Pregnant and Parenting Battered Women Speak Out about their Relationships and Challenges

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ABSTRACT. Domestic violence is one of the leading health risks to women in the United States. Abuse during pregnancy increases the negative health consequences for mothers and their unborn children. This article presents survey and open-ended interview data from participants in an innovative program for pregnant and parenting battered women and examines the health status of mothers and newborns, their experience and

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perception of both physical and nonphysical abuse, and their challenges to prenatal care.

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Domestic violence is one of the leading health risks to women in the United States. For pregnant and parenting women living with an abusive partner, the risk to their safety and the outcome of their pregnancies, as well as the risk to their children, increases dramatically (Bohn & Parker, 1993). In this article, preliminary data from a multimethod evaluation of an innovative program for pregnant and parenting battered women are presented that focus on overall health of mothers and their children, challenges to prenatal care, level of physical and nonphysical abuse in their lives, and their perceptions of that abuse. Participants' stories illustrate how these women think about their pregnancies and relationships, the interpersonal violence that is part of those relationships, and their need for support and services.

BACKGROUND

Each year in the United States, an estimated 2 million women are physically assaulted by their boyfriends, husbands, or male partners, and it is estimated that more than 50 million women will experience intimate partner violence at some time in their lives (Tjaden & Thoennes, 2000). Many of these women are pregnant, but little is known about this especially vulnerable group of women and children (Gazmararian et al., 1996; Halvorson, 2000; Jasinski, 2004; Stewart & Cecutti, 1993). The negative health consequences of battering for women and their unborn children are well documented (Campbell, Oliver, & Bullock, 2000; Cokkinides & Coker, 1998; Jasinski & Kaufman Kantor, 2001; Johnson, Haider, Ellis, Hay, & Lindow, 2003; Renker, 2003; Webster, Sweett, & Stolz, 1994). Gazmararian et al. (1996) synthesized the findings from 13 prevalence studies and reported that prevalence rates of intimate partner abuse during pregnancy range from approximately 1% to 20%. The following sections focus on the risks of violence that pregnancy presents, the impact of violence on pregnancy, and how pregnant women cope with violence.

Pregnancy and Violence

Research on whether pregnancy puts women at increased risk for violence at the hands of their intimate partners is inconclusive (Jasinski, 2004; Mahoney, Williams, & West, 2001). A body of research indicates that for some women, pregnancy may be a time of increased risk for intimate partner violence (Berenson, Stiglich, Wilkinson, & Anderson, 1991; Campbell, Soeken, McFarlane, & Parker, 2000; Smikle, Sorem, Stain, & Hankins, 1996; Webster et al., 1994). Campbell, Oliver, et al. (2000) outline a variety of reasons why men may be motivated to commit violence against their pregnant partners: jealousy of the infant, anger at the pregnancy, anger toward the infant, and as part of their regular pattern of violence and control. Other research indicates that pregnancy does not necessarily put women at higher risk for intimate partner violence (Gelles, 1990; Jasinski, 2001; Kaufman Kantor, Jasinski, & Aldarondo, 1994). For some women, pregnancy may be a time of respite from physical violence. Whether the pregnancy was planned, the degree of social and economic support reported by women, age, race, ethnicity, and substance abuse have all been found to be associated with violence during pregnancy (Jasinski, 2001).

Impact of Violence on Pregnancy

Interpersonal violence during pregnancy is associated with possible detrimental maternal behaviors and circumstances such as delayed prenatal care (Huth-Bocks, Levendosky, & Bogat, 2002; Parker, McFarlane, & Soeken, 1994; Parker, McFarlane, Soeken, Torres, & Campbell, 1993). However, Huth-Bocks and colleagues (2002) found that interpersonal violence was not significant once income was controlled for. Violence during pregnancy is also associated with depression (Amaro, Fried, Cabral, & Zuckerman, 1990; Bacchus, Mezey, & Bewley, 2003; Horrigan, Schroeder, & Schaffer, 2000), substance abuse (Amaro et al., 1990; Grimstad, Schei, Backe, & Jacobsen, 1997; Huth-Bocks et al., 2002; Kodituwakku, Kalberg, & May, 2001; Martin, Beaumont, & Kupper, 2003; Parker et al., 1994), poor nutrition (Bohn & Holz, 1996), and cigarette smoking (Dye, Tollivert, Lee, & Kenney, 1995; Grimstad et al., 1997; Parker et al., 1994). Moreover, women who experience interpersonal violence during pregnancy are at risk for low birthweight babies (Bohn & Parker, 1993; Curry & Harvey, 1998; Grimstad et al., 1997; Huth-Bocks et al., 2002; Kearney, Munro, Kelly, & Hawkins, 2004; Parker et al., 1994), premature labor and birth (Huth-Bocks et al.,

2002; Neggers, Goldenberg, Cliver, & Hauth, 2004; Wang & Chou, 2003), obstetric complications (Bacchus et al., 2003), low maternal weight gain (Parker et al., 1994), infections (Parker et al., 1994), and homicide (Campbell, Soeken, et al., 2000). Battered pregnant women also report more stress and "overload" (Curry & Harvey, 1998), less support from partners (Curry & Harvey, 1998), less overall social support (Amaro et al., 1990; Huth-Bocks et al., 2002), and less happiness about being pregnant (Amaro et al., 1990) than other pregnant women.

Coping with Violence During Pregnancy

Although there is extensive research on the negative consequences and outcomes of violence during pregnancy, little is known about how pregnant and parenting battered women perceive their relationships and cope with the violence in their lives (Cloutier et al., 2002). Most battered women express a desire for their partner's violence to stop (Cloutier et al., 2002) but do not necessarily want to leave their partners or know if leaving will solve their problems (Busch, 2004). The stay/leave decision-making process may be particularly difficult when a woman is pregnant. Understanding a battered woman's decision-making process (Busch, 2004) is particularly important information for health care workers, social workers, counselors/therapists, and other professionals who might be in positions to assist battered pregnant and parenting women (Sleutel, 1998).

To address this gap in the literature, the current research provides data from an innovative program for pregnant and parenting battered women and focuses on their health status and the health of their newborns, how they define and experience abuse, and their challenges to prenatal care. It focuses on some of the areas that domestic violence and health providers need to address with pregnant and parenting battered women.

METHODS

The data for this paper were drawn from a multimethod case study evaluation of an innovative program for pregnant and parenting battered women. A case study allows for the in-depth analysis of a bounded system through multiple data sources (Creswell, 1998). The project, which began in February 2002, provides education and support services to battered women who are pregnant or postpartum, including an aftercare component offering case management, domestic violence and parenting education,

and social supports to mothers who have been in abusive situations. From 2003 to 2005, the project served 190 pregnant or parenting clients. Although the focus of the program is on pregnant or parenting women, these statistics include three teen fathers who were experiencing abuse and attended support groups. The majority of program clients were Hispanic (64%), 13% were Anglo, 19% were African American, and 4% were identified as "Other." Fifty-two percent of clients were between the ages of 14 and 19, 40% were between 20 and 34, and 6% were over 35 years of age.

For this evaluation, survey data were collected from participants who received services (n = 62) and open-ended interviews were conducted with four participants. The university Institutional Review Board (IRB) approved this study for the protection of human subjects and all participants gave informed consent.

Research Design and Questions

The original design of this study involved collecting data from participants at more than one trimester to allow for insight into how levels of violence, needs, and other aspects related to health and well-being changed for these women over time. However, the crises that many of the program's clients found themselves in made it challenging for them to make their appointments and made completing multiple surveys over time nearly impossible. Therefore, this study contains descriptive cross-sectional data. The results presented in this article focus on five research questions: (a) What challenges did program participants experience with regard to prenatal care? (b) What was the status of their health? (c) What was the status of their newborns' health? (d) What was their perception and experience of nonphysical abuse? and (e) What was their perception and experience of physical abuse in their lives?

Recruitment of Participants and Description of the Sample

Program staff from the collaborating agency recruited pregnant and parenting battered women for participation in this study. This nonprobability, purposive sampling resulted in 62 pregnant and parenting battered women who completed the survey. A convenience sample of four women participated in open-ended interviews. Participants received a $15 gift card to a local grocery store for their time and participation in the first wave of data collection and personal care items during the second wave of data collection. Development of the instruments and data collection

occurred from March 2003 to February 2004. A second wave of data collection occurred between March 2005 and December 2005. The survey was available in English and Spanish.

The average age was 22 years (*SD* = 6), with a range of 15 to 39 years old. Of those who provided demographic information, women who were 20 and older (47%) made up a larger portion of participants than women who were between 15 and 19 years old (42%). The majority of the women who participated identified themselves as Hispanic (55%). A smaller percentage of African American (21%), Anglo (15%), and women who identified as Other (5%) also participated. The highest portion of participants resided in a shelter for battered women (39%), with a smaller percentage of women who lived alone or with their child (19%), resided with family members (16%), with child's father (14%), with friends (5%), or with family and their partner (3%). Although roughly representative of the program demographics, the survey underrepresented Hispanics and clients aged 19 and under.

Instrumentation

The survey included 23 *yes*/*no*/*don't know* questions about participants' general health status and well-being as well as their health practices; 24 questions about their newborn's health; and 18 questions about the mothers' health during delivery and birth, all adapted from Huth-Bocks et al. (2002). Thirty-two Likert-scale questions that assessed participants' experience of both physical and nonphysical abuse in their relationship were asked, drawing on similar questions from Tolman (n.d.), Mitchell (1999), and the New York State Department of Public Health (2002). They were also asked about their perception of these behaviors as abusive. The survey also included three demographic questions. In addition, the questionnaire included four open-ended questions about their concerns about the baby and their pregnancy, eight *yes*/*no* or short answer questions about use of prenatal care, and four Likert-scale questions about access to prenatal care. Likert-scale questions were originally asked utilizing a 7-point scale, but for analysis purposes were collapsed to a 5-point scale ranging from 1 (*Never*) to 5 (*Constantly*). Percentages were aggregated and reflected participants who reported *sometimes*, *frequently*, or *constantly* to each of these questions.

Each open-ended interview lasted approximately 30 minutes and focused on how the participant felt about her pregnancy, her relationship with her partner/baby's father and its effect on her pregnancy, and her

participation in the agency program. Each interview was audiotaped and transcribed verbatim.

Data Analysis

Both the quantitative and qualitative data were analyzed to answer the research questions. The survey data were analyzed and the results are presented descriptively. Due to the small number of in-depth interviews, these data are used for illustration only.

RESULTS

In the following section, qualitative and survey data illustrate the participants' challenges to prenatal care, health of mothers and babies, and participants' perception and experience of both physical and nonphysical abuse.

Research Question 1: Challenges to Prenatal Care

Nearly half of the women who answered this question reported that they sometimes, frequently, or constantly had difficulty going to prenatal appointments because they did not have childcare (46%) and/or reliable transportation (41%). Thirty-four percent of the participants' partners refused to provide childcare while they visited their physicians and 21% reported that their partners kept them from their appointments.

One of the women who participated in the open-ended interviews illustrated some of the challenges that these women face in accessing prenatal care. Mary had a history of abuse with her husband, the father of her children. They had received family counseling and the abuse ceased for a while but resumed when Mary discovered she was pregnant again. Mary said that her husband:

> . . . made my 7 months of pregnancy very bad, I mean very stressful. I mean, he did everything in his power to make sure that I, you know, was stressed out all the time. . . . When I'd ask him to go to the doctor with me he said, "Haaaa, no. Ride the bus." He would never go to the doctor with me. . .

This lack of support and sometimes active prevention by abusers, coupled with the lack of necessary supports such as transportation or childcare for

other children, may make it hard for pregnant battered women to get the prenatal care they need to deliver healthy babies.

Research Question 2: General Health Status and Well-Being of Women

Generally, program participants reported good health and maintained good health practices. Few reported drinking alcohol, smoking cigarettes, or taking other nonprescription drugs. Only a small minority of women reported serious health conditions such as high blood pressure, infections, albumin, toxemia, blood incompatibility, syphilis, gonorrhea, herpes, or streptococcus. A small percentage of women (2–8%) indicated that they did not know about their health status with regard to these conditions.

Although not common in this study, one participant did give an example of the effects that have been documented in previous studies that abuse can have on a mother's health and pregnancy. Sierra's boyfriend became violent when he found out she was pregnant because "he thought I was trying to trap him." She told medical personnel about the abuse and they helped her get into the shelter. After 3 weeks, she went back to her boyfriend. Their living situation and relationship were very unstable; there was more abuse and she eventually came back to the shelter. Sierra said,

> I have a feeling that if I wasn't so stressed out I would be so much bigger right now, because I don't have an appetite because of all this stress and everything. Other than that I really don't think it's affecting the pregnancy too much.

The program attempted to address the health issues these mothers faced. Mary, mentioned earlier, reported that the program counselors gave her useful information about ". . . things that would make me healthy and foods I could eat and medicines I could take." The information provided by program counselors about both healthy pregnancy and domestic violence helped mothers improve their chances of staying healthy during pregnancy and delivering healthy babies.

Research Question 3: General Health Status and Well-Being of Newborns

Participants were asked about their child's health immediately following the birth and again at 2 months of age. Generally, mothers reported

that their children were born without major complications and remained healthy into their second month. A minority of mothers reported that their children experienced poor feeding/sucking (11%) at or during birthing; 11% of mothers reported their children experienced shakiness, colic, or heart trouble; 17% reported their children experienced seizures; and 19% reported jaundice by age 2 months. An example from the open-ended interviews illustrates how domestic violence may cause problems for newborns. After an assault during the fourth month of her pregnancy, Mary called the police, obtained an emergency protective order, and separated from her husband. As a result of the stress and abuse, Mary's child was born 2 months early. Mary's husband continued to harass her, but she felt safe because she lived in supportive housing. She said if she were living alone "I'd be terrified." She said that her counselor " . . . tries to make me understand there's nothing I did wrong to make the baby be born premature. It's just something that happens." Program counselors address both the physical and psychological problems caused by abuse during pregnancy.

Perceptions and Experience of Nonphysical Abuse

As part of the survey, participants were asked about their perception and experience of nonphysical abuse in their relationships. These results are presented in Table 1. In general, these data reveal that participants were experiencing significant levels of nonphysical abuse. In all but three of the categories, large percentages of women reported nonphysically abusive strategies by their partners, such as yelling and screaming at her (75%), calling her names (67%), wanting to know her whereabouts at all times (56%), jealousy (66%), accusing her of having an affair (58%), blaming her for his problems (63%), and trying to make her feel crazy (66%). These strategies were most often directed toward the women, but several of the abusive behaviors were also directed toward the women's other children. Moreover, it appears that many of these abusive partners abuse alcohol and drugs (56%).

Participants were also asked whether they perceived these behaviors as abusive. There was substantial variation among the responses. A small percentage of women indicated that these behaviors were not abusive (ranging from 3% to 31%). A partner's arrest for a drug offense was seen as the least abusive trait. Thirty-one percent of the women indicated that being arrested for a drug offense was not abuse, 25% were not sure if this was abuse, and 44% indicated it was abuse. A high percentage of women

TABLE 1. Experiences and perceptions of levels of nonphysical abuse (N = 62)

Behavior	Experienced Behavior (Percent)*	Perception of Behavior(%)		
		Not abuse	Not sure	Abuse
Arrested for drug offense	12	31	25	44
Asked family members to watch or report on me	27	8	10	82
Criticized me or children	56	5	12	83
Prevented from taking medication	18	5	10	85
Refused to let sleep	41	7	10	83
Abused drugs/alcohol	56	12	17	72
Ignored feelings/withheld approval, appreciation	50	3	17	80
Punished children when mad at me	13	5	7	88
Called me names and swore	67	5	10	85
Yelled and screamed	75	3	12	85
Wanted to know whereabouts at all times	56	5	17	78
Spent money/made financial decisions without consultation	49	8	25	67
Jealous/suspicious of friends or family	66	9	15	76
Accused me of having an affair	58	10	17	73
Kept me from seeing friends or family members	49	7	13	80
Tried to keep me from self help	49	8	5	87
Kept me from using the phone	43	3	17	80
Blamed me for his problems	63	3	12	85
Tried to make me feel crazy	66	3	10	87

*The questions were analyzed utilizing a 5-point Likert-type scale (1 = *never*; 2 = *rarely*; 3 = *sometimes*; 4 = *frequently*, and 5 = *constantly*). Percentages were aggregated and reflect participants who reported *sometimes*, *frequently*, or *constantly* to each of these questions.

perceived overtly controlling behaviors by the intimate partner as abusive. These included situations in which the partner asked family members to watch and report on her (82%), criticized her or her children (83%), prevented her from taking medication (85%), and refused to allow her to sleep (83%).

Sylvia, a program participant, reflected on how hard it could be for women to identify abuse, whether physical or nonphysical, in their lives.

Her pregnancy was the result of a sexual assault by a stranger. At the time of the assault, Sylvia was homeless and her assailant had given her a ride. Sylvia is a bright woman with a college education but had a long history of abusive relationships, instability, and homelessness. She wondered if somehow she had caused the abuse. Sylvia said that talking with her program counselor helped her understand that what happened to her was a sexual assault and that it was not her fault. Although Sylvia's situation was uncommon, the challenges of identifying nonphysical abuse as abuse appeared to be a common experience in many participants' relationships.

Research Question 5: Perceptions and Experience of Physical Abuse

Table 2 represents participants' perception and experience of physical abuse. There was much less variability among the women on the indicators

TABLE 2. Experiences and perceptions of levels of physical violence or threat of physical violence (*N* = 62)

Behavior	Experience of Behavior (Percent)*	Perception of Behavior (Percent)		
		Not abuse	Not sure	Abuse
Pushed, grabbed, choked or kicked	64	5	3	91
Been arrested for assault	13	10	27	63
Forced sexual activity	38	5	3	92
Threatened me, my children, or someone close to me	43	5	3	92
Forced to do something	45	5	3	92
Hurt pets, clothing, objects, something I cared about	39	5	7	88
Threatened pregnancy	24	5	3	92
Threw or broke objects during arguments	48	5	15	80
Kept from leaving the home	48	7	8	85
Used or threatened weapon against me	27	5	5	90
Threatened to hurt me or children	45	5	7	88

*The questions were analyzed utilizing a 5-point Likert-type scale (1 = *never*; 2 = *rarely*; 3 = *sometimes*; 4 = *frequently*, and 5 = *constantly*). Percentages were aggregated and reflect participants who reported *sometimes*, *frequently*, or *constantly* to each of these questions.

of perception of physical violence. On each indicator, only 5–10% of women indicated that that these behaviors did not constitute abuse, whereas the majority of women indicated that they were abusive. Fifteen percent were not sure if the indicator "threw or broke objects during an argument" was abuse and 27% were not sure if the indicator "been arrested for assault" constituted abuse or not. However, on every other indicator, the women overwhelmingly reported that these behaviors were abusive.

Women participating in this study also reported a substantial level of physical violence in their intimate partner relationships. Almost two thirds (64%) had been pushed, shoved, or kicked by their partners. Over 40% had been threatened in some way, been forced to do something against their will, had objects thrown at them or broken, or been kept from leaving home. Over one third had witnessed injury to pets, damage to belongings, or been forced into sexual activity. Although the women indicated dangerous levels of physical violence, only a small percentage (13%) of their partners had been arrested for their assaultive behaviors.

Juana and her partner had been together for 2 years and had one child together. During those 2 years, Juana experienced verbal and emotional abuse from her partner and he occasionally pushed her. The police were called when they finally split up. Juana's boyfriend was arrested and had been in and out of jail since their separation. After they separated, Juana discovered she was pregnant. Juana's work with her program counselor focused on

> . . . the baby and where the baby should be as far as developmental stages and me and their father and what I plan on doing when he did get out of jail, you know, when he actually stayed out of jail. That's pretty much it — how the relationship was, how I wanted it to be and what I want as far as my future — what I wanted to happen to me. . . . I realize there was a lot more that I wanted for myself and my kids than what I was actually doing, ya know?

With the support of program staff, Juana was able to stay safe and gained resources to help her make the best decisions for her family.

In summary, these findings indicate that participants surveyed were in good health and maintained good health practices, and that their children were born without major complications and remained healthy into their second month. However, the women's access to prenatal care was often blocked by lack of childcare or transportation, or their partner preventing

them from seeking prenatal care. These women were experiencing significant levels of physical and nonphysical abuse.

DISCUSSION

The results of this study suggest that pregnant and parenting battered women have complex needs that call for medical and social service providers' attention. Participants reported significant levels of both physical and nonphysical abuse and they experienced a range of barriers, including homelessness, fear of their partners, and lack of access to prenatal care that complicated their pregnancies. Although the survey data do not specifically address the issue of whether pregnancy puts women at risk for abuse, the open-ended interviews reflect the divergent findings in the literature regarding whether pregnancy initiates violence. For some women pregnancy may initiate battering (Berenson et al., 1991; Campbell, Soeken, et al., 2000; Smikle et al., 1996; Webster et al., 1994) and for others, it may not (Gelles, 1990; Jasinski, 2001; Kaufman Kantor et al., 1994). Further research is needed to determine under what conditions pregnancy initiates violence.

Unlike other research (Bacchus et al., 2003; Bohn & Parker, 1993; Curry & Harvey, 1998; Grimstad et al., 1997; Huth-Bocks et al., 2002; Kearney et al., 2004; Neggers et al., 2004; Parker et al., 1994; Wang & Chou, 2003) that outlines an array of negative consequences for childbirth and the health of mother and newborn, the participants surveyed indicated that they used good health practices and their children were born without major complications and remain healthy. Without a comparison group, it is impossible to determine if this is significant. It is possible that this finding may have been the result of self-report and social desirability, which would encourage mothers to minimize the reported impact of their abuse on their health and the health of their infants. It may have also been the result of their participation in a program designed to meet the needs of pregnant and parenting battered women. Although the health trends for these mothers and children were positive, one of the mothers interviewed talked about intimate partner abuse that led to the premature birth of a child with significant health problems. This supports the notion that women and their unborn children who experience abuse during pregnancy are at risk.

Most of the women participating in this research indicated that they experienced nonphysical abuse during their pregnancies. This has been a

relatively ignored area of research. Abusers use a number of strategies to maintain power and control over their victims, most of which do not involve physical violence (Bancroft, 2002). A comprehensive definition of domestic violence should include both physical acts of violence and control as well as nonphysical acts that demean or terrorize victims (O'Leary & Maiuro, 2001).

The finding that abusive partners directed abuse toward both their partners and the women's children indicates that practitioners should attend to all types of abuse in the lives of pregnant and parenting battered women and critically assess what strategies might be most prevalent in her relationship. Further, many participants (56%) reported that their partners were abusing alcohol and other drugs. Research on alcohol use and abuse indicates a strong correlation between the use of alcohol and increased physical aggression (e.g., Collins & Messerschmidt, 1993).

To address the problems that pregnant and parenting battered women face, medical, mental health, and social service providers need to engage in an array of outreach and training efforts to the medical community and other agencies serving pregnant and parenting women. Such programs need to address the complex needs of pregnant and parenting battered women with a comprehensive, flexible program of support. These services need to address not only issues of safety planning, but also of health information. Providers of services to pregnant and parenting women, such as Women, Infant, and Children programs, prenatal health clinics, pediatric clinics, and welfare offices, need to screen for domestic violence and make appropriate referrals. Domestic violence agencies need to be informed about the health risks to both mother and child when abuse is occurring during pregnancy so that they can adequately explain the risks to pregnant battered women. Because many of these women are prevented from accessing prenatal care, domestic violence programs could create greater access to this service, perhaps by co-locating with health clinics or having health providers in shelters. Training and outreach to health providers is also needed so that health professionals can adequately detect and address domestic violence in patients. Health care providers may feel more comfortable addressing these issues with patients if they feel more informed. Most importantly, providers need to understand how pregnant and parenting battered women perceive their relationships and what they want for themselves and their children, thus coming to a better understanding of the ways in which they can help.

The results of this study must be considered within its limitations. It reflects many of the challenges of practice-based research. It was hoped that data could be collected from clients over time to examine changes in behavior and attitudes that might indicate program effectiveness. However, participation in a research project seemed to be a low priority for pregnant and parenting participants who were experiencing abuse. Participants routinely missed appointments with staff, so scheduling appointments for data collection was daunting. Therefore, it cannot be determined whether these findings reflect the impact of the program in which participants were enrolled. In addition, a substantial percentage of participants were Spanish-speaking and although the survey was translated into Spanish there was not enough funding to hire Spanish interviewers and transcribe open-ended interviews. Due to concerns about participants' safety, they were not re-contacted to review and comment on the findings of the open-ended interviews, as is often done with qualitative research to ensure its trustworthiness. Therefore, it is important to understand that these findings represent a small portion of pregnant and parenting battered women. They may underrepresent the experiences of Hispanics and teen parents. Given the challenges in recruiting participants, it is likely that these results may also underrepresent clients with more difficult life circumstances who might have been less likely to participate in research. Despite these limitations of practice-based research, this study illustrates some of the experiences of pregnant and parenting women experiencing domestic violence and highlights issues that service providers should attend to with this group of clients.

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