their experiences with the researcher and were open and forthright. For a few women who did not speak English as their first language they were a little unsure if they would be able to articulate all that they wanted to in their interviews, however, this proved not to be a barrier. Women stated that they were very relaxed being interviewed in a refuge, or the counselling rooms of a domestic violence service. Women noted they felt safe and comfortable in this setting. Women also spoke about participating in the study as important in order to help other women.

> Sophia: "But I feel very strongly about the fact that people go through the same situation as me but they don't get a positive outcome….Definitely I'm very, very grateful. I am grateful for all the support services and system that are already in place. I'm also glad that you are doing this study, and that's the reason why I wanted to take part in it, because I feel there's a lot of women out there who need help. They don't know how to find that help."

In relation to being interviewed some women stated they felt that it was their turn to give back and one woman found the interview experience cathartic.

> Lorraine: "At the end of the day, it's good to get it out."

In the only dyad interview the two women were very keen to keep talking with the researcher, even after two and a half hours had elapsed, as one noted:

> Emma: "We are very passionate about this."

After the interviews most women were sent a SMS/text or WhatsApp message by the researcher to express her thanks to them for participating in the study. Some of the women replied with the following messages.

> Brenda: "You're so much welcome Siobán I feel so good meeting you"

> Sophia: "I just wanted to say it was a pleasure to meet you too, I wish you all the best with the research. Feel free to contact me anytime.."

Women were very positive about the study and their participation in it. Many women asked when the research would be published and who would be told about the study findings, in order to implement recommendations arising from the research. They were reassured that copies of the PhD would be available to them if they wished and that the researcher had a strong history of disseminating publications and research findings to

politicians and policy makers in order to influence change in Ireland and the European Union.

Discussion: Women's suggestions and recommendations

Interviewees in the study were keen to offer suggestions and advice to other women in Ireland in relation to domestic violence and pregnancy. They also had clear recommendations to health and maternity services as to how women could be identified and supported better, this fundamentally requires universal and repeated screening for abuse during the ante and post-natal time frames. Women suggested more information in health care settings and that more time is needed in medical appointments to build trust and create a rapport which supports disclosing domestic violence. Training on domestic violence for a range of professionals was suggested as needed to ensure that women were met with sensitive and appropriate responses and given the support and information they need. Women were positive about being interviewed and were keen that the study findings would have an impact in the future in Ireland.

Chapter summary

Despite the initial and sustained study recruitment challenges women's voices, heard and captured via the study interviews, are the most important and crucial element to a qualitative feminist research study. Persevering to continue to invite women to participate in the study from across Ireland and to achieve a study sample of 18 women where the often used route to capture experiences of hard to reach study samples is by proxy interviews, such as using service providers, was not considered as an option for this study (O'Brien Green, 2018a). By recalling their lived experiences women interviewed created the foundation and source of the study findings, themes and recommendations and their voices and experiences resonated long after their interviews had concluded with the researcher.

Chapter 7 Discussion of Study Conceptual Framework, Study Findings and Themes

Introduction

This chapter will discuss the development of the data driven study themes, provide a descriptive narrative for the production of the study Thematic Map and describe how the Conceptual Framework provided the structure to guide the data synthesis and analysis. It will locate the themes in the context of relevant research and policy, from Ireland if available, and will describe how the study themes are interconnected and relate to each other and the study Conceptual Framework. Data for the study was collected in 18 semi-structured interviews with women who met the study criteria and who agreed to participate in the study. By the last interview the researcher was able to recognise that data saturation had occurred within some of the study themes; this became evident when women spoke about similar experiences, described similar reactions to these experiences and outlined similar responses by various professionals that they engaged with or met on their routes to seeking help and safety. The thematic analysis process to reach the study themes has been described in Chapter 5. Methodology and study data generation has been discussed in detail in the preceding thesis chapters. This chapter aims to consider the relationships between the themes, the research question and the study Conceptual Framework. Recommendations and further research questions generated by the themes emergent from the research will be presented in the final thesis chapter on study conclusions and recommendations.

Development of study Thematic Map

As the thematic data analysis progressed, guided by the Conceptual Framework, a visualisation of the themes indicating how they interacted and are interrelated was developed which complemented the Framework. This visualising process was refined, edited and re-worked as study data analysis continued and was constantly examined as to how study Conceptual Framework elements responded to and related with the study themes emerging. The final Thematic Map illustrates the five study themes, the three sub-themes and how they interconnect with one and other. The final study themes are listed below and are visualised in the study Thematic Map.

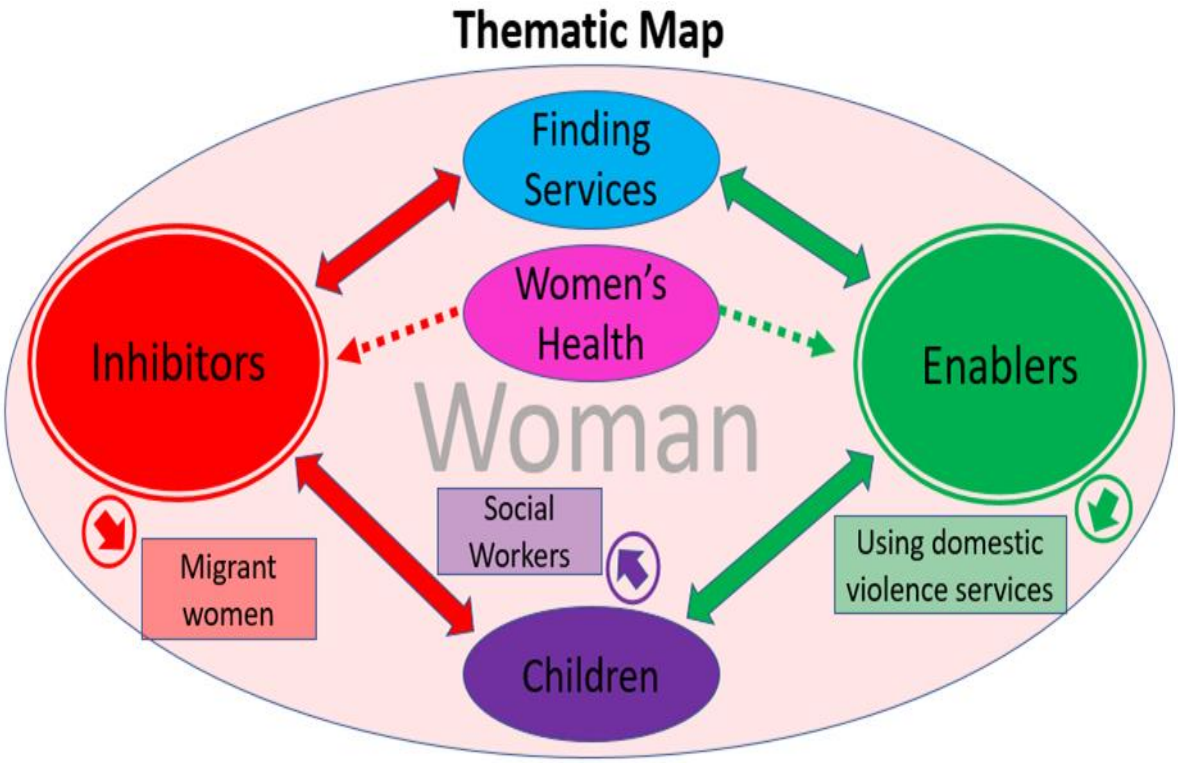
1. Finding Services.
2. Woman's Health.
3. Children, sub-theme; Social Workers.
4. Inhibitors, sub-theme; Migrant women.
5. Enablers, sub-theme; Using domestic violence services.

In keeping with feminist methodology and women being at the centre of the study Conceptual Framework, the Thematic Map is also grounded in woman's experiences and women are placed at the centre of the Map. All the themes relate to the study question of discovering what enables and allows women to seek help, support and safety in relation to domestic violence and pregnancy in Ireland as per the title of the study Conceptual Framework. The central themes of Finding Services, Women's Health and Children, can all act in positive, supportive and enabling ways or in negative, inhibiting and deterring ways. This fluctuation depends on a number of individual, situational and other factors. These elements of the thematic map correspond to the Conceptual Framework areas of: Family, Friends and Children; and Maternity Services, Doctor, Health & Social Services, and Domestic & Sexual Violence Services. How the study themes connect to and interrelate with each other are defined in the Map Legend or key presented below in Figure 13. The main solid arrows link themes, with the colour red signifying a link to inhibiting factors and the green colour signifying links between themes to enabling factors. The red broken arrow is symbolic of an unanticipated inhibiting factor for women in relation to the Women's Health theme. The green broken arrow represents an anticipated enabling factor in relation to the Women's Health study theme. There were other enabling factors that emerged in course of the study which were not thematically located but nevertheless appeared in sporadic expressions. These factors are represented by the green stars or positive enablers and catalysts and the red stars or negative inhibitors and catalysts in the study Conceptual Framework. Finally, the small arrows contained in a circle represent a sub-theme of a study main theme, of which there are three. The colours used for these connectors indicate the parent study theme that the sub-theme is linked to (i.e. red, green or purple).

Figure 13 Study Thematic Map Legend or Key

Theme Connector	Significance
	Links themes, related to inhibiting factors for women
	Links themes, related to enabling factors for women
	Anticipated enabling factor for women
	Unanticipated inhibiting factor for women
	Sub-theme of a study theme (all colours)

Figure 14 Study Thematic Map



Discussion of study themes

The discussion of the study themes and Thematic Map are in the context of the feminist and intersectional methodological underpinnings of the study and are inherently cognisant of the study Conceptual Framework. The study Conceptual Framework offers a visual representation of the layered, interconnected and intersecting elements and contexts that women need to negotiate to be enabled and empowered to navigate through to find a life free of abuse and violence. The Thematic Map presents how connections between the themes work and interplay as women make decisions and take paths their preferred or available routes to support and safety. However, the themes arising from the data collection and analysis phase presented in the Thematic Map present a paradoxical image of women navigating routes to seeking safety and support in relation to domestic violence and pregnancy. The contradiction lies in the fact that at a point in time where women are potentially more vulnerable in many ways, most reliant on the father of their child for care, financial provision, etc. and are at home more, due to caring for a baby, maternity leave from work, etc. they are also experiencing violence and abuse from the individual who should be the most loving and considerate in their lives. This contradiction is further amplified as women are accessing health care at a frequency and regularity unlikely to occur at any other

point in their lives, because of pregnancy and birth and the free health care provided to women in Ireland during these events. Women at this time are having more contact with health services who could identify and recognise domestic violence amongst their patients and provide a range of supports and referrals to them, yet this is not occurring. The final paradox evident in the Map is the role of children in women's routes to finding help and support. As discussed in the section on the study theme Children, a new baby or existing children are used by the perpetrator to keep women within abusive relationships by creating, reinforcing and manipulating the fear of having the child or children removed by social workers from child protection services. Therefore the outcome of pregnancy, a new baby, is another potential element of manipulation, control and fear in an abused women's life. This fear is not unique to the Irish context, but instead of being refuted and contradicted by services that women may attempt to engage with or are linking with, it appears to be heightened and act as a significant barrier to help seeking for some of the women interviewed. The implications of each study theme will be discussed in the subsequent sections below and their connection and interrelation with the Conceptual Framework is described.

Finding Services theme

Locating and accessing services that could offer women support, advice, information and safety was the first step for many in help-seeking and finding appropriate services was crucial for the women interviewed. Looking online was a major route for women in the study to find the important information they needed, often at a crisis point or time of increasing risk and abuse, to access safety. As a result, specialist domestic violence services need to have an accessible and easy to find presence online, so that they can be rapidly and discreetly consulted by women when possible. Search engine optimisation for all domestic and sexual violence services, utilising a very wide range of terms and phrases could allow women to easily and quickly find suitable services online and locally. As seven women in the sample did not speak English as their first language, or had literacy challenges, it is imperative that the terms and phrases used resonate with all women living in Ireland. Therefore some form of focus testing, or collaboration with migrant women's groups and associations, would be ideal to inform the terms and phrases used by websites as key words in order to rapidly direct women towards relevant online information.

The UK *Tech vs Abuse: Research Findings* report recognises that the internet, technology and online or social media communications all have the potential to allow and enable victims of domestic abuse to access information and seek support online

(Snook et al., 2017). Yet the report suggests that there is an acute need to improve the way in which information on relevant services is currently organised, presented and hosted online. The report also found that women may be under significant time pressures when they can look online for information, often due to the abuse they are living with, and subsequently online information and searches need to be quick and easy to access and respond to their key concerns (Snook et al., 2017). This report and the study findings indicate that much more can be done to assist women via online information provision in order to faster connect them with the services they are seeking. The report findings are pertinent and relevant to the Irish context as well. An additional issue is that women also need to be reassured if there are any costs associated with utilising services. Where services are free, have child care available and have transport vouchers or refunds, this should be clearly indicated on their websites to encourage women to access them without potential worry of financial implications.

There was a range of organisations and supports that women utilised, often prior to accessing specialist domestic violence services, referred to in interviews. This implies that a wider range of organisations need to be sensitised to the presence of domestic violence as a feature amongst their service users and clients. Citizen's Information Centres, social welfare offices and addiction services could all have pertinent information on local domestic violence services visible and available for their clients. In particular, homeless services need to be primed to offer information on the phone, online and in person to women seeking accommodation, potentially due to domestic violence. A heightened awareness and sensitisation in a range of services provided to the public in Ireland could give women soft entry points that are less stigmatising and more accessible, into specialist domestic and sexual violence services. If there was more awareness by service providers and more availability of information and details of services in public areas, women could potentially have faster referrals and more routes into the supports that they require from a wider range of agencies, especially at times of high risk or danger.

Women's Health theme

Women in the study interviews articulated a range of health concerns, which they felt were directly related to the abuse and violence they were experiencing, perpetrated by their partners. Their health concerns and complications described related to the ante and post-natal period, during birth, their mental health, addiction and other ongoing health issues not connected to pregnancy. In some cases the health issues were very serious and potentially life threatening for the woman or her baby. The impact of

domestic violence on women's health and its correlation with increased morbidity and mortality, especially during pregnancy, is well documented (World Health Organization, 2005a, MBRRACE-UK et al., 2015). Guidelines in use in Ireland for health care professionals, in addition to national strategies and reports, clearly state that health care professionals have an important role in primarily being alert to domestic violence amongst their patient groups (Department of Health, 2016a, Institute of Obstetrics and Gynaecologists, 2012a, Health Service Executive, 2012). There are additional roles health care professionals have in responding to domestic violence by providing structured and defined referral pathways and additional supports as needed (Kenny et al., 2014, National Institute for Health and Care Excellence, 2014). These significant roles for health care services and staff in relation to domestic violence were iterated in the *Kilkenny Incest Investigation Report* (McGuinness et al., 1993) and in the *Report of the Task Force on Violence Against Women* (Office of the Tánaiste, 1997), where both documents state the need for written protocols and procedures in relation to domestic violence are in place in health settings. Both reports also recommend that training be provided for staff in relation to recognising and recording cases of domestic violence. Despite this most women in the study did not find the health and maternity services they were accessing screened for, recognised or responded to the violence that they were living with.

The repeated presentations by women interviewed, often for conditions that are clearly described in medical journal articles and studies on domestic violence and pregnancy, to health services were not congruent with any distinctive responses or onward referral to specialist supports. Evans and Feder describe a "..cycle of disillusion.." for women when they attend health care professionals in relation to symptoms or problems they feel are linked to abuse yet do not receive appropriate response and referrals (2015 p.69). The settings that should have been most alert and responsive to domestic abuse and that women interviewed used frequently, were not, and instead became an inhibitor and barrier to accessing services in a timely way. It is important to state that many of the specialist domestic violence services consulted in relation to this study noted that they received few referrals from GPs or maternity hospitals into their services. Where women did receive a prompt, appropriate and caring response from health care professionals in relation to abuse this was greatly valued and appreciated, although rare in the study sample. The Thematic Map shows the theme Women's Health with broken arrows connecting it to the Inhibitors and Enablers themes. What was anticipated to be a route to safety and support for women, utilising health services

regularly and presenting with issues that are linked to domestic violence, actually became a frustrating inhibitor for them.

While maternity services may be very busy settings and not always provide the time and privacy necessary for screening and disclosure of domestic violence, women interviewed also utilised GP care for themselves and their babies and children. There were many opportunities in multiple settings for women to receive support, as outlined in the *HSE Policy on Domestic, Sexual and Gender Based Violence (Health Service Executive, 2010)* and the ICGP *Domestic Violence Guide* (Kenny et al., 2014), yet this rarely occurred. While the missed opportunities for health care professionals to identify and respond to domestic violence do represent a failure for many of the women in the study in what could have been an appropriate and appreciated intervention, the actual environment where women's health care occurred was also notably lacking. In the majority of cases, there was no visible information or details of specialist domestic violence services in the health care settings women used. Waiting rooms in hospitals and GP surgeries, toilets and baby changing facilities in these settings and patient consultation rooms are appropriate and suitable locations to have posters, leaflets, wallet cards and other information sources on local and national domestic violence services for women to engage with. Again, for the majority of women interviewed, they could not recall any such information in the health care environments which they were frequently accessing.

The study theme Women's Health represents a failure on the part of Irish health services, in particular maternity care services, to fully address the needs of their patients in relation to a vital issue with very serious potential outcomes. As women recounted in their interviews, becoming frustrated with the paucity of response they received and lack of connection to their presenting issues and concerns by health staff in what should be an efficient and sensitive route to help and safety seeking became another intersecting barrier that women needed to overcome to eventually find help. Women asked the researcher in their interviews if medical staff (and other professionals) get training on domestic violence as in some cases they felt that the response they received was so limited. Research by Bradbury Jones and Broadhurst (2015), Baird et al. (2015), the WHO (García-Moreno et al., 2015) and the Irish Women's Health Council (2007) all recommend ongoing and sustained training for midwives and health care professionals on the topic, which could potentially improve response to women. Yet training appears to be very limited or non-existent in Ireland currently for key professionals such as midwives, practice nurses and GPs. Maternity Services, Doctor, Health & Social Services form part of the largest element of the study

Conceptual Framework, appropriate considering the health care utilisation of women in Ireland during pregnancy and birth. Yet there was little connection to the remaining important element of this part of the framework Domestic & Sexual Violence Services by the health care professionals that women engaged with.

Children theme

Children, and a new baby, have a unique role in the study Thematic Map, they act as deterrents and accelerators to seeking help and support for women: their role depends on the level of fear women have in relation to their children being exposed to domestic violence and the fear of removal of the child/children from the woman by social workers. As Harwin very accurately states:

> "Men use children as a threat. It is very common for them to threaten abused women that the children will be taken into care, or that they will lose them is they tell anyone about the violence. But women's concerns about the effects of domestic violence on children, either witnessing it or experiencing it, are often, in fact, the catalyst to leave and seek help."(1997 p.65).

Harwin describes the exact phenomenon that many women spoke about in their interviews, yet almost 20 years before the study interviews occurred. This suggests that the information, research and knowledge on supporting mothers in relation to domestic violence is not being put into practice by Irish social services and child protection services. Another key aspect of the children study theme is the ongoing contact many of the women had with the father of their children for access and maintenance via courts or solicitors. This correlates to the intersecting elements of the Conceptual Framework of Woman and Partner/Ex/Husband/Boyfriend. Court or legal contact between a woman and the father of her baby/children ensured that for some of the women interviewed there were elements of control exerted over them by their abuser repeatedly bringing them to court to seek access to their children or to amend maintenance previously agreed. Yet overall women recognised that their children deserved a safe environment to grow up in and this drove women to see solutions and safety from the violence and motivated them to keep going in their help-seeking trajectories. Children and baby are central to the Conceptual Framework and are located close to the central, core element of woman highlighting their centrality in the research design and findings. The Children study theme had one sub-theme, discussed below.

Sub-theme: Social Workers

The three planets model developed by Hester, where professional approaches to domestic violence, child protection and visitation and contact with the father seem to co-exist in different realms, each contributing to very problematic and contradictory responses to mothers and children in situations of domestic violence (Radford and Hester, 2006). Much of the focus of the three planets model is where a woman should find support, empathy and constructive solutions for the abuse they have experienced, they often encounter blame and are given responsibility for keeping themselves and their children safe from abuse (Radford and Hester, 2006). This model resonated with data from women's interviews, some articulated a lack of choice in moving into a refuge, fleeing the Republic of Ireland due to fear of their children being taken into care and a lack of compassion, explanation, understanding and ongoing support in their dealings with social workers. The Irish and UK women in the study sample were the most concerned about removal of their children by social workers and two women interviewed had all their children living in foster care at the time of the interview. Migrant women from countries other than the UK in the study sample appeared to have much less awareness of the possibility of their children being removed from them by social workers and as a result may have been less concerned about it.

How women, either pregnant or who have children, can be best encouraged to disclose violence and seek support without fear of their children being removed is an issue that will need to be resolved if women in Ireland are to be fully enabled to find safety from domestic violence. The new Irish state child and family agency, Tusla, potentially has a unique opportunity to address this issue, given the restructuring, staff recruitment and rebranding that has occurred since its establishment under the Child and Family Act 2013. Without understanding the deep fear that women have, often a fear that is nurtured and stoked by their abuser, of losing their children and counteracting this fear with sensitive, communicative, and appropriate ongoing social work interventions, it is likely that the fear will remain. This fear is documented in international research as previously outlined. Many of the domestic violence services contacted by the researcher to assist with study recruitment spoke about a lack of trust by women of social workers, women making decisions from a place of fear in relation to the possibility of their children being removed and women being blamed for being a poor mother who can't protect her children by the courts and services she uses. One experienced refuge staff member described the fears that women live with as "a tape in their head" which is played over and over by their abuser, as a threat to control the woman and prevent her seeking help. Overcoming this fear barrier for women is crucial

and adapting social work and child protection practice to diffuse the fear and address women's concerns is vital to appropriately responding to mothers living with domestic violence. Building on and acknowledging women's sense of moving forward, seeking safely and keeping going for her baby/child/children and her drawing strength from her children, would appear to be a crucial route to enable more women to engage with appropriate services in a timely manner with regard to domestic violence. As a result the study theme Children also correlates with the Inhibitor and Enabler elements of the thematic map and the Conceptual Framework.

Inhibitors theme

Women in the study described the barriers and inhibitors they faced in seeking help and safety from abuse. Research acknowledges the non-linear and multiplicity of routes women take to live a life free from violence due to the restrictive and isolating nature of domestic violence, this coupled with the inhibitors women recalled in the study interviews which were often very challenging for them to navigate and overcome (Evans and Feder, 2015). A significant inhibitor for women interviewed was the time it took to locate and access specialist domestic violence services, as the information about these services was not easy to locate nor was given to them by the professionals they encountered. The primary inhibitors for the women in the study were that they were not asked, or screened, as part of their pregnancy and birth health care about domestic violence and/or if they were afraid of their partner. If women were asked about domestic violence it was once only and for some women the question was not clear to them or they felt they could not disclose their abuse. Asking about abuse can act as a trigger for women to begin to re-conceptualise what they are living with as unacceptable and in some studies it acts as a starting point to seeking support, or as a type of disrupter to the power and control the perpetrator wields (Van Parys et al., 2014, Bacchus et al., 2010). However, the converse situation where women are not asked about domestic violence in a clear way, in a private setting, by an empathetic professional can imply that the issue is irrelevant, unimportant or rare: none of which is true in relation to abuse during pregnancy in Ireland. Women described their abuse as concealed, they felt isolated and fearful and in some cases felt trapped in their relationship once they were pregnant. Added to a lack of information in health care settings, a lack of screening for abuse during pregnancy care and a lack of sensitive and professional responses by health staff when few women did disclose abuse, all fed into further isolation and reinforced the sense that domestic violence and pregnancy is a hidden topic in Ireland for the women in the study.

These absences assist in emphasising the stigma, shame and embarrassment that women reported as a key barrier to help seeking, especially for the Irish women interviewed in the study. Starting to access services, such as refuge accommodation, involved women acknowledging their abuse by the father of their baby/child/children and that they were in considerable danger from this person. It also meant that whatever optimism they had for change or amelioration within their relationship had dissipated and their need for safety had overcome their initial hope. Overcoming the stigma and shame reported through routine screening, increasing visibility of information materials and health care professionals embedding information about local and relevant domestic violence services as part of maternity care in Ireland could alleviate many of the inhibitors that women described with minimal financial implications for maternity services. By undertaking these activities maternity services would be responding to the required actions outlined by Cosc (2016a), the Department of Health (2016a) and HIQA (2016), in their respective action plan, policies and strategies and implementing the IOG (2012a), ICGP (2014) and the HSE (Health Service Executive, 2010, Health Service Executive and Sonas Domestic Violence Charity, 2018) guidelines.

Women disclosed their financial and housing concerns in the interviews as additional inhibitors for them. The costs of childcare, financial reliance on a partner or financial challenges due to maternity leave from work were all barriers outlined. The challenges for women to find appropriate housing and in some situations access state financial supports for rent if they leave the family home due to abuse, are well documented in previous Irish research (O'Brien Green, 2013, Mayock et al., 2012). The continuing pressures on refuge accommodation, the shortage of housing to rent in cities in Ireland and the current national homelessness crisis suggest that this situation is unlikely to improve in the near future (SAFE Ireland, 2016c).

Women's experiences with police/Gardaí due to domestic violence were in many cases unsatisfactory and often left women feeling more vulnerable, isolated and less safe. Regardless of the Garda Siochána Policy on domestic violence, which states a pro-arrest stance in cases of Domestic Violence Act Order breaches, this was not what women recalled as reflecting their experience (An Garda Síochána, 2010). Research by SAFE Ireland found varying responses to domestic violence by Gardaí and in some cases a trivialisation of the issue or a lack of risk assessment (SAFE Ireland, 2016a). Women who experienced domestic violence while pregnant were included in this study sample (SAFE Ireland, 2016a). The absence of a supportive and rapid response by police to women in the study fuelled their isolation and shame and in two cases perpetuated a misbelief that without serious physical injury Garda intervention was not

possible. A revised *Garda Domestic Abuse Intervention Policy*, and the training for Gardaí outlined in the Policy, may go some way to mitigating against these types of experiences for victims of domestic violence in Ireland in the future (2017).

In the study Thematic Map the Inhibitors theme connects and interacts with the other study themes of Children, Finding Services and, in an unpredicted way, to Women's Health. In a similar manner to the connections and synergies in the Conceptual Framework. These themes can also act as stimulating enablers for women in seeking help, support and safety rather than barriers, inhibitors and obstructions. Minimising the inhibiting factors related to these themes and maximising their potential to act as enablers is crucial and attainable, in order to better support and empower women in relation to domestic violence and pregnancy in Ireland. The Inhibitors study theme had one sub-theme, discussed below.

Sub-theme: Migrant women

Women felt alone and isolated in their abuse and pregnancies: this was particularly so for migrant women who had no immediate family close to them and limited or no social networks and friends in Ireland. Women with partial English or who were not confident in reading and writing English were particularly challenged in finding specialist domestic violence supports and in some cases felt reliant on their partner to access Irish state payments and services. Being unfamiliar with services and supports in Ireland, in relation to housing, social protection payments, domestic violence refuges and legal and police procedures were inhibitors migrant women described. Women also reported receiving poor advice from within their own community, often by church pastors in relation to the abuse they were experiencing. They recognised, in hindsight, that this advice was not constructive for them and acted as an inhibitor to their help-seeking. However, once migrant women in the study began to seek help they reported being very satisfied with the responses they received and very grateful for the services they accessed and utilised.

Enablers theme

The principal research question for the study is what enabled and supported women to seek safety and help and use relevant services in relation to domestic violence during and after pregnancy? Consequently, the Enablers theme and how it interconnects with other study themes is key to the study findings. Enablers relate to different elements of the study Conceptual Framework. These interconnections, as with the Inhibitors theme, can act in potentially constructive or disempowering ways. Chang and colleagues note a number of turning points for women that stimulated their openness to change and

seek help regarding their abusive relationships (2010). One of the turning points the research observed was when women had an increased awareness of their options and access to support and resources, this awareness can be triggered by informal or formal contacts women have with a range of services, such as health care (Chang et al., 2010). Similarly for some of the women interviewed it was a chance meeting or interaction with someone, which corresponds to the green stars or enablers in the study Conceptual Framework that acted as their stimulus for help-seeking. Chang and colleagues also observe that infidelity by a partner, although a negative experience, for some women, was a turning point that stimulated change (2010). Women in this study too recalled partner infidelity and how it acted as a trigger to their seeking support and a realisation that they were in an abusive relationship. Even though infidelity represented a negative part of their relationship, for some of the women interviewed this discovery enabled them to accept that their partner's behaviours would not change and that they needed to seek safety for themselves.

An element of the Enabler theme that resonated with many of the women interviewed was receiving a positive response to a query or initial contact from a range of services, which were not always specialist domestic violence services. Fanslow and Robinson note in their study of help seeking behaviours by women in New Zealand in relation to IPV, that the quality of response women receive can increase their confidence and enable them to seek out more supports and help (2009). Similarly, for the women interviewed, each positive professional or service contact seemed to re-enforce and support them moving forward and allowed for more help and safety seeking by women. Women reported feeling that "Help is there for me". Although very few women stated that their utilisation of health and maternity services were an enabling experience in relation to identifying abuse, in the few cases where it did occur women found it very beneficial and helpful for them. As a result the Women's Health and Enablers themes are connected by a broken green arrow indicating what could have been an anticipated enabler, women utilising health services repeatedly during and after pregnancy, did not always result in facilitating women to find help and support. The challenge emerging from the Enablers theme is how to amplify the potential for positive impacts for women via their service utilisation and how to magnify the pre-existing supports they may have, such as family and friends, to support their routes to help and safety seeking. The Enablers study theme had one sub-theme, discussed below.

Sub-theme: Using domestic violence services

The most widespread and positive experiences that women recalled in their interviews were their utilisation of specialist domestic violence services. Once women find, or are referred to these services and refuges, they are very satisfied with the services provided, especially migrant women in the sample. Despite the challenges and barriers to discovering and accessing the services women were overwhelmingly full of praise and thanks for the services, they valued enormously the support and information that they received, at no cost and on an ongoing basis (in some cases for years) from these services. Women also articulated that they felt safe in the services, this sense of safety was crucial in being able to plan their next steps and come to terms with their abuse. By utilising and accessing domestic violence services women were enabled and empowered to sustain their help and safety seeking through practical and professional support. Migrant women interviewed were especially appreciative of the services they used and found them very helpful and supportive, despite initial any reservations they may have had about utilising services in Ireland. The emergent issue from the research is now how to bypass the barriers evident in the Finding Services, Inhibitors and Women's Health study themes that prevented women from accessing domestic violence services in a rapid and straightforward manner, especially for women who do not speak English as a first language or who have literacy issues. Enhancing elements of the Enablers theme to ensure that this occurs is discussed in the final Chapter.

Chapter summary

The study Thematic Map visualises the themes produced during data analysis and relates to the study Conceptual Framework by placing the woman at the centre of both and illustrating the many structural, external, internal and logistical barriers that she may need to overcome to access support and safety. This is reflective of feminist methodology where the focal research point begins with the woman and her own experiences. The intersectional elements of the study methodology relate to how different elements of the Thematic Map, both the themes and their connections, can impact on groups of women in different ways. This was particularly evident in the increased fear that Irish and British women articulated in relation to their children being removed from them by social workers and the specific challenges that migrant women had in locating domestic violence services in Ireland. It also resonates with the greater stigma and shame reported by Irish women regarding domestic violence while pregnant which inhibited their help seeking. Many of the services women accessed are operating in the context of scare resources and increasing pressures, this is particularly

so in relation to maternity and domestic violence services in Ireland. Despite this women reported overwhelming positive and satisfactory interactions with domestic violence services and much less satisfaction with their maternity care, indicating that a greater prioritisation of the domestic violence and pregnancy is needed in Irish health and hospital settings. Resolving the paradoxes outlined at the start of this chapter remain a challenge, but not an insurmountable one. Recent strategies, legislation, policies, the forthcoming ratification of the Council of Europe Istanbul Convention by Ireland and research, such as this study, can all be leveraged to ensure enhanced responses to domestic violence and pregnancy occur in all relevant and appropriate settings for women in Ireland.

Chapter 8 Conclusions and Study Recommendations

Introduction

This research set out to explore, utilising qualitative methods and for the first time in Ireland, what supports and allows women to disclose their experience of domestic violence during pregnancy and consequently supported their accessing related services. The study found that by its controlling nature domestic violence feeds into many internal and external barriers women encounter when trying to seek help and find services. Despite using health services regularly during and after their pregnancies, women did not receive the supports and referrals that could be expected, given the range and severity of health issues that they presented to health and maternity services with. The research found that when women do find and engage with specialist domestic violence services they are very satisfied with the support and responses they receive. This chapter will outline the limitations of the research, recommendations for policy and practice in Ireland arising from the study and identify potential areas for future research.

Study limitations

As with all social research there are inherent limitations to the study findings. With more time, resources and interviews there could be scope for a greater range of women's experiences to be captured and analysed. The core research question set out to understand and capture women's processes and experiences of disclosing domestic violence and subsequently routes to utilising services: it did not aim to capture the typology, intensity and frequency of the abuse that women experienced. Nevertheless, many of the participants interviewed described the violence that they had lived through and the consequences it had for them. The original parameters for study participant inclusion criteria were too restrictive, women's lives are exceptionally busy with a new baby and the initial strict study time limits were not conducive to the instabilities and realities that women who wanted to participate in the study were living with. As a result amendments were made via the Research Ethics Committee, in consultation with gatekeepers, to broaden the study inclusion criteria and this greatly assisted with study recruitment. Therefore, an initial study limitation was the overly prescriptive study inclusion criteria, which was amended by the researcher. The final study sample is small, at 18 women, and so there are some limitations to the study findings. Yet qualitative research on complex and hidden phenomena is not driven by minimum

study sample sizes and elements of data saturation occurred towards the end of the data collection. The study sample of 18 women did include a wide range of ages, ethnicities, nationalities, number of children, women interviewed had given birth in 10 of the 19 maternity hospitals and lived in all four Provinces in Ireland. This variety and diversity in the study sample does in some ways mitigate against possible study limitations produced by a small sample size.

Policy recommendations

There have been several relevant policy developments since the start of this study. The first Irish National Maternity Strategy and *National Standards for Safer Better Maternity Services* provide the maternal health sector with new guidance and actions and include reference to domestic violence in both documents (Department of Health, 2016a, Health Information and Quality Authority, 2016). The Action Plan for the *Second National Strategy on Domestic Sexual and Gender-based Violence* commits to reviewing screening approaches of pregnant women in a range of settings, including maternity care, as part of its work plan (Cosc, 2016b). The new Domestic Violence Act 2018 references pregnancy as a factor that courts must consider when determining responses to applications for safety, protection and barring Orders. As a consequence of many of these recent developments Irish legislation and policy in relation to domestic violence and pregnancy is relatively robust, yet there are gaps remaining. Professional guidelines for obstetricians and gynaecologists need to be urgently updated as they were written in 2012 and are not representative of recent legislative changes. There are no national guidelines for midwives in relation to domestic violence and this is a substantial and serious gap. Recent guidance on perinatal mental health care scarcely mentions domestic violence, which inadvertently makes the issue even less visible to the relevant health care professionals the publication is targeting such as midwives, public health nurses and practice nurses (Higgins et al., 2017). The ICGP have produced revised guidance on domestic violence in general practice settings in 2014, however, their own research would indicate that these guidelines are not well known and utilised amongst their membership (O'Shea et al., 2016).

The principal policy recommendation is to implement uniform, repeated universal screening for domestic violence in all maternity health care settings; this would mean that women get asked, or screened, on more than one occasion and in at least one setting. This will require a systems level change across GP and maternity hospital settings where the screening can be audited and anonymised data collection can occur in order to begin to collect domestic violence and pregnancy prevalence data for

Ireland. Utilising the same screening and data collection tool, based on the National Maternity Health Care Record (NMHCR) nationwide, will also ensure that training on domestic violence screening can be delivered to health care staff on the same procedures and tools. However, the NMHCR will need to be linked to GP patient records, as a matter of urgency, if this is to be feasible, as currently in most settings the two patient records have no overlap, intercommunication or connection. The implementation of routine screening must also be measurable and auditable, with potential for patient led input and suggestions, the Association for Improvements in the Maternity Services would seem to be a suitable option for patient consultation. Early pregnancy loss, or miscarriages in the care settings of maternity hospitals appears to have no screening for, or protocols in responding to, domestic violence currently: this needs to change with screening, identification and referral procedures put in place.

The systemic change in maternity care settings will need to be sustainable with greater attention to the intersecting and diverse needs of women utilising maternity health care in Ireland. In order to achieve this, ongoing and regular training on domestic violence and its presentation in the ante and post-natal periods is needed for a range of health care professionals. Training for key professionals on domestic violence is included in the Cosc Action Plan and is a requirement for states who have ratified the Istanbul Convention (Cosc, 2016a). Finally, there exists a new potential site for patient screening for domestic violence and data collection with the legalisation and development of termination of pregnancy services in Ireland in 2019. Medical settings where women will access abortions could include screening for abuse and referral to appropriate services as part of their patient care protocols and can have information on helplines and refuges available in their patient after-care information resources. One of the main challenges emerging from the research is to implement policy into practice, so that women nationwide can expect to receive similar professional and appropriate responses and referrals if they disclose domestic violence in any maternity care setting.

Practice recommendations

To generate the systems level changes identified above staff responses need to be adapted and modified. Delivering changes in practice is situated in the context of major challenges including scarce resources and pressurised, exceptionally busy maternity care settings. Creating disclosure friendly environments for patients, however, can be achieved at low cost by the use of up to date and clear information materials on local and national domestic violence services such as posters, leaflets, wallet cards and information in women's toilets. Information should be available in the languages spoken

by patients and clients using the services to ensure comprehension of the supports available; that supports are free should be emphasised in all information displayed. In Ireland there are 19 maternity hospitals and 21 women's refuges, twinning these services and linking them in practical ways could be easily achieved and potentially this arrangement could be very beneficial. Offering training to hospital staff on domestic violence on a regular basis and ensuring that information materials are up to date, correct and on display are just two routes to developing good professional working relationships between refuges and hospitals. By developing these inter-agency links 'warm' referrals could stimulated and health care staff could become more confident in screening for domestic violence amongst their patients as they are familiar with the local staff and services that they are referring their patients into. Enhanced communication between health care staff is also needed in cases of domestic violence, so that if a woman discloses abuse or there is reason to be concerned about domestic violence she receives consistent responses and follow up. This continuity is very important once a woman is discharged from a maternity hospital post-birth into the care of her GP and the public health nurse for her post-natal care. Health care professionals need to be aware, alert and mindful of domestic violence in their patients, all health, and especially mental health presentations, during pregnancy need to be fully assessed. There should be no assumptions made that patients presenting with symptoms that could be related to domestic violence are solely caused by pregnancy.

Women in the study reported lacking confidence as to how their disclosures of abuse would be received by health care and other professionals. Providing a disclosure friendly environment where trained staff are attentive to the issue of domestic violence and familiar with services for onward referral, would help build women's confidence in disclosing, realising that they are not alone and that help and support is available to them. Activating positive catalysts for women (the green stars in the study Conceptual Framework) is also recommended, but due to their random and serendipitous nature this may be something of a challenge. However, greater awareness of domestic violence during pregnancy through media campaigns, research dissemination, professional training and guidelines could heighten sensitisation of this, with potential to generate attitudinal awareness at a cultural level, resulting in enhanced support for women in community and other settings.

Recommendations for research

A number of paradoxes became apparent in the study findings and further exploration of these issues could be explored through future research. There was an over-

representation of migrant women in the study sample and recruiting Irish women to be interviewed was very difficult. Migrant women faced more challenges and barriers in accessing supports but reported less stigma and shame in doing so than did Irish women. Migrant women's willingness to participate in the research could therefore be as a result of feeling less shame and embarrassment about the issue. Exploring how best to limit the shameful and stigmatising aspects of abuse during pregnancy needs to be examined in order to enhance disclosure and support safety and help-seeking by all women. No women reported miscarriage as a result of domestic violence in the study, yet FRA survey data suggests that this is an issue for 2% of the Irish female adult population (European Union Agency for Fundamental Rights, 2014). Research is required to begin to understand this issue and explore how best women who miscarry due to abuse can be best be supported and responded to in health care settings.

An audit of domestic violence screening tools, practices and the range of support service information visible in all 19 maternity hospitals in Ireland is recommended, to assess as a baseline where investment, training and improvements are required. This proposed audit can be repeated on a bi-annual basis to measure change and to document challenges and issues arising. A condensed version of this audit could occur on a regional basis in GP practices who are contracted to provide the Maternity and Infant Care scheme. Finally, research with perpetrators of domestic violence during pregnancy is needed to gain a deeper understanding of the issue in order to develop evidence informed and effective responses. The Istanbul Convention requires ratifying states to undertake research on all forms of GBV on a regular basis, ensuring that data on domestic violence during pregnancy is included in such research is recommended (Walby, 2016).

Concluding remarks

One of the clearest study findings is that women are making decisions and navigating their help and safety seeking routes in the absence of information, screening in health care settings, referrals from professionals they are meeting in these settings and from a place of fear: the fear of removal of their children and the fear of their partner. Starting from this point and working to mitigate against this fear is crucial to develop better, woman-centred responses to domestic violence as experienced during and after pregnancy in Ireland. Leveraging existing policy into national practice is the predominant remaining challenge and will require concerted and collective effort over time. This is to ensure that women in Ireland in need of help and support in relation to

domestic violence and pregnancy receive the most appropriate and patient centred responses necessary to meet their needs.

Afterword

How much has changed for women who are pregnant seeking safety and support regarding domestic violence in Ireland since 1998 when I began to work in a refuge? My PhD research would suggest not a lot, unfortunately. Domestic violence and pregnancy is still a hidden issue in Ireland and this undoubtedly had implications for my study recruitment challenges in relation to Irish women. Stigma, shame and embarrassment are significant barriers for women to overcome and then seek support. Women receive minimal screening as part of their maternity health care and the topic appears hidden in terms of information displayed in settings or locations where women can engage with it or take it with them. There is work to be done to change this.

So what next as a result of my study? I now have an obligation as a social scientist and feminist researcher to bring my research study and findings to people who need to hear about it and engage with it. Links have already been established with the Department of Health, Health Service Executive, Tusla, Coru, Irish College of General Practitioners, Irish Association of Social Workers and Centre for Midwifery Education, amongst many other staff, services and professionals in Ireland and further afield. My task is to highlight the need for universal screening of women during their maternity care regarding domestic violence and to develop the supports and training that staff need to successfully do this, in conjunction with others. I need to report my research findings to all the domestic violence and community organisations that assisted with my study promotion and recruitment and produce a study summary that can be disseminated to staff and clients in these services. Finally, I need to use my academic teaching connections to leverage more time dedicated to the issue in relevant undergraduate and postgraduate teaching. There remains a lot of work still to be done.

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Appendices

Appendix 1 PhD International Expert Advisory Group

1. Dr An-Sofie Van Parys, Post-Doctoral Researcher International Centre for Reproductive Health, Ghent University, Belgium.
2. Dr Dalila Cerejo, Researcher National Observatory on GBV, Faculty of Social Sciences and Humanities (FCSH), Universidade Nova de Lisboa, Portugal.
3. Dr Kathleen Baird, Director of Midwifery and Nursing Education, Griffith University, Australia.
4. Professor Mirjam Lukasse, Department of Nursing and Health Promotion, Oslo Metropolitan University, Norway.

Appendix 2 TCD REC letters of approval for study and study amendments

Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Siobán O'Brien Green
School of Nursing and Midwifery
Trinity College Dublin
24 D'Olier Street, Dublin 2
Ireland

Ref: 160101

Title Of Study: An exploration of the process involved when women chose to disclose they are experiencing domestic violence during pregnancy.

Dear Siobán,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in February 2016, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely,

Prof. Brian O'Connell
Chairperson
Faculty Research Ethics Committee

Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Siobán O'Brien Green
School of Nursing and Midwifery,
Trinity College Dublin
24 D'Olier Street, Dublin 2
Ireland

Ref: 160101

Title of Study: An exploration of the process involved when women chose to disclose they are experiencing domestic violence during pregnancy.

Dear Siobán,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in September 2016, we are pleased to inform you that the above project (as amended with the following changes) has been approved without further audit.

Please give specific details of the requested amendment(s):

Amend time frame proposed for research interviews to take place with participants from the current time frame which is stated in as: "If a woman is recruited during pregnancy she will be offered the opportunity to participate in a second and third interview up to one year post-pregnancy." to a revised time frame of "If a woman meets the study inclusion criteria she may be interviewed up to three times, including during pregnancy and up to five years post-pregnancy." The amendment I am requesting is in order to allow women to participate in interviews for a longer time frame post-pregnancy/birth. This request is as a result of gatekeeper feedback on existing recruitment criteria and study design. It is also expected to allow for increased interviewee recruitment for the study and to continue to ensure participant safety.

The definition of disclosure for the purposes of this study will not change, it is currently: "study disclosure will be defined as: when a woman discloses that she is experiencing domestic violence and is referred, or self-refers, to a domestic violence support service or refuge at some point between conception and one year post-pregnancy, regardless of outcome of the pregnancy."

As a result of this requested amendment some study documents will require text changes and these are listed below:

- Appendix C: Participant Information Leaflet.
- Appendix D: Letter and Study Information to Gatekeepers.

Amended versions of these study documents are attached with changes proposed in track changes.

Following consultation with gatekeepers information on the nature of questions in the interviews has also been included in the following study documents:

- Appendix B: Letter to Prospective Participants.
- Appendix C: Participant Information Leaflet.

This amendment has been made to re-assure potential study participants that the interviews will not seek information on the experience, intensity, levels and types of violence that they have survived only their experience of help, support and safety seeking. Amended versions of these study documents are attached with changes proposed in track changes.

A one page summary of the study has been produced at the request of gatekeepers to briefly outline the study for circulation at meetings and between colleagues. This summary document is attached.

Yours sincerely,

Prof. Brian O'Connell
Chairperson
Faculty Research Ethics Committee

Appendix 3 Study recruitment documentation

Letter to Prospective Participants

Dear ……,

My name is Siobán O'Brien Green, I am a PhD student in Trinity College Dublin. I am conducting a study as part of the requirements of my PhD exploring the process involved when women chose to disclose they are experiencing domestic violence during pregnancy. I would like to invite you to participate in the study by being interviewed.

The interview will take place in a private, safe and secure location at a time and date that suits you. Each interview will last about two hours, with time for breaks if you want. During the interview I want to hear your experiences, thoughts and feelings and there are no right or wrong answers. You will not be asked about your experience of violence **only** about seeking support, help and safety. You can stop the interview at any point if you feel uncomfortable or upset or need to take a break. All information provided in the interview will be assigned a code which will make it unidentifiable. Neither your name nor any of your details will appear in any report or publication so that no one can know your identity or that you took part in the study. Within the limits of the Irish law, I guarantee the confidential treatment of all the information you tell me. Participation in this study is **voluntary**.

This study will enable a greater understanding of the process involved when pregnant women decide and chose to disclose that they are experiencing/experienced domestic violence. It will also enable better supports to be given to women in these situations in the future. I have worked in services and completed other research studies on the issues of domestic violence, women's health and gender-based violence since 1998.

You can get more information about participating in the study by reading the Participant Information Leaflet (attached) and then contacting me by text, sending me a WhatsApp or phoning me on 086 171 6170. I will call you back at a time that suits you to answer any questions you may have. You can also email me on: OBRIENGS@tcd.ie

Thank you for your time, yours sincerely,

Siobán O'Brien Green

Participant Information Leaflet

Title of study: An exploration of the process involved when women chose to disclose they are experiencing domestic violence during pregnancy.

Principle Investigator/Researcher: Siobán O'Brien Green, Trinity College Dublin. Siobán is an experienced researcher who has worked on the issues of domestic violence, gender based violence and women's health since 1998. She has worked on research studies on violence against women in Ireland and in the European Union. This study is part of her PhD in Trinity College Dublin.

Description of the study: This is a qualitative study exploring the process involved when women chose to disclose and seek support when experiencing/experienced violence during pregnancy. This study will give a greater understanding of this process and the complexities for pregnant women when thinking about whether to tell or disclose and when disclosing that they were experiencing/had experienced domestic violence to professionals such as midwives, GPs and domestic violence service staff. The study will interview women who have experienced domestic violence when pregnant to understand the process involved in disclosing and what helped them and what did not, to disclose their experiences and seek support, safety and appropriate services. Women from all backgrounds all over Ireland will be interviewed. The interviews will take place in a safe, secure and private location at a time and date that suits the woman being interviewed. Only the researcher and the woman being interviewed will be in the room during the interview (unless the interviewee requests an advocate to be present). It is expected that the interviews will not be longer than two hours, with time for breaks. The interviews will be recorded and transcribed (written out word for word) to help with analysis. Please ask the researcher if you would like to get a copy of your own interview transcript. The results of this study will be written up as a PhD thesis and may also be published and presented at professional conferences and meetings, but the identities of all study participants will be coded and therefore unidentifiable.

Women will be interviewed once, either during pregnancy or up to five years post-pregnancy, regardless of the outcome of their pregnancy. If the woman agrees and it is safe to do so, she may be interviewed at two further occasions during the five years post-pregnancy time frame.

Participation in the study: You can participate in this study if you are female and:

- You are over 18 years of age.
- You experienced domestic violence during a pregnancy or pregnancies.

- You are currently accessing and/or in contact with domestic violence support services or have done so in the past and you made initial contact while pregnant or in the first year post-pregnancy.
- You are **not** in immediate or current danger from a violent (ex) partner(s).
- You can read, speak and understand English at a level that allows for a verbal interview in English to take place.
- You can meet the researcher for an interview face to face at a time, date and location that suits you.

Maintaining confidentiality: Your identity will remain confidential. Your name or other identifying details will be given a code; they will not be published and will not be disclosed to anyone. The researcher will ensure that all documents, recordings, data and information will be kept securely in a locked filing cabinet in a locked office. All data from this study will be handled and stored in accordance with the Data Protection Act 1998 and the Data Protection (Amendment) Act 2003 and will be destroyed as soon as is possible and not be kept for more than five years. All information will be used for research purposes only, information will not be used in future unrelated studies without further specific permission being obtained. There are only two possible exceptions to maintaining confidentiality. Firstly, the researcher is obliged to take steps, including reporting to relevant supports and authorities, to prevent serious harm to yourself or others should this intention be disclosed to her during the interview. Secondly, the researcher is obliged by law to report child abuse that is disclosed to her during the interview, to a Designated Child Protection Officer and/or authorities.

Benefits of participating in the study: There are no direct benefits for you when participating in this study. However, the study findings will contribute to an explanation of why women disclose that they are experiencing/experienced domestic violence during pregnancy and seek help and support. This knowledge will allow for health and other key professionals, in the future, to better support other women to leave or seek help when in similar situations. Some literature suggests that taking part in studies like this one enables women to use their experiences to help others, you may find the interview a liberating experience and feel listened to. Women will not be asked about their experience of violence in the interviews only their experiences of seeking help, support and safety.

Risks: There are no immediate and foreseeable risks to you taking part in this study. However, you may find the interview emotionally stressful and upsetting, if this happens you can stop or pause the interview at any time without any consequences.

Exclusion from participation in this study: You cannot participate in this study if:

- You are under 18 years of age.
- You cannot communicate in and understand English.

- If you are in immediate or current danger from a violent (ex) partner(s).
- If you do not have an established link or connection with a domestic violence support service or refuge.

Compensation: This study is covered by standard institutional indemnity insurance. Participation in this study does not entail any costs at all to you.

Participation in the study is voluntary: If you decide to volunteer to participate in this study, you may withdraw your participation or stop the interview at any time. If you decide not to participate, or if you withdraw, this will in no way affect your relationship with the researcher or any support services you may be using.

Stopping the study: The researcher may withdraw your participation in the study at any time, without your consent, this is to ensure your safety and welfare.

Permission to conduct the study: This study has received approval from the Research Ethics Committee in the Faulty of Health Sciences in Trinity College Dublin. However, this approval does not mean you should be influenced in any way to take part in this study.

For further information about the study and to take part: You can get more information or answers to your questions about the study by contacting the researcher Siobán O'Brien Green by texting her, sending her a WhatsApp or phoning her on 086 171 6170. You can also email her on: OBRIENGS@tcd.ie

Supports for all women in Ireland: The following services listed offer, free, confidential supports to women who are experiencing or have experienced domestic violence and can be accessed by any woman at any time. The researcher can assist you with contacting the most appropriate service for you if needed.

County	Name of Service	Contact Number
Carlow	Carlow Women's Aid	1800 444 944
Clare	Clare Haven Services, Ennis (includes 24 hour refuge)	065 682 2435
Cork	Cuanlee Refuge, Cork City (includes 24 hour refuge)	021 427 7698
Cork	Mna Feasa, Women's Domestic Violence Project	021 421 1757
Cork	OSS, Cork City	1800 497 497
Cork	West Cork Women Against Violence Project, Bantry	1800 203 136
Cork	Yana, North Cork Domestic Violence Project, Mallow	022 53915
Donegal	Donegal Women's Domestic Violence Service (includes 24 hour refuge)	1800 262 677
Donegal	Letterkenny Women's Centre (Counselling Service Only)	074 912 4985
Dublin	Aoibhneas Women's Refuge, Dublin 5 (includes 24 hour refuge)	01 867 0701
Dublin	Dublin 12 Domestic Violence Service	01 400 2080
Dublin	Inchicore Outreach Violence Against Women Centre	01 454 5239
Dublin	Rathmines Women's Refuge (includes 24 hour refuge)	01 496 1002
Dublin	Saoirse Women's Refuge, Tallaght (includes 24 hour refuge)	01 463 0000
Dublin	Sonas Domestic Violence Charity	01 872 0068
Dublin	Viva House Women's Refuge (includes 24 hour refuge)	01 866 2015
Dublin	Women's Aid, Dublin (including National Freephone Helpline 10am-10pm)	1800 341 900
Dublin	Cuan Alainn Women & Children's Refuge (Second stage supported housing)	01 804 0251
Galway	Cope Waterside House Women's Refuge, Galway (includes 24 hour refuge)	091 565985
Galway	Domestic Violence Response, Oughterard, Co Galway	091 866740

County	Name of Service	Contact Number
Kerry	Adapt Kerry Women's Refuge and Support Service, Tralee (includes 24 hour refuge)	066 712 9100
Kildare	Teach Tearmainn Women and Children's Refuge (includes 24 hour refuge)	045 527584
Kilkenny	Amber Women's Refuge, Kilkenny (includes 24 hour refuge)	056 777 1404
Laois	Laois Domestic Abuse Service	057 867 1100
Limerick	ADAPT Domestic Abuse Services (includes 24 hour refuge)	1800 200 504
Longford	Longford Women's Link	043 334 1511
Louth	Drogheda Women and Children's Refuge (includes 24 hour refuge)	041 984 4550
Louth	Women's Aid, Dundalk (includes 24 hour refuge)	042 933 3244
Mayo	Mayo Women's Support Services (includes refuge)	094 902 5409
Meath	Meath Women's Refuge & Support Service (includes 24 hour refuge)	046 902 2393
Monaghan & Cavan	Tearmann Domestic Violence Services (Monaghan & Cavan)	047 72311
Offaly	Offaly Domestic Violence Support Service, Tullamore	057 935 1886
Sligo/Leitrim/ West Cavan	Domestic Violence Advocacy Service, Sligo, Leitrim & West Cavan	071 914 1515
Tipperary	Ascend Domestic Abuse Service, Roscrea	0505 23999
Tipperary	Cuan Saor Refuge & Support Service, Clonmel (includes 24 hour refuge)	1800 576 757
Waterford	Oasis House, Waterford City (includes 24 hour refuge)	1890 264 364
Westmeath	Esker House, Athlone (includes 24 hour refuge)	090 6474122
Wexford	Wexford Women's Refuge, Wexford Town (includes 24 hour refuge)	053 912 1876
Wicklow	Bray Women's Refuge (includes 24 hour refuge)	01 286 6163

Appendix 4 Study Informed Consent Form

Title of Study: An exploration of the process involved when women chose to disclose they are experiencing domestic violence during pregnancy.

Principle Investigator/Researcher: Siobán O'Brien Green, Trinity College Dublin, Ireland.

Background: You have been invited to participate in an interview as part of this study because you are a woman, aged over 18, who at some point has experienced domestic violence while pregnant and you told someone about the violence. The interview will last as long as you want it to and you can stop or pause the interview at any point if you feel uncomfortable or upset. The interview will be recorded and later transcribed or written out word for word. This is to assist the researcher with the study. Please ask the researcher if you would like to get a copy of your own interview transcript. Your participation in this study is **voluntary and confidential** (within the constraints of Irish law) and the data from your interview will be made completely unidentifiable before it is used in any related publications and presentations. There are only two times where the researcher may have to break confidentiality. Firstly, the researcher is obliged to take steps, including reporting to relevant authorities, to prevent serious harm to yourself or others should this intention be disclosed to her during the interview. Secondly, the researcher is obliged by law to report child abuse that is disclosed to her during the interview, to a designated Child Protection Officer and/or authorities. All the information will be used for research purposes only, information will not be used in future unrelated studies without further specific permission being obtained. The information will be stored securely for five years then destroyed. If you wish to have/need support or help during or following your interview, the researcher will provide assistance by referring you to appropriate services.

Please answer the following questions by ticking the relevant box

1. Have you read and understood the Participant Information Leaflet for this study?

YES ☐ NO ☐

2. Have you been able to ask questions about this study?

YES ☐ NO ☐

3. Have you received enough information about this study?

YES ☐ NO ☐

4. Do you understand that you are free to withdraw from or stop this interview at any time?

YES ☐ NO ☐

5. Do you give permission for the researcher to record your interview?

YES ☐ NO ☐

I have/have not taken part in the MAMMI (Maternal health And

Maternal Morbidity in Ireland) study. (Delete as appropriate).

Declaration: I have read, or had read to me, the Participant Information Leaflet for this study and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement (the consent form).

PARTICIPANT'S NAME: ……..

CONTACT DETAILS: ……..

PARTICIPANT'S SIGNATURE: ……..

DATE:……..

Statement of Investigator's responsibility: I have explained the nature and purpose of this study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

RESEARCHER'S/INVESTIGATOR'S
SIGNATURE:……..

DATE:……

If you have questions about the study or your interview or you wish to receive more information about any related services or supports or a copy of your interview transcript, you can contact the researcher Siobán O'Brien Green, on 086 171 6170 or 083 852 0928 or by email OBRIENGS@tcd.ie

Appendix 5 Study research summary

Factors associated with the disclosure of domestic violence and subsequent positive service utilisation during and after pregnancy. PhD Research Study 2016-2018.

What is the research study about?

This is a qualitative research study that explores the process(es) when women chose to disclose and seek support when experiencing domestic violence during pregnancy. The study will interview women who have experienced domestic violence while pregnant to understand and identify what helped them, and what did not, to seek support, safety, help and appropriate services. Women will not be asked about their experience of violence in the interviews **only** their experience of seeking support and safety. This study will enable a greater understanding of the process involved and it will inform the planning and provision of services and supports available to women in such situations in the future.

For the purposes of this study disclosure will be defined as:

'When a woman discloses that she is experiencing domestic violence and is referred, or self-refers, to a domestic violence support service or refuge at some point between conception and one year post-pregnancy, regardless of the outcome of her pregnancy (i.e. the pregnancy may end in termination or miscarriage).'

Who can participate in the study?

Women over 18 years of age living in Ireland who;

1) Experienced domestic violence during a pregnancy or pregnancies;

2) Are currently accessing and/or in contact with domestic violence support services or made initial contact while pregnant or in the first year after pregnancy (regardless of how the pregnancy ended).

3) Are willing to take part/participate in the study and to be interviewed;

4) Are deemed not to be in immediate or current danger from a violent (ex) partner(s); and

5) Can read, speak and understand English at a level that allows for written informed consent to be understood and obtained and for a spoken research interview in English to take place.

Women taking part in the study may be interviewed up to three times, if they wish, including during pregnancy and up to 5 years after birth/pregnancy, regardless of the outcome of their pregnancy.

Participation in this study is voluntary. Women can withdraw from the study or stop their interview at any time. All identifying information from the interviews will be assigned a code to make it unidentifiable and to ensure confidentiality. All data from the study will be handled and stored in accordance with the Data Protection Act 1998 and the Data Protection (Amendment) Act 2003. This study has received approval from the Research Ethics Committee in the Faculty of Health Sciences in Trinity College Dublin. The researcher, Siobán, has worked in the area of domestic violence, gender based violence and women's health since 1998. She has worked on research studies on violence against women in Ireland and in the European Union.

For more information, study documents, to take part, or any queries please feel free to contact Siobán O'Brien Green on 086 171 6170 or by email OBRIENGS@tcd.ie

Appendix 6 Interview questions and prompt schedule

Opening question

In Ireland, many women experience domestic violence when they are pregnant or after having a baby, we don't know exactly what process enables and supports some women to seek safety and help. What can you tell me about your experiences?

Questions:

1. Were you asked (or screened) about domestic violence as part of your maternity care (by a GP, midwife, etc.)?
2. How was your health during and after your pregnancy? And the birth?
3. Can you tell me again what supported or helped you at this point in your life/pregnancy?
4. When you sought help what was your relationship with the perpetrator?
5. If you have any other children were they aware or did they know what was going on?
6. Based on what you have told me so far what would you say to others about your experiences?
7. What else could health and maternity services do?
8. What could health and maternity services do better?
9. Is there anything else you want to say or add?

Prompts:

- Could you explain a bit more about what you just said?
- Can you tell me more about what happened at that time?
- What you said is very important, can you elaborate and share more about your experience?
- Just so I am clear, can you go over what you just told me?

Appendix 7 Study recruitment documentation for key informant interviews

Letter to Domestic Violence Service Providers as Prospective Study Participants

Dear XXXX,

My name is Siobán O'Brien Green, I am a PhD student in Trinity College Dublin. I am conducting a qualitative study as part of the requirements of my PhD exploring the process involved when women chose to disclose they are experiencing domestic violence during pregnancy. Staff who support women in this situation are key to better understanding this complex issue and therefore, I would like to invite you to participate in the study by being interviewed.

The interview will take place in a location at a time and date that suits you. Each interview will last about 30 minutes, with time for breaks if you want. During the interview I want to hear your experiences and thoughts on providing services to women experiencing domestic violence and there are no right or wrong answers. All information will be analysed by using codes and will be unidentifiable. Neither your name nor any of your work details will appear in any report or publication so that no one can know your identity or that you took part in the study. Within the limits of the Irish law, I guarantee the confidential treatment of all the information you tell me. Participation in this study is voluntary and confidential (within the constraints of Irish law) and the data from your interview will be anonymised before it is used in any related publications and presentations. There are only two times where the researcher may have to break confidentiality. Firstly, the researcher is obliged to take steps including reporting to relevant authorities, to prevent serious harm to yourself or others should this intention be disclosed to her during the interview. Secondly, the researcher is obliged by law to issues of concern and/or report child abuse that is disclosed to her during the interview, to the appropriate authorities. All the information will be used for research purposes only, information will not be used in future unrelated studies without further specific permission being obtained. The information will be stored securely and destroyed as soon as is feasible.

This study will enable a greater understanding of the process involved in disclosing experiencing domestic violence for pregnant women. You can get more information about participating in the study by reading the Participant Information Leaflet to Domestic Violence Service Providers (attached) and then contacting me by text, sending me a WhatsApp or phoning me on 086 171 6170. I will call you back at a time

that suits you to answer any questions you may have. You can also email me on: OBRIENGS@tcd.ie

Thank you for your time, yours sincerely,

Siobán O'Brien Green MSocSc (Social Policy)

Participant Information Leaflet for Domestic Violence Service Providers

Title of the study: An exploration of the process involved when women chose to disclose they are experiencing domestic violence during pregnancy.

Principle Investigator/Researcher: Siobán O'Brien Green, Trinity Research in Childhood Centre, Trinity College Dublin. Siobán is an experienced researcher who has worked on the issues of domestic violence, gender based violence (GBV) and women's health since 1998. Since 2010 Siobán has worked with SAFE Ireland, undertaking research and communication projects. Siobán was a research team member on the 2015 INASC (Improving Needs Assessment and Victim's Support in Domestic Violence), multi-country research funded by the Criminal Justice Programme of the European Union (EU). Siobán has also undertaken research commissioned by the European Institute of Gender Equality on GBV in Ireland and the EU. This current study is part of her PhD in Trinity College Dublin.

Description of the study: This is a qualitative study exploring the process involved when women chose to disclose and seek support when experiencing or having experienced violence during pregnancy. This study will give a greater understanding of this process and the complexities for pregnant women when thinking about whether to tell or disclose and when disclosing that they were experiencing/had experienced domestic violence to professionals such as midwives, GPs and domestic violence service staff. The study will interview women who have experienced domestic violence when they were pregnant to understand the process involved in disclosing and what helped them and what did not, to seek support, safety and appropriate services. Interviews with key staff providing support in domestic violence and other relevant services to women will also be conducted as part of this study. The results of this study will be written up as a PhD thesis and may also be published and presented at professional conferences and meetings, but the identities of all study participants will be unidentifiable.

For the purposes of this study the 1997 Task Force definition of domestic violence will be used (see below).

> '…the use of physical or emotional force or threat of physical force, including sexual violence in close adult relationships. This includes violence perpetrated by a spouse, partner, son or daughter or any other person who has a close or blood relationship with the victim. The term 'domestic violence' goes beyond actual physical violence. It can also involve emotional abuse; the destruction of property; isolation from friends, family and other potential sources of support;

threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone' (Office of the Tánaiste 1997, p. 27)

Participation in the study: You can participate in this study if:

- You can meet the researcher for an interview face to face at a time, date and location convenient for you and you agree to be interviewed.
- Your work includes providing supports, advocacy and help to women who have experienced, or are experiencing, domestic violence while pregnant.
- You are over 18 years of age.

Maintaining confidentiality: Your identity will remain confidential. Your name or other identifying details, such as where you work, will be anonymised by using codes, which will not be published and will not be disclosed to anyone. The researcher will ensure that all documents, recordings, data and information will be kept securely in a locked filing cabinet in a locked room. All data from this study will be handled and stored in accordance with the Data Protection Act 1998 and the Data Protection (Amendment) Act 2003 and will be destroyed as soon as possible and prior to five years. All information will be used for research purposes only, information will not be used in future unrelated studies without further specific permission being obtained. There are only two possible exceptions to maintaining confidentiality. Firstly, the researcher is obliged to take steps, including reporting to relevant supports and authorities, to prevent serious harm to yourself or others should this intention be disclosed to her during the interview. Secondly, the researcher is obliged by law to report any issue of concern relating to the provision of services for groups perceived to be vulnerable and/or if child abuse is disclosed to her during the interview, to the appropriate authorities.

Benefits of participating in the study: There are no direct benefits for you when participating in this study. However, the study findings will contribute to an explanation of why women disclose that they are experiencing/experienced domestic violence during pregnancy and seek help and support.

Risks: There are no immediate and foreseeable risks to you taking part in this study.

Compensation: This study is covered by standard institutional indemnity insurance. Participation in this study does not entail any costs at all to you.

Participation in the study is voluntary: If you decide to volunteer to participate in this study, you may withdraw your participation or stop the interview at any time. If you decide not to participate, or if you withdraw, this will in no way affect your relationship with the researcher.

Stopping the study: The researcher may withdraw your participation in the study at any time without your consent, this is to ensure your safety and welfare.

Permission: This research study has received approval from the Research Ethics Committee in the Faculty of Health Sciences in Trinity College Dublin. However, this approval does not mean you should be influenced in any way to take part in this study.

For further information and to take part: You can get more information or answers to your questions about the study by contacting the researcher Siobán O'Brien Green by texting her, sending her a WhatsApp or phoning her on 086 171 6170. You can also email her on: OBRIENGS@tcd.ie

Informed Consent Form Service providers

Title of Study: An exploration of the process involved when women chose to disclose they are experiencing domestic violence during pregnancy.

Principle Investigator/Researcher: Siobán O'Brien Green, Trinity College Dublin, Ireland.

Background: You have been invited to participate in an interview as part of this study because you are aged over 18 and your work includes providing supports, advocacy and help to women who have experienced, or are experiencing, domestic violence while pregnant. The interview will last as long as you want it to and you can stop or pause the interview at any point. Your participation in this study is **voluntary and confidential** (within the constraints of Irish law) and the data from your interview will be made completely unidentifiable before it is used in any related publications and presentations. There are only two times where the researcher may have to break confidentiality. Firstly, the researcher is obliged to take steps, including reporting to relevant authorities, to prevent serious harm to yourself or others should this intention be disclosed to her during the interview. Secondly, the researcher is obliged by law to report child abuse that is disclosed to her during the interview, to a designated Child Protection Officer and/or authorities. All the information will be used for research purposes only, information will not be used in future unrelated studies without further specific permission being obtained. The information will be stored securely for up to five years then destroyed.

Please answer the following questions by ticking the relevant box

1. Have you read and understood the Participant Information Leaflet for this study?

   YES ☐ NO ☐

2. Have you been able to ask questions about this study?

   YES ☐ NO ☐

3. Have you received enough information about this study?

   YES ☐ NO ☐

4. Do you understand that you are free to withdraw from or stop this interview at any time?

   YES ☐ NO ☐

Declaration: I have read, or had read to me, the Participant Information Leaflet for Domestic Violence Service Providers for this study and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement (the consent form).

PARTICIPANT'S NAME: ……..

CONTACT DETAILS: ……..

PARTICIPANT'S SIGNATURE: ……..

DATE:……..

Statement of Investigator's responsibility: I have explained the nature and purpose of this study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

RESEARCHER'S/INVESTIGATOR'S
SIGNATURE:……..

DATE:……

If you have questions about the study or your interview you can contact the researcher Siobán O'Brien Green on 086 171 6170 or by email OBRIENGS@tcd.ie

Interview Questions for Domestic Violence Service Providers

Opening Question:

In Ireland, many women experience domestic violence when they are pregnant or after having a baby, we don't know exactly what process enables and supports some women to seek safety and help. What can you tell me about your professional experiences when you meet and support these women?

Questions:

1. No women interviewed in the study reported experiencing an abortion or a miscarriage – do you have any thoughts on this?
2. It was very challenging to recruit Irish women to be interviewed for this study, do you have any suggestions why this might be?
3. Do you want to add or say anything else?

Thank you.