**“*Opening the door”*: a qualitative interpretive study of women’s experiences of being asked about intimate partner violence and receiving an intervention during perinatal home visits in rural and urban settings in the USA**

Loraine J Bacchus PhD, MA, BSc1,2, Linda Bullock PhD, RN, FAAN2, Phyllis Sharps PhD, RN, FAAN3, Camille Burnett PhD, MPA, APHN-BC, RN, BScN, DSW2, Donna Schminkey PhD, MPH, RN, CNM2, Ana Maria Buller PhD MAC BA1, Jacqueline Campbell PhD, RN, FAAN 3

1London School of Hygiene & Tropical Medicine, London, United Kingdom

2 University of Virginia, Charlottesville, Virginia

3 John Hopkins University, Baltimore, Maryland

**Corresponding Author:**

Loraine J Bacchus

Loraine.Bacchus@lshtm.ac.uk

T: +44 (0) 207 958 8244

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**ABSTRACT**

**Research Aim**

This study explored women’s experiences of being screened for intimate partner violence (IPV) and receiving an intervention during perinatal home visits in urban and rural settings in the USA. Twenty-six women were recruited from the DOVE (Domestic Violence Enhanced Intervention) trial to participate in a nested qualitative interpretive study.

**Major Findings**

Women valued the opportunity to discuss their IPV experiences and access support. Disclosure was a staged process and home visitor communication style and the development of a trusting relationship were influencing factors. Safety planning was an important feature of the DOVE intervention, whether the abuse was past or ongoing. Women highlighted the need for post-abuse support services.

**Conclusion**

Perinatal home visitors require training in IPV that supports the development of good communication skills, and provides opportunities for experiential learning and feedback with regards to asking about and responding to IPV. Reinforcement training activities are necessary in order to enhance home visitor’ confidence and comfort, and sustain practice. Rigorous protocols are needed to ensure the safety of home visitors and women.

**INTRODUCTION**

Intimate partner violence (IPV) affects one in three women globally and one in four women in the USA (World Health Organization, 2013a) with serious long term health consequences for women and their children (Campbell, 2002; Devries et al. 2013; Holt, Buckley & Whelan, 2008). Exposure to IPV during pregnancy is significantly associated with increased rates of depression, alcohol, tobacco, illicit drug use (Amaro et al. 1990; Campbell et al. 1992; Martin et al. 1996) and termination of pregnancy (Hall et al. 2014). IPV has also been linked to pregnancy complications and adverse outcomes such as preterm delivery and low birth weight (Shah & Shah, 2010).

As a significant public health issue, the role of heath care in addressing IPV is recognised in recommendations from the WHO (2013b). For the purposes of this paper, we use the term IPV, although in the international literature, the terms domestic violence and domestic abuse are also used to describe various forms of abuse between current or former intimate partners. The WHO (2000) has defined IPV as “*any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship*” (WHO, 2000, p.89). Although men are abused by female partners, the overwhelming burden of IPV is assumed by women who have been abused by male partners (World Health Organization, 2000).

The question of whether or not to screen all women for IPV during healthcare consultations has been widely debated by academics, health practitioners and organisations that provide support to women and children exposed to IPV (Taket et al. 2003; Taket, Wathen & Macmillan, 2004). Currently the WHO (2013b) do not recommend universal screening of women for IPV in health care settings due to the lack of robust evidence from trials of its effectiveness in reducing the levels of violence and improving health outcomes for women (O’Doherty et al. 2014). Instead the WHO recommend that health care providers receive training regarding the common indicators of IPV, how to ask questions when abuse is suspected, and how to respond sensitively and appropriately to disclosures of abuse (WHO, 2013b). Some academics maintain that partner violence and abuse cannot be approached within a traditional medical model because it is not a disease, but rather a risk factor for numerous health problems. Consequently, the term *screening* is considered to be inappropriate and it has been suggested that the terms *routine enquiry* or *asking all women* are preferable (Taket, Wathen & Macmillan, 2004). Taket et al. (2004) argue that enquiry for IPV should be implemented flexibly and in a way that responds to the circumstances of the consultation. For example, integrating questions about IPV would be appropriate during a health check in a Well Woman Clinic or when there is a structured history taking. However, when there is limited time, questions about IPV may only be appropriate when the index of suspicion is high or when a woman presents with injuries (Taket et al. 2003). A systematic review reports that the majority of women find routine questions about IPV during health consultations acceptable, whilst health care providers are more reticent about asking (Feder et al. 2009). Nevertheless, enquiry about IPV provides validation of women’s experiences and an opportunity for them to discuss their experiences which is considered an important intervention in itself (Bacchus et al. 2002).

Although screening for IPV is recommended in the USA (Moyer, 2013) barriers such as provider attitudes and training needs (Sprague et al, 2012; Tower, 2006) impact screening and intervention practices. There have been studies evaluating IPV interventions in antenatal care settings involving enquiry for IPV, counselling and advocacy interventions (Bacchus et al. 2010; McFarlane, Soeken & Wiist, 2000; Humphreys et al. 2011). However, to date, no studies have specifically explored the feasibility and acceptability of enquiry for IPV during perinatal home visitation. In the United States perinatal home visitation has been demonstrated to improve pregnancy outcomes, parenting skills, enhance the development of children (Sharps et al. 2008) and reduce child abuse and neglect (Eckenrode et al. 2000). As a preventive strategy, it provides a range of services to young children and their family in the home environment from a trained care provider. This includes coordinating referrals to community services, parenting and child education and support during and after pregnancy. Although such programmes are voluntary, families that are considered at risk of child maltreatment are encouraged to participate. Home visitors are predominantly female and the qualifications required of them vary from a graduate degree in teaching, social work or nursing, to a high-school diploma, to none at all (Barnet, 2013). Therefore, staff range from lay persons who live in the community in which they work and have no more than a high school education, to those with a professional qualification (Gromby et al. 1993). Olds and Kitzman (1993) have suggested that programmes that use professionals as home visitors are of a higher quality than those that use paraprofessionals. Furthermore, they state that nurses are better equipped to respond to health related questions and make referrals within the health care system compared to paraprofessionals. A randomized controlled trial by Olds and colleagues tested the effectiveness of home visiting by paraprofessionals and by nurses on maternal and child health outcomes, when both types of visitors were trained in a programme that had demonstrated effectiveness when delivered by nurses. In contrast to women who were visited by paraprofessionals, nurse-visited women showed greater reductions in smoking, had fewer subsequent pregnancies and births, delayed pregnancies for longer intervals and were more likely to be employed. At 6 months of age, nurse-visited infants were less likely to exhibit emotional vulnerability in response to fear stimuli compared to paraprofessional-visited infants, and at 21 months were less likely to exhibit language delays (Olds et al. 2002).

Perinatal home visiting and other parenting and early childhood development programmes present barriers and opportunities for supporting women and children exposed to IPV. Care is delivered to families in their homes which affords many advantages in that parents do not need to organise transportation or childcare. Continuity of care provider enables rapport building and the home visitor is able to observe relationship dynamics. The ability to engage parents through the development of a trusting relationship with open communication are essential components of home visiting work, but equally valuable skills for discussing IPV. However, there are safety and confidentiality issues associated with delivering IPV interventions in the home that, to some extent, can be circumvented in a clinical setting. The most significant being the risk of interruption by the abuser or family members (Eddy et al. 2008; Jack et al. 2008; Sharps et al. 2008). Women and home visitors may experience more discomfort discussing IPV in the home where the abuse takes place. A UK study of midwives found that they had concerns about screening for IPV in the home, which they regarded as the “*woman’s territory*”, and it was not seen as a legitimate place to ask for confidential time (Mezey et al. 2003).

A systematic review by Prossman et al. (2015) assessed the effectiveness of randomised controlled trial home visiting interventions in reducing IPV experienced by mothers. Three of the six home visiting programmes identified, based in the United States, Australia and the Netherlands, found a statistically significant reduction in IPV in the short-term. The Australian study, MOSAIC, also demonstrated the feasibility of using trained and supervised local mentor mothers to deliver the IPV intervention as opposed to nurses (Taft et al, 2011). To our knowledge, there has been no qualitative exploration of these interventions regarding their acceptability to women or the challenges of implementation.

This study seeks to address the gap in current knowledge by exploring women’s experiences and perceptions of being screened for IPV during perinatal home visits and receiving support as part of the Domestic Violence Enhanced Intervention (DOVE). The term *screening* was used in all DOVE study materials and the training curriculum, as universal screening of women for IPV during health consultations is recommended in the USA. Therefore, we use this term in our presentation of the findings and discussion.

**METHODS**

**Aim**

The aim of this study was to explore: (i) women’s views and experiences of being screened for IPV during perinatal home visits in rural and urban contexts in the US (ii) and their perceptions of how the DOVE intervention helped them.

**Design**

A nested qualitative interpretive study was conducted to explore the views and experiences of women in the Domestic Violence Enhanced Intervention (DOVE). Our study is underpinned by an interpretivist paradigm (Denzin & Lincoln, 2005) based on the supposition that women’s understandings and experiences of IPV screening would be diverse and socially constructed. Furthermore, the meanings attached to their experiences of receiving the DOVE intervention would be influenced by time, context, culture and values.

DOVE is a randomized controlled trial which compares two approaches for screening women for IPV and offering an intervention. In the first approach, a trained home visitor screens women for IPV using the Abuse Assessment Screen (McFarlane et al. 1996) and the Women’s Experience of Battering Scale (Smith, Earp & DeVellis, 1995). Women who are pregnant or up to three months postpartum are eligible to participate in the DOVE trial. Women who score positive for IPV on the scales in the year prior to their current pregnancy are eligible for the intervention. The intervention consists of a home visitor led discussion of the DOVE brochure which contains information on IPV health consequences, assessment of risk factors for homicide using the Danger Assessment Scale (Campbell et al. 2009), safety planning and information about community resources. In the second approach, the same materials are delivered using mHealth (i.e. a computer tablet) although safety planning is carried out by the home visitor. For safety, the computer tablet was always kept by the home visitor and they checked whether it was safe to leave the DOVE brochure in the home.

**Data collection**

Between November 2013 and August 2014, semi-structured interviews were conducted with 26 women enrolled in DOVE. Women were recruited from perinatal home visiting programmes in rural (Virginia and Missouri) and urban (Maryland) locations of the USA. The interviews explored women’s views and experiences of screening for IPV by home visitors, aspects of the home visitor-client relationship that acted as facilitators or barriers to discussion about IPV and what women found helpful about DOVE.

**Participants**

Women were sampled purposively based on factors that might affect their experience of the DOVE screening and intervention such as rural versus urban; paper versus computer tablet method; currently with the abuser or not; Spanish or English speaking and age. Women who had not experienced IPV in the year before their pregnancy were interviewed to elicit their views on screening. The researcher was provided with a list of women in the DOVE trial who consented to participate in a qualitative interview including their socio-demographic and other details. Women were selected on a range of characteristics and invited to participate in an interview. Interviews took place in women’s homes if it was safe to do so or away from the home in the researcher’s car. All participants received a gift voucher for their participation.

**Ethical considerations**

The study was approved by the University Institutional Review Board for Social and Behaviour Sciences (2011-0243-00). Women gave informed consent to the DOVE trial via the computer tablet and during this time also indicated whether or not they consented to a qualitative interview at a later date. The safety of the researchers and the women were of the utmost importance in undertaking the study. Women were only interviewed in their homes if the abusive partner was away during the interview and confidential space in the home was available. Otherwise they were interviewed away from the home, in the researcher’s car. As standard practice, two researchers attended all interviews and details were provided to the DOVE trial Principal Investigator at the University of Virginia (LBK) regarding the time and location of interviews. Once an interview was complete, confirmation via a text message was sent to the Principal Investigator. Another important consideration was to minimize participant distress. Prior to starting the interview, women were reminded that they could refuse to answer any question they found upsetting and could stop the interview altogether. During interviews, the researcher monitored women’s reactions for signs of distress. Women were encouraged to take a moment to collect themselves if they became emotional and were asked how they felt about continuing with the interview (Ellsberg & Heise, 2005). The Principal Investigator (LBK) was available to discuss any difficult interviews or concerns. All interview transcripts and digital recordings contained unique identifiers. All study materials were kept in the locked research offices. The data sources imported in to NVivo did not contain any identifying information. Data files were stored on a secure University server.

**Data analysis**

Interviews were digitally recorded and transcribed verbatim. NVivo 10 software was used to facilitate the organisation and analysis (NVivo, 2012). Thematic analysis was used to identify, analyse and report on patterns within the data (Boyatizis, 1998) and was both deductive and inductive (Miles and Huberman, 1994). The initial coding framework was based on topics within the interview schedule. However, the framework was refined as coding of interview transcripts progressed and new themes emerged. To ensure dependability, three interviews were double coded by LB and AMB using the framework developed in NVivo and discrepancies were discussed (Miles & Huberman, 1994). Codes representing similar themes were collapsed and new codes were developed where additional themes were identified. As a further check for consistency, LBK reviewed a range of quotes representing each theme in the first draft of the paper. Interviews conducted in Spanish were translated into English and the recording and transcript were compared for accuracy. In the quotes presented, *IPV+* refers to women who disclosed IPV in the year prior to their current pregnancy and IPV- refers to women who did not disclose IPV in the year prior to their current pregnancy.

**RESULTS**

**Table 1: Socio-demographic characteristics of 26 women enrolled in DOVE**

|  |  |  |
| --- | --- | --- |
| **Socio-demographics**  | **N=26** | **%** |
| **Age**16 – 19 20 – 23 24 – 27 28 – 35  | 41174 | 15422715 |
| **Ethnicity**White/CaucasianAfrican/African/American/BlackMore than one raceNot reported | 12842 | 4631158 |
| **Language**EnglishSpanish | 233 | 8812 |
| **Location**UrbanRural | 719 | 2773 |
| **Marital Status**MarriedSinglePartnered, not married | 1178 | 46531 |
| **Education level attained**7th to 9th grade10th to 12th gradeHigh school graduate/GEDSome college or trade schoolCollege graduate | 177101 | 42727384 |
| **Number of live births at interview**12345 | 174311 | 65151244 |
| **Number of partners in the year****before the current pregnancy**12More than 2 | 1664 | 622315 |
| **IPV abuse status**IPV in the year before the current pregnancyNo IPV in the year before the current pregnancya | 188 | 6931 |
| **DOVE method**Paper Computer tablet | 179 | 6535 |

a Two of the women reported experiencing IPV more than one year prior to their current pregnancy.

**Perceived benefits and risks of the home visitor asking about IPV**

Women’s views of screening for IPV during perinatal home visitation were generally positive. They felt it was important for home visitors to ask about IPV to help de-stigmatize the issue, provide opportunities to talk about their experiences, and connect them to support. The impact on children exposed to IPV was also recognised as a reason for home visitors to ask questions about it. Women recognised IPV as an issue that was common within their communities and this was reflected in their references to friends and family who were affected.

*‘Cause back then I was ashamed to talk about it, but my DOVE nurse made it so that I’m able to talk about it and not hold things in.* [Martha, 26 yrs, Urban, IPV+]

*You never know if the parents are getting abused by each other and there’s a child coming into it, so I think it’s a good idea*. [Kathleen, 22yrs, Rural, IPV-]

*I think it’s a good idea. It needs to be more widely known because it does happen quite frequently and more than people realize. I mean my brother was abusive to his girlfriend and still is. People I know say that their partner has been abusive to them. I’ve seen it through my parents.* [Ellen, 23 yrs, Rural, IPV+]

It appeared to be easier for women to talk to their home visitor about IPV than to friends or family. It may be that women were less emotionally invested in the relationship with their home visitor and felt that they would provide more objective advice. In comparison there was more pressure to follow advice offered by family because their opinions mattered more to women and because the abuse may have an indirect impact on their lives.

*Well I think it’s good because it helps give us confidence that there is someone out there that can help us…I think it’s good for me*…*Aside from that, it helps us because sometimes we do not trust our family to talk to them about this and knowing that there is someone who doesn’t know us very well gives us a little courage to tell them* [Gabriela, 21 yrs, Rural, IPV+]

*I think it’s really great…they can open up and have someone to talk to ‘cause sometimes you don’t feel comfortable talking about it to the people that you’re close to, you don’t want them to judge you*. [Megan, 24 yrs, Rural, IPV-]

Even amongst women with no recent history of IPV there was a belief that their participation in the screening programme could be helpful to other women. In the following quote, Denise’s perceptions of partner abuse can be understood within her experiences as a survivor of childhood sexual abuse. She identifies with the internalised self-blame that women affected by IPV experience and how this often prevents them from seeking help.

*I haven’t actually been in that situation [IPV] but when I was a kid I was being abused sexually by a family member, somebody I trusted. I was blaming myself all along whilst it wasn’t even my fault…But I have come to realize that people who go through such things find it very difficult to talk about. For somebody to ask you that question…you realize somebody’s out there that is actually caring, wants to help you, or wants to know if you’re okay. So it’s very beneficial.* [Denise, 31 yrs, Urban, IPV-]

In the following quote, Lori expressed conflict about home visitors asking about IPV and regarded it as an intrusion in to her personal life. She felt protective of her relationship because her partner was attending a court-mandated anger management course and they were “*working on the relationship*”. Although she disclosed that “*he beat me up*”, she implicated herself in the abuse, suggesting that her bipolar disorder caused her to be abusive to him and that he ought to be the one to call the police. Her views about the role of home visitors’ were complex, given that she felt it was “*better to* *talk about it openly*”. However, the potential source of her anxiety was revealed in a brief comment: “*I didn’t want her to judge me for still having relations with this guy*”.

*I do and I don’t [think IPV screening is a good idea] because to be honest that’s somebody’s personal business and somebody’s life. But then I do because as a home visitor you got to ask certain questions about the kids and the kid’s father. I feel I’m grown and you shouldn’t ask a whole lot of personal questions…but it has an advantage because if something was to ever go wrong you know where to start…If the person came and told you that they was in an abusive relationship, then yeah it’s okay to question. But if they don’t come to you, then don’t ask them.* [Lori, 24 yrs, Urban, IPV+]

With regards to the perceived risks of talking to the home visitor about IPV, one concern amongst women related to the repercussions of the abuser or someone else inadvertently finding out that they had discussed the issue with their home visitor. Some also expressed fears of worsening abuse, the abuser trying to take their children away, attempting to locate them if they were no longer in a relationship, and unwanted police involvement.

*I felt a little nervous about it because you know, if something did get out he would probably come over here. I worry about him trying to take my daughter from me*. [Sandra, 18 yrs, Rural, IPV+]

**Views on home visitor qualities that facilitated IPV screening and disclosure**

Disclosure of abuse was a staged process and women carefully assessed their home visitor’s responses before divulging more information. Trust was a predominant theme in women’s descriptions of the factors that encouraged open discussion about abuse with their home visitor. This view was not restricted to women assigned to receive DOVE using the home visitor method, as some women assigned to the computer tablet chose to involve their home visitor in the process.

*Well, like everything, at first you don’t trust other people, but as she talked and gave me advice, I started to feel more comfortable, confiding in her and telling everything that I thought was wrong with my partner…At first [the questions]made me feel uncomfortable because I thought this was between my partner and I, but with time I started gaining confidence and I felt like if I had any problems then there was someone who I could count on and that’s what gave me a little bit of strength sometimes.* [Gabriela, 21 yrs, Rural, IPV+]

Women’s capacity for trusting their home visitor was sometimes affected by past events where trust had been abused. A second woman in this sample who spontaneously disclosed childhood sexual abuse revealed how this impacted her ability to confide in her home visitor.

*I had been through something very traumatic in my life. I was molested at a very young age ‘til I was like 16. So trust building, it took a very long time. So then going through the abuse with my boyfriend, my trust didn’t really…[participant stuck for words] sometimes I get a vibe off people you know, my trust barrier comes up. But she was very down to earth, so it made me say “okay I can trust her”. She’s a great woman you know, so I respect that*. [Rosie, 23 yrs, Urban, IPV+]

Descriptions of home visitor attributes that contributed to developing trust included “*honesty*”; “*being caring*” and “*friendly*”; demonstrating knowledge; appearing confident; reassurances of confidentiality; listening to women’s accounts without showing judgement or a heightened response; and letting women know that IPV was common.

*Her [re]action wasn’t like “oh my God!”…her [re]action never changed. It was like when I first met her all the way up to now, she’s still treating me the same way*. [Martha, 26 yrs, Urban, IPV+]

*I’m able to talk about it now, yet it still bothers me. I mean I was able to open up to her. It took me a good maybe 30 minutes to be able to open up that way. But she made it very comfortable for me ‘cause she said it happens a lot. It’s not something that’s so rare. So I didn’t feel alone anymore. It still hurt, but it wasn’t as bad*. [Joanne, 18 yrs, Rural, IPV+]

Women were attuned to any signs of home visitor discomfort with IPV and this was described as a potential barrier to discussing their experiences of abuse.

*Well just the sound in her voice, I know I can trust her. I’m pretty good at trusting people and not trusting people. I’ve got an instinct. When it gets down to a really serious question, where I sense a tone in their voice, I’ll stop talking or I’ll let them know I don’t feel comfortable*. [Sandra, 18 yrs, Rural, IPV+]

*She was talking to me like I was a friend. She gave me the sense of “you can trust me and I’m not putting you in a position that you wouldn’t want to be in”. Like if I wanted to say something, she made it feel like I was in a safe environment…the way I see it is, I don’t like it when people act all nervous and stuff. That just sends a sign in me. If they’re nervous, I feel like they don’t wanna be there.* [Kimberley, 20 yrs, Rural, IPV+]

Women’s perceived similarity with their home visitor also facilitated open communication about IPV and many other sensitive issues. In the following quotes, women described how they felt more affinity with home visitors who had experienced similar struggles to them.

*I got along more with Sarah [home visitor] because we have a lot of similar things. We can relate to each other on a certain level and that makes me feel a little bit more comfortable. With Eleanor [another home visitor] I’m comfortable with her, but I just don’t sense the things in common. It doesn’t seem like she’s ever had to struggle. It doesn’t seem as if she’s ever been in a similar position so it makes it harder for me to explain to her this is why I’m doing what I’m doing*. [Suzanne, Client, 35 yrs, Rural, IPV+]

*She’s helped in so many ways, just giving me insights on what is available to me, being a single struggling mom…and the fact that she opened up a little bit about herself. So she’s been in certain predicaments herself. So that kind of made me feel she was somebody that I could talk to and be open with*. [Lauren, 28 yrs, Rural, IPV+]

**Helpful aspects of the DOVE intervention**

Having “*someone to talk to*”, to “*recognise* *and understand*” the violence, feeling “*cared for*” and “*relief and comfort*” were amongst the helpful aspects of DOVE identified by women. Being able to talk to the home visitor was an important intervention in itself, which seemed to positively impact women’s self-esteem as well as increase their awareness of services they were entitled to.

*She helped me when I needed her most…When I arrived here I didn’t know anyone or anything, but with her I started becoming familiar with everything and I’ve learned how to move around here*. [Melissa, 27 yrs, Rural]

*I do think that most of all, the communication with her has helped me. Lately, I feel better, like I value myself more than before…because my self-esteem was a little low and now I feel a little better with myself*. [Gabriela, 21 yrs, Rural, IPV+]

Women appreciated the safety planning with their home visitor and list of useful resources. Even for those still living with an abuser, simply knowing about organisations to which they could turn seemed to enhance their feelings of safety.

*Definitely the pointers, you know I hadn’t thought of the safety plan, and packing a small bag and sticking it away for the boys and myself and money*…*she gave me a sheet with like shelters and things, step-by-step…what a woman can do to try and get out of their relationship*. [Lauren, 28 yrs, Rural]

Amongst rural women there was a lack of awareness of the national domestic violence hotline and other abuse services. Their geographic isolation and poor access to transport also made it difficult to them to access support. In the following comment, Sandra discusses her awareness of services in the context of historical abuse for which she did not receive help.

*When I turned sixteen I was raped twice by the same guy…I didn’t know they had an abuse hot line because if I would have known that, I probably would have been able to call it sooner in my life. A lot of those numbers I didn’t even know about until I was introduced to them.* [Sandra, 18 yrs, Rural]

One of the women alluded to the cycle of abuse which formed part of the DOVE intervention and how it made her more cognisant of behaviours that might precede an abusive episode.

*There is a young lady [referring to the DOVE computer tablet video], she talks about the stages [of abuse], things to look out for and what to do…and that helped me out…I don’t know if my next partner is going to do it, so it just keeps me on my toes*. [Jennifer, 30 yrs, Urban]

In contrast, Jamie, who had left her abusive partner when she received the DOVE intervention, stated that if she had still been with her partner “*it would have been a little too much”*. Her comment suggests that women who are invested in making their relationship work may be less receptive to IPV interventions that focus on making tangible changes. Interventions that address cognitive constructs, women’s understanding and labelling of abusive behaviours may be more appropriate for women who wish to remain in the relationship.

 *R: Why do you think it would have been too much during the time?*

*I: ‘Cause of denial…It’s my fault, or it’s not going to happen again. Or you know, he just got really angry and he regrets it. Stuff like that.* [Jamie, 22 yrs, Rural]

When prompted about what they found least helpful about DOVE and how it could be improved, only three of the women offered suggestions. One woman commented that she initially worried about involving friends or family in her safety plan, although with hindsight she thought it was a good idea because they could also be in danger. Another woman said that she would have appreciated a support group and a third wanted advice on how to ask her partner to leave after pre-arranged child visits if he became agitated.

**Perceptions of the impact of DOVE**

Women’s descriptions of how DOVE impacted on their circumstances and feelings were diverse, detailed and dependent upon where they were situated in the process of change and recovery. Some who had left the abuser spoke about developing a sense of achievement in living independently, being able to make decisions freely, engaging in education or being employed.

*I feel more in control of my life. It’s the first time I’ve ever been on my own. I was either with my mom, my dad, roommates. First time I’ve ever lived by myself with my kids. I feel fine about it now. It was scary, but I could do it*. [Carrie, 29 yrs, Rural]

*He was controlling. Like I couldn’t go to school, I couldn’t work, had to stay home. That’s what he wanted. And if I left to go to work, he’d call up my phone twenty times a day. When I got home, it was like a big explosion waiting to happen. Now I think my future is bright. I like the peace and being employed. Now I’m going to school to be a nurse*. [Tammy, 23 yrs, Urban]

*I feel a lot more freedom, more independent. Because when I was with him, he had me like a prisoner, he was like my warden and he was watching me and making sure I was staying in my cell*. [Sandra, 18 yrs, Rural]

Another impact of DOVE was an increased awareness of what constituted abusive behaviour, which helped women to identify similarities and differences between healthy and unhealthy relationships.

*It made me realise the past and where I don’t want to go and what I don’t want to be in again…And not just her dad, but my family life as well. ‘Cause that’s what I’ve gone through ever since I was knee-high to here*…*I didn’t realise it before, given how I was raised and what I went through growing up, it put me on the path of finding similar [abusive] relationships. It hasn’t been just one, but two.* [Suzanne, 35 yrs, Rural]

*With my fiancée we both make decisions, we talk them over. But if I don’t like something we try to reach an agreement, we’re not just saying well that’s too bad…I don’t allow people to talk to me in a negative way. I don’t allow them to put me in a situation that I don’t want to be in*. [Kimberley, 20 yrs, Rural]

However, others were less trustful of relationships which resulted in them feeling that they lacked judgement in finding a non-abusive partner or applying a more analytical lens to their current non-abusive relationships. There was some indication that women were anticipating abuse from their new partner or experiencing heightened threat perception despite being in a positive relationship. These women may have benefitted from information on how to recognise aspects of a healthy relationship in addition to risk markers for an abusive episode.

*I’m not looking for a relationship…Honestly because of him, because of past things, I’m finding it hard…I’m not going to be able to trust somebody*. [Suzanne, 35 yrs, Rural]

*It makes me a little more cautious. I pay attention to every little thing. Like in my [new] relationship, like what he says, his body language, how he reacts to certain things. That’s what I pay attention to now*. [Jamie, 22 yrs, Rural]

*Even though I’m in a [new] relationship now, like I said it’s the trust issues. If we get into an argument I think “oh is this man going to try and put his hands on me?” Oh I think all types of stuff*. [Jennifer, 30 yrs, Urban]

Only two of the women reported that DOVE had an impact on their partner’s behaviour, both of whom referred to improved communication. In both cases, the men were aware of their partner’s participation in DOVE, and although the women referred to ongoing arguments, the physical abuse had stopped.

*We would insult each other when we were angry or we would scream at each other. [My home visitor] helped him realise that he needs to be more patient and that things can’t be solved with punches, but instead by talking to each other…and that we don’t necessarily need to solve the problem when we are both angry*. [Gabriela, 21 yrs, Rural]

Despite having positive aspirations about her partner’s behaviour one of the women, Lauren, reported that she regularly ‘*stuck money back*” just in case she needed to leave, emphasising the value of safety planning with women who do not wish to leave.

*[My home visitor] is the one that brought DOVE to my attention. She’s great and she’s brought a lot of things to help our family and try to make things work so that we can stay a family…I do say all the time, that I don’t want to be in a relationship with him no more, but I do. I will try anything to keep our family together*. [Lauren, 28 yrs, Rural]

**The need for post-abuse support services**

Women spoke of the hardships they encountered whilst trying re-build their lives after leaving the abuser. Their accounts included financial difficulties, lack of child care support, being unable to work, trying to cope with their children’s challenging behaviour, and feeling depressed and isolated. The residual feelings of anger and injustice were palpable in women’s stories of their lives after leaving the abuser.

*I’m very angry at my relationships. I have two children by my past relationships and neither of their daddies has seen them. It makes me so angry. It makes me hurt, it makes me want to cry. ‘Cause I’m doing it by myself and where are they at? I mean I get support from my mom, but it still doesn’t help. When [the baby’s] screaming for the whole morning, there’s no one [to say] “hey, give him to me for like five minutes while you re-group”. My oldest is autistic and ADHD and [has] development delays. Who deals with that?* [Ellen, 23 yrs, Rural, IPV+]

Post-separation abuse and harassment was a recurrent theme. Lori [24 yrs, Urban] recounted how her ex-partner told her that he had a dream about killing her current partner. Carrie [29 yrs, Rural] talked about her partner’s verbal abuse and his persistent pressure on her to have sex whenever he visited their children. Kimberley [20 yrs, Rural] who ended her relationship after her partner pushed her out of the car whilst driving, reported that he stalked her for weeks and tried to obtain information about her from mutual friends. Although she did not want to take legal action, she informed her home visitor that she had seen him locally and they reviewed the safety plan. Suzanne’s [35 yrs, Rural] accounts related to her partner’s delayed child support payments and failure to attend child visits. The multitude of needs expressed by women highlights the necessity of intensive post-abuse support services.

**DISCUSSION**

Our study extends the current evidence base on women’s views about IPV screening, by exploring the feasibility and acceptability of screening and offering interventions during perinatal home visits. Although the study was conducted in the United States, the findings are likely to be transferrable to other high income countries that offer maternal, infant and early childhood home visiting with continuity of care provider. There is less certainty about the feasibility of integrating IPV interventions in parenting programmes in low and middle income countries, although there is promising evidence that they reduce harsh parenting and child maltreatment (Knerr et al. 2013). Further research is needed to explore how IPV interventions can be embedded within these contexts.

The findings are highly relevant to the current national health policy in England, specifically the framework on the public health contribution of nurses and midwives (Public Health England, 2013). As part of the framework, the UK Department of Health (2013) issued guidance outlining the role of health visiting nurses in the early identification of families affected by domestic violence and reducing the risk of ongoing harm. This is also reinforced by the National Institute for Health and Care Excellence (2014) domestic violence and abuse guidelines which highlights the role of postnatal care as an entry point for developing interventions for women and children exposed to IPV. Despite published guidance, there has been little exploration of the types of interventions within health visiting that women and children exposed to domestic violence find helpful.

Paraprofessionals, nurses and other licensed practitioners involved in delivering parenting and early childhood development programmes require training on the overlapping issues of IPV and child maltreatment, as well as the negative impact on children of being exposed to IPV (Holt, Buckley & Whelan, 2008). Training should also address care providers’ responsibilities in relation to child safeguarding and readiness to report to the appropriate authorities. The emotionally challenging nature of supporting families affected by IPV should be recognised and care providers who are experiencing IPV in their own relationships may require assistance. Organisations should create a supportive environment with policies that facilitate staff affected by IPV in seeking help. Regular clinical supervision and opportunities to discuss complex cases is necessary to maintaining good practice.

Women’s views of screening for IPV during perinatal home visits were mostly favourable, although it should be considered that those who elected not to be interviewed may have been less satisfied with DOVE. It would also have been beneficial to include undocumented migrants in the sample, as their views of IPV screening may have been less positive due to their fear of being reported to the authorities.

The key benefits of screening was that it helped to break the silence and secrecy surrounding the abuse, gave women the opportunity to talk about their experiences and be provided with information about community resources. Women valued the safety planning with their home visitor, regardless of whether the abuse had ended or was ongoing. The DOVE intervention also enabled them to define and label behaviours as abusive, which some women used as a guide for evaluating new non-abusive relationships. A trial of a maternal and child health IPV screening programme in Australia, reported increased safety planning rates at 24 months post-intervention, but not referrals to community resources (Taft et al. 2015). The authors propose that safety planning, as opposed to referrals, may be a more appropriate goal for women in the pre-contemplative or contemplative phases of the abuse cycle (Reisenhofer et al. 2013) although this should also be part of post-abuse support.

Our findings suggest that screening for IPV during perinatal home visits may be less tolerable to women who are still with the abuser. Women’s fear of being judged is likely to be intensified when they harbour hopes for change in their partner’s behaviour. Screening for IPV and the ensuing discussions with their home visitor may conflict with coping strategies that many women adopt during the early stages of the relationship to rationalise, minimise or explain away the abuse (Cavanagh 2003; Kearney, 2001; Lempert 1996; Sleutel, 1998). Feminist writers have described women’s coping strategies as a way of fortifying their defences, self-agency and part of the process of breaking free (Merrit-Gray & Wuest, 1995). Given the complexity of abused women’s experiences and situations, it has been suggested that health service interventions provide a means of evaluating and supporting abused women’s readiness and ability for change and provide tailored interventions (Reisenhofer & Taft, 2013).

Disclosure of IPV to the home visitor was a staged process, a finding which has also been reported in a UK study of health professionals’ beliefs about domestic abuse disclosure (Taylor et al. 2013). The home visitor’s communication skills were an influential factor in the disclosure process and women were deterred by home visitors who appeared to be uncomfortable with the topic. This echoes the findings of a US study examining abused women’s interactions with care providers, which found that doctors did not listen well and made little effort in encouraging women to explain their problems completely. A quarter of abused women (compared to only 9.7% of non-abused women) stated that they chose not to discuss a medical problem with their doctor because their physician was uncomfortable or embarrassed (Plichta et al. 1996). Our findings highlight the importance of including skill building and practice-enabling components alongside basic awareness raising in IPV training programmes. Confidence and comfort with IPV screening can be developed by employing teaching methods that facilitate experiential learning. This includes the use of exercises that involve watching and modelling good practice, problem solving using actual clinical cases and obtaining feedback from trainers (Bacchus et al. 2012; Feder et al. 2011; Torres-Vitolas, Bacchus & Aston, 2010; Lo Fo Wong et al. 2007).

Establishing a trusting relationship with the home visitor was a precursor to IPV disclosure, a finding that corroborates other research exploring women’s views of what aids IPV disclosure to health care providers (Bacchus et al. 2002; Eddy et al. 2008). Parenting programmes provide optimal conditions for developing trust due to their longevity and continuity of care provider. However, trust building is a process rather than an inherent feature of the patient-provider relationship. Gilson (2003) describes trust as a psychological statethat involves a degree of risk taking because there is uncertainty about the intensions and future actions of the individual in whom trust is placed. This is especially true for abused women whose vulnerability increases once they disclose IPV due to fear of the potential negative repercussions (Evans & Feder, 2014). Some of the women in our study disclosed multiple abuse experiences which included witnessing IPV between caregivers during childhood, childhood sexual abuse and experiencing IPV in more than one relationship. IPV training programmes need to sensitise health practitioners to the possibility of trauma across the lifespan and how this impacts women’s ability to engage with IPV interventions.

Women felt more comfortable discussing IPV with a home visitor whom they perceived to be similar to themselves, indicating that the presence of homophily (i.e. the tendency to bond with similar others) facilitates disclosure of IPV. Levendosky’s (2004) US study comparing the support networks of abused and non-abused women found that homophily had a positive and negative impact on support. Women who experienced IPV had significantly more support network members who had experienced IPV compared to non-abused women. However, within the IPV group, homophily had a positive relationship with disclosure, but a negative relationship with emotional support and criticism. The latter may be due to the fact that network members consisted primarily of friends and family who lacked knowledge of how to provide support or were experiencing IPV themselves and therefore unable to be supportive. In our study, women’s accounts revealed that some home visitors shared personal experiences as a way of establishing connection. The use of personal disclosure to establish parity in a relationship has also described in Kennedy’s (2004) exploration of the process of midwifery care. In Kennedy’s study, midwives attempted to construct relationships based on mutuality by recognising the knowledge that women brought to the clinical situation. However, it required them to be open with women and at times, entailed personal disclosure.

Leaving an abuser can create new risks and ongoing support is needed to help women maintain changes in their lives. In our study, women who ended their abusive relationship faced multiple challenges in re-building their lives and some felt ill-equipped to negotiate services and deal with ongoing problems. Kelly and Humphreys (2001) argue that negotiating with bureaucratic organisations can be a disempowering experience for abused women. Without the safety net of helping agencies and ongoing risk assessment women may be more vulnerable to returning to their abuser (Humphreys & Thiara, 2002). Post-abuse IPV advocacy services need to be developed and promoted in communities to assist women in the re-establishment of a safe home and community life for themselves and their children.

**Key points**

* Parenting and early childhood development programmes provide opportunities for supporting women and children affected by IPV. The ongoing relationships with care providers are likely to facilitate disclosure and enhance opportunities to support healthy changes in families affected by IPV.
* Paraprofessionals, nurses and other licensed practitioners involved in delivering these programmes require initial and reinforcement training activities in how to recognise and respond to women and children affected by IPV.
* Programmes should consider utilising culturally fluent care providers with whom the target population can identify with.
* Mechanisms are needed to support the resilience of care providers, who may find that in addressing abuse with their clients they must also process their own experiences of IPV.
* Further research is needed to explore the types of intervention that may benefit women at different stages of an abusive relationship.

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