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# Women's Experiences of Accessing Breastfeeding and Perinatal Health Support in the Context of Intimate Partner Violence: An Interpretive Description Study

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Nursing

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## ABSTRACT

Background: Women experiencing intimate partner violence are at a heightened risk of negative perinatal and breastfeeding outcomes. This study explored the experiences of accessing breastfeeding support for women who endorse a history of intimate partner violence. A study of five in-depth semi-structured interviews were completed at 12-weeks postpartum with breastfeeding mothers with a history of intimate partner violence. Findings: Women expressed difficulties in accessing a healthcare provider who had specialized skill in breastfeeding support. Trust in their healthcare provider, built through displays of compassion and competence, was important to mitigate obstacles experienced during care access for this population. Trauma-and-violence-informed care principles were beneficial to the development of the therapeutic relationship in perinatal care. Women placed value on breastfeeding support received from both healthcare providers and social supports, which impacted mothers' perceived breastfeeding support and self-efficacy. Further, mothers described increased levels of breastfeeding self-efficacy after engaging in a trauma-and-violence-informed care program aimed at supporting breastfeeding. Conclusions: Trauma-informed care may aid in the development of trust in the therapeutic relationship, which in turn impacts access to breastfeeding support and breastfeeding self-efficacy. The inclusion of trauma-and-violence informed principles in perinatal care may be effective at mitigating barriers to access for women who endorse a history of intimate partner violence. health care on how to employ trauma-informed breastfeeding care to may lead to better support for this population.

**Keywords:** intimate partner violence, breastfeeding, access to health care, perinatal health care, trauma-and-violence-informed care, interpretative description, qualitative

## SUMMARY FOR LAY AUDIENCE

In Canada, roughly 35% of women experience intimate partner violence (IPV) at some point in their lifetime, costing the Canadian economy roughly \$10.6 billion dollars in victim, health care, legal, and criminal costs. For mothers and pregnant women, their risk of experiencing IPV can increase, leading to many health and wellness consequences for both the mother and the infant. Despite having similar desires to breastfeed as women who do not experience violence, women who experience violence perinatally are less likely to breastfeed their infants, breastfeed for a shorter duration, and report more difficulties with breastfeeding. It is unclear how IPV impacts women's decisions or experiences with breastfeeding. Receiving healthcare during pregnancy and breastfeeding education has been shown to help women who have experienced IPV meet their breastfeeding goals, but women are less likely to access this type of care if they are experiencing violence. Women who experience violence are less likely to receive health care during their pregnancy and go to fewer health care appointments overall. It is poorly understood why women who experience violence have a more difficult time accessing health care and breastfeeding supports, as limited research is available that has explored this. Through this study, we spoke to women who experience IPV about their experiences of receiving health care and breastfeeding support in order to better understand their experiences. By increasing access to health care services that are trauma and violence informed, we can assist women who experience IPV in obtaining the breastfeeding support they need to achieve their breastfeeding goals.

## CO-AUTHORSHIP STATEMENT

The completion of my thesis has been a labour of love that would not be possible without the overwhelming support received from my supervisor and co-authors. My supervisor, Dr. Kimberley Jackson: I am truly grateful for you. Your guidance and support – emotional, informational, and otherwise – has been integral to my journey in completing this study. Thank you for including me in your research team and fostering my passion for women’s health. My co-authors – Dr. Tara Mantler, Dr. Brenna Velker, and Dr. Shauna Burke – were essential to the completion of this study through their continuous support and guidance. My research partner Emila: thank you for your support through the recruitment, data collection, and analysis phases of this study. To the Women’s Health Matters Research (WHRM) team: thank you for your informational and practical support through this process. Again, thank you all for your support and guidance. I am thankful for each and every one of you.

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## LIST OF ABBREVIATIONS

PNC/PNC	Perinatal care
EBF	Exclusive breastfeeding
FP	Family physician
HCP	Health care professional
ID	Interpretive description
IF	Intersectional framework
IR	Interactive-relational approach
IPV	Intimate partner violence
MD	Medical doctor/Physician
NP	Nurse practitioner
PNC	Prenatal care
PWC	Postnatal wellness centre
RN	Registered nurse
SES	Socioeconomic status
TVIC	Trauma-and-violence-informed care

## CHAPTER 1

### INTRODUCTION

#### **Background and Significance**

Intimate partner violence (IPV) describes a pattern of physical, emotional, sexual, and/or psychological violence against an intimate partner that has the potential for serious negative psychological, emotional, and physical health consequences (Tjaden & Thoennes, 2000b; World Health Organization, 2011). Behaviours consistent with IPV are vast and can include emotional abuse, such as name calling or insulting (Sinha, 2011), extreme controlling behaviours inclusive of intimate terrorism (Lysova, Dim & Dutton, 2019), sexual assault, and/or physical abuse such as common assault, battery, and homicide (Sinha, 2011). Intimate partner violence remains one of the most common and serious public health concerns for women across the world. In Canada, 35% of all women experience IPV within their lifetime (Bruckert & Law, 2018). Despite the estimation that 78% of IPV goes unreported to police (Zorn, Wuerch, Faller & Hampton, 2017), IPV represents about 30% of all police-reported violent crimes in this country (Burczyka, 2017; Sinha, 2011). Intimate partner violence can result in longstanding negative physical, emotional, and psychological health consequences for women (Ford-Gilboe et al., 2009). Physical injuries from the violence itself, including broken bones, bruises, and cuts (Black, 2011), as well as dysfunctions of the gastrointestinal, cardiovascular, endocrine, neurological, and reproductive systems (Black, 2011; Campbell & Lewandowski, 1997; Silverman et al., 2006) can result from IPV. Women experiencing IPV are also at an increased risk for mental health challenges, with depression (Black, 2011; Campbell & Lewandowski, 1997), post traumatic stress disorder (Black, 2011; Rivara et al., 2007; Silverman et al., 2006), and anxiety (Black, 2011, Rivara et al., 2007; Silverman et al., 2006) as the most reported mental health sequelae. Justice Canada

estimated that in 2009, IPV cost Canadian society roughly \$7.4 billion in costs, such as pain and suffering, counselling expenses, legal expenses, and costs within civil, criminal, and social services systems (Zhang et al., 2013). In 2013, this number increased to approximately \$10.6 billion (McInturff, 2013).

When a woman is pregnant, her risk for IPV can increase (Campbell & Lewandowski, 1997; Silverman et al., 2006). In a comprehensive review of the literature, it was found that anywhere between 1% and 20% of pregnant women experience some form of IPV (Gazmararian et al., 1996), with widely varying prevalence rates based on differences in screening techniques and reluctance to disclose IPV while pregnant (Rennison, 2000). While pregnancy can be shown to be a protective factor against violence for approximately one-third of abused women, approximately 15% of pregnant abused women report that violence either started or worsened significantly during their pregnancy (Campbell, Oliver, & Bullock, 1998). Internationally, between 4% and 12% of women experience at least one form of IPV during their pregnancies (Devries et al., 2010; World Health Organization, 2011). Data exploring at-risk women (defined in this study as women who are under the age of 25, have low income, have experienced IPV, and/or perceive a lack of social support) have found that women of lower socioeconomic status (SES), and/or from developing nations report a prevalence of IPV during pregnancy up to 50% (Bailey, 2010; Bailey & Daugherty, 2007; Shamu, Abrahams, Temmerman, Musekiwa & Zarowsky, 2011; World Health Organization, 2011). For single women under the age of 20, the risk for IPV during pregnancy doubles (Saltzman et al., 2003).

The consequences of IPV are profoundly complex at the individual, cultural, medical, and societal levels and can have compounded negative impacts on the woman's perinatal health, the health of her fetus, and overall birth outcomes. For mothers, inadequate weight gain (Nunes,



Camey, Ferri, Manzolli, Manenti & Schmidt, 2011), high blood pressure, vaginal bleeding, severe nausea and vomiting, increased hospital visits during pregnancy (Campbell & Lewandowski, 1997; Silverman et al., 2006), placental abruption, preeclampsia (Black, 2011; Campbell & Lewandowski, 1997; Lipsky, Holt, Easterling & Critchlow, 2003; Silverman et al., 2006) and major depressive symptoms (Jackson, Ciciolla, Crnic, Luecken, Gonzales & Coonrod, 2015; Tiwari et al., 2008) are some of the serious health concerns associated with IPV during pregnancy. At-risk women, including those who experience IPV, are less likely to initiate breastfeeding (Statistics Canada, 2019), less likely to breastfeed exclusively, and are more likely to cease breastfeeding earlier than women who are not at-risk (Misch & Yount, 2014; Schmied et al., 2012). Pregnant women reporting IPV during their pregnancy are more likely than pregnant woman who do not report IPV to be hospitalized for mental health or substance abuse diagnoses (Lipsky, Holt, Easterling & Critchlow, 2004). As well, women who are exposed to violence during pregnancy report a higher incidence of negative pregnancy symptoms and score significantly higher on the Pregnancy Symptoms Index than women who do not experience violence during pregnancy (Gürkan et al., 2020). The infants of women who have experienced IPV can experience negative effects as well, such as low birthweight (Nunes et al., 2011; Silverman et al., 2006), fetomaternal hemorrhaging, (Black, 2011; Campbell & Lewandowski, 1997; Lipsky, Holt, Easterling & Critchlow, 2003; Silverman et al., 2006), and perinatal death (Coker, Sanderson & Dong, 2004). Finally, maternal-infant bonding may also suffer when women experience violence both during pregnancy and throughout the postpartum period (Ozcan & Kirca, 2018).

Breastfeeding and decisions around infant feeding methods remain of concern for mothers with histories of IPV. Despite the commonly understood benefits of breastfeeding,

women who have experienced IPV tend to have lower rates of breastfeeding initiation (Caleyachetty et al., 2019; Lau & Chan, 2007; Misch & Yount, 2015; Silverman et al., 2006), exclusive breastfeeding (Caleyachetty et al., 2019; Islam, Baird, Mazerolle & Broidy, 2017; Misch & Yount, 2015; Zureick-Brown, Lavilla & Yount, 2015), and cease breastfeeding earlier (Frith et al., 2017; Miller-Graff, Ahmed & Paulson, 2018; Silverman et al., 2006; Wallenborn, Cha & Masho, 2018) than women who did not experience IPV. As a result of the far-reaching consequences of IPV on mothers, their children, and families, the World Health Organization (2005) has declared IPV a serious, worldwide public health issue, especially in the context of pregnancy.

While it has been established in the literature that IPV has negative consequences for breastfeeding exclusivity, initiation, and duration, the relationship between breastfeeding and IPV is still poorly understood and largely under-studied. Intimate partner violence at any point in the perinatal period can have serious and long-lasting impacts on a woman's breastfeeding decision-making (Wallenborn et al., 2020). Breastfeeding support from health professionals, including perinatal care (PNC) and breastfeeding education, has been shown to significantly improve breastfeeding outcomes for all mothers and their infants (Benedict, Craic Torlesse & Stoltzfus, 2018; Bibbins-Domingo et al., 2016; Lee, Chang & Chang, 2019; Prasitwattanaseree, Sinsucksai, Prasopkittikun & Viwatwongkasem, 2019) and is most effective if it continues throughout pregnancy and the postpartum period (Benedict et al., 2018; Kim, Park, Oh, Kim & Ahn, 2018). Miller-Graff and colleagues (2018) found pregnant women who experienced IPV and were exposed to prenatal breastfeeding education were more likely to initiate breastfeeding and less likely to cease breastfeeding than women who experienced IPV and did not receive prenatal education. Of concern, though, is the rate at which pregnant women who experience

IPV are late to enter or fail to enter PNC where they can receive prenatal and breastfeeding education. Women who experience IPV are more likely to initiate PNC much later than women who do not experience IPV and attend fewer PNC appointments throughout the perinatal period (Islam et al., 2017; Torres, 2016; Quelopana et al., 2008). While some reasons for this delay in care may include restriction of health care access by the abusive partner (Dietz et al., 1997; Islam et al., 2017; Taggart & Mattson, 1996), fear of disclosing and exposing signs of IPV to medical professionals (Dietz et al., 1997; Taggart & Mattson, 1996), and women's isolation from their support systems, studies examining this phenomenon are scarce (Murray et al., 2018). Women who fail to attend PNC or attend fewer than the World Health Organization (2016) recommended four PNC appointments throughout their pregnancy experience more pregnancy complications and adverse birth outcomes (Asundep et al., 2014; Raatikainen, Heiskanen, & Heinonen, 2007; Tucker, Ogutu, Yoong, Nauta, & Fakokunde, 2010). As well, women who do not attend PNC have fewer opportunities to have their pregnancy, IPV, and/or breastfeeding-related concerns addressed with a health care provider, allowing providers fewer opportunities to provide the specific care and support that is needed. For mothers who breastfeed, this could potentially result in underutilization of breastfeeding services that could result in greater rates of initiation, exclusivity, and duration of breastfeeding for this population.

### **Definitions**

The following section will include definitions of important concepts in relation to this study. While there may be multiple definitions of the concepts described, the descriptions provided below will be the operationalized definitions utilized for this study.

**Perinatal care.** Perinatal care is a concept of healthcare involving comprehensive integration of an array of health services spanning all levels and intensity of care during the pre-pregnancy, pregnancy, delivery, and postpartum periods (Evashwick, 1989; Shibanuma et al., 2018).

**‘At-risk’ Women.** For the purposes of this study, at-risk women are women who experience health disparities that put them at an increased risk of experiencing inadequate access to equitable healthcare. Women in this study were considered at risk if they were: under 25 years of age (Dennis, 2006); low income (less than \$31,000 per year; Dennis, 2006), experiencing or had previously experienced intimate partner violence (Cerulli, et al., 2010; Tjaden & Thoennes, 2000), and/or perceived a lack of social support (defined as the assistance and protection given to a woman from her support system of family, friends, and close relationships through acts such as respecting, caring, and sharing of information (Coffman & Ray, 2001; Dennis, 2006; Shumaker & Brownell, 1984; Wortman & Dunkel-Schetter, 1987).

**Intimate partner violence.** Intimate partner violence (IPV) can be conceptualized in many different ways. For the purpose of this study, the operational definition of IPV was taken from Tjaden and Thoennes’ definition (2000a). Conceptualised as violence or aggression that occurs in a romantic relationship perpetrated by one partner towards the other of either; whereby “intimate partner” includes current and former spouses and dating partners of either the same or different gender. IPV can vary in frequency and severity and occurs on a continuum, ranging from one episode that might or might not have lasting impact, to chronic and severe episodes over a period of years. IPV can include four types of behavior: physical violence, sexual violence, stalking, and psychological aggression (CDC, 2018). Physical violence can include forceful contact, hitting, pushing, beating, and physical acts that can result in injury or death. Sexual violence can include coercive sexual contact, using physical behaviours or intimidation to

attempt to persuade someone to perform a sexual act against their will, physically forced sexual acts, and ignoring a partner's objection towards sexual acts (Tjaden & Thoennes, 2000a).

Psychological or emotional violence may include verbal threats, degradation, ridicule, restricting one's social or financial freedoms, and withholding support or affection (Capaldi, Knoble, Shortt & Kim, 2012; O'Leary & Maiuro, 2001; Teten, Hall & Capaldi, 2009; Tjaden & Thoennes, 2000a).

**Socioeconomic Status (SES).** SES is the social standing of an individual or group of people, often based on a combination of their level of education, income, occupation, and quality of life attributes that can cause physical and psychosocial stressors. Socioeconomic status is often examined in terms of inequities in access to supports or resources, or in issues relating to power, privilege, and control. Socioeconomic status is a reliable predictor of physical and psychological health and is relevant to all aspects of behavioural and social sciences, including research, practice, education, and advocacy (American Psychological Association Task Force on Socioeconomic Status, 2007).

**Trauma-and-Violence-Informed Care (TVIC).** TVIC is an approach to practice that acknowledges the relationship between violence, trauma, negative health outcomes, and behaviours in an effort to increase safety, control, and resilience for health-seeking individuals who have experiences of violence or trauma. Approaches to TVIC involves fundamental changes to healthcare providers' approaches to engaging and treating people with histories of violence and in how systems designated to care for people with violent histories are designed, organized, and function. The ultimate goal of TVIC is to minimize the harm that the health system inflicts on the people it serves by increasing understanding of trauma and violence, creating emotionally and physically safe environments, fostering choice, collaboration, and connection, and enacting

strengths-based approaches to support clients' coping and resilience. TVIC includes six principles: (1) physical and emotional safety; (2) trust through transparency; (3) peer support; (4) inclusivity and collaboration; (5) empowerment, voice, and choice; and (6) contextual, historical, and cultural awareness (Substance Abuse and Mental Health Services Administration, 2014; EQUIP Health Care, 2017; Government of Canada, 2018).

### **Research Purpose**

Despite the fact that IPV is prevalent during pregnancy and that it results in complex, multifaceted consequences at the individual, family, and societal levels, inquiry aimed at exploring this phenomenon is lacking (Howell, Miller-Graff, Hasselle & Scrafford, 2017). Research is needed to fill the gap in the current literature exploring the experiences of women with histories of IPV during pregnancy (James, Taft, Amir & Agius, 2014). Further, no studies have been found that seek to examine the experiences of women who are breastfeeding and attempting to access breastfeeding supports while also experiencing IPV. This study aims to explore the experiences of perinatal women who have experienced IPV as they attempt to access breastfeeding and PNC services and supports. Increasing knowledge of how IPV affects and is experienced during the perinatal period could result in the development of care strategies that support breastfeeding women who have experienced IPV to have better access to necessary breastfeeding support services.

### **Self-Reflection**

My interest in improving breastfeeding support for women experiencing IPV first developed when I was in school to become a registered nurse (RN) and had my final placement on a mixed maternal/child/women's health unit in a small community hospital. I was quickly enamoured by the labour department and witnessing infants being born was – and still is – a

highlight of my nursing career. I involved myself in all aspects of intrapartum and postnatal care that I was able to. I found, early on, that the messages that were being given to mothers, especially in regards to infant feeding methods, were inconsistent. Some practitioners would offer out formula samples and bottle feed infants while others were very supportive and encouraging of breastfeeding. In my care of women who with disabilities, of low SES, or were suspected of experiencing violence, I noticed that much of the care they received did not address their health disparities, despite many of them reporting increased barriers to both breastfeeding and attending their postnatal care appointments. It was evident early on in my career that the information that HCPs were providing to women about many aspects of the perinatal period was often confusing, contradicting, and inaccessible to some women.

My interest in PNC and improving breastfeeding support continued into my graduate studies when I was presented with the opportunity to join a research group that focused on creating and disseminating knowledge on women's health issues. I was able to learn about the research projects that my colleagues and research supervisors were undertaking to explore varied areas of maternal and child health. Through these exposures to perinatal women, breastfeeding education, and research into both, my interest grew. In searching the literature in relation to other research projects, I was surprised to find that there was very limited research on breastfeeding education at all, let alone breastfeeding education in relation to marginalized populations of women. I saw my graduate thesis as an opportunity to explore this gap in research and contribute to the growing body of knowledge on IPV during the perinatal continuum. I hope to be able to support and encourage women to be able to make the best decisions for themselves and their families and influence the healthcare system to acknowledge the experiences of these women as true, important, and worthy of exploration.

This research paper explores the qualitative experiences of at-risk mothers with a disclosed history of IPV in navigating the healthcare system during the postpartum period while also attempting to breastfeed their infants. As a cis-gendered, heterosexual woman, I acknowledge that my positionality may allow me to understand some of the experiences of being a woman and attempting to access healthcare services. However, I do not identify as a mother and therefore lack first-hand knowledge of the roles and responsibilities associated with motherhood and infant-rearing. My experiences with these phenomena are purely from an PNC provider and researcher standpoint and I, therefore, lack personal understanding of the thoughts, feelings, and emotions associated with accessing PNC and breastfeeding. As a Caucasian woman pursuing graduate studies who lacks experience with financial or food insecurity, I acknowledge that I am unable to understand the experience of being a racial or ethnic minority, being of low SES, and having inaccessibility to education, as some of my study participants have disclosed.



CHAPTER 2  
LITERATURE REVIEW

**Search Strategy**

The following chapter will discuss the literature review used to guide this study, including the search strategy utilized, the literature review itself, summary of the literature review results, and the research questions associated with this study.

A comprehensive literature review was completed to explore existing research relating to the experience of accessing breastfeeding and perinatal healthcare services for women who are experiencing intimate partner violence. Databases accessed included the Cumulative Index to Nursing & Allied Health Literature (CINAHL), Ovid MEDLINE®, SCOPUS, PubMed, and PsychINFO. Articles were included if they were written in English and were peer reviewed. No date restriction was specified to allow for a breadth of research and seminal works to be found. Key words searched pertaining to breastfeeding, health service access, and IPV were used (see Appendix A). This initial search yielded no results through any database. As very little research has been completed to date that examines how breastfeeding women who experience IPV access perinatal health services, the literature review conducted to guide this study required the variable of breastfeeding to be removed to obtain results. The search was thus modified to include perinatal women experiencing IPV with no direct referencing to breastfeeding.

After this modified search, articles found were title and abstract reviewed for inclusion based upon relevance to the study. Articles were excluded if they did not include pregnant, postpartum or breastfeeding women, if they did not involve women who have experienced IPV in some form, or if they did not focus on healthcare access or barriers to healthcare service utilization. A hand search of reference lists and using a ‘cited by’ function and through the

Google Scholar website was completed as well. Once reviewed for their eligibility in this literature review, eight articles were selected (see Appendix B for literature review PRISMA Diagram). These articles included findings that explored the experiences of both healthcare providers and a variety of perinatal women populations, and explored many different variables and barriers involved in healthcare access for IPV-impacted pregnant and postpartum women. The studies included were of varying methodologies. Half of the articles included ( $n=4$ ) were quantitative, including case-control ( $n=1$ ) (Quelopana et al., 2008), cross-sectional ( $n=2$ ) (Islam, Broidy, Baird, & Mazerolle, 2017; Furuta, Bick, Matsufuji, & Coxon, 2016), and online survey ( $n=1$ ) (Torres, 2016) study designs. The three qualitative studies included critical incident technique ( $n=1$ ) (Bradbury-Jones, Breckenridge, Devaney, Kroll, Lazenbatt & Taylor, 2015a) and focus group methods ( $n=2$ ) (Kulkarni, Lewis & Rhodes, 2011; Pun, Infanti, Koju, Schei, & Darj, 2016). One mixed-methods study (Bradbury-Jones, Breckenridge, Devaney, Kroll, Lazenbatt & Taylor, 2015b) was included that incorporated modified concept mapping methods, as well as qualitative focus group interviews. The studies were conducted in Bangladesh (Islam et al., 2017), Mexico (Quelopana et al., 2008), Nepal (Furuta et al., 2016; Pun et al., 2016), the United Kingdom (Bradbury-Jones et al., 2015a; Bradbury-Jones et al., 2015b), and the United States of America (Kulkarni et al., 2011; Torres, 2016). Five articles examined populations of women who had reported a history of IPV and attempted to access PNC services (Bradbury-Jones et al., 2015a; Furuta et al., 2016; Islam et al., 2017; Quelopana et al., 2008; Torres, 2016), two studies examined healthcare providers and their experiences in providing IPV and PNC services to this population (Bradbury-Jones et al., 2015b; Kulkarni et al., 2011), and one study conducted interviews with multiple community members of mixed genders and family roles about their experiences with IPV (Pun et al., 2016). The studies included examined the

experiences of women who experienced IPV during pregnancy, the health care providers (HCPs) who provided IPV and perinatal care to this population, and community and family members of women who experienced IPV during pregnancy (see Appendix C breakdown of articles in the literature review).

Of the eight articles collected for this literature review, none were conducted in Canada. Further, four of the articles were conducted in developing nations with cultural differences that may not allow the research to be transferrable to the current study. Despite this, these articles were included in this literature review as the current research on the topic of interest to this study is scant and underscores the importance of conducting research on this phenomenon in Canadian and western contexts. Through the examination of these articles, three prevailing themes emerged which highlighted barriers that women experiencing IPV during pregnancy encounter in accessing adequate healthcare during the perinatal period: individual and interpersonal barriers to care, health systems barriers to adequate access to care, and cultural and societal barriers to care.

### **Individual and Interpersonal Barriers to Perinatal Healthcare**

The review of the literature revealed that many of the obstacles that women who experience IPV encountered when accessing PNC stemmed from individual or interpersonal factors. Individual barriers are categorized here as personal life experiences, emotions, attitudes, and behaviours that affect the ways in which the woman who has experienced IPV perceives her level of support and her ability to access PNC within the context of her IPV. Interpersonal barriers can include the prejudices, opinions, perceptions, and behaviours of persons other than the pregnant woman who have experienced IPV that can undermine their access to PNC. The reviewed studies revealed many ways in which individual or interpersonal barriers affect women who have experienced IPV and their access to PNC, including: (a) self identification of IPV

(Bradbury-Jones et al., 2015a; Bradbury-Jones et al., 2015b; Kulkarni et al., 2011), (b) fear and diminished autonomy (Bradbury-Jones et al., 2015a; Furuta et al., 2016; Islam et al., 2017; Pun et al., 2016; Quelopana et al., 2008; Torres, 2016), (c) psychological barriers (Bradbury-Jones et al., 2015b; Islam et al., 2017; Kulkarni et al., 2011; Pun et al., 2016; Quelopana et al., 2008; Torres, 2016), (d) alcohol and substance use (Pun et al., 2016; Torres, 2016), (e) disability and IPV (Bradbury-Jones et al., 2015b; Furuta et al., 2016), (f) families as perpetrators of violence (Islam et al., 2017; Kulkarni et al., 2011; Pun et al., 2016) (g) intergenerational violence (Kulkarni et al., 2011), (h) attitudes towards pregnancy and PNC (Bradbury-Jones et al., 2015a; Quelopana et al., 2008; Torres, 2016) and (i) history and/or contemplation of abortion (Pun et al., 2016; Quelopana et al., 2008). Each of these themes will be discussed in turn.

### **Self-Identification of IPV**

A woman's recognition that she has experienced IPV is important to her ability to access PNC and IPV-related healthcare. Pregnant women may not recognize their experiences as abusive, especially in the absence of physical violence, and tended to 'mask' their experiences to prevent 'outsiders' from knowing about their abuse (Bradbury-Jones et al., 2015b). When they do recognize that they are in a violent relationship, many pregnant women were wary about labelling their experiences as such, for fear of being perceived as incapable as a mother or 'abnormal' (Bradbury Jones et al., 2015b). Kulkarni and colleagues (2011) found this to be a primary barrier to adequate PNC in their sample of pregnant adolescents who experience IPV. In their study, pregnant adolescents viewed emotionally violent behaviours, such as jealousy, controlling, and possessiveness, as expressions of love as opposed to IPV (Kulkarni et al., 2011). Some adolescents who did disclose violence in their relationships thought of themselves as the aggressor and blamed themselves for behaviours that they exhibited that they felt promoted or

led to their abuse. These adolescents tended to dismiss violence as ‘normal’ and when it was identified, tended to justify the abuse based on their own behaviours (Kulkarni et al., 2011).

### **Fear and Diminished Autonomy**

Fear of their partner, increased violence, and the consequences of IPV disclosure were real threats to the autonomy of women who experienced violence during the perinatal period. Perceived lack of control was frequently cited as one of the most important factors impacting a woman’s PNC experience (Bradbury-Jones et al., 2015a). Women who experienced IPV during pregnancy were less likely to receive PNC throughout the perinatal period compared with women who do not (Furuta et al., 2016). Women who experienced IPV frequently cited having their freedoms challenged or removed by their abusive partner and worried about losing control over their care, bodies, families, and infants when considering whether to access PNC (Bradbury-Jones et al., 2015a). Women who experienced IPV had less decision-making autonomy than women who do not experience IPV and endured less freedom to move and manage their financial and logistical futures (Islam et al., 2017). Some women felt that they had to ask for permission before they could access health services (Furuta et al., 2016), were prevented from attending PNC appointments (Islam et al., 2017; Torres, 2016), or were prevented from accessing work or relationships outside of the home (Quelopana et al., 2008). Pun and colleagues (2016) found fear of further abuse from partners was a significant reason for avoidance of healthcare services for pregnant abused women. This was supported by Taggart and Mattson (1996) who found that partners often disallowed abused women from accessing healthcare services to avoid exposure of physical signs of IPV, such as bruises or other injuries. Women often felt helpless to stand up to their partners for fear of further oppression or retribution (Pun et al., 2016). This study found that some women feared that if they were to

speaking out against their intimate partner that it would only increase the violence they would experience, as opposed to staying quiet. Fear was also an important factor in the disclosure of IPV to healthcare providers. Many women feared that disclosing IPV to healthcare providers would result in social services deeming them to be incapable mothers and removing their children from their custody (Bradbury-Jones et al., 2015a; Islam et al., 2017; Kulkarni et al., 2011). Some women who experienced violence from their intimate partner had custody of their children removed because of legal or financial disempowering by their intimate partners (Kulkarni et al., 2011), displaying that the fear of disclosure had very real consequences for mothers. When HCPs failed to listen to or respect the opinions of women during their PNC visits, women's sense of control over their health and their IPV experiences were greatly diminished (Bradbury-Jones et al., 2015a). Thus, it was important for women to feel a sense of control over their bodies and their care during PNC and IPV disclosure (Bradbury-Jones et al., 2015a). Being able to control how, when, and to whom women disclosed their IPV experiences and pregnancies was very important to women (Bradbury-Jones et al., 2015a).

### **Psychological Barriers**

Mental health challenges that can result from IPV, such as helplessness, chronic pain, powerlessness, anxiety, trauma, mental strain, and depression all impeded a woman's ability to access healthcare, especially within the perinatal period (Islam, et al., 2017; Pun et al., 2016; Torres, 2016). For pregnant women experiencing IPV, self-blame was seen as a barrier to obtaining adequate PNC. Kulkarni and colleagues (2011) found that self-blame prevented women from taking their violent situations seriously and prevented them from understanding that violence was not part of a normal, healthy relationship. In general, pregnant women experiencing IPV did not feel well about themselves, reported more family, relationship, and personal

problems, and disclosed that they felt more stress and depression than pregnant women who did not experience IPV (Quelopana et al., 2008).

### **Alcohol and Substance Use**

Alcohol and substance use were significant factors that hindered abused women's access and utilization of PNC. Alcohol and substance use and abuse was reported more often amongst women who had experienced IPV than women who had not. Torres (2016) found 89% of her young adult participants aged 18 to 21 reported alcohol or substance use prevented them from accessing PNC for fears of consequences, such as being reprimanded or having social services become involved in their care. Pun and colleagues (2016) found that increased alcohol and substance consumption by intimate partners was strongly linked with the prevalence of IPV during pregnancy.

### **Disability and IPV**

Pregnant women who identified as disabled not only experienced an increase in IPV but an increase in barriers to PNC both related and unrelated to the presence of IPV. Women with literacy and communication difficulties experienced a reduction in control of their health situation and made screening for, identifying, and responding to IPV more complicated for HCPs (Bradbury-Jones et al., 2015b). Women who identified as disabled whose violent partners also assumed a caregiver role for them faced unique challenges in the disclosure of IPV to their HCPs. Women who received care from and also had violence inflicted upon them by their intimate partner believed that their experiences of IPV would not be believed by their HCPs. Instead, many women believed that their HCPs will be biased towards their partner as helpful and supportive as opposed to abusive because of their role as caregiver (Bradbury-Jones et al., 2015b). Women with disabilities who had economic and physical strength were thought to be

better able to address IPV within their relationships in comparison to women who experienced economic or physical disability or dependency upon their intimate partner. A woman who was more economically advantaged had more power in the form of resources and money to address her IPV. Women who felt dependent financially or socially on their intimate partners due to disability felt that they had limited decision-making autonomy in their homes (Islam et al., 2017) and generally felt powerless to address their abuse and tended to accept their abusive situations as ‘the lesser of two evils’ (Pun et al., 2016). Women with disabilities who were higher educated or had a higher SES reported less abuse during pregnancy than other women with disabilities and were more likely to have adequate maternal care throughout the pregnancy spectrum despite IPV (Furuta et al., 2016).

### **Families as Perpetrators of Violence**

Family members posed a barrier to a woman’s access to PNC and disclosure of her abusive situation. Abused women often experienced a lack of support from family and friends because of their abuse, which in turn restricted their access and utilization of social supports and health services (Islam et al., 2017). Abused women more frequently reported difficulties in their familial relationships, relationships with their employers, and relationships with their HCPs (Islam et al., 2017). Addressing complex family relationship issues was seen as an important factor for HCPs in addressing IPV. Kulkarni and colleagues (2011) found that when parents of pregnant adolescents experiencing IPV normalized violence in relationships, it hindered HCP’s work in addressing IPV and delivering PNC for their clients. Only through mending the complex parent-child relationships could progress be made when working with adolescent mothers to identify IPV within their own situations.



Mothers-in-law were seen in some studies to be very impactful to a woman's experiences of abuse within their intimate partnerships. Many pregnant women in both Bangladesh and Nepal reported relationship difficulties with their mothers-in-law that served to amplify the effects of their IPV (Islam et al., 2017; Pun et al., 2016). While mothers-in-law often thought of their daughters-in-law as the perpetrators of arguments and abuse in the home, both men in the family and daughters-in-law perceived the mothers-in-law to be the main perpetrators of the violence within the relationship. Violence such as bullying, belittling, uttering threats, forced labour, and denial of food from their mothers-in-law were reported by the pregnant abused participants of Pun and colleagues' (2016) study. Physical violence towards pregnant women in Nepal tended to increase from both sons and mothers-in-law during pregnancy in the form of forced labour, withholding of food, and hitting to ensure household work was completed. Mothers often felt pressure from their intimate partner and his family to not go to PNC appointments or even to the hospital for their deliveries. Participants in Pun's (2016) study reported that mothers-in-law questioned why their daughters-in-law would incur the cost of going to an PNC appointment and questioned the value of PNC in general. The Nepali women studied felt pressure from their mothers-in-law to save money by avoiding PNC and putting that money towards post-pregnancy expenses instead (Pun et al., 2016).

In contrast, some of the mothers-in-law in these studies felt that it was their duty to help their daughters-in-law who were experiencing violence from their sons. Some mothers-in-law felt that it was her duty to teach her daughters to become independent and to believe that violence perpetrated against them by their partner was not to be tolerated (Pun et al., 2016). In instances where violence was perpetuated by family members, it was agreed that all family

members hold responsibility to help the pregnant women experiencing the violence and act to intervene against said violence (Pun et al., 2016).

**Intergenerational violence.** Kulkarni and colleagues' (2011) found that violence within adolescent partnerships was strongly associated with intergenerational violence. Intimate partner violence was seen to be intergenerational in that adolescents who observed violence at home from their own parents' relationships were less able to accurately identify IPV within their own relationships and seek services to address their IPV (Kulkarni et al., 2011). Adolescents who grew up observing violence tended to normalize the violence inflicted upon them within their intimate partnerships, making it difficult for HCPs to assure their clients that IPV was not normal and was potentially harmful to themselves and their babies. Mothers of pregnant adolescents experiencing IPV who themselves experienced IPV were often perpetrators of IPV normalization and seemed unconcerned with the IPV experiences disclosed by their pregnant adolescent daughters (Kulkarni et al., 2011). Intergenerational effects of IPV were further seen with abused adolescent mothers as perpetrators towards their children. Service providers working with young women who had experienced IPV reported identifying abusive behaviours from their clients towards their babies and children, including emotional and physical abuse, that their clients did not identify as harmful behaviours (Kulkarni et al., 2011). This is further supported by Howell and colleagues (2017) who found that the broad, intergenerational effects of IPV on pregnant women are multifaceted and interventions are limited in scope.

### **Attitudes Towards Pregnancy and PNC**

Violence during pregnancy was found to be positively associated with negative attitudes towards pregnancy and PNC for women (Quelopana et al., 2008). Negative attitudes towards pregnancy, such as being embarrassed or depressed about the pregnancy or being unsure or

unwilling to carry the pregnancy to term, was associated with late entry or failure to enter PNC during the pregnancy continuum (Torres, 2016). When women felt negatively about their pregnancies, they perceived greater barriers to adequate PNC access, perceived fewer benefits of PNC, and reported higher incidences of violence within their intimate partnerships (Quelopana et al., 2008). Previous negative experiences or views of PNC can lead a woman to avoid accessing PNC in the future (Bradbury-Jones et al., 2015a; Torres, 2016). Some women, particularly those who are marginalized, were unaware of the importance of PNC and viewed it as negative and unnecessary (Torres, 2016). Bradbury-Jones and colleagues (2015a) reported that women's negative views of PNC were sometimes overshadowed by their desire to protect and ensure the health of their unborn baby. Thus, some women attempted to access PNC despite feeling negatively towards PNC in general. However, it was also seen that women's perceptions of PNC and HCPs can be changed. Through consistent positive experiences with a trusted provider or team, HCPs were able to build positive relationships with women who were previously averse to PNC in general (Bradbury-Jones et al., 2015a).

**History and/or Contemplation of Abortion.** Abortion history and contemplation was associated with violence during pregnancy. Quelopana and colleagues (2008) found that pregnant women experiencing IPV were ten times more likely to contemplate receiving an abortion in comparison to women who do not experience IPV. Women who experienced IPV were also more likely to report their pregnancies were unintended, that they did not want other people to know about their pregnancy, and that they were unhappy about becoming pregnant (Quelopana et al., 2008). Reproductive coercion was often utilized by violent partners in this study to disempower pregnant women. Reproductive coercion could include any behaviours intended to control the reproductive health of another and often involves the interference with

contraception use and pregnancy (Chamberlain & Levenson, 2012). Some methods of coercion involve sabotaging contraceptive methods through withholding, hiding, or destroying them, pregnancy pressure towards a female partner who does not wish to become pregnant, and coercion to become pregnant (Chamberlain & Levenson, 2012). Quelopana and colleagues (2008) saw that in the incidence of an unintended or unwanted pregnancy, many women were not able to participate in conversations or decisions around the use of contraception with their intimate partners. Many women were under the assumption that their intimate partner would obtain and utilize contraception. These findings are supported by INEGI (2006) that found only 51% of Mexican women, like those studied within Quelopana's study, felt supported to take part in the decisions regarding family planning and contraceptive use in their relationships, further decreasing the perceived power a woman has over her body. In contrast to the pressure to become pregnant, violence-inflicting intimate partners were seen to pressure their partners to undergo an abortion in the event of an unintended pregnancy. As such, abortion contemplation was indicated as a potentially important factor in the screening and identification of IPV for pregnant women (Pun et al., 2016; Quelopana et al., 2008). Even though the literature included in this regard were not from US or Canadian contexts, they allude to the potential family planning decisions that many pregnant women who experience IPV contemplate, especially those who experience physical or sexual violence. Further, the ramifications of reproductive coercion and perceived powerlessness over family planning decisions is transferable to Western contexts, where reproductive coercion is prevalent. Grace and Anderson (2018) found in the US that 7% to 11% of women experienced birth control sabotage by an intimate partner, 1% to 19% experienced pressure to become pregnant, 0.1% to 4% experienced pressure to terminate their pregnancy, and 8% experienced pressure by their intimate partner to not terminate their

pregnancy. This phenomenon is further exacerbated for at-risk women in developed nations; reproductive coercion was reported to be significantly higher for women who identified as racial or ethnic minorities (Grace & Anderson, 2018), young, undereducated women (Katz & LaRose, 2019), and those concurrently experiencing IPV (Grace & Anderson, 2018; Katz, Poleshuck, Beach, & Olin, 2017).

### **Structural Violence Within Health Systems**

The health systems that abused women attempt to access may itself pose barriers to equitable access to PNC. The social, physical, and political constructs that surround and enmesh the healthcare system can alienate abused women and lead to underutilization of resources by the population that they are specifically designed to serve. The ways in which the health system impedes a woman's access to IPV and PNC services are many and include: (a) lack of healthcare provider training, knowledge, and support (Bradbury-Jones et al., 2015a; Bradbury-Jones et al., 2015b; Kulkarni et al., 2011), (b) accessibility barriers to PNC (Bradbury-Jones et al., 2015a; Bradbury-Jones et al., 2015b; Furuta et al., 2016; Islam et al., 2017; Kulkarni et al., 2011; Torres, 2016), (c) fear of disclosure, trust, and securing an ally (Bradbury-Jones et al., 2015a; Bradbury-Jones et al., 2015b; Furuta et al., 2016; Islam et al., 2017; Kulkarni et al., 2011; Quelopana et al., 2008; Torres, 2016), (d) interprofessional team approach (Bradbury-Jones et al., 2015b; Kulkarni et al., 2011), (e) provider discomfort in responding to IPV disclosures (Bradbury-Jones et al., 2015b; Kulkarni et al., 2011; Quelopana et al., 2008), (f) inappropriate or inaccessible tools and resources (Bradbury-Jones et al., 2015a; Bradbury-Jones et al., 2015b; Kulkarni et al., 2011), and (g) challenges in responding to IPV for PNC services (Kulkarni et al., 2011; Pun et al., 2016).

#### **Lack of Healthcare Provider Training, Knowledge, and Support**

When women were informed on what to expect from their PNC HCPs for their care plans during the perinatal period, they were more likely to utilize PNC services (Bradbury-Jones et al., 2015a). Unfortunately, HCPs themselves reported not being fully informed on their roles and processes involved with perinatal IPV care. Bradbury-Jones et al. (2015b) found that providers felt their training was inadequate to prepare them to address IPV and that much of their knowledge on IPV was generated through experience working with women who had experienced IPV. Health professionals reported lacking awareness of how to address IPV in context with other health concerns, such as disability and pregnancy. As well, they found definitions of IPV, disability, and mental health concerns to be ambiguous and difficult to operationalize (Bradbury-Jones et al., 2015b). Finally, HCPs who worked with pregnant abused adolescents felt that they lacked adequate time, privacy, training, and resources to appropriately assist their clients in accessing PNC and IPV resources (Kulkarni et al., 2011).

### **Accessibility Barriers to PNC**

The accessibility of the physical location and organization of PNC appointments and clinics was important when considering women's ability to disclose IPV. Studies found that physical barriers, such as the distance women would travel to a healthcare facility, the cost of treatment, and securing money for treatment, were all reported as serious challenges women faced in accessing PNC (Torres, 2016; Furuta et al., 2016). Long wait times, crowded clinics, having to leave work or school to attend PNC appointments, and a lack of support from family and friends to get to and from appointments were all cited as physical barriers to accessing adequate PNC (Torres, 2016). Women who lived in urban areas were significantly more likely to have adequate PNC from skilled HCPs in comparison to women who lived in rural areas (Furuta et al., 2016). Islam and colleagues' (2017) findings support this. Within their study, they found

that women who were from rural areas reported significant delays in entry to PNC compared with women living in urban areas.

### **Fear of Disclosure, Trust, and Securing an Ally**

Disclosing IPV was incredibly difficult for women and required them to have a person whom they trusted to disclose to. Most pregnant women who experienced IPV attempted to secure an HCP ally with whom they could trust to share their sensitive information with and disclose their experiences with violence to (Bradbury-Jones et al., 2015a). This was a difficult relationship to establish, as women who experienced IPV were more likely to anticipate poor relationships with health professionals, fearing judgment and negative treatment (Bradbury-Jones et al., 2015a; Bradbury-Jones et al., 2015b). As well, trust in the healthcare system was negatively impacted by both their IPV experiences and previous negative experiences with PNC (Bradbury-Jones et al., 2015b; Islam et al., 2017; Kulkarni et al., 2011). Torres (2016) found that a majority of women who have experienced IPV are distrustful of the healthcare system and nearly 80% of participants indicated that they did not like going to their PNC appointments. Anticipation of a poor relationship with HCPs alone was shown to be a barrier to PNC utilization (Bradbury-Jones et al., 2015a; Islam, et al., 2017). Past negative experiences with HCPs and the healthcare system led women to approach PNC services cautiously, fearing judgment and/or negative interactions with HCPs. Furuta and colleagues (2016) found women who had multiple children were less likely to access, and therefore receive, skilled maternity care throughout the pregnancy continuum, citing that negative experiences with HCPs in their earlier pregnancies caused them to choose not to access PNC for their subsequent pregnancies.

Lack of information and misinformation negatively impacted the level of trust an abused woman had in her HCPs (Bradbury-Jones et al., 2015a). Having greater, accurate knowledge of

PNC and the processes that follow disclosure was identified by Bradbury-Jones and colleagues (2015b) as being an essential step in trust-building for pregnant women with a history of IPV. Continuity of care with a familiar individual or team of HCPs was thought to improve trust in the healthcare team and thus increased the likelihood of disclosure for women experiencing violence (Bradbury-Jones et al., 2015b). Having the opportunity to develop relationships over time was helpful for providers to foster trust, and in turn, allowed their clients a safe space to discuss what was important to them (Kulkarni et al., 2011).

**Interprofessional team approach.** Providers felt that working within an interprofessional team was a facilitator to adequate PNC and IPV care. Providers felt that collaborative interactions and having a team to support their work were better able to cooperate and communicate amongst the team, increasing the quality and availability of care for pregnant women experiencing IPV (Kulkarni et al., 2011). An interprofessional collaborative approach allowed clients to build a relationship with multiple members of the team and disclose to whomever she felt most comfortable speaking with (Kulkarni et al., 2011). Additionally, the immediacy with which supports could be made available would be improved by having an interprofessional team responding to IPV disclosures. Participants from Bradbury-Jones and colleagues' (2015b) study found that having professional supports available to women at the time of disclosure encouraged them to come forward about their abuse and have trust that their team were able to help them. In contrast, providers who worked in isolation, such as a school nurse attempting to care for pregnant abused adolescents, felt that they were limited in their ability to address IPV and unable to respond as well as they would have liked to (Kulkarni et al., 2011). An interprofessional team approach to PNC was seen as helpful to alleviate women of some of the accessibility issues and structural barriers to IPV intervention and PNC (Bradbury-



Jones et al., 2015b). A ‘one-stop-shop’ where women were able to see many of their HCPs in one place was suggested as a way to ease the burden of having to travel far distances, taking too much time and financial resources to see their PNC and IPV care teams, and would allow for a more comprehensive, holistic, tailored approach to their care (Bradbury-Jones et al., 2015b).

### **Provider Discomfort in Responding to IPV Disclosures**

Providers, like their clients, were often fearful of IPV disclosure (Bradbury-Jones et al., 2015b; Kulkarni et al., 2011; Quelopana et al., 2008). Providers sometimes felt that they lacked the ‘right words’ and training to adequately respond to disclosures of IPV. Particularly, HCPs endorsed being fearful of offending women and subsequently damaging the therapeutic relationship (Bradbury-Jones et al., 2015b). While HCPs found that asking questions about abuse alone was difficult, they recognized a much greater difficulty in responding once a disclosure was made. Many of the HCPs surveyed found that not having the correct words to say was a significant cause of anxiety in dealing with IPV disclosures in their practices. Some providers opted to wait until late within the PNC appointment to bring up violence due to their discomfort in discussing the topic with their clients. If IPV and abuse came up unexpectedly within the appointment, providers felt unsettled and lacked knowledge on how to appropriately respond to spontaneous disclosures (Kulkarni et al., 2011). Quelopana and colleagues (2008) found that HCPs in their study of Mexican women experiencing violence were so uncomfortable with IPV that they were hesitant to even screen for violence. Often times, midwives and providers would “hide” or “take distance” from a woman after a disclosure of IPV or if she was commonly known to be experiencing violence (Quelopana et al., 2008).

After a disclosure had occurred, many providers reported being unsure of the processes that follow disclosure and their reporting obligations. Providers reported lacking knowledge of

what resources they could refer their clients to, how to adequately address IPV during the perinatal continuum, the potential consequences associated with disclosure, and a clear pathway as to what to do next (Bradbury-Jones et al., 2015b; Kulkarni et al., 2011). Providers felt that women required greater clarity about specific processes that followed a positive IPV disclosure and required explicit information on what takes place once a disclosure occurs. Women lacked knowledge on how their HCPs would maintain their confidentiality, when their HCPs would be obligated to disclose the violence and to whom, how their information would be used by their HCP team, supports available to them, and processes that accompany an IPV disclosure. It was found that discussing the disclosure process and what happens once a disclosure is made before the disclosure occurs allowed women to ‘weigh the pros and cons’ of disclosing and have more autonomy over their decisions (Bradbury-Jones et al., 2015b).

### **Inappropriate or Inaccessible Tools and Resources**

It was seen as important for resources and supports to be tailored to the unique needs of the woman accessing the supports in order to be both accessible and effective (Bradbury-Jones et al., 2015a). However, many services and screening tools meant to address IPV, either during or outside of the antenatal continuum, were not accessible or appropriate for use for many populations of women attempting to utilize them. The use of biomedical jargon and difficult language was found to limit access to PNC services for abused women who also have disabilities or language barriers. Too much medical language prevented women from being able to make informed decisions about her care, limiting the accessibility of the information she was given and her ability to make autonomous decisions in regard to IPV disclosure and treatment (Bradbury-Jones et al., 2015a). Furthermore, women who relied on their intimate partners for

communication or language assistance were also limited in their access to PNC, particularly where IPV is concerned (Bradbury-Jones et al., 2015b).

Overall, researchers suggest that providers felt there is a lack of inclusive and accessible information that can assist pregnant women experiencing IPV with acknowledging, seeking help for, and accessing care for their IPV during the perinatal continuum (Bradbury-Jones et al., 2015a). Free and low-cost resources to assist in IPV situations during the perinatal spectrum were scarce, limiting the ability for HCPs to refer their clients to resources that they could both physically access and financially afford (Bradbury-Jones et al., 2015a; Kulkarni et al., 2011). Frequent visits to clinics or hospitals, particularly for women considered ‘high-risk’, such as women who are disabled or who experience IPV, lead to frequent physical and environmental barriers to adequate IPV and PNC. Transportation to multiple appointments, time off work, and the cost of seeing multiple specialists for care in different locations compounded the amount of work and the costs of receiving care for disabled or at-risk women (Bradbury-Jones et al., 2015b). This was found to be further complicated for pregnant and IPV-endorsing women. In some cases, services that were deemed to be overly specialized, such as women’s shelters that use ‘physical IPV’ as a criterion for admission while discounting other forms of IPV, hindered HCP’s ability to adequately refer their clients to appropriate resources (Kulkarni et al., 2011). Some IPV and PNC services were contingent on having permission from the parent of the pregnant adolescent experiencing IPV for them to have access, compounding issues with intergenerational violence. Pregnant adolescents experiencing IPV who were unable or unwilling to disclose their pregnancies to their parents would be unable to access services such as shelters, support programs, or other IPV-related healthcare services (Kulkarni et al., 2011).

### **Challenges in Responding to IPV for PNC Services**

Services designed to respond to IPV and protect pregnant women were often seen by both women and HCPs as futile in addressing violence. Women reported being reluctant to accept help from healthcare services for fear that the severity of their violence would increase and they would not be protected (Pun et al., 2016). Women in Pun and authors' (2016) study described that when they did report abuse to health or social services, the reporting agencies kept their cases ongoing for an extended period of time and there were no ramifications for the person committing the violence. The women were often sent back into the community to the home where the violence was experienced in order to wait for the agency to potentially act for her. As such, women experienced further abuse from her intimate partner and sometimes his family for disrupting the 'domestic harmony' and taking personal matters outside of the home (Pun et al., 2016). Even when IPV was recognized by informal community helpers, such as other family, friends, or neighbours, Pun's (2016) study with Nepali women saw that interventions by this population were largely counterproductive. The person who would attempt to assist a pregnant woman in an abusive situation would often become an 'enemy' of the family for intervening in personal matters.

In cases where reporting of violence to authorities and social services was necessary, often times this resulted in damaged provider-client relationships with HCPs working with pregnant abused adolescent populations (Kulkarni et al., 2011). Furthermore, trust between the HCP and client was often lost, and these reports were rarely taken seriously and protective action was not undertaken. One provider stated that she had not had 'a single case substantiated' once they were reported to authorities. Another noted that she experienced hostile interactions with social services and police when she reported that her client, a minor at the time, was sexually assaulted (Kulkarni et al., 2011). Providers felt that there was a lack of knowledge on reporting

obligations for themselves and their clients, and that reporting damaged their provider-client relationships while affecting little positive change.

### **Cultural and Societal Barriers**

Societal and cultural perceptions of both the perinatal continuum and abuse within intimate partnerships can impede a woman's access to necessary healthcare during her pregnancy. Certain cultural beliefs and gender biases that endorse patriarchal views can lead to permissive societal views towards IPV that further reduce a woman's autonomy to access and receive support in addressing IPV and her perinatal health. The ways in which cultural and societal barriers impact women experiencing IPV from accessing PNC include: (a) lack of societal knowledge of IPV (Bradbury-Jones et al., 2015b; Kulkarni et al., 2011), (b) permissive societal attitudes towards IPV (Kulkarni et al., 2011; Pun et al., 2016), (c) prevailing IPV stereotypes (Bradbury-Jones et al., 2015a; Bradbury-Jones et al., 2015b), (d) cultural barriers to IPV intervention (Furuta et al., 2016; Islam et al., 2017; Kulkarni et al., 2011; Pun et al., 2016; Quelopana et al., 2008) and (e) endorsement of traditional gender roles (Furuta et al., 2016; Pun et al., 2016; Islam et al., 2017).

#### **Lack of Societal Knowledge of IPV**

Many HCPs who worked with women experiencing IPV during the perinatal period believed that a lack of societal knowledge and understanding of IPV and its impacts on women, their children, and society contributes to the ineffectiveness of IPV interventions within PNC (Bradbury-Jones et al., 2015b; Kulkarni et al., 2011). Kulkarni and colleagues (2011) interviewed HCPs who endorsed that a major barrier to effective PNC care for adolescents experiencing IPV was a lack of societal response to both the issues of IPV and adolescent pregnancy. Participants in this study cited that society's lack of interest in tackling social

problems like IPV and teen pregnancy have left them without adequate youth prevention resources and the ability to adequately identify, intervene, and prevent IPV and pregnancy for their clients (Kulkarni et al., 2011).

### **Permissive Societal Attitudes towards IPV**

Paired with a lack of knowledge of the multifaceted and often devastating effects of IPV for pregnant women and their families, permissive societal attitudes towards IPV further hindered a larger societal response to addressing violence against pregnant and mothering women in both developed and developing nations. Within developed nations, normalization of IPV was an important barrier preventing abused and pregnant adolescents from receiving adequate PNC. Kulkarni (2011) and colleagues' health care provider participants felt that when parents of pregnant adolescents experiencing IPV were permissive towards the violence that their child endured, or endorsed traditional gender roles within their own relationships, IPV was normalized. Its presence within these relationships was overlooked by parents and viewed as a normal part of a relationship, minimizing the significance and impacts that IPV has on women, their children, and their families.

For some women in developing nations, IPV is seen as a commonplace phenomenon and, therefore, not worthy of reporting in any formal capacity. Pun (2016) found that within their studied Nepali community that, not only were women unwilling to report their own experiences with violence, their neighbours, families, and friends refused to intervene as intimate partner violence was thought to be a family matter. Women felt it was not okay to speak against their husband to community members if he had been violent with her (Pun et al., 2016). The community surveyed within Pun's (2016) study viewed IPV to be a common phenomenon that occurred in normal and healthy households. The presence of IPV during pregnancy was

described as a lottery in which participants felt that whether or not IPV was present for women during pregnancy was attributed to luck; some women must suffer (Pun et al., 2016). Some of the men surveyed who were perpetrators of IPV felt that violence was necessary and should be used on their intimate partner to show dominance and ensure obedience. One participant in Pun's (2016) study stated, "Beating is also necessary. First, we should try to make her understand. If she does not understand, then [the husband] should beat her. [Ha! Ha!]." At the same time, though, it was acknowledged by all participants of Pun's (2016) study that attitudes towards family violence are changing. Sons, daughters, mothers-in-law and fathers-in-law alike felt that they had more awareness now than they used to about violence within the family, physical and mental health, education, and the needs of pregnant women and their unborn infants. Some participants stated that they were aware of laws protecting women from violence and that empowerment of women is an important social issue that is starting to be addressed in Nepal (Pun et al., 2016).

### **Prevailing IPV Stereotypes**

Stereotypes of women experiencing IPV can act as a barrier to adequate PNC and IPV care. Societal norms played a significant role in women's decisions about whether or not to access PNC, especially where IPV is concerned. Abused women's perceptions of how society viewed them, and their desire to be seen as 'normal pregnant women' as opposed to abnormal or at-risk, caused them to have concerns about how their IPV disclosure would change the way their HCPs treated them (Bradbury-Jones et al., 2015a). Women were often concerned that when they were labelled a 'high-risk' pregnancy as a result of their IPV experience, their HCPs perception of them would be altered. In Bradbury-Jones and colleague's (2015b) study of disabled women who experienced violence, it was found that women felt that HCPs perceived them to have put

themselves into violent situations, as opposed to addressing the abuse itself. Biases against abused women were persistent within HCPs tasked with identifying and responding to IPV disclosures. This was supported by the statement from some HCPs that reflected the perception of women “liking” when their partners were in control of them and that women’s endorsement of traditional gender roles perpetuated their own abuse (Bradbury-Jones et al., 2015b). Some HCPs blamed women experiencing violence and believed that HCPs were unable to help because their clients were keeping themselves within violent situations and would continue to experience violence due to their choice of partner. Prevailing social norms about women experiencing IPV led to many of the women in Bradbury-Jones and colleagues’ (2015a) study to see their wishes of being respected as experts in their own care to rarely be actualized. Often in the presence of biases or stereotypes against pregnant women who experienced IPV, women’s opinions were disregarded, choices denied, and preferences for care usually ignored. Ultimately, autonomy and perceived power for decision-making were greatly limited by the societal norms that still persist within the healthcare system against women and mothers experiencing IPV.

### **Cultural Barriers to IPV Intervention**

Living in a cultural landscape that strongly endorses traditional gender roles for males and females greatly impacted a woman’s experiences of pregnancy, IPV, and access to necessary healthcare services (Furuta et al., 2016; Islam et al., 2017; Pun et al., 2016; Quelopana et al., 2008). Culture was seen as important to IPV incidence and disclosure in many ways. A focus group conducted in the United States with African American women (Kulkarni et al., 2011) found they had great difficulty disclosing IPV based on the cultural expectation to be “strong”. Thus, some service providers felt that African American women were less able to identify their experiences as IPV, or that they were less willing to disclose IPV. When African American



adolescents did disclose incidences of IPV to their HCPs, they often thought of themselves as the aggressor of the violence, stating behaviours of theirs that they felt led to them experiencing the violence. In many cases, these adolescents justified the violence as being their own fault (Kulkarni et al., 2011). Service providers, in contrast, blamed society and law enforcement for not taking incidences of early teen pregnancy and sexual assault more seriously.

### **Endorsement of Traditional Gender Roles**

Strongly endorsed traditional gender roles were found to further complicate the experience of IPV during pregnancy. Islam (2017) suggested that endorsing traditional gender roles could be cultural and social tools used to control and intimidate women into submission. Approximately 62.2% of Bangladeshi women endorsed that their homes reflect conservative attitudes towards gender and traditional gender roles (Islam, et al., 2017). In Furuta's (2016) study of Nepali women accessing PNC in the context of IPV, it was suggested that gender inequality and inequity could be a core cause of the gross underutilization of PNC across the pregnancy continuum for all women. Prevailing cultural norms of gender inequity perpetuated the high incidence of IPV in Nepal and the belief that PNC is not important. Women's health-seeking behaviours and ability to autonomously seek out PNC were negatively impacted by social discrimination and in turn influenced decisions about whether to access PNC. Pun and colleagues (2016) found that violence against pregnant Nepali women could be considered culturally significant, seeing that women were subjected to heavy lifting, difficult housework, denial of food, and specific forms of emotional and physical abuse by not only their intimate partner but their intimate partner's immediate family as well. In Nepal, after marriage, daughters-in-law often relocated to live with their husbands' families and were often treated as an 'extra set of hands' for cooking and other household labour. Furthermore, Pun (2016) found that mothers-

in-law often requested their sons be married at young ages in order to secure a daughter-in-law who could perform household duties for them. This was considered by many pregnant women to be a form of emotional abuse perpetrated by their mothers-in-law and supported by their intimate partners as a result of encultured gender expectations. Considerable importance was placed upon the woman's endurance and ability to reconcile domestic disputes within the household regardless of the consequences (Pun et al., 2016).

Intrenched within patriarchal cultures, the deep-rooted child preferences for male offspring can cause psychological stress and mental health concerns for pregnant women in some parts of the world. Pun's (2016) examination into Nepali women found that son preferencing existed regardless of educational or SES and resulted in a culture that was strongly patriarchal. The pressure and taunting that pregnant women experienced during their pregnancies to birth a male child depicts a very specific cultural form of psychological IPV existing as a result of entrenched gender ideals and cultural gender role expectations. In some cases, intimate partners told their labouring wives to not return home if she gave birth to a female child. Both male and female participants of Pun's (2016) focus groups contemplated the level of emotional torture that a woman who already had multiple female children would experience during labour, worrying about the sex of her unborn child. There was the suggestion of change happening in some areas, though. Pun (2016) found that their Nepali participants felt that cultural traditions were evolving in a way that afforded women more rights and opportunities.

### **Literature Review Summary**

The review of the literature emphasized that accessing PNC for women who experience IPV is a complex and poorly understood phenomenon. As no research pertaining to breastfeeding women who endorse a history of IPV could be found, the above literature review focused on a

relevant population of women who have experienced IPV and their experiences in accessing general PNC as opposed to breastfeeding support.

Having adequate access to and utilization of PNC has been proven to positively impact many aspects of perinatal health, including a wide array of benefits to both mother and infant (Bailey et al., 2020; Linard et al., 2017). Despite its proven importance to the perinatal continuum, especially for women who face extenuating challenges and barriers to optimal health during their pregnancies, PNC is underutilized by women experiencing IPV (Cha & Masho, 2014; Metheny & Stephenson, 2017; Stewart et al., 2017). Women with a history of IPV have higher rates of delayed entry to PNC than women who do not report violence during their pregnancies (Islam et al., 2017; Quelopana et al., 2008; Torres, 2016). Barriers to PNC access, in the form of past negative interactions with HCPs or social services, multifaceted environmental barriers, and societal and cultural prevailing stereotypes against marginalized women and women experiencing IPV, can limit a woman's safe, equitable access to PNC. While numerous barriers to care access have been identified in the literature, no research studies have yet been completed that explore women's lived experiences with this phenomenon. The resources that women seek out, often at great personal cost, are not always equitable nor accessible to the women who require them. Accessing PNC services, especially for mothers who are at-risk, is often complex and confusing for women. The frequency of appointments and the number of varied specialists that are required to be involved in the PNC of a woman experiencing IPV during pregnancy increases the cost, time, misinformation, and stress she experiences in accessing these services. Having access to an interprofessional team that is communicative and situated in a way that allows them to respond to IPV disclosures in a dynamic and immediate way was indicated by several studies as being important in aiding women's access and utilization of PNC services.

Cultural and societal permissive attitudes towards IPV and a lack of knowledge on the effects of IPV on women and their infants throughout the perinatal spectrum are serious barriers to adequate PNC care and can preserve long-held gender inequities that are at the root of this issue. Women-centred and trauma-informed care was identified as essential to the development of trust and autonomy for women experiencing IPV who are attempting to access.

While this literature review was able to identify many barriers to PNC access for women experiencing IPV, no studies have yet been completed that directly address this concern. Despite research that suggests that women who experience IPV during pregnancy breastfeed their infants less exclusively and for less time than their counterparts who do not endorse violence in their intimate partnerships (Caleyachetty et al., 2019; Martin-de-las-Heras et al., 2019), no qualitative research exploring this issue was found. In fact, no qualitative research could be found that explores how IPV impacts breastfeeding in any capacity, resulting in women's experiences largely unheard. To my knowledge, no research – qualitative nor otherwise – has been completed that explores how women experiencing IPV navigate the healthcare system to access breastfeeding supports. Further, limited Canadian research has been completed that has addressed the intersection of IPV and PNC for women. Of what has been completed, no qualitative Canadian research studies have been found to investigate the perinatal health-seeking experiences of this underserved, marginalized population. The impact that IPV can have on a woman's access to adequate PNC is, as well, largely underexplored, as evidenced by the small number of works discovered by this literature review.

### **Research Questions**

One primary and two secondary research questions were developed for this study. The primary research question was: *What is the experience of accessing breastfeeding support for*

*perinatal women who endorse a history of intimate partner violence?* The secondary research questions were: 1) *What are the perceived barriers to accessing breastfeeding support for perinatal women who endorse a history of intimate partner violence?* and 2) *What is the experience of receiving trauma-and-violence informed healthcare in the perinatal period for breastfeeding women who endorse a history of intimate partner violence?*

## CHAPTER 3

### METHODS

#### **Design**

The experiences of abused women attempting to access breastfeeding support services was studied using an interpretive description (ID) methodology (Thorne, 2008; Thorne, 2010; Thorne, Kirkman, & O’Flynn-Magee, 2004). Interpretive description is a qualitative methodology that focuses on describing phenomena associated with human health experiences and generating an interpretation of them. Interpretive description seeks to illuminate characteristics, patterns, and structure of clinical phenomena in a way that can be useful to nurses and clinical practitioners using inductive analytic approaches (Thorne, Kirkham, & O’Flynn-Magee, 2004). Grounded in the realm of nursing practice, ID assumes that nurses and clinicians not only seek to have phenomena described, but to have interpretations of the phenomena developed so that they may understand the phenomena in a way that they may be applicable to their clinical practices. Thus, ID is a useful methodology to use for reflective exploration of a phenomenon with the goal of informing clinical change and disciplinary thought.

Interpretive description was chosen as the methodology for this study because it can aid in understanding the multifaceted barriers to healthcare that perinatal and breastfeeding women facing abuse experience and interpret these experiences in a way that can aid the healthcare system to address the immediate needs of this population. Through describing and interpreting the experienced strengths and barriers to PNC and breastfeeding support service access, this ID study aimed to be beneficial in guiding the assessment, planning, and implementation of strategies that can improve healthcare experiences for women experiencing abuse. Interpretive

description allows for the knowledge from this study to be generated in a way that is sense-making, clinically relevant, and applicable to the real world of perinatal healthcare.

### **Intersectional Framework**

An intersectional framework (IF), as defined by Crenshaw (1991) was used to guide the design of this research study. An IF is a lens for viewing inequality and how different forms of inequality can exist concurrently and exacerbate one another (Crenshaw, 1991). It aims to address the sociocultural, political, and economic constructs that are influencing and perpetuating the barriers that women experiencing IPV can face in their attempts to access PNC and formalized breastfeeding support (CRIAOW, 2006; Morris & Bunjun, 2007). Intersectionality-informed qualitative inquiry endeavours to uncover and address inequity and power imbalances (Hunting, 2014). An IF was fitting for this research study as it aims to bring light to the experiences that at-risk women experiencing violence face through the examination of the complexities of health, healthcare access, and gender-based violence.

Reflexivity was an essential component to the development and framing of the research study itself. Reflexive inquiry requires the researcher to examine how the processes they are undertaking to produce knowledge are shaped by society, politics, biases, values, and the personal interests of the researcher (Hankivsky & Cormier, 2009; Hunting, 2014). An IF was especially well-suited to this study as it allows for focus on the intersection of violence and PNC for women that are marginalized and disempowered. Through this study examining IPV for breastfeeding women attempting to access the healthcare system for breastfeeding support, it was important to recognize my positionality and be reflexive about my preconceptions and biases towards the phenomenon of interest. Intersectionality-informed qualitative research can help

bring to light factors beyond gender and culture that influence the experience of violence and healthcare access for breastfeeding mothers.

An IF is well-suited to qualitative research, particularly ID, as it allows for the acknowledgment of power differentials between the ‘researcher’ and the ‘researched’. It allows the research participants to speak of their own experiences with power, resilience, struggle, and discrimination and allows the researcher to highlight both differences and similarities between and across groups (Hunting, 2014). Intersectionality also guided the formulation of this study’s implications and future directions, aiming that they are real-world applicable and address the structural, cultural, and political factors that contribute to the inequity of healthcare access and experience of violence for this population (Hankivsky & Cormier, 2009). Through exploring the structural, societal, and political inequities that women experiencing IPV face when accessing PNC and breastfeeding support, we can acknowledge the strengths and resilience of these women and undertake research that aims to shift the dynamics of power and privilege to support women in obtaining equitable perinatal healthcare.

## **Setting and Participant Recruitment**

### **Study Setting**

This study was undertaken as a sub-study within a larger primary study. The data for this study was collected from a single perinatal health clinic in a mid-sized city in southwestern Ontario, Canada. The perinatal health clinic encompassed a team of family physicians (FPs) focused on providing community based TVIC to at-risk perinatal women without a primary care provider. This clinic served many populations, including new immigrants to Canada, women of low SES, women who perceive a lack of social support, and women who have experienced IPV. The program of TVIC being trialled at this perinatal health clinic included seeing women within



72 hours of the delivery of their infants in order to provide them with additional support around breastfeeding, such as education, self-efficacy, support, and social support. This site was selected as the most appropriate study setting as TVIC is currently utilized as part of their standard of care. As well, the population of interest to this study, which included women who have experienced IPV, are often referred to this clinic to receive their PNC. Thus, conducting the study through the selected perinatal health clinic allowed for the greatest chance to access as many women who are living the experience of accessing breastfeeding support services while also facing IPV in the recruitment area as possible.

### **Recruitment**

Women who do not have a primary care practitioner were referred to the perinatal health clinic for postpartum care through their perinatal health appointments with their midwives or through the hospital where they would give birth. Women who disclosed a lack of social support or a history of IPV were also referred to the PWC via the same referring source. Women were thus recruited from the PWC during their first postnatal visit at 72 hours postpartum. When women arrived at the PWC for their first scheduled postpartum appointment, they were provided with a tablet with which to complete their clinic intake forms and baseline demographic data questionnaire, as per the clinic's intake procedures. After the mandatory forms were completed, the final form on the tablet was the study recruitment letter (see Appendix E: Recruitment Form) which provided potential participating women information about the purpose of the study, eligibility criteria, time commitment, and honorarium. Study participants indicated on the form that they were interested in participating by selecting, 'yes, I am interested' on the tablet. The tablet then displayed a form that allowed women to go through the eligibility criteria to see if they would have been suitable to participate. Once participants were identified as eligible, the

study's Letter of Information and Consent was provided on the tablet (see Appendix F: Letter of Information and Consent) to allow for informed consent to participate in this study to be obtained. At twelve-weeks postpartum participants were contacted via their provided email addresses about whether they would be interested in completing a face-to-face or telephone interview on their experiences both attending PNC at the perinatal health clinic and what barriers they faced in accessing and utilizing PNC services. A \$5.00 CAD Amazon gift card was provided to participants upon completion of the twelve-week follow-up survey and an additional \$20.00 CAD Amazon gift card was provided at the beginning of their interview to recognize participants for their time. Participants were made aware that they could keep all gift cards they received even if they withdrew from the study. Five participants were interested in completing a follow-up interview. Two interviews were conducted in person and three were conducted via telephone.

## **Participants**

Five participants were included in this sub- study. Inclusion criteria included: 1) participants were over 18 years of age; 2) could read and speak in English, 3) had access to a telephone and the internet, 4) were breastfeeding their infant, 5) did not have any pre-existing health history or conditions that would prevent successful breastfeeding (e.g., mastectomy, breast reduction/augmentation), 6) had received care at the perinatal health clinic associated with the study recruitment, and 7) had self-identified as having experienced IPV. Experiences of IPV were assessed using the Abuse Assessment Screen (AAS) (Soeken, McFarlane, Parker & Lominack, 1998).

Table 2 outlines Participant Demographic Characteristics for the included participants. All five of the included participants identified as females between the ages of 24 and 40 and had

received TVIC at the recruitment site during the perinatal period. Three were Canadian born (n=3) and identified as Euro-Canadian/Caucasian (n=3). One participant (n=1) had less than a high school education, two (n=2) hold undergraduate degrees, and two (n=2) hold graduate degrees. Income was varied, with three participants (n=3) reporting earning an annual family income between \$20,000-\$49,999, one (n=1) reported earnings of \$50,000-\$99,999 annually, and one (n=1) reported greater than \$100,000 annual family income. Most participants were employed (n=4) and identified as being married (n=4). All participants (n=5) were breastfeeding their infants at the time of their interview, and all (n=5) indicated that they had, at one point, been physically or emotionally abused by their partner or someone close to them.

### **Sampling**

Qualitative descriptive inquiry is most commonly conducted by use of a purposive sampling technique and was the sampling method for this study (Kim, Sefcik, & Bradway, 2018). This sampling approach involves recruiting a small number of participants by virtue of their lived experience with the phenomena of interest to the study (Thorne, 2016). Through this, participants' individual experiences with IPV in the context of breastfeeding could help us to better understand this phenomenon and explore the variables that shape this health experience in a way that is relevant to the population of interest.

### **Sample Size**

A number of factors were considered when selecting a sample size for this study. Thorne (2016) acknowledges that a majority of studies within the ID approach have relatively small sample sizes, usually between five and thirty participants, but that it may be utilized on studies of smaller and larger samples. In ID, sample size is determined by the research question and what data is needed to satisfy the purpose of the study (Thorne, 2016). Saturation is achieved when a

comprehensive description of the phenomenon of study is displayed and there is a redundancy in the themes or categories portrayed (Patton, 2015).

In this study, which sought to explore women's experiences in accessing PNC in the context of their IPV experiences, the preliminary sample size estimate was that 5-12 participants were needed to reach data saturation and garner more understanding of this phenomena. This sample size was thought to be appropriate as studies founded in ID often include smaller sample sizes but employ rich qualitative data collection methods in order to generate accessible interpretive descriptions of subjective experiences, themes, and perceptions of the phenomenon of study (Thorne, Kirkman & O'Flynn-Magee, 2004). Due to the relative lack of existing research into women who have experienced intimate partner violence and their experiences of accessing breastfeeding support, limited studies exist that could be drawn on to compare relative sample sizes. In examination of the literature review conducted with this study, it is seen that IPV for mothers is a relatively common phenomenon that has been inadequately explored through qualitative research. In light of this lack of research, a small sample size of experientially familiar subject participants interested in discussing their experiences could lend a breadth of quality subjective data into this novel area of study. Compounded with the pragmatic difficulties in recruitment and data collection posed by the COVID-19 pandemic, highlighted below, a sample size of five study participants was considered sufficient for this study.

**Research Impact Statement: COVID-19**

The COVID-19 global pandemic and subsequent quarantine in Ontario impacted this research study in many ways, from recruitment to data collection and analysis. With the temporary closure of many perinatal health clinics and transition of care to mainly online and telephone-based consultations, recruitment and access to our target study population was greatly

impacted. Prior to the pandemic, potential participants accessed the perinatal health clinic that served as our recruitment site within 72 hours of birth of their infant. During their initial visit, the Letter of Information and Consent for this study and associated parent study was provided to potential participants, who would then provide their consent and complete baseline data collection and provide the clinic with demographic data relevant to the study. Participants who consented to participate in the study would be contacted by myself and notified that they would receive further contact from me at twelve-weeks postpartum to complete their second of two surveys and an in-person interview. Interviews would be recorded and participants would receive a \$20 Visa gift card at the beginning of the interview. An initial sample of eight to twelve participants was anticipated for this study to satisfy data saturation and result in a breadth of qualitative data.

As a result of the pandemic, necessary changes to the recruitment site to allow for compliance with public health emergency measures saw a temporary delay in care for some participants to greater than 72 hours. As well, many potential participants had difficulty accessing the clinic due to their reduced days and hours of operation. Thus, it is possible for some potential study participants to have been lost due to these restrictions and accessibility issues they experienced in accessing our recruitment site. To further comply with public health and safety measures, we received ethical approval to conduct interviews over the telephone as opposed to the originally intended face-to-face format to help reduce the amount of in-person contact for our study participants. Acknowledging the sensitive nature of the interview questions and topics associated with this study, including those about perinatal health experiences and IPV, participants were made aware via their provided email addresses of the change to our interview format. Some participants did not feel comfortable conducting their interviews over the

telephone. One participant stated via email that she would not be able to complete an interview as her husband was off work due to the COVID-19 quarantine and would be present in the home for the telephone conversation. Thus, some participants opted to drop out of the study before completing an interview. Additionally, some potentially grounding observational data could have been missed by completing the interviews over the phone as opposed to face-to-face.

Participants' actions, behaviour, and body language during the interviewing process and while discussing their experiences can potentially provide important grounding sensory data to accompany the interview recordings and transcripts (Sandelowski, 2002). This was taken into consideration when analyzing the data, as non-verbal cues and emotional triggers can provide rich contextualizing data to the verbal collection of experiences. Further, providing honorariums to our participants required adjustment. Instead of providing the interviewees with \$20.00 CAD Visa gift cards at the beginning of their interview, the participants were provided with a \$20.00 CAD Amazon gift card at the completion of their interview. The gift card was sent to the participants electronically via their previously provided email address, with their consent.

In light of the difficulties in recruitment and data collection as a result of the COVID-19 pandemic and stay-at-home quarantine suggestions made by public health authorities, a decision was made between myself and my thesis supervisor to complete this study with the five participants. The five completed interviews were found to be comprehensive enough to provide a rich description of the phenomenon of study and sufficiently addressed the research questions.

### **Data Collection**

Data collection for this study included a survey and a semi-structured interview. The survey sought to collect demographic information and was completed on their intake at their first perinatal health appointment (see Appendix H: Patient Demographic Questionnaire and Table 2:

Patient Demographic Data). Demographics collected included age, gender, ethnicity, creed, country of birth, marital status, employment status, education, and annual household income.

Semi-structured, one-on-one interviews were conducted with the study participants to ground and contextualize the study findings. Interviews were completed either in-person or via telephone approximately twelve weeks after the birth of their infant and were 30-90 minutes in length. The semi-structured interview guide was developed in collaboration with the principle researchers of the associated parent study. Through the interviewing process, valuable experiential data was collected from the study participants that required expansion, at which time the interviewer asked probing questions to allow for deeper participant responses. Interview questions were designed to allow the participants to expand upon and discuss their experiences of care, obstacles, support, and violence from multiple possible sources.

During interviews, participants were first asked to share their experiences of accessing and receiving TVIC in the postpartum period and were probed to explore both positives and negatives about their experience. This allows for comparison with other research about women's experiences in PNC that is not TVIC, which could lend rich data about the efficacy of the utilization of this type of care program for violence-affected perinatal women. Participants were given the opportunity to discuss assets and obstacles they faced in accessing and receiving care through a series of open-ended questions about what care was beneficial to them, what was not, and what care they felt they could have benefitted from that they did not receive. Then, a series of open-ended questions about their breastfeeding journey were asked. Participants were prompted to reflect upon the support they did or did not receive from their healthcare practitioners, family, friends, and partner throughout pregnancy, postpartum, and breastfeeding, and how that impacted their perception of their postpartum experiences. Whether they had

positive or negative perceptions of their support, participants were asked to elaborate on the type of support they received and how it impacted their breastfeeding success. The open-ended nature of the interview questions purposed to allow participants to describe what is meaningful and relevant to them without biasing the data towards what patterns may be expected or predetermined to emerge (Patton, 2015).

### **Interactive-Relational (IR) Approach**

The IR approach to interviewing was utilized in this study as a way to promote trust and engagement with participants, as well as a deeper understanding of their experiences through purposeful reflection (Chirban, 1996). As the ideal interview is democratized, allowing for the interviewer and interviewee to be equal participants in knowledge acquisition (Sandelowski, 2002), IR was used to promote the extension of power from the interviewer to the interviewee and to allow for the development of a trusting co-researcher relationship (Chirban, 1996). Qualities of the IR approach aid in the interviewer becoming more involved in the interview itself, which helps to foster the development of a more sensitive, engaged relationship between the interviewer and the study participant (Chirban, 1996). An IR approach to interviewing can lead to the participant and the interviewer both engaging more authentically and naturally, allowing for space for honest dialogue and co-reflection that can aid in the exploration of deeper, hidden meaning within the phenomena of exploration (Chirban, 1996).

Prior to engaging in the interviews, I reflected on my own preconceived ideas about breastfeeding, IPV, and PNC as it exists within the greater healthcare system. Reflecting upon my values, feelings, motivations, beliefs, and conventions about these phenomena, of which I have no personal lived experience of, was necessary in order for me to develop self-awareness of my positionality and reflexivity within this research context. Through active reflection, the



interviewer can manage to create connections with the participants' experiences while still maintaining professionalism and objectivity (Chirban, 1996). I was cognizant of how rigid, structured interviews may serve to reduce the participant's role to that of 'subject', leading to the reduction of the humanity and vitality within the participants' responses. Instead, I aimed to be empathetic, authentic, and open throughout the interviews in an effort to encourage deep, self-reflective exchange of dialogue (Chirban, 1996). I utilized personal characteristics such as humour and genuine interest to establish trust and confidence with the interview participants. I used listening skills to actively interpret, prompt, and seek clarification about the interviewees' experiences, as well as to encourage them to reflect upon these experiences in a deeper, more purposeful way. I was clear about allowing the interviews to extend beyond the pre-determined timeline in order to allow the participants the opportunity to fully reflect and express their knowledge of the phenomena of study.

Paramount to all of this, the participants were recognized as the research experts and I the co-reflector of their lived experiences (Chirban, 1996; Thorne, 2016). I utilized my knowledge of breastfeeding, IPV, and PNC to relate to the participants, allow them to trust me as an interested observer, and seek clarification about their disclosed experiences. I reflected my interpretations of their experiences back to them during the interview to ensure that my understanding of the phenomena was in-line with theirs. The utilization of an IR approach to interviewing was crucial in the context of the sensitive nature of IPV and breastfeeding challenges, as it allowed for purposeful power sharing and trust-building between myself and the study participants that is critical to the disclosure of such experiences.

### **Data Analysis**

The primary source of data collection for this study was through the conduction of semi-structured interviews with the research participants. Interviews were deemed to be necessary as they would allow for the exploration of the largely indiscernible phenomena of interest to this study and the personal meaning and experience associated with it (Patton, 2015). Participants' thoughts, feelings, and reflections on breastfeeding in the context of IPV, both current and retrospective, are unable to be observed and thus required exploration through qualitative interviewing. In this study, interviews allowed for the collection of robust experiential data on the phenomenon of interest and provided the opportunity to probe participants' responses for deeper meaning. Interviews were electronically recorded with the participants' consent.

Data analysis and coding were completed using an inductive approach that involved working with the collected data until patterns, concepts, explanations, and descriptions about the phenomena of study emerged (Patton, 2015). Handwritten field notes were taken throughout the interviews and recorded observations not confined to what the participant was saying, such as emotional tension, feel, sights, and sounds that occurred during the interview process. Recorded sensory observations served to prevent naïve conflation of the importance of what the participant said while neglecting to attend to other human experiences and senses that can provide important context to the recorded interview data (Sandelowski, 2002). These field notes included recordings about participant and interviewer actions, behaviours, and feelings and were reviewed immediately following each interview for analysis of trends, themes, and patterns. Early analysis through journaling and memo writing about emerging connections and relationships allowed for deepened familiarity and immersion in the data (Patton, 2015; Thorne, 2016). Recordings were manually transcribed verbatim by the student researchers associated with this study. The student researchers listened to each recording and read the accompanying transcription twice in order to

ensure accuracy of the transcription prior to coding. The transcriptions were then uploaded to a secure web-based server only accessible to the study researchers and student researchers. Transcriptions were entered into QSR International's Nvivo 12 (QSR International Pty Ltd., 2020) data analysis software program, and were analyzed. Transcriptions of the interviews were coded separately three times in order to generate an exhaustive list of codes relevant to this study's research questions. Codes were then compared and revised between transcriptions. A coding chart and table were created to compare emerging themes within and across interviews in order to examine relationships between themes and codes. A working draft of the coding chart, inclusive of 24 main codes, was presented to and reviewed by the thesis committee. With approval, coding commenced utilizing a revised coding chart and line-by-line analysis (see Table 4: Themes and Subthemes).

### **Rigour**

Lincoln and Guba's (1985) seminal criteria to enhance study rigour was utilized as a strategy to guide trustworthiness and reliability within this study. These criteria were chosen to guide this study's research design as they philosophically align with ID as a method of naturalistic inquiry (Thorne, Kirkham & O'Flynn-Magee, 2004). Lincoln and Guba's (1985) criteria recognize that reality is complex, subjective, is influenced by both the interviewer and the interviewee as inseparable entities, and that multiple realities can exist within a single object of inquiry (Thorne, Kirkham & O'Flynn-Magee, 2004).

Credibility within interpretive research refers to how reliable the interpretations of the phenomena are to the experience of the phenomena (Lincoln & Guba, 1985). When confronted with the interpretations of the experience, the respondents should be able to recognize it and feel that the researcher's depiction of their experience is valid (Guba & Lincoln, 1989). Credibility

was enhanced through researcher triangulation (Lincoln & Guba, 1985; Patton, 2015). This involved two analysts coding each of the interview transcripts and was monitored by the primary researchers involved with the main study that this study is associated with. Data-source triangulation was utilized as multiple methods of data collection were utilized, including semi-structured interviews, questionnaires, and surveys. Field notes and observations were compared to the data collected to further strengthen credibility and confirm the interpretations made through data collection (Patton, 2015). Peer debriefing was utilized between the two analysts of the transcriptions to detect biases and assumptions (Nowell et al., 2017).

Transferability is attained when the findings of the research have applicability in additional research contexts (Lincoln & Guba, 1985). In qualitative research, a rich description of the participants and study setting should be supplied so that researchers interested in transferring the study findings should be able to judge transferability for their studies (Lincoln & Guba, 1985). The data collected for this study, including an in-depth description of the study setting and participant characteristics, increases the potential for this study's findings to be applicable to further research involving breastfeeding women who have experienced intimate partner violence.

Dependability establishes that the research findings are consistent and repeatable, and confirmability establishes that the findings are grounded in the participants' narratives and experiences as opposed to the researcher's biases (Lincoln & Guba, 1985). When credibility, transferability, and dependability are achieved, a study can also be considered to achieve confirmability (Lincoln & Guba, 1985). The research and methodological processes utilized within this study, including study design and decisions related to analysis, are clearly documented throughout this thesis and are logical, traceable, and repeatable (Emden &

Sandelowski, 1998). Raw data, field notes, transcripts, and a reflexive journal were kept which captured the researcher's reflections during data collection and surrounding methodological decision making (Emden & Sandelowski, 1998; Thorne et al., 2004).

### **Ethical Considerations**

Careful considerations were made before engaging in potentially emotionally rousing conversations about violence, breastfeeding struggles, perinatal complications, and negative healthcare experiences. While it can be noted that HCP intervention for IPV is particularly beneficial for pregnant woman in that it may improve overall quality of life, reduce depression, aid in the creation of safety plans, deal with the emotional and physical ramifications of IPV, and access necessary community resources (Rivas et al., 2015) it must also be noted that discussions around IPV must be done so with great care, training, and compassion. As provider discomfort and a lack of provider knowledge in discussing IPV are major barriers to adequate IPV screening, identification, and intervention (Sprague et al., 2012), it was firstly important to examine my positionality and personal feelings in relation to this subject. Secondly, it was important to ensure that all team members were adequately trained and felt competent in discussing IPV and related issues with our participants. My co-researchers and myself met to engage in training on safety plan creation, TVIC, and interviewing considerations in relation to IPV and IPV disclosure prior to any interviewing taking place.

For the first two interviews, participants were given the option of meeting at a neutral and private location of their preference. As such, these two interviews were conducted at a public library in a private meeting room away from members of the public. The rest of the interviews were conducted via telephone to comply with Covid-19 'stay-at-home' restrictions that came into effect in the midst of data collection. Prior to telephone calls, participants were asked to provide

a phone number to be contacted at and a time and date of preference for their interview. Before conducting the interview, participants were ensured that I was in a private and secure location and were asked if they were in a safe location for our interview duration. It was reinforced to all participants that they were free to withdraw from the interview at any time and that their participation was voluntary. Participants were also informed that their personal data, interview recordings, and all study data would be protected and kept confidential.

Since it is known that a major barrier to IPV disclosure is when the woman's partner is present for her conversations with healthcare practitioners (Garnweidner-Holme et al., 2017), participants were asked if they were alone and in a safe place at the beginning of their interview. This said, participants were welcome and encouraged to bring their infants to face-to-face interviews and were encouraged to take breaks to provide their infants with attention and care. At the conclusion of all interviews, participants were asked if there was anything else that they would like to discuss and were provided with my email and telephone number in case there was additional information they needed to share. Two participants required breaks during their telephone interviews to care for their infants and, after a short break, were able to continue talking about their experiences.

It must also be noted that during the Covid-19 pandemic, there are increased considerations for accessing and implementing care for women who are experiencing intimate partner violence. Quarantine and 'stay-at-home' orders have meant that women experiencing IPV can potentially be isolated with their abusive partners and unable to access supports and resources necessary for their safety (Lanier & Maume, 2009). Thus, during this time, access to healthcare and health practitioners could potentially be one of the only escape strategies available to women experiencing IPV during a time of social isolation (Riddell, Ford-Gilboe &

Leipert, 2009). In the event of its necessity, I was prepared to provide the study participants with the contact information for their perinatal health clinic, the London Abused Women's Center, and the National Domestic Abuse Hotline.

All participants were assigned an identification code that was kept secured in an encrypted document on a password protected computer. All paper and electronic information is kept secured by the principle researchers until the completion of the associated co-study, upon which time it will be destroyed. Transcripts without participant identification will be kept for five years, secured and encrypted, with patient consent. This study received approval from the Western University's Research Ethics Board (project number 113464).

## CHAPTER 4:

### FINDINGS

#### **Overview of Major Findings**

Analysis of the qualitative interviews revealed three key themes that shed light onto the experience of accessing breastfeeding support for women who endorse a history of IPV and the perceived barriers that they face when attempting to access this support. The three themes that emerged were: 1) Navigating the Perinatal Healthcare System: ‘The most challenging thing’; 2) Seeking and Receiving Informal Support: ‘Worth its weight in gold’; and 3) Coping with the Challenges of Breastfeeding: ‘Sheer stubbornness and pure willpower’ (see Table 4: Themes and Subthemes).

#### **Navigating the Perinatal Healthcare System: ‘The Most Challenging Thing.’**

Participants emphasized that the journey of navigating the PNC system involved securing a healthcare team that was available and accessible to them and their families, building trust with that healthcare team through confidence and competence, gaining access to health services despite the ongoing obstacles posed by the COVID-19 pandemic and associated public health guidelines, and receiving care within an PNC program that was trauma-and-violence informed (TVIC). These reflections centred on the participants’ experiences of encountering facilitators and barriers to breastfeeding support within the PNC system, which one participant described as ‘impossible’ and ‘the most challenging thing [she] dealt with during [her] pregnancy.’ Four subthemes will be explored that relate to participants’ experiences as they relate to the healthcare system that they were attempting to access.

#### ***Securing a Healthcare Team: ‘Demoralized and Deflated.’***



Each participant faced obstacles when attempting to secure a healthcare team to care for them during the perinatal period. Many women felt that being a pregnant woman, having a history of mental health concerns, or a history of IPV made them less of a priority for healthcare providers and, thus, felt that they had a more difficult time securing a healthcare team than others might have. For some participants, it was felt that they were ‘slipping through the cracks’ and had to make multiple attempts to find a provider to take them on during their pregnancy or postpartum period. Participants continued to persevere through struggles to find a provider that would care for them despite feeling “demoralized and deflated” [003]. One participant described this process as ‘impossible’:

Like, I'm telling you, trying to find a doctor anywhere... Finding out I was pregnant, I called, like, a ton of walk-in clinics asking. And if you're pregnant, they just send you to Emerge. It's honestly impossible. Like, it was just... The only places that would take me are family med. I've been fairly healthy, and my family doctor actually just stopped [seeing me] because I've gone to a couple walk-in clinics. They just let me go. Adding everything up, having anxiety, calling and having everyone just be like, ‘No, like, go to Emerge. We can't see you. [003]

On top of the challenge of finding a healthcare team available to take them on as a patient, women faced issues to care access once they found a team to assume their care. Women found it a challenge to access breastfeeding support for many reasons, such as clinic location, unavailability of transportation, short opening hours, and having to see many providers through many time-consuming appointments to have their concerns addressed. What was also apparent was the feeling that appointment times, once they had them, were not long or comprehensive enough to allow women to disclose and receive help for their breastfeeding concerns. One

participant felt that her first care provider, whom she eventually left, didn't have adequate time for her to ask her questions:

She was really busy all the time, you know? And so, it was hard to, to ask all the questions and everything. I always forgot everything that I want to ask because she was so busy, and so hurry to finish everything, you know, really quickly. [006].

This was echoed by another participant, who encountered problems when attempting to ask questions about her breastfeeding practice to two of the PNC settings she accessed before securing her healthcare team at the study PWC:

When you ask those things at the hospital, they were, like... The other clinics and hospital seem to be more like, 'You should know this' kind of thing... But I really didn't, if you know what I mean? I understand they have a lot on their hands, but I just wish that they showed me simple things like, yeah, breastfeeding. [007].

Women described wanting to feel heard, despite understanding that there are time and space constraints associated with their health appointments. Women reported knowing that their HCPs were busy but felt that if they had adequate time to demonstrate breastfeeding, to ask their breastfeeding questions, and a safe space to breastfeed their infants during their appointment time, they would have had their needs more adequately met by their HCPs. Participants knew that they found the right healthcare team when they felt that their needs, as well as the needs of their child, were being met and respected during their appointment. One participant knew she had finally secured a trustworthy healthcare team within the PWC when she felt that she could work with her healthcare provider to balance their time to ensure her needs were met:

Her approach was different. Umm... Again, I understand that she had a limited time to talk to me, and not just because of [COVID-19]. But she would ask me, like, if I had any

other questions to go with... Before going to the appointment, I would write down any questions I had so I'm not forgetting once I get there, and I'm not wasting their time as well. So, then I know what questions I have. And, sometimes, through those questions, something new arises, and they were always really helpful at explaining and helping me through those things. [005].

***Building Trust Through Competence: 'It's Support, but It's Also Knowledge.'***

While participants' initial priority was often to secure a healthcare team, being able to develop a trusting, therapeutic relationship with their healthcare team was seen as just as important to their breastfeeding success. Being able to trust that their healthcare team was knowledgeable on perinatal care and breastfeeding prompted women to continually attempt to secure a healthcare team that met these criteria, despite the challenges that they faced. All participants felt that having a healthcare team that specialized in perinatal care and breastfeeding was important to them, as described by one participant. For one woman, "Just having someone who can guide you through that, or just say, 'That's completely normal', or, 'That's not normal'... Someone who can see you. So, I guess it's support, but it's also, like, the knowledge of the doctors." [003]. This was supported by another participant, who sought out an PNC provider and breastfeeding specialist while pregnant, seeking reassurance that her healthcare team was proficient with the care that she and her child would require:

Sometimes your family doctors are not so specialized in that area, and you don't know if they are going to know the right things or not. Like, I was not comfortable going to my family doctor, that they would know all of these things. Like, maybe he knows these things, but I was not satisfied with seeing him both times. I wanted to go to someone more specialized in this area to help me." [005].

For mothers, finding a team that they could trust to be competent was hindered, at times, by a lack of continuity of healthcare team. Many women established trusting relationships with HCPs, only to have their care transferred to another HCP. Some women didn't have the chance to build relationships with HCPs at all, due in part to the lack of continuity they experienced. When asked about whether she thought having a consistent HCP would have improved her experience of accessing breastfeeding support, one woman stated:

Yeah, but that was not my case because I had, like...I think I, saw four different doctors there and [the one] who delivered my baby was a different doctor, too. And every time that I went to the [postpartum clinic] was a different doctor, too. [006].

When one participant had serious concerns about her infant's breastfeeding, she described having to access multiple HCPs through several appointments before she was able to secure an HCP with the expertise to help her:

[infant name] had quite a few issues, not just with latching, but projectile vomiting. And so, I think we saw probably every care provider at [PWC] and then sort of ended up settling with [clinic physician]. She followed him for quite a bit. Turns out he has, well, several issues which were the main cause of our breastfeeding problems. So, [clinic physician] was wonderful; very caring... For about two-plus weeks, we kind of didn't have any support at all. So, that was pretty rough. [002].

For women who were able to secure a consistent healthcare team, feeling that those providers were competent and knowledgeable was seen as essential to building trust. When providers answered their questions, provided them with resources, and addressed their concerns, women felt that they and their baby were important and well taken care of. After experiencing a

healthcare team that she felt did not prioritize her needs, one participant described the process of developing trust in her new HCP team as ‘clicking’:

You know they knew what they were doing and there was, like... They were thinking about what they were doing with my baby and all. I am a registered nurse as well, so that kicks in when you’re watching somebody taking the care. And its something that kicks in your mind like, ‘Are they doing it right or not?’ But when they were doing care with my baby, I found I was thinking, ‘Okay, they are doing it right’. [005].

Being able to trust that their HCP team was competent to provide them with the right information or refer them to a specialist who could meant peace of mind for participants and helped them to relieve some of the stress they experienced during the perinatal period and ultimately feel more secure in their breastfeeding practices.

### ***COVID-19: ‘In a Limbo.’***

The COVID-19 pandemic created additional barriers for all of the participants attempting to access breastfeeding support. Public health guidelines that prevented some clinics from being open at all, reduced working hours for others, and limited the number of patients and support persons who could be present in the clinic created challenges for women who already felt that the odds were stacked against them. One participant, on how COVID-19 impacted her experience of accessing PNC, said,

It was really stressful. I was looking before, as well, but they were not accepting patients and with the pandemic going on. Even the pediatricians who were accepting patients, they put everything on hold. So, even now, I am kind of in a limbo to find a good doctor for [baby]. [005].

Of those who had established healthcare teams, COVID-19 impacted their ability to connect with those providers. Some women had issues with accessing the clinics due to the changing nature of the public health guidelines, leaving them confused as to what they could do and who they could contact to receive breastfeeding help. One woman felt she simply had nowhere to turn to receive breastfeeding help and wasn't sure if attempting to access help was safe for herself and her child:

I've talked to so many different people because I had to call to cancel... I called when they first called to get me to come [to the clinic]. I called because I was upset about a problem and, again, I have not had it dealt with. So, it's not like I've been... it's hard. Like, even when I was trying to make my six-week appointment, calling around, and these people are just like, 'No, we won't. We can't take you, like, sorry. It's COVID.' And they were, like, kind of... It's hard and you don't really know what to do because you don't know what's safe. [003]

As resources changed from in-person to online, some women noticed their appointments being cancelled or dropped, like one who said, "They booked me that class with the nurse to answer all your questions. I don't know the name of it. But, because of [COVID-19], they had to cancel." [006].

***TVIC: 'I Mattered, and That's Everything.'***

When the participants were exposed to an PNC program that practiced elements of TVIC, many felt that their obstacles in accessing PNC were lessened in comparison to previous experiences with PNC in other settings. Once enrolled in an PNC clinic that promotes TVIC, women described feeling safe, welcomed, and connected with their HCPs. For many women, the act of their HCP asking about and acknowledging their breastfeeding experiences, mental health, or IPV concerns helped them to feel understood by their HCPs, which ultimately led to trusting

them more. This was particularly important for one participant, who accessed the trauma-and-violence informed PNC clinic for breastfeeding support and received mental health support she was not initially expecting to receive:

Every time that I went there, they always asked me about my mental health and everything about motherhood... if I have any concerns. They are really great with [baby], too. Because I already had depression, right? I'm always really concerned I will have it back and, so, I was trying to cope with it. I don't know, sometimes you're just a little bit overwhelmed, right? And sometimes it's just nice to have someone tell you, 'Everything is okay. You're doing every thing well', right? [006].

This participant's previous experience with postpartum depression caused her to be wary of accessing PNC, but through accessing trauma-and-violence informed perinatal care, she found she was able to get the breastfeeding and mental health support that she needed. She described her mental health concerns as negatively impacting her breastfeeding experiences and causing her increased stress. When she disclosed her mental health concerns, her HCP provided her with supports and engaged a multidisciplinary team to help address her needs: "They asked me if I was okay to talk with a social worker. In the same week, [social worker] called me. It was great because I could talk about all of my concerns really fast... and I am okay now." [006]. Some women expressed that their first time ever being asked about IPV or mental health concerns was during their initial appointment with their trauma-and-violence informed PNC provider. One woman described this revelation as being 'everything' to her: "Just being able to have people who you don't know call, and who genuinely care. And who are advocating for you to come in for your mental health... That's beautiful." [003]. Many participants described that they felt more confident in their breastfeeding abilities after their visits to the trauma-and-

violence informed PNC setting and that they felt heard, understood, and valued by their perinatal care team.

### **Seeking and Receiving Informal Support: ‘Worth its Weight in Gold.’**

Participants often discussed the informal breastfeeding support they sought out as being just as important to their breastfeeding experiences as formal healthcare support. Seeking and receiving support to breastfeed from their partner, friends, and families was endorsed by all participants, but for some, the involvement of their support systems was, at times, a barrier to their breastfeeding success. One participant summed up her experience in reaching out to her support system by saying ‘compassion is worth its weight in gold’. “I got through my pregnancy and kind of... I had a great pregnancy. And I think that's because of the support I had with family, friends, and also medical practitioners. So, I think that's everything.” [003]. Four subthemes will be focused on that explore participants’ efforts in accessing and receiving breastfeeding support from their partner, friends, families, and in-laws and how this impacted their breastfeeding experiences.

### ***Partner: ‘When He’s Good, He’s Good. But When He’s Not, He’s Not.’***

Having partner supporting their decision to breastfeed and being present for them during their breastfeeding journey was important to most participants. While some participants articulated that their partners would verbally express their support of the participants’ breastfeeding decisions, most participants described a lack of physical and emotional support. Further, many women felt that the support that they did receive from their partner was inconsistent and lacking: “There were times he was there, and there were definitely times where he absolutely wasn’t.” [002]. At times, the feedback that participants received from their partner in relation to breastfeeding was well-meaning but in contrast to their breastfeeding goals, making



this experience frustrating for them. One woman stated that her husband felt, “it would be just so much easier if we just did formula” [002] while another found her husband’s attempts at emotional support to be discouraging: “If I’m trying to breastfeed and nothing’s coming up, he was there to tell me, ‘It’s okay to use formula for now and you can try later instead of having him cry constantly’. [005]. Partners were described by participants as having limited knowledge of and involvement in breastfeeding themselves but, at times, encouraged participants to access professional breastfeeding support. In most cases, partners supported women’s decisions to access PNC to receive breastfeeding support when breastfeeding challenges were apparent. One woman, who described her husband as supportive of her decision to breastfeed but had limited time to assist her, described the necessity of both his support and the support of her HCPs:

Without his support, it will be really more difficult for me, you know? I think the most important thing for me was that first appointment in the [PWC]. And I’ll describe that my husband was working during the whole time. But without [her husband’s support], I think I probably would give up, you know? Because it was really tough in the beginning. [006].

While most women discussed the emotional support they either did or did not receive from their partner, some women described that having physical support from their partner would have helped to facilitate her access to PNC. One participant stated that having her husband present with her during her PNC appointments would have made it easier to attend those appointments, as the pain she experienced postpartum made it difficult for her to walk and carrying her infant. Women discussed that having the physical support of their partner to help hold the infant, assist with latching, carry supplies, and attend PNC appointments would have been helpful to them, but no participants described receiving this support. Overall, partners seemed content with the participants’ decision to breastfeed but were described to have little

involvement in the actual process of breastfeeding, troubleshooting breastfeeding challenges, and accessing formalized breastfeeding support.

***Friends: ‘Solidarity Through the Struggles.’***

Having a supportive group of friends was important to most women when it came to seeking out breastfeeding emotional and informational support. For many women, accessing information and tips from friends who have breastfed before was seen as more accessible than accessing their HCP, especially in the context of the COVID-19 pandemic. Friends were readily available sources of information for mothers, especially when they had concerns about breastfeeding or infant issues. One woman, whose friend also breastfed, stated:

I would text her, and she was, like, really great at texting me back to tell me if it was normal or what to do. So that... this is... I feel like she’s my person that I can always text her and I feel like I can trust what she is saying to me. Even now, like, if there are any concerns with the baby or if I need any advice, I just text her and ask her, like, ‘Okay, this is going on, what should I do?’. [005].

Friends who had previously struggled with breastfeeding were common, and the support received from them was often in solidarity through the struggles. Participants who had friends who did not meet their own breastfeeding goals seemed to have a negative impact on participants’ sense of confidence in their breastfeeding abilities. One participant described the support she received from friends who struggled to breastfeed:

So, my momma friends have either... not been able to do it at all, and it's one of those, ‘You need to do what's best for you guys and then if it doesn’t work, it doesn’t mean you’re a failure and if it does work, then good on you’. And you just take it one day at a time.’ And then commiserating in the sense that, yes, this is, like, the hardest thing and while everyone thinks

it's natural – and it might be natural – it's the most unnatural process to go through and it doesn't... it's not intuitive. [002]

Friends who had experienced breastfeeding struggles of their own often encouraged participants to access formalized breastfeeding support as soon as possible, citing their own issues as cautionary tales for the participants:

I had a lot of friends that had babies recently before me, and so they helped me to break out my frustrations about [breastfeeding] before my baby was born. And so, my friends said, 'Don't wait too much to ask help', right? 'Because after, it'll be really hard to make it right. And so just ask for help with a doctor or with a lactation consultant. But ask for help now, because after you have issues, it will be hard'. And so, I was so lucky for it. [006].

On top of accessing their friends for informational support, participants valued having their emotional support as well, regardless of whether they had breastfeeding or infant-rearing experiences of their own.

They've been very open that they don't know how to be, so please let me know how I can be supportive. But, also, just really wanting an honest perspective themselves. When I have explained how trying, how difficult it is, they're like, 'Wow. We really didn't know that and I'm glad you're telling me that. I'm sorry you're going through it but thank you for being honest.' [002].

Friends were ultimately described as being accessible, non-judgmental, and relatable sources of information and emotional support for participants and were accessed more readily and more frequently for breastfeeding support than participants' perinatal HCPs.

***Family: 'They Know Me.'***

Family, described as a participant's own parents, siblings, or extended family and not including their in-laws, was a polarizing topic for many of the participants. While some participants were satisfied with the level of physical and emotional involvement their families had in their breastfeeding experiences, others felt that they required either more or less support from their families to facilitate successful breastfeeding. Of those that felt positively about their family's support, women described their families as integral to their self-confidence, not only at breastfeeding, but as mothers, and that their families were supportive in a multitude of physical and emotional means. One participant described the physical help she received from her parents while she was struggling with breastfeeding:

My dad's an incredible cook so he just cooked the whole time and made sure our fridge and our freezer was fully stocked with pre-made meals so we didn't have to worry. And then my mum was similar; she made sure my house was cleaned up and kept up with laundry and also did the cooking and just made sure that I was eating. [002].

The participants' parents, particularly their mother, was seen as a positive source of emotional support for most. Many of the participants felt that their mother was an unparalleled source of knowledge, expertise, and reassurance that they could not receive from anyone else, including their HCPs. Some participants who had positive relationships with their mothers described feeling that, because their mother knows them well, they know how best to support them when they're learning to become mothers themselves. One participant described her mother's gentle approach to support when she was struggling with breastfeeding concerns:

She was not too pushy on me. There were one or two things she would tell me. She would not say to me, 'You should do this', because she raised me and she knows how I

am. She would say, like, ‘You can do these things’ but never, ‘Do this’. So, that was really helpful, and I felt like, okay, she’s giving me a choice. [005].

For other participants, their families were described to be a source of contention and, at times, increased stress during the postpartum period. Some participants interpreted the constant advice they received from their families as judgment and, thus, felt pressured to behave in a certain way around them for fear of further negative scrutiny. Some families were described as ‘telling’ instead of ‘asking’, especially when participants disclosed when they were having breastfeeding struggles. One participant described the feedback she received from her family and how it impacted her breastfeeding experience as such:

Everyone is like, calling and doing the video chat and asking, ‘How are you doing? How are you doing?’. And so, like, ‘Are you breastfeeding? Are you breastfeeding, or not?’. And so, it felt like a constant pressure on me because everyone is giving you negativity and you’re already going through, like, the pain process and big hormone changes in your body. They don’t understand that, I think. They think... you’re a woman, and so just put your baby on your breast and everything will be okay, you know? And it’s not like that. [005].

This was echoed by another participant, whose family was similarly felt to be overbearing with negative feedback: “They think we are doing everything wrong, and they want to be here to correct us. They think their way is always correct and everything we are doing is wrong, because we do not have any experience, you know?” [006]. Women described valuing when their families were present for them physically and emotionally, especially in the context of breastfeeding support, but also expressed struggling with their own identities as mothers when they received extensive input from their families as to how to feed and parent their child. Some

participants, particularly those who were new mothers, stated that they felt that their families did not value them as their child's mother because of their lack of experience with mothering. In this way, families were, at times, seen as a deterrent to breastfeeding self-confidence and caused mothers to be discouraged with their breastfeeding abilities.

***In-Laws: 'More Tension Than Support.'***

Many of the participants described negative experiences with their in-laws during the postpartum period despite, in most cases, describing having previously positive relationships with them. In-laws were often seen to be a source of stress that impacted their breastfeeding and their relationship with their partner negatively. One woman described an experience where her mother-in-law's behaviour at the participant's home prevented her partner from providing breastfeeding support to her while she was struggling:

I was shot at this point. Latching still isn't working and we pretty much, as you do with newborns, spend 90% of our day feeding or at least trying to feed, as their sessions take forever. I'd gone upstairs because breastfeeding was so hard – I just like to be alone – and my husband was up with me. He then went downstairs, and his mom was sitting down there just crying because she was all upset because she couldn't help [feed the baby] and felt totally useless. And, 'she might as well go home', and 'she thinks she's gonna have his dad come pick her up the next day'. It was very... not what I needed in that moment. Yeah, so it's more stuff like that, like, 'we're all gonna come up and help' and then, 'nope'; it's all about you. I think the parents were more high-strung than they needed to be, and they weren't very good at not making it about them. ... There's been more tension than support. They've also been great in other ways, and they've been very happy for us, but just haven't really succeeded in that whole, 'it's not about you' piece. [002].

This participant described that her mother-in-law's behaviour resulted in her husband neglecting to assist her and her infant with breastfeeding so that he could attend to his mother's disappointment at not being able to feed her grandchild. While some participants describe being shocked by these negative experiences, others were prepared for negativity from their in-laws before their child was even born. One participant stated she was prepared for her in-laws' behaviour prior to giving birth and, when asked to explain what she was prepared for, stated:

I know that they have a lot of concerns about us, and they will give a lot of advice and argue with us. And we were doing everything wrong, and I already knew that it would happen. And so, I was mentally preparing myself to cope with it and not be upset with it. [006].

The participants who described negative experiences with their in-laws during their breastfeeding journeys described feeling as though their in-laws, particularly their mother-in-law, did not trust them as a mother and did not believe that they could parent their child properly. This is well described by one participant, who had repeated struggles with her mother-in-law and felt judged for having difficulty with breastfeeding:

They wanted to call me through the [breastfeeding] process. They are like, 'Your sister-in-law has gone through this process. Do this, do this, do this.' All those things they wanted me to do without questioning... And I was not feeling comfortable to do it all. There were all these questions and they just wanted me to follow, like, strict stuff. And more of them were related to the breastfeeding. Like, anytime I thought about giving him a bottle, they were like, 'No, if you just put the baby to your breast, the breastmilk will come. Do this'. But at that point, my baby was losing weight and crying, and you just have to give him something to settle him down. You cannot have him crying all of the

time. But they were not really understanding of that at all. And then, there was calls coming in at inappropriate times, sometimes at like midnight and very early morning. So, I was feeling like I needed a break from that. They wanted me to go with the way that they had raised their babies. Like, I'm open to opinions, but don't call me again to check to see if I'm following your rules or not. That's what bothered me. I was just feeling like everybody was trying to control me. [005].

When asked if interference from her in-laws negatively impacted her breastfeeding experiences, this participant stated,

Initially, yes, but then I had to... Once I was going through that stage for, like, a good three weeks, I had to just step up and I had to say to them, 'You guys need to stop and I'm going to do it the way I want to.' And after that, things started to get a little bit better. [005].

In-laws, in particular the participants' mother-in-law, were largely described as a deterrent to breastfeeding self-confidence and success. Many participants described that they did not receive support from their mothers-in-law; rather, they experienced judgment and devaluing of their position in their infant and partners' lives. Many participants expressed feeling like their mothers-in-law did not trust them to take proper care of their infants and that this, at times, led to tension in their intimate partnerships. Ultimately, in-laws were seen as a source of stress for most participants and represented an unfortunate obstacle to breastfeeding success.

### **Coping with the Challenges of Breastfeeding: 'Sheer Stubbornness and Pure Willpower.'**

Participants underlined the importance of developing their own identity as a mother when attempting to access breastfeeding support and PNC in the context of IPV. For participants, developing confidence and self-efficacy, prioritizing their baby's wellbeing, and fostering resiliency



were all important individual factors that both facilitated and hindered their efforts to access breastfeeding support. One participant described her overall breastfeeding journey as being fueled by ‘sheer stubbornness and pure willpower’. In the following sections, three subthemes will be explored as they relate to participants’ experiences of accessing breastfeeding support while concurrently coping with the challenges that breastfeeding can pose.

***Developing Confidence and Self-Efficacy: ‘I Felt Like Less of a Mother.’***

Having the confidence to succeed at breastfeeding was described as being important to all participants and developing breastfeeding self-efficacy was done in a multitude of ways. For many women, support from their HCP provided them with the emotional and informational assistance they needed to feel competent in their mothering and breastfeeding skills.

We went to the [PWC] and they told me, ‘It’s okay. Everyone takes their own time to develop a breast milk supply’. And, like, we are all different. Everybody is different. They told me that, like, even if your mother had a good milk supply doesn’t mean you will have a good milk supply. So those things... I just needed some reassurance to make me relax and say, “Okay you’re doing all of these things right. Maybe it’s your body” instead of saying to me like, “Oh, she’s tired. You shouldn’t breastfeed, you shouldn’t breastfeed”. Sometimes you just need another person to listen to you. I got that from the clinic. [005].

This was echoed by another participant, who felt her experience receiving PNC from a trusted HCP helped to boost her confidence and self-efficacy:

I had a little bit of difficulty with breastfeeding, so the fact that that came up in the appointment and that they kind of immediately were in-tuned that I was not one hundred

percent. That made me a lot more confident when I went home and I had to do it on my own kind of thing. [007].

Positive experiences with accessing PNC for breastfeeding support helped mothers to feel more confident in their breastfeeding abilities, even in the presence of challenges and setbacks. In contrast, negative experiences with HCPs were found to undermine a woman's breastfeeding self-efficacy and discourage her from accessing further formalized breastfeeding supports. One participant described that a poor experience with a lactation consultant completely derailed her breastfeeding efforts and left her feeling defeated:

The lactation specialist actually, like, made me feel really horrible. Yeah, and I cried, and it was... She got really frustrated with me and she wasn't the nicest. And, again, that's such a, like, it's not an issue, but I think if I had had a different lactation specialist, I would have felt a lot better about breastfeeding. When I left there, I felt like completely demoralized and deflated. It just kind of made me feel really horrible about myself. [003].

Developing their own identity as a mother, regardless of their breastfeeding struggles, was highlighted by some of the participants as important to their self-confidence. Perceived pressures to conform to the societal standard of the 'perfect mother', as portrayed via social media, were prevalent amongst the participants. Some mothers found social media to be detrimental to their self-confidence as breastfeeding women and had to acknowledge that their experiences, at times, did not look like the ones they saw on the internet. As stated by one participant: "I just bought into the Instagram, Pinterest family pictures that are all beautiful and wonderful everything is super easy and great and... Well, there's definitely those moments, but there's also a lot of really, really, really hard, trying, difficult things." [002]. In the end, women described having to draw from positive supports – inclusive of HCPs, friends, support groups,

and family members – in order to increase their confidence in their breastfeeding abilities and persevere through breastfeeding challenges.

***Prioritizing Baby's Wellbeing: 'This is My Baby's Life. My Life.'***

Participants prioritized the wellbeing of their babies first and foremost during their experiences of accessing PNC for breastfeeding support. Mothers described a sense of duty to protect their child and ensure that their health needs were met even when they were faced with obstacles. The participants described persevering through the challenges they faced with breastfeeding and obtaining support for breastfeeding because they felt breastfeeding was the best option for their child. A participant talked about her decision to keep breastfeeding despite the challenges she was facing by saying, 'this is my baby's life; my life'.

Felt along with the sense of duty was the sense of guilt for struggling with breastfeeding at all. Even in the presence of support from HCPs and their social support system, some mothers felt disappointed in themselves for struggling with breastfeeding, feeling either that it is natural and, therefore, easy, or that their struggles simply meant they were inadequate as mothers. One participant described the feelings of guilt and failure she experienced when she was struggling to breastfeed, and how she felt misunderstood throughout those feelings:

That's part of what drives my husband nuts, 'cause he's going, 'You don't, you know, you don't need to kill yourself' and, 'Why are you doing this?' But I think, for any of our guys, friends, and spouses... Anybody. They really don't understand the feeding connection or the feelings of failure if you do quit. The hardest part, I think, for them, or any other supportive party, to understand is it doesn't matter how supportive you are, or how caring you are. If that journey is cut short in any capacity, how much of a failure you feel like... There are no magic words to fix it. [002].

Feelings of failure, shame, frustration, and guilt were common for mothers who were struggling to breastfeed. A second participant recognized how her breastfeeding challenges made her feel like ‘less of a mother’. She persisted through her struggles because she believed it to be the best feeding option for her baby. She describes her feelings around not having an ‘easy’ breastfeeding journey as such:

I don’t know if this makes sense for you, but I was feeling really frustrated about it. And so, after that, and how breastfeeding was not working too, and I thought, ‘Oh, my God. Everything that I planned is not going in that direction. Everything was going right in the opposite direction.’ I was feeling really down, and really... As if I was not enough. As if I was not, I don’t know, a real mother, because I didn’t have those experiences. [006].

For most participants, including this one, feelings of guilt and shame were lessened when their support system was in tune to their emotional needs. Despite feeling negatively about her experiences as a mother, this participant’s connection with her HCP allowed her to feel more in control of her breastfeeding experiences and cope with the challenges:

But, this is why, I was telling you, why it’s so important to me when the doctors ask about my mental health and things like that, because sometimes it’s just one word. One word can help you a lot to cope with it. I don’t know how, but [PWC HCPs] made me feel okay and not ashamed. [006].

Ultimately, doing what was best for their child was prioritized above all else. In the face of breastfeeding challenges, a lack of positive social support, and issues with obtaining a trustworthy HCP, mothers did what they knew was best for their child. This was described by one participant as: “I feel that if I [talk to my family about] breastfeeding, then they would have to be very supportive of it because, yeah, they don’t really get a choice. It’s not their tummies that’s getting filled.” [007].

### ***Fostering Resiliency: ‘One Day at a Time.’***

Participants each, in their own way, described moments of resiliency and how they were essential to their journey in accessing breastfeeding support. For each participant, there were moments that they could recall where they had to call on their strength, or the strength of their support system, and endure through the obstacles to accessing breastfeeding support and the challenges associated with breastfeeding itself. Those who described being well-supported by their HCPs and social support system to breastfeed discussed leaning on those supports in times of hopelessness:

And, so, because breastfeeding was not working well, I was really, really sad, you know? So, when the doctor said to me, ‘Everything was okay; the baby was okay, the tests were okay... Everything was okay.’ We just... we just needed some time to get used to breastfeeding. So, I don't know how, but everything just started to work after that, you know? Sometimes we just need a friendly word. [006].

This was echoed by another participant, whose positive experience with an HCP after she sought support for a lack of breastmilk supply was exactly what she needed at the time:

So those tiny things were, like, helping somewhere in your mental status. Like, ‘Okay, you are fine. You’re doing things okay. It’s just your body’. So those small things were good. Like, initially I thought maybe he was lip tied or tongue tied but [PWC HCP] were like, “No, everything’s good. The latch is good. Try this position... Try this, try this.” So, they were giving me all of these options, which was really helpful. I was really grateful. Like, okay I can try these things; I can try this position. It was really helpful at the time. That’s what I needed at that time to keep going. [005].

The response of their support system to their support-seeking behaviours was important to participants. Support systems, inclusive of HCPs, who responded with judgment or negativity when

a participant sought support during her breastfeeding struggles had a detrimental impact on the participant's resiliency. After having a negative experience with an HCP, who discouraged her from breastfeeding, one participant developed resiliency through the encouragement of a different HCP, who worked with her through her breastfeeding concerns:

There was never a question of will I formula feed or breastfeed. Like, it was totally... if I could breastfeed, I'm gonna breastfeed. I just felt after [negative experience with prior HCP], like, I couldn't do it. I felt horrible about it. It wasn't until the [PWC HCP] came and she was like, 'Let's get you pumping' that we were able to get more supply, and I started breastfeeding again. But, like, after [[negative experience with prior HCP], I was in tears and thought I could not breastfeed. [003].

Receiving positive, non-judgmental support while experiencing struggles with PNC access or breastfeeding allowed mothers to accept that facing challenges with breastfeeding did not diminish their worth as a mother. Understanding that support would be available to them when struggles arose was described as important to participants and to the development of their resiliency. One participant described taking her breastfeeding journey 'one day at a time':

Some people really struggle for a week or two. Some people struggle for six weeks. Some people struggle their entire feeding journey and, literally, are just counting down the days to six months. And, 'I just need to make it one more day'. They just need one more day. That's really where that supporting piece is coming into key to maintain that. 'I can do this', like, 'Let's keep going to about six months or a year', or whatever your breastfeeding goal is, really. [002].

This was supported by another participant who said, “It felt like a constant pressure on me. Even though I wanted, personally, to breastfeed... It was... hard. At that point, I was so much... With what experience I had with breastfeeding, I was just taking it day by day.” [005].

Eventually, mothers felt resilient once they accepted that their vision for their perinatal journey was not often what was experienced in reality. Through the support of their HCPs and social support system, mothers were able to recognize that the contrast between their perception of what their perinatal and breastfeeding experiences would look like and the reality of what they went through did not mean they failed at meeting their baby’s needs. Rather, participants talked about ‘forging a new path’ and ‘accepting it for what it was’ when talking about how their expectations for their breastfeeding journey changed. This was summed up by one participant: “Sometimes we planned a lot of stuff, but it didn’t work out in that way. So, we have to restart everything and go in another direction. And if the baby is healthy, it’s okay. If you’re healthy, it’s okay, too.” [006].

### **Summary of Findings**

Three major themes emerged which described women’s experiences of navigating the PNC system, seeking and obtaining informal breastfeeding supports, and coping with the challenges of breastfeeding. Mothers described their experiences of attempting to secure a healthcare team and the obstacles that they encountered while trying to find a care team to assume their care both while pregnant and when attempting to received help with breastfeeding concerns. Once able to secure an HCP to assume their care, participants expressed the importance of building a trusting relationship with their healthcare team. Trust was described to have been built between mothers and HCPs through displays of competence, support, and knowledge from HCPs when mothers accessed them for breastfeeding support. COVID-19 was

described to further exacerbate healthcare accessibility challenges for mothers, as many sought-after perinatal services were cancelled or unavailable to them. TVIC, however, was described by participants as a helpful factor to alleviate some of their breastfeeding concerns and obstacles, as they described feeling that their mental health and breastfeeding concerns were important to their HCPs.

Participants described seeking and obtaining informal breastfeeding support from their partner, friends, family, and in-laws as being just as important as formal breastfeeding supports. Partners were described by some women as being supportive of their decision to breastfeed but were ultimately lacking both emotionally and physically during breastfeeding itself, troubleshooting, and accessing formalized support. Participants described receiving emotional support and solidarity through their breastfeeding struggles from their friends and ultimately found their friends a more accessible form of informational support when compared to breastfeeding supports. The breastfeeding support received by participants from their families was described as supportive by some participants and overbearing by others. In-laws in particular were a deterrent to breastfeeding success and a source of tension in the postnatal period.

Mothers in this study described the support they received from their formal and informal supports and how that support impacted their breastfeeding self-efficacy. Those who had positive experiences with accessing breastfeeding supports from family, friends, and HCPs described an increase in their confidence to meet their breastfeeding goals. Meeting these goals was important to participants, who discussed prioritizing the wellbeing of their babies and felt that breastfeeding was the best way to do so. To achieve this, women described calling on their strength and fostering resiliency to persevere through the challenges that they encountered in accessing breastfeeding and perinatal support.



## CHAPTER 5: DISCUSSION

The purpose of this study was to explore the experiences of perinatal women who have experienced IPV as they attempt to access breastfeeding and PNC services and supports. The findings of this study contribute to the current knowledge on the experience of this phenomena in four key areas: (1) supporting women in accessing formalized breastfeeding support care; (2) the influence of TVIC on breastfeeding experience; (3) the impact of social support on breastfeeding; (4) fostering the development of breastfeeding self-efficacy.

### **Supporting Women in Accessing Formalized Breastfeeding Care**

An important finding from this study was that women who have experienced IPV often make multiple attempts to secure a healthcare provider during the perinatal period but find this to be an arduous task. This finding has been well supported by existing literature that has shown women with histories of violence to be less likely to uptake and obtain adequate PNC (Furuta et al., 2016; Islam et al., 2017; Metheny & Stephenson, 2017; Musa et al., 2019). Structural barriers, such as unavailability of transportation, inopportune clinic hours of operation, and having to navigate through multiple providers to have their concerns addressed were of great concern to the participants of this study. Two factors that had the greatest impact on access to formalized breastfeeding support for breastfeeding women endorsing a history of IPV were difficulties in accessing a provider skilled in breastfeeding support and a lack of continuity of care within the PNC team.

It was found in this study that not only did women have difficulties in obtaining access to any PNC provider due to a multitude of structural, personal, and interpersonal barriers but that they were often referred to HCPs that they believed lacked professional knowledge on PNC,

IPV, and breastfeeding. Women of this study sought out an HCP team that was knowledgeable on perinatal care and breastfeeding and often had to make multiple attempts to obtain a provider that fit with their care needs. Having access to a perinatal HCP who had specialized knowledge on breastfeeding was seen as preferable as women felt this would ensure they would receive the best, most reliable breastfeeding information and support. Existing literature supports this finding; HCP competence to provide specialized PNC was seen as essential to perinatal women with histories of trauma and violence (Origlia et al., 2017; Li et al., 2019; Reeves, 2015; Kuzma et al., 2020). Participants described being referred to practitioners that they felt did not possess expert knowledge on breastfeeding and once they were unable to receive the specialized care that they required, they had to continue to make attempts to secure an appropriate practitioner. Women who perceived the quality of care they received to be subpar as a result of PNC provider approach to care or perceived lack of knowledge of breastfeeding were less likely to access these providers for support when they needed it. This is supported by literature that found that women, especially those deemed to be at-risk or who endorsed a history of trauma, found provider approach and the quality of care they received to be barriers to obtaining adequate PNC (Downe et al., 2009; Origlia et al., 2017; Antsey et al., 2018).

The findings of this study are significant as they could demonstrate a lack of knowledgeable breastfeeding community supports. As well, these findings, consistent with prior literature, continue to stress the need for specialized training and educational programs for HCPs in the support of breastfeeding mothers. Women of this study felt that they had to seek care from multiple HCPs before they were able to find one with the knowledge and skills to support them at breastfeeding, suggesting a potential lack of available HCPs with specialized breastfeeding training and education. Adopting the BFHI in Ontario has been shown to be effective in

increasing breastfeeding access and, therefore, success. In fact, one of the few Canadian facilities that promoted the BFHI found a significant increase in successful breastfeeding rate from 73% to 92% within their served population in one year of holding the designation (Daniel, 2020). An increase in availability of Baby-Friendly facilities could result in an increase in healthcare professional competency at providing skilled perinatal and breastfeeding care, thus increasing the accessibility of these practitioners. At present, only 2% of Canada's hospitals and clinics hold the Baby-Friendly Hospital Initiative (BFHI) designation as described by UNICEF and the World Health Organization (2018). In Ontario where this study was conducted, only seven hospitals and 23 community health clinics are Baby-Friendly designated (Baby-Friendly Initiative Ontario, 2021), representing just 2.2% of the available facilities in the province. This contextualizes the difficulties that this study's participants expressed encountering in attempting to secure an HCP with specialized knowledge on breastfeeding practices, as there is a known shortage of these providers available to this population. A lack of Baby-Friendly facilities could demonstrate that there is a lack of providers working within facilities that undertake Baby-Friendly policies, practices, and training. Further research needs to be completed to determine whether an increase in adherence to Baby-Friendly policies for PNC settings would have a significant impact on mothers' experiences in securing a skilled breastfeeding care provider.

Once women were able to secure an HCP team they deemed knowledgeable on breastfeeding, a lack of continuity of PNC provider was a compounding factor affecting women's access to adequate skilled PNC. It was found that collaboration and continuity of care were beneficial to increasing women's access to holistic perinatal care through the building of a trusting therapeutic relationship. Participants who were able to consistently see an HCP for breastfeeding support felt more positively about their relationships with their care providers and

about their experiences with formalized breastfeeding supports. Literature into continuity of care in PNC has shown its importance to both maternal and infant outcomes. Women that are able to see a consistent care team have been shown to have reduced risk for pre-term labour (Fernandez et al., 2015) and caesarean delivery (Homer et al., 2001). Models of community-based PNC that promote continuity of HCP further improve maternal and infant outcomes specifically for at-risk women (Gokhale et al., 2020; Rayment-Jones et al., 2021). Despite research that shows continuity of care in PNC is beneficial to breastfeeding success, especially as it pertains to women identified to be at-risk or who have disclosed a history of IPV, continuity of care is not achieved for many women. Barimani and colleagues (2014) found that nearly 40% of perinatal women studied reported insufficient support stemming from an absence of continuity of HCP that contributed to a lack of physical and emotional breastfeeding support. The findings of this study contribute to this existing body of knowledge in that they offer a qualitative perspective on women's experiences with a lack of continuity of care in the PNC setting and how it impacts their perception of the breastfeeding experience.

### **The Influence of TVIC on Breastfeeding Experience**

The impact of the purposeful implementation of the principles of TVIC in the care received by participants of this study was evident throughout their narratives and had a meaningful influence on participants' experience of accessibility, quality, and usefulness of the breastfeeding support they received. Prior to entering a setting that promotes trauma- and violence-informed PNC, women in this study described feeling that having a history of mental health concerns and/or disclosing a history of IPV negatively impacted their ability to access breastfeeding support. Women of this study who entered the PWC, an PNC setting that endorsed the principles of TVIC, felt positively about the care that they received in contrast to prior non-

TVIC settings. A central principle to TVIC is building trust between providers and patients through transparency, collaboration, empowerment, and choice (Substance Abuse and Mental Health Services Administration, 2014). Trusting, therapeutic relationships with HCPs are essential to adequate PNC for women who have a history of trauma or violence (Reeves, 2015; Menscher, 2016; Li et al., 2019; Gokhale et al., 2020; Kuzma et al., 2020). Having a trusting relationship with their HCP was expressed as being very important to mothers within this study, underscoring the potential benefits that a TVIC model could have on trust-building for this population. Participants expressed feeling more positively about their breastfeeding experiences once they had established a therapeutic relationship with an HCP who was trained in providing TVIC. Positive, trusting relationships with HCPs were built with participants through provider displays of compassion, competence to address physical and emotional concerns, and time spent engaging with the participant.

Literature that has examined what women with a history IPV find important to their care has supported the implementation of TVIC principles for this population. Feder and colleagues (2006) found that women who had experienced violence from their intimate partner placed importance on provider compassion, sensitivity, openness, and professionalism when accessing healthcare. This was echoed by Origlia (2017), who found that women who felt valued by, engaged with, and were trusting of their perinatal HCP built stronger, more positive relationships with them. Participants of this study who expressed positive relationships with HCPs felt that their provider cared about them personally, felt safe discussing their breastfeeding issues with their provider, and felt that their provider supported their infant feeding decisions. The desire to feel personally connected to and valued by their HCP was endorsed by existing literature and can

have positive impacts on breastfeeding outcomes (Origlia et al., 2017; Li et al., 2019; Reeves, 2015; Kuzma et al., 2020).

Kuzma and colleagues (2020) found that HCPs that implemented principles of TVIC in their care models through the creation of physically and emotionally safe environments, demonstrations of compassion and caring, and establishing trusting therapeutic relationships could help to mitigate the effects that trauma has for women and their infants during the perinatal period. Trauma- and violence- informed care specific to PNC has shown it to be a positive influencing factor in access to breastfeeding support, trauma and violence identification by HCPs, and the promotion of client-oriented individualized care administration. When models of healthcare are trauma- and violence-informed, healthcare consumers report increased levels of trust in their HCP, feelings of safety in accessing care (Lanphier, 2021), and health-related autonomy (Feder et al., 2006). At-risk perinatal women report their relationships with their HCPs to be non-threatening and non-judgemental when HCPs implement the principles of TVIC in their care plans (Downe et al., 2009). The present study supports current evidence that suggests HCPs be educated on how to provide TVIC (Feder et al., 2006), as training on how to care for individuals who have experienced trauma or violence can help to improve HCP's knowledge of IPV, HCP's attitudes towards IPV survivors, and HCP readiness to identify and respond to IPV (Kalra et al., 2021). Providers who are educated in the effects of trauma and who work with their clients to understand how trauma impacts their health, specifically as it pertains to breastfeeding women with a history of IPV, can potentially mitigate some of the negative impacts of trauma on maternal, infant, and breastfeeding outcomes.

An interprofessional approach to breastfeeding support was shown to improve the delivery of TVIC in this study. Interprofessional collaboration between different HCPs and their

clients resulted in increased attention to maternal mental health needs, leading to increased feelings of trust and understanding in the therapeutic relationship between provider and mother. An interprofessional approach to care has previously been shown to lead to better integration of experienced and educated health professionals, more holistic approach to the management of breastfeeding problems, and an increase in maternal satisfaction with formalized breastfeeding supports (Antsey et al., 2018). Studies that informed the literature review for this study also highlighted the importance of interprofessional collaboration in the care of IPV-indicating breastfeeding women (Kulkarni et al., 2011; Bradbury-Jones et al., 2015b). This study strengthened the claims made by Kulkarni (2011) and Bradbury-Jones (2015b) that advocated for interprofessional collaboration in PNC to reduce structural and personal barriers to adequate care access and improve intervention for perinatal women with a history of IPV. Specific to TVIC, Levine, Varcoe and Browne (2020) found that an interprofessional approach to educating providers on TVIC enhanced provider knowledge, awareness, and competence in providing TVIC. An interprofessional approach was beneficial in supporting conversations around decisions, influenced how providers understood trauma, and influenced the priority they placed on the importance of trauma-informed care (Levine, Varcoe & Browne, 2020). It could be suggested then that provider education and training on TVIC in PNC should be interprofessional in nature to increase its effectiveness and uptake by PNC providers. Further research investigating the effects of an interprofessional TVIC educational program in PNC is thus required to support these claims.

### **The Impact of Social Support on Breastfeeding**

Social support from partners, families, and friends was found in the current study to be as important as formalized breastfeeding support in impacting women's perception of breastfeeding

support in the perinatal period. Novel in this study was the finding that even in the presence of a history of IPV, many women desired the support, both physical and emotional, of their partner while breastfeeding. In light of these findings, it might be beneficial to the mother's sense of support and breastfeeding self-efficacy to include their partner in breastfeeding care and education, should their partner be receptive to being involved. This could lead to potentially confounding situation for perinatal HCPs in that they might know violence to be occurring within the intimate partnership but desire for their client to have the support that she believes she requires in order to be successful at achieving her breastfeeding goals. Feder (2006) found that women desired their HCPs to be understanding of how complex IPV situations can be and not pressure them to rush to leave the partnership. Of note is that none of this study's participants disclosed a current history of IPV and we are unable to know whether the participants' current partner has ever been violent towards them. There is a need for future research to assess this phenomenon, as to whether only mothers in the pre-contemplation stage of acknowledging the seriousness of their IPV, or those who endorse a history of violence but express that violence is not currently occurring, desire to have their partner involved in their PNC planning.

While partners were seen as largely uninvolved in the breastfeeding journey, participants described the social support they received from their families and friends as being highly accessible and reliable sources of emotional and informational support. The support a mother receives from her family and peers is an important factor for the HCP involved in her care to consider as these supports, or lack there of, can have far-reaching impacts on breastfeeding outcomes. Letorneau and colleagues (2013) found that mothers who had experienced IPV reported that emotional support from their social support group in the form of encouragement and understanding positively impacted their ability to bond in a healthy, nurturing way with their



infant. When HCPs include a mother's social support system in their care, breastfeeding outcomes are improved (Demirtas, 2012). Women who are deemed at-risk, such as those of low SES or who have disclosed a history of IPV, are found to rely primarily on their social supports for informational and emotional breastfeeding assistance (Barona-Vilar et al., 2009). Doig and colleagues (2021) found mothers who had experienced trauma or violence cited lack of social support as the main reason for ceasing breastfeeding earlier than they originally had intended. This study supports these findings, as many participants described moments where they were required to draw from the strength of their social support systems to persevere through breastfeeding challenges.

Humphreys (2005) found that the inclusion of a woman's social supports in the implementation of breastfeeding education and support was more effective at improving breastfeeding outcomes for at-risk women of low SES than care programs that focused solely on HCP-led breastfeeding interventions. Implementing an interprofessional approach to care, utilizing peers who had been successful at breastfeeding in conjunction with breastfeeding specialists such as nurses or lactation consultants, was found to significantly enhance breastfeeding rates for this population (Humphreys et al., 2005). Implementing peer-support programs and involving trusted friends and family members in the care of the breastfeeding woman would be supported by the results of this study. It was found that women often sought out peer breastfeeding supports on their own, consulting them for emotional and informational support more readily than they did their HCPs. Of interest, though, was that many participants reported that their peer supports encouraged them to access and obtain formalized breastfeeding support from an HCP, regardless of whether the support person had breastfeeding experience, felt positively about breastfeeding, or were unable to successfully breastfeed themselves. Peers

can, as this study suggests, act as a catalyst for mothers with a history of IPV to access breastfeeding support from a perinatal health professional through encouraging them to engage with PNC. As PNC acts as an important first-contact point for many women experiencing IPV (Devries et al., 2010; Stephenson et al., 2016), these findings can potentially lead to higher rates of uptake of PNC and IPV identification for breastfeeding mothers.

This study contributes new findings to the body of knowledge on the impact that mothers-in-law have on women's breastfeeding success in the presence of a history of IPV. To my knowledge, this is the first Canadian study to uncover the potential impact that in-laws can have on breastfeeding self-efficacy and success for mothers who endorse a history of IPV. As such, this study offers new insights into the qualitative experiences of navigating in-law relationships and mitigating the stressors of these relationships in conjunction with the stressors associated with breastfeeding, mothering, and IPV. Most extant literature addressing the complexities of in-law relationships on women's experience of mothering and breastfeeding have been conducted in developing nations or in cultural contexts where traditional gender norms are heavily endorsed (Furuta et al., 2016; Islam et al., 2017; Pun et al., 2016). This study introduces the experiential knowledge of women who have endorsed a history of IPV and how they navigate their in-law relationships in developed nations. Similarities exist between this study and findings of previous studies in the sense that in-law relationships are largely viewed as negative and stress-inducing for IPV-indicating perinatal mothers. The participants who expressed having a difficulty coping with the negative opinions of their in-laws spoke more negatively about their breastfeeding experiences as opposed to participants who disregarded the negative opinions of their in-laws, who generally felt positively towards their breastfeeding experiences. This finding is supported by Wallenborn and colleagues' (2019) study into

American women's perception of social breastfeeding support that found women were more likely to fail to initiate or prematurely cease breastfeeding if they placed a high value on their mother-in-law's opinion of them and their breastfeeding practices. The current study displays the importance of assessing for stressors within the social support system of women with a history of IPV as they approach PNC, as these relationships can be key influencers of breastfeeding success or failure. Mothers-in-law were seen to add to the tension experienced in intimate partnerships as some participants felt that their mother-in-law undermined their identity within the family structure as 'partner' and 'mother' through mistrust of their mothering skills and judgment of their mothering practices. These findings also suggest a need for future literature that examines in-law relationships and how they might contribute to the experience of IPV for women in developed nations, particularly as it pertains to the experience of mothering and breastfeeding.

### **Fostering the Development of Breastfeeding Self-Efficacy**

The support women received from trusted HCPs and their social support systems were integral to their coping and resiliency through breastfeeding struggles. Breastfeeding self-efficacy, described as a mother's confidence in her ability to successfully breastfeed her infant (Dennis, 1999), is an important factor affecting a woman's success at meeting her breastfeeding goals and can be positively impacted by the involvement and support provided by a woman's HCPs and social support systems (Brockway et al., 2017; Corby et al., 2021; Demirtas, 2012; Mildon et al., 2021). Awaliyah (2019) found breastfeeding self-efficacy to be the most important factor in determining maternal satisfaction with breastfeeding experiences. This study supported previous findings that positive interactions with HCPs in the perinatal period can positively influence breastfeeding self-efficacy (Brockway et al., 2017; Dennis, 1999; Mildon et al., 2021), even in the face of breastfeeding challenges.

Breastfeeding self-efficacy has been well known to be closely related to a woman's perception of her level of breastfeeding support from both HCPs and their social support networks (Maleki-Saghooni et al., 2019; Mildon et al., 2021). Conversely, negative experiences with breastfeeding and PNC access can be detrimental to breastfeeding outcomes (Nilsson et al., 2020). In this study, negative experiences with PNC and HCPs were found to undermine a woman's breastfeeding self-efficacy, discourage her from accessing further formalized breastfeeding supports, and feel more negatively about their breastfeeding experiences. Negative experiences with breastfeeding have been shown to significantly impact the perinatal experience and are closely associated with low breastfeeding self-efficacy. In turn, a low breastfeeding self-efficacy can result in a shortened breastfeeding duration and lower rates of future breastfeeding initiation (Nilsson et al., 2020). This study confirms existing research that shows negative experiences with PNC and breastfeeding to be strongly associated with poor breastfeeding outcomes. Preventing negative experiences with HCPs through the development of trust and non-judgmental support can, in turn, aid women in coping through negative breastfeeding experiences, ultimately improving breastfeeding self-efficacy.

Underscored in the current study was the impact of social pressures and the development of a self-identity as a mother to women's coping with breastfeeding challenges. This study strengthens existing research that shows breastfeeding behaviours to be strongly impacted by socially mediated constructs, such as the concept of 'good mothering' defined through unrealistic depictions of motherhood via social media. Women of this study felt pressures to conform to the 'ideal mother' image that they observed from peers, pressures from their HCPs, pressures from their families, and social media influence. Women highlighted the mental turmoil they encountered in comparing themselves to their perception of the 'ideal mother', often influenced

by other mothers they viewed on social media or in their own social circles. The pressure to conform to their own perception of the ‘ideal mother’ negatively impacted participants’ breastfeeding experiences and, at times, caused feelings of guilt, shame, and disappointment in their breastfeeding and mothering abilities. This is not a novel discovery, as there is ample literature that suggests that mothers frequently experience extreme pressures, both from society and themselves, to conform to the ‘ideal mother’ perception (Constantinou et al., 2021; Hunt & Thomson, 2017; Jackson et al., 2021; Palmer et al., 2014; Spencer et al., 2014). The perception of shortcomings as a mother is associated with poorer maternal mental health and a decreased self-efficacy to breastfeed (Jackson et al., 2012). Negative attitudes towards breastfeeding that can occur as a result of a lack of support can contribute to a decrease in self-efficacy and negatively impact the maternal-infant relationship (Morns et al., 2021). Compounding these concerns is the finding that maternal feelings of guilt, shame, and frustration relating to breastfeeding can inhibit a mother’s desire to seek help for her breastfeeding concerns, fearing judgment from HCPs and her social support network (Jackson et al., 2021; Regan & Brown, 2019; Williams et al., 2012; Williams et al., 2013). Mothers would persevere through breastfeeding difficulties due to a sense of moral obligation to their child, even if continuing to breastfeed was seen as detrimental to their own mental health (Morns et al., 2021; Palmer et al., 2014; Shakespeare et al., 2004; Spencer et al., 2014).

Previous literature has found that PNC and prenatal breastfeeding education is often not effective in adequately preparing mothers for the challenges potentially faced during breastfeeding. Mothers describe wishing that they were made aware of the possible difficulties of breastfeeding prior to initiating, as unexpectedly encountering challenges can have a negative impact on maternal breastfeeding self-efficacy and mental health (Constantinou et al., 2021;

Corby et al., 2021; Hoddinott et al., 2012; Jackson et al., 2021; Trickey & Newburn, 2014). This study found that women were often not aware of what breastfeeding would be like or how to troubleshoot common breastfeeding concerns. These findings suggest that anticipatory guidance education of breastfeeding challenges by a skilled PNC provider could be effective in preparing women to recognize, seek help for, and alleviate their breastfeeding challenges. In turn, anticipatory breastfeeding education could result in the reduction of loss of maternal self-efficacy and rates of postpartum depression and anxiety. Groleau (2017) found that education from specialized PNC providers within facilities that promote the Baby-Friendly Initiative have been shown to be effective in reducing a woman's feelings of guilt and shame surrounding the experience of breastfeeding difficulties.

### **Discussion Summary**

The findings from this study explore and expand upon our knowledge of the experiences that women, especially those who have experienced IPV, encounter when accessing both formalized and informalized breastfeeding support. This study confirmed that relationships between patients, their families, and HCPs are important factors influencing how women seek out and perceive their level of breastfeeding support. It also lends to the importance of educating providers on breastfeeding and TVIC, as women are positively impacted by receiving PNC from consistent, skilled PNC providers who promote trust, empowerment, and collaboration in their care of women who have experienced violence. This study offers a deeper qualitative understanding of these experiences as, to my knowledge, no qualitative studies exist that explore what accessing breastfeeding support is like for women endorsing a history of IPV. The knowledge of the potential benefit of TVIC in PNC for at-risk women was enriched and our understanding of the health-seeking behaviours of women who experienced IPV was deepened.

The discussed findings have implications for nursing practice, education, policy, and research that will be examined in the following sections on limitations, implications, and conclusion.

### **Limitations**

Firstly, this study must be examined in context of its limitations. The COVID-19 pandemic presented unique and challenging obstacles to care for participants and impacted the researcher's ability to conduct this study (refer to *COVID-19 Impact Statement*). Namely, the ability to collect rich, face-to-face observational data – including facial expressions, body language, and non-verbal emotional cues – were missed as interviews shifted to being held over the telephone to accommodate for stay-at-home public health advisories. Future studies should be conducted outside of the limitations posed by the pandemic and associated public health advisories to determine the impact these restrictions have had on breastfeeding support access.

Although a small sample may be sufficient to achieve qualitative data saturation (Thorne, 2008), a sample size of five was smaller than was originally intended by this study due to pragmatic considerations, such as the COVID-19 pandemic, accessibility of the sample population, and time and resource constraints. Fugard and Potts' (2015) model to determine sample size for thematic analyses was utilized. While an achieved sample size of five participants is sufficient to reach data saturation, data collection was ceased due to the aforementioned pragmatic concerns as opposed to once thematic data saturation was obtained. Further research with greater numbers of participants may be beneficial to confirmability of this study.

The composition of the achieved sample could have been more heterogenous in terms of age (25-30 years of age, n=4) and ethnicity (Caucasian, n=3) in order to ensure that the results of the study are transferable to other settings (Patton, 2015). As well, the sample was homogenous

in terms of IPV history for participants; all participants (n=5) disclosed a history of IPV but indicated that they had not experienced IPV within the past year. It may have been beneficial in contextualizing the study findings to have clarified whether IPV had been experienced within the participants' current or most recent intimate partnership and to determine when the IPV was identified to have stopped. As well, it is not specified what classifications of IPV were experienced by the participants, which could have offered further contextualization of the study findings as to whether the subtype of IPV impacts the experience of breastfeeding support access for women. Some consented participants who disclosed current IPV or a history of IPV during their most recent pregnancy were lost to follow-up and therefore were unable to be included in this study. Barriers to involving a sample of participants with more heterogenous experiences associated with IPV surrounded safety issues in accessing this population, especially during the COVID-19 pandemic and subsequent stay-at-home orders. Future studies that involve mothers currently experiencing IPV, who disclose IPV during their most recent pregnancy, or who disclose IPV concurrent with their most recent breastfeeding experience may be beneficial to further contextualize the results from this study and add to the knowledge of how this population experiences this phenomenon.

As was identified in the literature review, self-identification of IPV is a potentially confounding factor for accessing and caring for women experiencing violence. As such, another limitation of this study is that only participants who are able to self-identify their experiences as being consistent with IPV and disclose those experiences to their PNC provider were able to be included in this study. Some participants may have been excluded from this study despite having a history of IPV as a result. Women who are fearful of their intimate partner or disclosure issues associated with healthcare providers were unlikely to want to participate in this study.



This study's recruitment took place within one postnatal wellness centre utilizing a model of TVIC within a city in Southwestern Ontario. All participants had access to the same clinic and all identified as having lived within the recruitment city, potentially negatively impacting the transferability of this study's results to other settings (Patton, 2015). All study participants were exposed to TVIC for their postnatal and breastfeeding care. While many participants disclosed experiences of attempting to access PNC and breastfeeding support from settings that do not include TVIC into their care models, the results of this study may not be transferable to settings that do not endorse TVIC. The culture of care in PNC has been shown within this study to have an impact on the experience of accessing and obtaining formalized breastfeeding support for IPV-endorsing women and, therefore, the results of this study may further have issues with transferability to PNC settings with dissimilar care cultures, those that do not endorse a trauma-and-violence informed model of care, or postnatal care centres outside of Ontario. Studies that compare women's experiences in accessing breastfeeding support from TVIC centres to non-TVIC centres could be beneficial in more clearly determining the effect that TVIC has on this population's experience of their breastfeeding journeys.

Lastly, this study utilizes ID, a qualitative methodology, to explore the phenomena of interest. To my knowledge, very little quantitative and little-to-no qualitative research currently exists that explores how women who have experienced IPV access breastfeeding support in the perinatal period. As such, a comparable population of women who have experienced IPV who are accessing PNC, but not specifically for formalized breastfeeding support, was utilized for the literature review completed to ground and contextualize the findings of this study. More research, both quantitative and qualitative, is required, to further explore this phenomenon in

order to contextualize the findings of this study and begin to develop a more in depth understanding of how the experience of IPV can impact breastfeeding and PNC outcomes.

## **Implications**

### **Implications for Practice**

The findings from this study have several implications for nursing practice in PNC. A fundamental finding from the current investigation was the effectiveness of an interprofessional TVIC plan, one which includes and integrates a woman's social support system, in increasing access to safe and equitable formalized breastfeeding support for women endorsing a history of IPV. The effectiveness of TVIC has been well documented and professional organizations such as the RNAO (RNAO, 2017) and the Society of Gynecologists and Obstetricians (MacMillan, 2020) are in support of its incorporation with PNC settings. While TVIC can be executed in any care setting (SAMHSA, 2017), implementation should be guided by a systematic approach in order to ensure that care is delivered in a way that is meant to promote healing from trauma (Sperlich et al., 2017). Recently, providers in PNC are becoming more comfortable and competent with screening for IPV and mental health concerns and intervening through referral to trauma-specific professionals and programs (Sperlich et al., 2017). However, guidelines for the implementation of trauma-informed interventions within PNC settings to address needs specific to breastfeeding women with a history of IPV do not currently exist (Sperlich et al., 2017). Some frameworks have recently appeared to guide TVIC implementation in PNC. The National Center for Trauma-Informed Care Technical Assistance framework that guides providers towards realizing the impact of trauma, recognizing the signs and symptoms, responding to trauma through the integration of knowledge-informed policies and procedures, and resisting against practices that can retraumatize the maternal care participant (Substance Abuse and Mental Health

Services Administration, 2014). Enacting this, or similar, systematic frameworks into PNC practice could be beneficial in supporting providers to screen for, identify, and address the complexities of IPV on maternal and fetal outcomes in PNC.

Based on the findings of this study, suggestions for the implementation of a trauma-informed breastfeeding care practice in PNC for women who endorse a history of IPV will be discussed. The current study and extant literature suggest that implementation of a TVIC-approach may be beneficial for breastfeeding women with a history of IPV. Consideration of adopting and evaluating trauma- and violence-informed PNC for breastfeeding women should be undertaken in most, if not all PNC settings in order to equitably support women whether trauma is known to have occurred or not. Care providers in PNC should ensure that elements of TVIC are present in every aspect of care, as PNC is often the first-point of entry into healthcare for women experiencing IPV (Devries et al., 2010; Stephenson et al., 2016). Both hospital-based and community-based care environments should adopt principles of IPV to ensure women receive adequate, trauma-sensitive care throughout the perinatal continuum.

Perinatal care practice can help to maximize the support that is provided to women who have experienced IPV adopting an interprofessional approach to care. Collaboration between mothers, their care providers, the interprofessional PNC team, and a mother's social support system should be a priority for PNC practice as it increases trust in the PNC system through ensuring that the care participant receives the competent, individually tailored PNC care they require. While it is currently in practice that PNC providers refer women experiencing violence to programs seeking to address these concerns, engaging an interprofessional team that is skilled in providing the mental and physical care that women need, both in terms of their breastfeeding concerns and IPV histories, could increase care access for this population. This study

underscored the importance of care team consistency and that having to access multiple care settings through multiple timely appointments was a deterrent to adequate PNC and breastfeeding support. Women who have readily-available access to an interprofessional team – inclusive of nurses, obstetricians, lactation consultants, social workers, and more – were more satisfied with the care that they received and believed their care to be holistic, timely, and skilled. Care settings should endeavour to include interprofessional teams within their settings, especially those with knowledge in addressing breastfeeding-specific and IPV-specific concerns.

The benefits of increasing collaboration with a woman’s social support system in the development and implementation of an PNC program is also a primary finding of this study. Perinatal care practice should support the inclusion of a woman’s social support persons in the implementation of breastfeeding care services, as having social support during breastfeeding is beneficial to its success. Assessing for positive social supports that a woman has available to her should be a priority in PNC practice, as these supports can be integral to breastfeeding success. The inclusion of these care persons in breastfeeding education can increase a woman’s perception of the physical, emotional, and social support she receives during this often-challenging time. This study suggests that supportive persons should be physically present with mothers for their breastfeeding education and should be provided with education on how best to support women during their breastfeeding journey. Providing education to a breastfeeding woman’s support system on breastfeeding positions, latching, and challenges can help the supportive persons to better understand what the woman is going through and help her to identify when she may benefit from further formalized breastfeeding support from her HCP. Care providers should routinely assess for inadequate social supports and be able to provide programs

that could increase a woman's experience of social support while breastfeeding, such as focus groups and online support resources.

With the consideration of these implications, of primary importance to PNC practice is the development of trauma- and violence-informed PNC guidelines to assist practitioners in the assessment, identification, and addressing of IPV for breastfeeding mothers. The results of this study suggest that practitioners adopt trauma-informed practice in all PNC settings, as this can facilitate the development of trust, safety, and understanding in the provider-client relationship, which could allow for increased access to PNC, breastfeeding support services, and services aimed at addressing the impact of IPV.

### **Implications for Education**

At present, the breastfeeding-specific education provided to HCPs is lacking (Britton et al., 2007; Dodgson & Tarrant, 2007; Dubik et al., 2021). Esselmont and colleagues (2018) found in their study of Canadian pediatric residents that only 4% felt comfortable with evaluating breastfeeding technique, latch, positioning, and addressing maternal concerns regarding breastfeeding, despite nearly all participants agreeing that breastfeeding promotion was integral to their role. Less than half of training physicians described receiving education on breastfeeding during residency (Esselmont et al., 2018). For nurses, baccalaureate education does not adequately prepare them to support breastfeeding mothers either (Folker-Maglaya, 2020). Yang and colleagues (2018) found that there were limited opportunities for students to be educated on breastfeeding, resulting in many having low levels of knowledge on breastfeeding assessment and management. After exposure to a specialized breastfeeding educational program, nursing students' knowledge on breastfeeding care and attitudes towards breastfeeding were significantly improved (Yang et al., 2018). While the Canada's Baby-Friendly Initiative (Breastfeeding

Committee for Canada, 2021) recommends that HCPs that are involved in direct breastfeeding support and care should receive 18 to 20 hours of education on breastfeeding with the inclusion of supervised tactile breastfeeding support, it has been shown that very few settings provide their HCPs with this education. In terms of feasibility of implementing this level of education across all PNC settings, studies show that any duration of breastfeeding education for HCPs can have a great impact on provider knowledge, skill, and practices (Ward & Byrne, 2011). Martens (2000) found that providing perinatal nursing staff with a 90-minute educational session designed to create positive beliefs and attitudes amongst staff towards exclusive breastfeeding saw a significant increase in positive beliefs towards breastfeeding for staff and an increase in exclusive breastfeeding rates of their clients. This study supports the inclusion of formal breastfeeding education for HCPs of all professions who are working within the PNC setting in order to increase their comfort and competency in assisting with breastfeeding challenges that their clients face.

Evident from this study is that women are highly preferential towards skilled providers with knowledge of breastfeeding for their PNC but have a difficult time obtaining this level of support. Several women of this study addressed interacting with HCPs that lacked competency to address their breastfeeding concerns, stressing a need for further provider education in this area. Improving evidence-based breastfeeding educational opportunities for baccalaureate and graduate nursing students has the potential to increase the quality and availability of breastfeeding support for mothers (Dodgson & Tarrant, 2007). The availability of perinatal and breastfeeding education in Canadian undergraduate nursing programs could help to educate nursing students on ways to support breastfeeding mothers in their future practices. Further, allowing opportunities for practical breastfeeding support experiences, such as those suggested

by Canada's Baby-Friendly Initiative (Breastfeeding Committee for Canada, 2021) would further the experiential knowledge of these novice providers in providing holistic breastfeeding support, potentially impacting their long-term breastfeeding attitudes, knowledge, and skills. Utilizing different modes of education administration, such as mentorships, didactic modules, and online educational support tools has also been shown to be effective in increasing provider education on breastfeeding assessment, intervention, and support (Feldman-Winter et al., 2010).

The inclusion of trauma, violence, and their impact on healthcare is also lacking in formalized HCP education. While trauma-informed care has been shown to be effective in many care settings in the identification and mitigation of trauma-related negative health effects, provider education on TVIC is insufficient. In order to provide effective TVIC, practitioners must first be educated on and understand trauma itself. It is important that care providers are knowledgeable on the long-reaching effects of trauma and violence and are provided with the education and organizational support to respond purposefully when they suspect or discover that their client has experienced trauma and/or violence. Burton et al. (2019) found that providing nursing students with education on the sensitive care of vulnerable populations, understanding different types of trauma, and understanding trauma's overall impact on health, nursing students were better prepared to identify and address trauma within their practices. Yang and colleagues' (2019) comprehensive literature review, however, revealed only two articles in medicine and no articles in nursing that described trauma-informed educational courses and specific educational practices to implement trauma-informed care into the health sciences. As such, the implementation of trauma-informed care in nursing and health science education is in its early stages and requires further research to support its implementation.

This study underscored the importance of implementing TVIC in PNC settings, especially for at-risk mothers and those with histories of IPV. As such, educating providers on the prevalence of trauma in populations, the far-reaching consequences of trauma and violence for health, how to identify trauma in their clients, and how to implement the principles of TVIC in their practices is essential to providing necessary TVIC. Education on trauma- and violence-informed care can theoretically be implemented in baccalaureate nursing curricula in sections that focus on health inequities, such as the social determinants of health, and be expanded upon in areas discussing interpersonal communication, health promotion, and population health (Burton et al., 2019). Much the same as with breastfeeding education, the use of mentorships, online educational materials, and didactic modules should be implemented in to increase the availability of educational materials on TVIC for providers.

Considering the discussed implications, the findings from this study suggest that implementing educational opportunities for providers on breastfeeding support and providing TVIC in PNC settings can have benefits for this population in terms of breastfeeding outcomes, maternal and infant outcomes, and IPV identification and intervention.

### **Implications for Policy**

The findings of this study have implications for policy surrounding the administration of healthcare for breastfeeding women with a history of IPV. Of utmost importance, this study emphasized the importance of implementing policies in PNC that promote safe and comfortable breastfeeding experiences. A finding of this study was that women felt more satisfied and expressed higher levels of breastfeeding support and self-efficacy when they were allotted adequate time and space to discuss breastfeeding with their provider. Women who had safe places to breastfeed their infants during their PNC appointments were able to express their



breastfeeding concerns to their HCP without fear of judgment or fear that feeding their infant would disturb their ability to be present for their appointment. Policies in perinatal settings that promote healthy breastfeeding, such as safe spaces to breastfeed during clinic times and adequate time for appointments to promote the development of a trusting provider-client relationship could contribute to the safe disclosure of breastfeeding concerns and IPV. Care settings could implement buffer times between appointments to allow mothers to breastfeed their infants and provide them with a private area, such as a quiet room with breastfeeding-friendly equipment and furniture, to create a physically supportive breastfeeding environment. These policies could facilitate ease of identification of breastfeeding issues, as providers may be called in to view breastfeeding position, latch, or other difficulties as mothers are actively breastfeeding.

In terms of national healthy breastfeeding policy, no countries, inclusive of Canada, currently have policies in place that fully meet the recommendations put forth by World Health Organization and UNICEF within their Baby-Friendly Initiative (Daniel, 2020; World Health Organization, 2018). Only 30 Ontario healthcare facilities achieved Baby-Friendly designation (Baby Friendly Initiative Ontario, 2020) which represents roughly 2.2% of the available facilities in the province. Primary influences for why breastfeeding-friendly healthcare policies are not enacted or followed were found to be inadequate support for breastfeeding policies from administrators and policymakers, lack of effective leadership to support these policies, a lack of integrated hospital and community health services (Semenic et al., 2012). Further, federal support for breastfeeding and breastfeeding-healthy policy is low, evidenced by the withdrawal Public Health Agency of Canada funding that the Breastfeeding Committee of Canada received (Chalmers, 2013). This study suggests closer adherence to the existing breastfeeding policies set out by public health agencies for Ontario and Canada would further increase maternal access to

competent, skillful breastfeeding support, thus positively influencing breastfeeding outcomes. Following the Breastfeeding Committee for Canada's Baby-Friendly Implementation Guideline (Breastfeeding Committee for Canada, 2021) and aiming for Baby-Friendly designation could benefit PNC providers in acknowledging healthy breastfeeding policy and creating environments that better support their breastfeeding populations.

### **Implications for Research**

Limited research exists that aims to address how mothers with a history of IPV navigate the healthcare system in relation to accessing perinatal support. Further, almost no research exists that examines how breastfeeding intersects with this experience and how mothers endorsing a history of IPV access support for breastfeeding challenges. In fact, few comprehensive Canadian studies into breastfeeding experiences have been conducted to date (Chalmers, 2013). Since it has been identified that IPV has negative impacts on perinatal outcomes for mothers, infants, and breastfeeding, investigating these experiences and exploring ways to effectively address these phenomena in PNC should be a priority for future nursing and health science research. Research addressing how PNC settings can address the breastfeeding needs of IPV survivors has not yet been completed. Evaluating trauma-informed guidelines and interventions that are useful, feasible, and accessible to PNC providers and their clients is the next step in addressing IPV for breastfeeding mothers via PNC (Sperlich et al., 2017).

A key finding from this study is that women had difficulty securing an PNC provider with specialized knowledge on breastfeeding. It is unknown how accessible these care providers are in Ontario; further research that investigates issues with organizational accessibility to a skilled PNC provider would be beneficial to determine the scale of impact that a lack of provider has for this population. Further, studies are strongly needed that determine effective

implementation, evaluation, and outcomes of TVIC intervention in PNC (Sperlich et al., 2017). At present, there is limited literature that evaluates how effective TVIC programs are at addressing IPV and structural violence within PNC systems, and no research as it pertains to breastfeeding women with histories of IPV.

Women who express that they are actively experiencing IPV were not included in this study. All participants included in this study disclosed a history of IPV but disclosed that it had not occurred during the perinatal period. Hence, no literature currently exists on breastfeeding women who are current sufferers of IPV and the ways in which they interact with the PNC system. The findings of this study suggest that women value the physical and emotional breastfeeding support they receive from their partners. It is unclear from the scope of this study as to whether the current partner was the perpetrator of the violence against the participants studied and whether their opinion of their partner's involvement in perinatal and breastfeeding care would change if IPV experience was current. One of the main principles of TVIC includes the assumption that the care participant's family, partner, or social supports are not inherently safe or helpful (Substance Abuse and Mental Health Services Administration, 2014). Research exploring the benefits and consequences of one-to-one PNC appointments, where women attend alone, on the identification and disclosure of violence would be beneficial, especially in the context of an PNC system that increasingly encourages a woman's partner to attend appointments (Creedy et al., 2020).

Mothers-in-law's negative influence on breastfeeding experiences was an interesting finding from this study. While previous literature has shown mothers-in-law, especially in contexts outside of North America, have an impact on the experience of breastfeeding and IPV (Islam et al., 2017; Kulkarni et al., 2011; Pun et al., 2016), no Canadian or North American

studies have been completed that show this finding is transferrable to Western contexts. In this study, mothers-in-law had a negative impact on most participants' perception of support, experiences with breastfeeding, and breastfeeding self-efficacy. Future research that explores the impact that families can have on breastfeeding, especially for women experiencing IPV, would be beneficial. Determining the causes of the negative impact that mothers-in-law have on this phenomenon could assist providers in developing ways to assess for, identify, and implement interventions to counteract social relationships that are negatively impacting breastfeeding experience and self-efficacy for their clients. Additional qualitative, quantitative, and mixed-methods research exploring the complexities of the mother-in-law relationship as it pertains to the breastfeeding experiences of at-risk and IPV-endorsing women could lead to the further identification the ways in which social systems can impact a woman's breastfeeding success.

Lastly, an additional finding from this study is that TVIC may be positively impactful on mother's experiences with self-efficacy when accessing and undertaking PNC. An increase in breastfeeding self-efficacy was described by some participants, but additional research is necessary to determine exactly what impact TVIC has on breastfeeding self-efficacy. At present, no research into TVIC in PNC and how breastfeeding outcomes, inclusive of breastfeeding self-efficacy, exist. The completion of this research could lead to further identification of TVIC as an essential component to PNC for all women by supporting this study's findings that TVIC has positive impacts on breastfeeding self-efficacy. Research that explores positive and negative factors influencing breastfeeding self-efficacy for mothers with a history of IPV would be beneficial in guiding further research into program development, implementation, and outcome evaluation of TVIC in PNC.

### **Summary of Implications**

The findings from the current study have significant implications for nursing practice, education, policy, and research. Encouraging HCPs in PNC to adopt the principles of TVIC and utilize those principles to guide care collaboration between women, HCPs, the interprofessional PNC team, and a woman's social support system could be beneficial in increasing access to PNC for IPV-endorsing women. Healthcare practices that support the development of trust in the provider-client relationship should be prioritized, including the use of safe, breastfeeding-friendly spaces and adequate timing of appointments to facilitate the disclosure of IPV and breastfeeding-related concerns. Nurses and HCPs as a whole require additional education in both the support of the breastfeeding woman and the impact of trauma on health. Providing HCPs with education both within baccalaureate programs and on-going educational support for providers who specialize in PNC is essential to the administration of safe, trauma-informed specialized breastfeeding care and should be a priority for healthcare administrators and health sciences educators. These same educators and administrators can also examine their hospital and community PNC setting policies to ensure that they adhere to Baby-Friendly guidelines in order to promote successful breastfeeding within their served populations. A more robust understanding of the phenomenon of study would be achieved by further research on how women with a history of IPV access and utilize PNC and breastfeeding supports. Studies that assess for the availability of skilled PNC resources for this population, the accessibility of PNC settings and organizations to at-risk women, and the efficacy of these supports in positively impacting breastfeeding maternal and infant outcomes is necessary to further understand this nuanced experience.

## **Conclusion**

This study enhances our knowledge of women's experiences in accessing breastfeeding support while having a known history of IPV. Understanding that IPV and breastfeeding are themselves complex and dynamic phenomena can help in the creation of PNC models that work to mitigate the risks that IPV has for mothers and infants while concurrently improving breastfeeding outcomes. Through the interpretive description of these experiences, it has been shown that access to breastfeeding supports can be enhanced and diminished by a multitude of system, interpersonal, and personal factors. Increasing continuity of access to interprofessional perinatal health with specialized knowledge of breastfeeding and trauma can lead to increases in safe, equitable care for women endorsing a history of IPV. This study supports the implementation of the Baby-Friendly Initiative in all PNC hospitals and community care settings to increase the availability of skilled breastfeeding providers and, hence, increase rates of successful breastfeeding in Ontario and Canada. Adopting the principles of TVIC within PNC settings, where IPV is most likely to be identified and disclosed to an HCP, can lead to the development of trusting therapeutic relationships between HCPs and mothers, which in turn improves both breastfeeding and IPV outcomes. It is apparent that the inclusion of a woman's social supports in breastfeeding education is critical to its success, as social supports are more accessed and relied upon by women with a history of IPV. The inclusion of these supports in PNC, combined with the established trusting relationship with competent HCPs, greatly contribute to a woman's breastfeeding self-efficacy and desire to persevere through the challenges posed during the perinatal period. Social support inclusion in PNC, however, should be evaluated in collaboration between HCPs and the client, as some relationships, namely those with their mother-in-law, can have a negative impact on an IPV-endorsing woman's breastfeeding self-efficacy. Adopting TVIC and Baby-Friendly policies further improve a

woman's breastfeeding self-efficacy, which can reduce the feelings of guilt, shame, and frustration at experiencing breastfeeding challenges that can negatively impact their breastfeeding outcomes.

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Appendix A:  
Literature Review Search Terms

	Health services access* Health seeking* Health-seeking* Access to health Access to services Access to care Barriers to health Barriers to services Barriers to care	
	<b>AND</b>	
	Intimate partner violence Intimate partner abuse Intimate partner assault Domestic violence Domestic abuse Domestic assault Relationship violence Relationship abuse Relationship assault Spousal violence Spousal abuse Spousal assault Abused women Batter*	
<b>AND</b>		<b>AND</b>
Breastfe* Breast-fe* Breast fe* Human milk expression Lactation Infant feeding		Pregnan* Matern* Perinatal Prenatal Pre-natal Postnatal Post-natal Mother*

Terms: Access to Health

- "Health Services Accessibility" OR "Health Seeking Behaviors NANDA" OR "access to services OR access to support OR support OR access OR access to health OR access to healthcare OR access to health care OR access to health services OR health seeking behaviours OR health-seeking behaviours OR health seeking behaviors OR health-seeking behaviors OR barriers to care OR barriers to health OR barriers to healthcare

Terms: Intimate Partner Violence

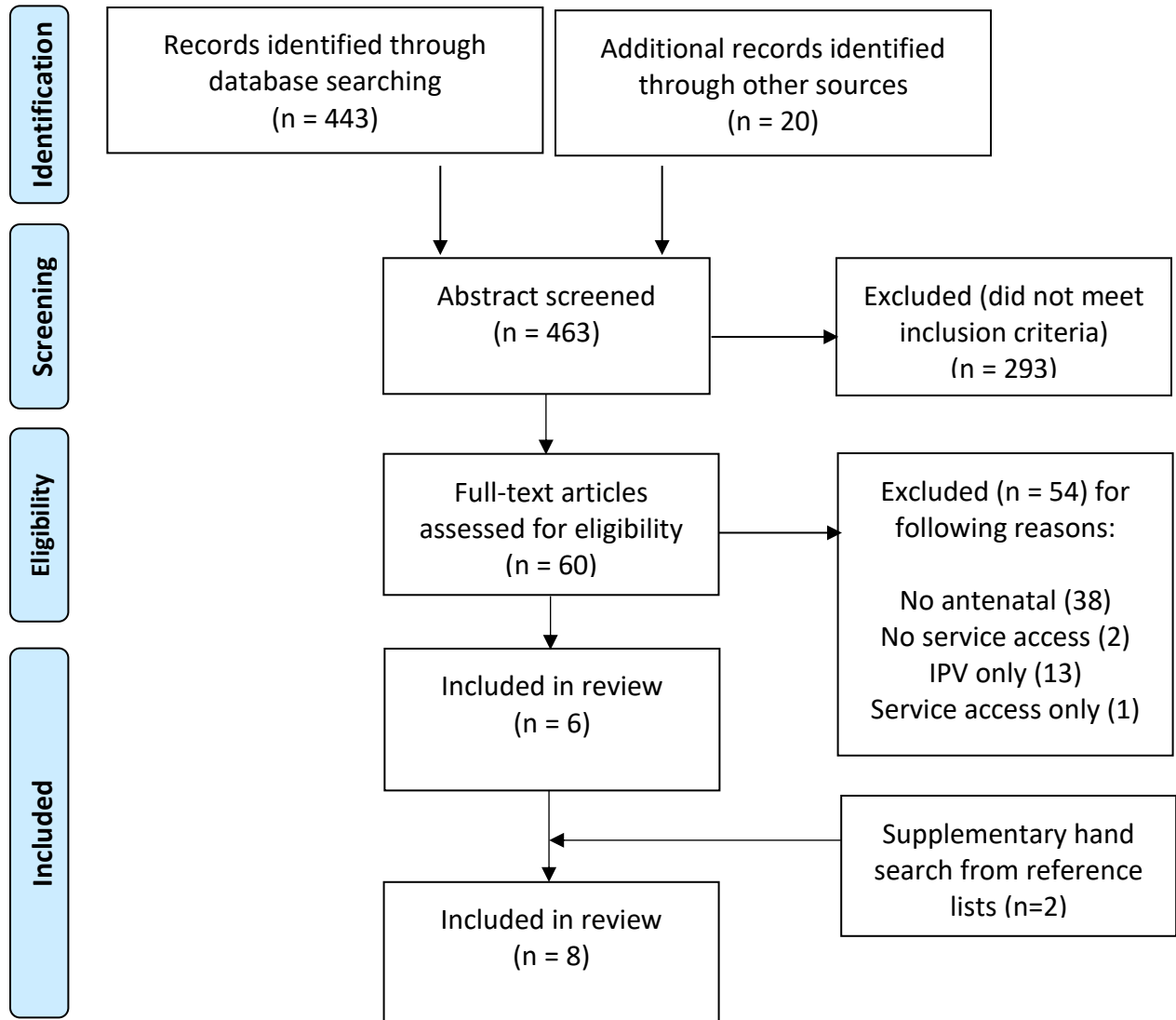
- "Intimate Partner Violence" OR intimate partner abuse OR intimate partner assault OR domestic abuse OR domestic assault OR domestic violence OR relationship violence OR relationship abuse OR relationship assault OR spousal abuse OR spousal assault OR spousal violence OR partner abuse OR partner violence OR partner assault OR abused women OR battered women

Terms: Breastfeeding and Perinatal

- "Breast feeding" OR breastfeeding OR breast-feeding OR breastfed OR breast fed OR breast-fed OR infant feeding OR human milk expression OR pregnant OR pregnancy OR maternal OR maternity OR perinatal OR prenatal OR postnatal OR pre-natal OR pre natal OR post-natal OR post natal OR mothers OR mothering

Appendix B:

Literature Search PRISMA Diagram



Appendix C:

Literature Review Articles

Study Methods	Studies and Articles
<b>Quantitative</b>	
<b>Case Control Study</b>	Quelopana, Champion & Salazar, 2008
<b>Online Survey</b>	Torres, 2016
<b>Cross-Sectional</b>	Islam, Broidy, Baird, & Mazerolle, 2017 Furuta, Bick, Matsufuji & Coxon, 2016
<b>Qualitative</b>	
<b>Critical Incident Technique</b>	Bradbury-Jones, Breckenridge, Devaney, Kroll, Lazenbatt & Taylor, 2015a
<b>Focus Groups</b>	Kulkarni, Lewis & Rhodes, 2011 Pun, Infanti, Koju, Schei, & Darj, 2016
<b>Mixed Methods</b>	
<b>Concept Mapping, Focus Groups</b>	Bradbury-Jones, Breckenridge, Devaney, Kroll, Lazenbatt & Taylor, 2015b



**Date:** 28 May 2019  
**To:** Dr. Kimberley Jackson  
**Project ID:** 113464  
**Study Title:** The impact of early postpartum care by a primary care team among breastfeeding women.  
**Application Type:** HSREB Initial Application  
**Review Type:** Delegated  
**Full Board Reporting Date:** June 18, 2019  
**Date Approval Issued:** 28/May/2019  
**REB Approval Expiry Date:** 28/May/2020

Dear Dr. Kimberley Jackson

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

**Documents Approved:**

Document Name	Document Type	Document Date
EMBRACE Complete Protocol Draft 2019-05-18	Protocol	Received May 24, 2019
EMBRACE Debriefing Form 2019-03-05	Debriefing Script	2019/03/05
EMBRACE Eligibility Criteria_Revised_May 8 2019	Other Data Collection Instruments	08/May/2019
EMBRACE Letter of Information and Consent 2019-05-18	Written Consent/Assent	03/May/2019
EMBRACE Recruitment and Follow Up Scripts 2019-05-18	Other Data Collection Instruments	18/May/2019
EMBRACE Recruitment Poster 2019-05-15	Other Data Collection Instruments	15/May/2019
EMBRACE Safety Plan Protocol 2019-03-05	Other Data Collection Instruments	
EMBRACE Semi-Structured Interview Guide 2019-03-14	Interview Guide	14/Mar/2019
EMBRACE Questionnaire_revised_May 8 2019	Online Survey	08/May/2019

**Documents Acknowledged:**

Document Name	Document Type	Document Date
PWC Letter of Support for EMBRACE	Letter Document	01/Dec/2018

No deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

[Redacted Signature]



Appendix E:  
Recruitment Form

## **PARTICIPANTS NEEDED FOR RESEARCH ABOUT BREASTFEEDING**

We are looking for volunteers to take part in a study looking at the experiences of breastfeeding mothers receiving postpartum care at this clinic.

Are you a breastfeeding mother over 18 years of age? Yes/No  
Are you proficient in the English language? Yes/No  
Do you have access to the internet and a telephone? Yes/No

**AND**

Do you feel you have limited social support? [Yes/No]

**OR**

Do you have a family income of less than \$31,061 per year? [Yes/No]

**OR**

Have you experienced intimate partner violence at some point in your life? [Yes/No]

If you are interested and agree to participate, you would be asked to: Complete a demographic questionnaire and pre- survey (approximately 10 minutes), a questionnaire 12-weeks later regarding your postpartum care and breastfeeding experiences (approximately 30 minutes), and optionally attend a one-on-one interview (approximately 60 to 90 minutes). In recognition of your time we will provide an honorarium for each survey completed and an additional honorarium for the completion of an interview.

Would you like more information about the study? Yes/No



Appendix F:

Letter of Information and Consent

**Letter of Information and Consent**

**EMBRACE**

**Engaging Mothers in a Breastfeeding Intervention to Promote Relational-Attachment, Child Health, and Empowerment**

**Official Study Title**

The impact of early postpartum care by a primary care team among ‘At-risk’ breastfeeding women.

**Name of Principal Investigators**

Kimberley Jackson, PhD, Western University

Tara Mantler, PhD, Western University

**Name of Co-Investigators**

Brenna Velker, MD, Thompson Postnatal Wellness Clinic

Shauna Burke, PhD, Western University

**Other Team Members**

Samantha Larose, RN, BScN, Graduate Student, Western University

**Funding Agency**

This study is funded through the Faculty Research Development Fund at Western University.

**Conflict of Interest**

Although we do not foresee any conflicts of interest arising from this study, we wish to disclose that the intervention will be provided by Dr. Brenna Velker. Dr. Velker is a physician and the director of the Thompson Postnatal Wellness Clinic, the site from which we are recruiting participants and is also a member of the research team.

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**Background**

We invite you to take part in this research study looking at the experience of ‘At-risk’ postpartum women who are breastfeeding their infants. We are interested in hearing about your experiences in attending the Postnatal Wellness Clinic and particularly with how they relate to your thoughts and feelings around breastfeeding and the postpartum period. Approximately 50 women will take part in this study.

**Who is Eligible to Take Part**

A woman who:

- 1) Can read and speak in English
- 2) Is breastfeeding their newborn
- 3) Is 18 years of age or older
- 4) Has access the internet and a telephone

- 5) Has limited social support OR Has a family income of less than \$31,061 per year OR Has experienced intimate partner violence at some point during her life

### **What Taking Part Means**

Taking part in this study first involves answering some questions about you and your baby both today as well as 12 weeks from now. If you choose to participate, we will ask you to answer online questions, using this tablet, that will take less than 10 minutes. Then, in 12 weeks time, we will contact you and ask you to complete another online questionnaire that can be done from the comfort of your own home and will take at most 30 minutes. The questionnaire(s) will ask questions about you, your pregnancy, your experiences at the Postnatal Wellness Clinic, your breastfeeding experiences, and your overall health and well-being (physical and emotional). You will receive an honorarium for each questionnaire you complete, which will be emailed to you in the form of Amazon gift cards.

At the end of the second questionnaire we will ask if you are interested in completing an interview. The interview will take place after completion of the 12-week questionnaire. The one-on-one interviews will last in total between 1 and 1.5 hours and will include questions about your experience at the Postnatal Wellness Clinic, your postpartum experience, your physical and emotional health, and your breastfeeding experiences. If you agree to it, we will audio record the interviews. If you do not agree to audio recording, you may still participate. Interviews will be conducted at either London Health Sciences Centre (Victoria Hospital) or at a public meeting place (such as a private meeting room at a local public library) or over the telephone– whichever location/method is most convenient for you. You can bring your infant to the interview. If you agree to participate in the interview, you will be provided with an additional cash honorarium to thank you for your time and contribution.

### **Voluntary Participation/Withdrawal from Study**

Taking part in this study is entirely voluntary. You may refuse to answer specific questions. You may decide not to be in this study. At any time, you may leave the study, or ask to have your information removed. If you decide to refuse to answer any questions or to withdraw from the study, this will not impact the care you are receiving in any way, or your ability to access services through the Postnatal Wellness Clinic.

### **Risks**

There are some risks associated with participating in this study. There is a possibility that you may have a stress reaction when speaking about your experiences during the study interviews. In the event that you become distressed during the interview, we can: stop the interview, take a break, and provide you with local resources (such as the Women's Community House 24-hour Helpline). If you feel safe retaining written information, after the completion of each interview you will be provided with a handout on stress reactions and community resources. Given that a stress reaction can happen post-interview, regardless of whether or not a stress reaction was observed during the interview process, a Research Assistant will review common signs of a stress reaction and available community resources.

If you have experienced intimate partner violence there is also the possibility of increased violence if your partner becomes aware of your participation in the study. To help ensure your

safety, upon enrolling in this study a safety plan will be created with you. This plan will consist of safety information regarding when/how to contact you, whether it is safe to leave voice mail messages, study materials, etc. with you. If it is not safe for you to keep this letter of information our research staff will retain a copy and bring it to all subsequent meetings if you request.

### **Benefits**

You may not directly benefit from this study; however, what we learn in this study may help us gain a greater understanding of how best to provide postnatal care to women in the community. This research may help to improve the health of women and children and help healthcare providers understand how best to care for ‘At-risk’ breastfeeding women.

### **Reminders and Responsibilities**

We will remind you, using the email address you provided us and telephone number when it is time for you to complete the 12-week questionnaire. You will have a two-week time frame to complete this questionnaire. During that time, we will send you two reminder emails and two telephone calls. We will only leave a message if, in your communication plan you agree that it is safe for us to do so.

### **Alternatives to Being in the Study**

An alternative to being in the study is not to participate in the study and continue on just as you do now receive the exact same care.

### **Confidentiality**

The information you tell us will be kept confidential. Your personal information (name and contact information) will be kept confidential, securely stored by researchers on a master list which is separate from the study data.

The study researchers will be using information that you provide to your healthcare provider during your regular clinic visits relating to breastfeeding and your mental and physical health in the post-partum period. When we receive this information, the researchers will not be able to link the information to you directly.

Your interviews (audio recordings) will be sent to a third-party transcription company who adhere to rigorous confidentiality protocols. These audio recordings are stored by the researchers but will be shared via a secure web portal with a professional transcription company who upholds confidentiality practices to create a transcript of the interview. The digital copies of your interviews will be kept at Western University behind a secure firewall. De-identified study data (i.e., by use of pseudonym) will be securely stored by researchers but may be included in publications/presentations of results (e.g., including in the form of direct quotes if participant checks yes on consent form) but no identifiable information will be ever be shared publicly.

If you tell us that you are at risk of harming yourself or others, by law we have a duty to breach confidentiality and report the relevant information that was disclosed. If we are going to share this information, we will talk to you first.

If you tell us about any current abuse of children, by law we have a duty to breach confidentiality and report the relevant information that was disclosed and report this to the local child protection agency. Before reporting, we will discuss this with you.

All personal health information collected for this study (mental health and attachment) will be kept confidential. Quotations provided during your interview may be used during dissemination of research findings. All identifiers will be removed prior to publication. The principal investigators will keep any personal information about you in a secure and confidential location for a minimum of 15 years. A list linking your study number with your first name will be kept by the principal investigator in a secure place, separate from your study file. Transcriptions of audio recordings will be kept up to a maximum of 15 years and will then be destroyed.

To oversee the ethical conduct of the study, representatives of Western University's Health Sciences Research Ethics Board may require access to all study-related information in order to ensure the study is following the proper laws and regulations. Representatives of Lawson Quality Assurance Education Program may require access to all your study-related documents to ensure that proper laws and guidelines are being followed.

Finally, while we will respond to your email communication, it is important for you to be aware that email is not considered a secure form of communication.

### **Costs**

There are no costs associated with participating in this study.

### **Compensation**

To thank you for your time, after completing the two questionnaires, we will provide you with an Amazon gift card. Those who are participating in interviews will receive an additional gift card honorarium at the start of the interview. If you decide to withdraw from the study, you can keep any gift cards that you have already received.

### **Rights as a Participant**

You have the right to withdraw from the study at any time. You do not waive any legal rights by signing the consent form.

### **Questions about the Study**

If you have questions about your participating in this study, you may contact:

Dr. Kimberley Jackson

Dr. Tara Mantler

If you have any questions about your rights as a research participant or the conduct of this study, you may contact: The Office of Human Research Ethics (519) 661-3036, email: [ethics@uwo.ca](mailto:ethics@uwo.ca)

**This letter is yours to keep for future reference.**

## **Consent Form**

**Project Title: EMBRACE**  
**Engaging Mothers in a Breastfeeding Intervention to Promote Relational-Attachment, Child Health, and Empowerment**

**Investigators' Names:**

Dr. Kimberley Jackson, Dr. Tara Mantler, Dr. Brenna Velker, & Dr. Shauna Burke

Your participation in this study is completely voluntary.

If you decided to participate in this study and then change your mind, you are free to withdraw from the project at any time with no consequence.

If you have questions about your rights as a research participant or the conduct of this study, you may contact the Office of Research Ethics at 519-661-3036, email: [ethics@uwo.ca](mailto:ethics@uwo.ca)

You do not waive any legal right by consenting to this study.

By clicking below, you agree to participate in the study described above.

'I agree to participate'

'I do not agree to participate'

**\*\*\* The following consent form will be completed prior to the interview\*\*\***

# Consent Form

**Project Title: EMBRACE**

**Engaging Mothers in a Breastfeeding Intervention to Promote Relational-Attachment, Child Health, and Empowerment**

**Investigators' Names:** Dr. Kimberley Jackson, Dr. Tara Mantler, Dr. Brenna Velker, & Dr. Burke

Your participation in this study is completely voluntary.

If you decided to participate in this study and then change your mind, you are free to withdraw from the project at any time with no consequence.

If you have questions about your rights as a research participant or the conduct of this study, you may contact the Office of Research Ethics at 519-661-3036, email: ethics@uwo.ca

You do not waive any legal right by consenting to this study.

By signing below, you agree to participate in the study described above.

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | I agree to have my interview audio-recorded  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | I agree to have unidentifiable direct quotes obtained from the interview used for dissemination. |

Participant's Name (Please Print):

Date:

Participant's Signature

Person Obtaining Informed Consent (Please Print):

Signature:

## Appendix G:

### Qualitative Interview Guide

- 1) What was your experience at the Postnatal Wellness Clinic?
  - a) What was different about the Postnatal Wellness clinic compared to other health care offices?
- 2) What was helpful about your visits?
- 3) What was not helpful about your visits?
  - a) What would you have liked to see added?
  - b) What would you have liked to see removed?
- 4) Were there any obstacles that you had to face in attending your clinic visits?
  - a) What created those obstacles?
  - b) What would remove those obstacles?
- 5) Would you recommend the clinic to others? Why or why not?
- 6) How would you describe your experience in finding a health care team while you were pregnant? Breastfeeding?
  - a) What obstacles did you face in getting the care you needed?
  - b) What created those obstacles?
  - c) What would remove those obstacles?
- 7) What was helpful to you in terms of accessing health care during your pregnancy? While breastfeeding?
- 8) Did you feel supported during your pregnancy? Breastfeeding?
  - a) By your partner?
  - b) By your family?
  - c) By your friends?
  - d) By your health care providers?
- 9) What contributed to your feelings of support?
  - a) What made you feel unsupported?
  - b) What could have made you feel more supported?
- 10) How did the level of support you had impact your pregnancy? Breastfeeding success?
  - a) How did the level of support you had impact your experience with health care services?
- 11) Is there anything else about your experiences accessing care that you would like to share?

Appendix H:

Participant Demographic Questionnaire

- 1) What is/are the ethnic or cultural background(s) you identify with most? (For example: Canadian, English, French, Chinese, East Indian, Italian, German, Scottish, Irish, Cree, Mi'kmaq, Salish, Metis, Inuit, Filipino, Dutch, Ukrainian, Polish, Portuguese, Greek, Korean, Vietnamese, Jamaican, Jewish, Lebanese, Salvadoran, Solami, Colombian, etc.)

Please specify as many origins as you like: \_\_\_\_\_

- 2) Were you born in Canada?

Yes

No

If no, how long have you lived in Canada? Please specify years and months.

- 3) What is your age in years? \_\_\_\_\_

- 4) What is your current marital status?

Single

Married/Common Law/Engaged

Divorced/Separated

Widowed

I prefer not to answer

- 5) About how many years have you been with, or were you with, your partner? You may use half years (for example: 2.5 years). \_\_\_\_\_

- 6) What is the highest level of education that you have completed?

Less than high school

High school completed

Community college and/or journeyman apprenticeship completed

University undergraduate degree completed

University graduate degree or higher completed

I prefer not to answer, other.

If other, please specify

- 7) What is your current employment status?

Employed full-time

Employed part-time

Unemployed

Casual/Seasonal

I prefer not to answer, other.

If other, please specify.

- 8) If unemployed, are you:



- Unemployed but looking for paid work
  - A homemaker or stay-at-home mother
  - On maternity/parental leave
  - On sick leave
  - Disabled or unable to work due to health reasons
  - A student
  - I prefer not to answer
  - Other.
- If other, please specify.

- 9) What is your estimated yearly combined family income (after taxes are deducted) including employment, government cheques, child support, and other sources of income?
- Less than \$19,999
  - \$20,000-\$49,999
  - \$50,000-\$99,999
  - Greater than \$100,000
  - I prefer not to answer

Table 1:  
Literature Review Overview

<b>Main Section Titles</b>	<b>Sub-Section Titles</b>
<b>Individual and Interpersonal Barriers to Perinatal Healthcare</b>	Self-Identification of IPV
	Fear and Diminished Autonomy
	Psychological Barriers
	Alcohol and Substance Use
	Disability and IPV
	Families as Perpetrators of Violence
	Intergenerational violence
	Attitudes Towards Pregnancy and PNC
	History and/or contemplation of abortion
	<b>Structural Violence Within Health Systems</b>
Accessibility Barriers to PNC	
Fear of Disclosure, Trust, and Securing an Ally	
Interprofessional team approach	
Provider Discomfort in Responding to IPV Disclosures	
Inappropriate or Inaccessible Tools and Resources	
Challenges in Responding to IPV for PNC Services	
<b>Cultural and Societal Barriers</b>	Lack of Societal Knowledge of IPV
	Permissive Societal Attitudes towards IPV
	Prevailing IPV Stereotypes
	Cultural Barriers to IPV Intervention
	Endorsement of Traditional Gender Roles

Table 2:

## Participant Demographic Characteristics

<b>Demographic Categories</b>	<b>Frequency</b>	<b>Valid Percentage (%)</b>
<b>Gender</b>		
Female	5	100
<b>Age in Years</b>		
18-24	0	0
25-30	4	80
31-40	1	20
<b>Ethnicity</b>		
African Canadian	0	0
Asian	2	40
Caucasian	2	40
Hispanic/Latina	1	20
Other	0	0
<b>Country of Birth</b>		
Canada	3	60
Other	2	40
<b>Marital Status</b>		
Married	3	60
Single/Never Married	2	40
Divorced/Separated/Widowed	0	0
<b>Employment</b>		
Full-time	1	20
Part-time	2	40
Casual/Seasonal/Self-Employed	1	20
Unemployed/Disability	1	20
<b>Highest Level of Education</b>		
Less than high school	1	20
High school	0	0
Community college/Apprenticeship	0	0
University Undergraduate	2	40
University Graduate	2	40
<b>Annual Household Income</b>		
Less than \$19,999	0	0
\$20,000 - \$49,999	2	40
\$50,000 - \$99,999	1	20
Greater than \$100,000	1	20
Unspecified	1	20
<b>History of IPV</b>		
Yes	5	100
No	0	0
<b>If yes, have you experienced IPV while pregnant?</b>		
Yes	0	0
No	5	100

Table 3:

## Participant Perinatal and Breastfeeding Characteristics

<b>Perinatal and Breastfeeding Characteristics</b>	<b>Frequency</b>	<b>Valid Percentage (%)</b>
<b>Gestational Age</b>		
Less than 37 weeks	1	20
37.5-39.5 weeks	1	20
40-42 weeks	3	60
<b>Term</b>		
Preterm	0	0
Full term	5	100
<b>NICU Admission</b>		
Yes	0	0
No	5	100
<b>Type of Delivery</b>		
Uncomplicated Vaginal	4	80
Urgent or emergency C-section	1	20
Planned C-section	0	0
<b>First Breastfeed</b>		
Within an hour after birth	4	80
A few hours after birth	1	20
<b>Breastfeeding at 12-weeks Postpartum</b>		
Yes	5	100
No	0	0
<b>Breastfeeding Exclusively at 12-weeks</b>		
Yes	3	60
No	2	40
<b>How Often Do You Breastfeed?</b>		
Every 2-3 Hours	2	40
Every 4+ Hours	1	20
Uncertain	2	40
<b>Do You Supplement with Formula?</b>		
Yes	2	40
No	3	60
<b>If yes (n=2), how often?</b>		
Less than 50% of the time	1	50
Greater than 50%	1	50

Table 4:

Themes and Subthemes

Theme	Subtheme
Navigating the Perinatal Healthcare System: 'The most challenging thing.'	<ul style="list-style-type: none"><li>• Securing a Healthcare Team: 'Demoralized and deflated.'</li><li>• Building Trust Through Competence: 'It's support, but it's also knowledge.'</li><li>• Covid-19: 'In a limbo.'</li><li>• TVIC: 'I mattered, and that's everything.'</li></ul>
Seeking and Receiving Informal Support: 'Worth its weight in gold.'	<ul style="list-style-type: none"><li>• Partner: 'When he's good, he's good. But when he's not, he's not.'</li><li>• Friends: 'Solidarity through the struggles.'</li><li>• Family: 'They know me.'</li><li>• In-Laws: 'More tension than support'</li></ul>
Coping with the Challenges of Motherhood: 'Sheer stubbornness and pure willpower.'	<ul style="list-style-type: none"><li>• Developing Confidence and Self-Efficacy: 'I felt like less of a mother.'</li><li>• Prioritizing Baby's Wellbeing: 'This is my baby's life. My life.'</li><li>• Fostering Resiliency: 'One day at a time.'</li></ul>

CURRICULUM VITAE

**SAMANTHA LAROSE**

• RN, BScN, MScN (c) •

EMPLOYMENT

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**Lecturer** 2020 – Current

*Arthur Labatt Family School of Nursing, Western University  
London, Ontario, Canada*

Lectures in the high-fidelity simulation lab setting for second- and third-year Undergraduate nursing students. Instructs on various clinical skills including vital signs, systems assessments, infection control procedures, medication administration, medication calculations, and more. Holds briefing and debriefing sessions for students to discuss scenarios and skills learned.

**Registered Nurse** 2014 – Current

*Critical Care, University Hospital, London Health Sciences Centre  
London, Ontario, Canada*

Registered Nurse in the Medical-Surgical Intensive Care Unit and Cardiac Surgical Recovery Unit (MSICU/CSRU). Manages complex and dynamic clients in a fast-paced and high-pressure care environment. Works as a leader within a highly specialized interprofessional team environment to provide holistic and client-structured care to clients experiencing critical illness, injury, and intensive surgery.

EDUCATION

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**Master of Science in Nursing** 2017 - Current

*Western University  
London, Ontario, Canada*

Enrolled in the MScN program with a focus on Leadership in Nursing Education  
Specialization: Feminist studies, antenatal education research, nursing leadership, and advanced nursing practice.

**Bachelor of Science in Nursing** 2010 - 2013

*Western University  
London, Ontario, Canada*

Graduated with Honours and Dean's List recognition  
Specialization: practical and theoretical skills related to nursing, including courses focused on ethics, research, professional practice, pharmacology, physiology, and interpersonal relations.