Violence against women in the childbearing period: Women's and men's experiences

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ABSTRACT

***Aim*:** The overall aim of this thesis is to describe and interpret women´s experiences of being exposed to intimate partner violence (IPV) during pregnancy and of important others in relation to change, and men´s experiences of becoming fathers and of being in change in the context of pregnancy and early parenthood.

Methods: In Studies l and ll, a phenomenological method was used to describe women's experiences of being exposed to IPV during pregnancy and women´s experience of important others in a pregnancy dominated by IPV. In Study lll, a phenomenological hermeneutic method was used to illuminate the lived experiences of becoming a father in men who have subjected their partners to violence. In Study lV, a lifeworld hermeneutic method was used to explore men's experiences of perpetrating IPV and of being in change in the childbearing period. Data were collected from interviews with five (Study l) and seven (Study ll) women who were exposed to IPV, and with ten men (Studies lll and lV) who had perpetrated IPV in the childbearing period.

Findings*:*Being exposed to violence by one's partner during pregnancy was characterised by difficult existential choices and ambivalence. The existential choices are related to the women's whole life, both before and during pregnancy. By ambivalence is meant being uncertain about one's own feelings, self-esteem and abilities. (Study l). Women's experiences of important others implied striving for control in an uncontrolled situation, where other people might be experienced as representing both a rescue and a risk (Study ll). Becoming and being fatherswas experienced as a demanding transition and was affected by the men's experiences with their own fathers. It forced men to grow up and to take responsibility, and it seemed that the men were struggling hard to keep control. Being a father implied being able to protect the child (Study lll). The men's experiences showed that to be perceived as a multifaceted individual was a prerequisite for finding the motivation to change. Men expressed a need for support in learning how to become good fathers, and their experiences of being in change is about seeing oneself through the eyes of others. The child is crucial as a motivator for change (Study lV).

Conclusions: The childbearing period is experienced as a period for change for both the women and the men which involves the past, present time, and the future. Both the men and the women harbour desires to change their life situations with respect to IPV. To be seen by others as multifaceted individuals and not just be associated with the role of victim or perpetrator of violence is important. The child represents a key motivating factor for change, and both the men and women want to be good parents. The childbearing period is a significant time in terms of meeting women who are being exposed to violence. Both men and women need support and help with changing their life situation and in their role as parents.

Keywords: : Intimate partner violence, childbearing, pregnancy, becoming fathers, change, phenomenology, hermeneutics, lifeworld.

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Svensk sammanfattning

Denna avhandling handlar om våld i nära relationer (Intimate Partner Violence – IPV) i samband med graviditet och tidigt föräldraskap. Problematiken är förknippad med betydande hälsorisker för både barn och berörda kvinnor på kort och på lång sikt. Tidigare forskning har visat att graviditet kan utgöra en triggande faktor som utlöser eller förvärrar IPV. Mödrahälsovård är därför en potentiell arena för tidig upptäckt och stöd för berörda parter. Få studier har belyst IPV i samband med graviditet och nästan inga ur de blivande eller nyblivna fädernas perspektiv. Det övergripande syftet för denna avhandling var därför att beskriva och tolka kvinnors levda erfarenheter av att vara utsatt för IPV under graviditet (Studie I) samt vilka personer och på vilket dessa personer var betydelsefulla i situationen (Studie II). Syftet var vidare att beskriva och tolka männens upplevelser av att bli far (Studie III) samt av att vara i förändring relaterat till att de utsatte sin partner för våld under graviditet och tidigt föräldraskapet (Studie IV). För att få del av både kvinnors och mäns levda erfarenheter av detta komplexa och relativt outforskade fenomen valdes en design som bestod av fyra kvalitativa studier. I studie I och II tillämpades en fenomenologisk metod, i studie III en fenomenologisk hermeneutisk metod och i studie IV en livsvärldshermeneutisk metod. Alla informanter i studien rekryterades från ”Alternativ till våld” (ATV), ett norskt kompetenscentrum med fokus på våld i nära relationer.

Resultatet av den fenomenologiska analysen av kvinnornas upplevelser visar att vara utsatt för IPV under graviditeten innebär svåra existentiella val och ambivalens. De existentiella valen är relaterade till kvinnornas hela livssituation, både före och under graviditeten. Ambivalensen innebär att vara osäker på sina egna känslor, självuppskattning och tilltro till sin egen förmåga (Studie I). I resultatet framkom vidare att kvinnorna strävade efter att behålla kontrollen i en okontrollerbar situation. Relaterat till denna strävan kunde betydelsefulla personer i kvinnornas närhet, som vänner, närstående eller vårdpersonal, upplevas både som en räddning och som en risk. Kvinnornas egna mödrar beskrevs som ett särskilt viktigt stöd i situationen (Studie II). Innebörden i männens berättelser, om att bli eller att vara nybliven far samtidigt som de utövar våld mot sin partner, tolkades som att vara i en krävande förändringsprocess och att upplevelsen av denna var påverkad av deras relation till sin egen far. De var tvingade att växa upp och ta ansvar och berättelserna gav intryck av att de kämpade hårt för att behålla kontrollen i situationen. Innebörden i att bli far tolkades även som att vilja och kunna skydda barnet trots att de utövar/t våld mot barnets mödrar (III). I männens berättelser framkom att en förutsättning för att finna motivation till en förändring relaterat till våldet är att de blir sedda, inte bara som en våldsman, utom som en mer komplex person. Männen uttryckte ett behov av stöd för att lära sig att bli bra pappor och deras upplevelser av att förändras handlar om att få förmåga att se sig själv genom andras ögon. Att uppleva att barnet ser dig är i det sammanhanget avgörande för männens motivation till förändring (IV).

Sammanfattningsvis kan sägas att graviditet och tidigt föräldraskap är en period som kännetecknas av förändring, både för kvinnor och män. Förändringen är relaterad till både personernas livshistoria, nu-situation och tankar om framtiden. En önskan om en förändrad livssituation relaterat till IPV förekommer både hos män och kvinnor, enligt resultatet av denna studie och barnet är en central, men samtidigt sårbar, motivationsfaktor. Både män och kvinnor vill vara goda föräldrar men kan behöva stöd i en förändringsprocess som kännetecknats av en för samtliga berörda, men framför allt för barnet, destruktiv miljö. Metoder för att möjliggöra upptäckt, till exempel genom att fråga om våld i samband med kontroller mödravården, diskuteras. Evidens för hur detta kan eller bör genomföras saknas dock ännu.

LIST OF PAPERS

l. Engnes, K., Lidén, E., & Lundgren, I. (2012). Experiences of being exposed to intimate partner violence during pregnancy. International Journal of Qualitative Studies on Health and Well-being,7.

ll. Engnes, K., Lidén, E., & Lundgren, I. (2012). Women's experiences of important others in a pregnancy dominated by intimate partner violence. Scandinavian Journal of Caring Sciences.

lll. Håland, K., Lundgren, I., Eri, T. Schauer, Lidén, E. The meaning of men's experiences of becoming and being fathers, in men who have subjected their partners to violence. Fathering: A Journal of Theory, Research, and Practice about Men as Fathers. Submitted 21.07.13. Revised 16.12.13.

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CONTENT

1.0 Introduction

In 2005 I was asked to take part in a pilot project run by the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS), whereby routine questions should be put to pregnant women during maternity care. The project was part of the Norwegian government`s Action Plan "Domestic violence" (The Norwegian Ministry of Justice and the Police, 2005). The purpose was to develop methods to uncover violence, including developing routines and measurements for cooperation and follow-up when violence was detected (Hjemdal & Engnes, 2009). Before starting the project, I asked myself: Who are these women? What are their experiences of being exposed to violence and at the same time being pregnant? How can I as a midwife support them without humiliating or infringe on their privacy ? My focus then shifted from the women to their partners; Who are these men who perpetrate violence on their partners during pregnancy? How do they experience their role as fathers? How do I relate myself to them? Is pregnancy a period that offers possibilities for change for these parents? What do women and men consider significant enough about their situation to tell others? What kind of support do the expectant mothers and fathers consider useful?

My work on the issue of violence is characterised by a particular focus on the child. How can I as a midwife contribute to giving the unborn child the best possible start in life? How can I help women and men feel competent in their role as parents so that they can provide their child with good health care and a secure childhood? Two of the duties of a midwife concern the health and the life situation of pregnant women, and he/she can therefore provide support to women who are exposed to violence during their pregnancy. This thesis has been written from the perspective of the midwife, but I hope it will also prove useful to other groups of professionals involved in work related to pregnant women and family formation.

The thesis is based on studies conducted in Norway. The topic is intimate partner violence (IPV) during pregnancy and women's and men's experiences in this connection. The women and men who participated in the study were recruited via Alternative to Violence (ATV), a professional research and treatment centre in Norway for violent offenders and for people who witness or who are exposed to violence. Two of the objectives for ATV are to treat and change the behaviour of men who use violence against their partners and to treat women exposed to violence in intimate relationships. Consequently, the participants are presented in a context in which the focus is on change.

2.0 Background

This chapter contains a presentation of definitions, perspectives, and prevalence of men's violence against their female partners. Based on research studies, an account is given of the risk factors that leave women vulnerable to exposure to violence, the background similarities of men who use violence, and the consequences of violence for the women and for the health and quality of life of the unborn/newborn child. The pregnant woman's first encounter with the midwife in the context of pregnancy care, where some of the objectives are to safeguard and promote health and psychosocial needs (Norwegian Directorate of Health, 2005). Antenatal care in Norway is described to illustrate the setting in which the midwife meets the expectant parents and to provide some background information for the discussion on possible changes in

pregnancy care. A presentation of Norwegian legislation concerning the obligations of the midwife when dealing with women exposed to violence is also given. Finally, the chapter gives an account of prior research in the topics for the studies.

2.1 Intimate partner violence

Violence inflicted by a partner is referred to as intimate partner violence (IPV), defined by the World Health Organization (WHO) as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). IPV is sometimes referred to as domestic violence or spouse abuse,and includes acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviours by a present or former spouse or partner (Heise & Garcia-Moreno, 2002). Domestic violence (DV) might have a wider definition than IPV,because it can involve violence perpetrated by family members or othersclose the the family who are or who have been in a partner relationship (The United States Department of Justice, 2011). This study is limited to IPV. A study on women's health and DV, conducted by WHO shows that, in most cases, women are exposed to violence by their partners (Garcia-Moreno, Jansen, Ellsberg, Heise, & et al., 2006). This also applies to pregnant women (Ezechi et al., 2004; J. K. Johnson, Haider, Ellis, Hay, & Lindow, 2003).

IPV can be categorised in different ways and is therefore open to different understandings, perspectives, and views on how it should be handled. Johnsen (M.P. Johnson, 2006) refers to two types of IPV: episodic partner violence and patriarchal terrorism, also known as intimate terrorism. Episodic partner violence may entail isolated incidents where stress and frustration create conflicts that result in aggression and physically violent behaviour. Both men and women can be participants. Patriarchal violence has to do with power relations, where the man has a need to control the woman. This form of violence is often recurrent and has an escalating pattern, and is therefore more harmful to the health of those subjected to it (M.P. Johnson, 2006).

A study from the United States explored men´s perspectives of the intimate partner violence related to their understanding of manhood. Three categories of themes were identified. First, justifications; it is a man' right to control a woman who disrespects and provokes him. Second, dissociations; denial of being an abusive 'type' and trivialising the violence. Third, remorse; regret for abusing the woman (Wood, 2004). The first category has a distinctly patriarchal orientation. The construction of masculinity plays a crucial role in shaping violence against women through men's attitudes, behaviours, identitie, and relations, and it is therefore important to involve men in efforts to end violence against women (Lancaster et al., 2010).

After further developing his theory of two categories of IPV (M.P. Johnson, 2006), Johnsen classified four types of violence (Michael P Johnson, 2010). The first of these is coercive controlling violence, and entails controlling behaviour, often combined with physical violence. Men are the more frequent perpetrators in this category. The second form of violence is violent resistance. which is a counter-reaction to exposure to the first form of violence, and is more common among women. Situational couple violence, or common couple violence, is common among both women and men, and is related to poor anger management, stress, and frustration. In the case of situational couple violence, a couple may use violence on each other. The fourth and final form of violence is separation-instigated violence, which is violence that is instigated by the break-up of a relationship, and is more frequently used by men. Although men are also victims of intimate partner violence and sexual assault, women experience more sexual violence,

more severe physical violence, and more coercive control by male partners (WHO, 2013). This thesis deals with the use of violence by men against women.

2.1.1 Prevalence of IPV

IPV can be defined and understood in various ways in different cultures, which makes it difficult to accurately determine its prevalence (Bailey, 2010; Espinosa & Osborne, 2002). In addition, it is often associated with feelings of shame, fear and guilt among women, and they may feel unable to disclose their experiences of violence during pregnancy. It is therefore possible that the prevalence may be under-reported (Devries et al., 2010; K. E. Edin, Dahlgren, Lalos, & Hogberg, 2010; Lutz, 2005a; Seng, Sparbel, Low, & Killion, 2002).

An incidence study recently published in Norway shows that both women (16.3%) and men (14.4%) are exposed to "less severe" violence by their partners (pinching, scratching, hair-pulling or hitting with the flat of the hand), whereas women (8.2%) are significantly more exposed than men (1.9%) to severe physical violence (kicking, strangling, and beating) by their partners (Thoresen & Hjemdal, 2014).

With respect to the prevalence of IPV against women during pregnancy, studies from different countries show considerable variations of between 1% and 29% (L. Bacchus, Mezey, & Bewley, 2004; Bailey, 2010; Devries et al., 2010; Dunn & Oths, 2004; Ezechi et al., 2004; J. K. Johnson et al., 2003; Krug et al., 2002). A meta-analysis of 92 studies from 23 countries shows an average prevalence of violence against pregnant women of 19.8%. The prevalence of emotional/mental violence is 28.4%, physical violence 13.8%, and sexual violence 8%. No Norwegian studies were included in the meta-analysis, but figures from Sweden show an overall prevalence of 24%: physical violence 14.5%, physical violence 11%, and sexual violence 3.3% (James, Brody, & Hamilton, 2013).

The first large-scale Norwegian study of exposure to violence was conducted in 2005, and 4% of the women participants reported that they had been subjected to violence during pregnancy (Haaland, Clausen, & Schei, 2005). Taking prevalence into consideration, violence during pregnancy is more common than several recognised maternal health conditions that are routinely screened for during antenatal care, including pre-eclampsia (2-8% globally) and gestational diabetes (1-5%), according to an article discussing 19 studies conducted in different countries (Devries et al., 2010). Although it is difficult to measure the prevalence of exposure to violence, the studies show that violence against women – including violence against pregnant women – is a widespread problem.

2.2 Risk factors of women who are exposed to IPV

Pregnancy is a time of change, and IPV may begin, escalate or stop during this period. Prior abuse is the strongest predictor of violence during pregnancy (James et al., 2013; Stewart, MacMillan, & Wathen, 2013), but the characteristics and risk factors of women exposed to violence are complex. Several studies indicate that women exposed to violence have a lower socioeconomic status (L. Bacchus et al., 2004; Bhandari et al., 2008; Espinosa & Osborne, 2002; James et al., 2013; Jeanjot, Barlow, & Rozenberg, 2008). However, one study conducted in Nigeria involving different social and ethnic groups showed no association between prevalence, pattern of abuse, and sociodemographic characteristics (Ezechi et al., 2004). A study from Sweden revealed that the risk of being exposed to IPV from early pregnancy until a year after childbirth is greater for women who are aged 24 years or younger, unmarried, born outside

Europe, have a partner born outside Europe, have a low level of education, and are unemployed (Rådestad, Rubertsson, Ebeling, & Hildingsson, 2004). This is confirmed in a meta-analytic review were seven risk factors were identified: abused before pregnancy, low level of educational, low socioeconomic status, single, alcohol abuse, unplanned/unwanted pregnancy, and lifetime adversity/exposure to violence (James et al., 2013). Jealousy and stress are also related to women's psychological victimisation (Hellmuth, Gordon, Stuart, & Moore, 2013). Other risk factors for violence during pregnancy are witnessing or experiencing violence as children and a history of substance abuse by one of the partners in the couple (Hellmuth et al., 2013; Huth-Bocks, Levendosky, & Bogat, 2002; Wilson et al., 1996).

2.3 Risk factors for men who perpetrate IPV

A Swedish study (K. Edin, Hogberg, Dahlgren, & Lalos, 2009) where health professionals working with men inclined to violence were interviewed about gender and pregnancy, combinations of several circumstances could become stressors for men related to violence. Pregnancy was identified as one triggering factor. According the interviewees, these men might be more vulnerable and less able to cope with the transitions around pregnancy and parenthood than other men, One reason for this lack of flexibility may be difficulties in their family history (K. Edin et al., 2009). A survey consisting of data collected from men taking part in a domestic violence and treatment programme shows that pregnancy is a time where women are in greater danger in terms of frequency and severity of violence by their partners (Burch & Gallup, 2004).

According to a systematic review where nine scientific databases were consulted (1960–2004), an association was found between being battered during childhood, witnessing marital violence as a child within the family of origin, having an absent or rejecting father, and the occurrence of IPV behaviour among men (Gil-Gonzalez, Vives-Cases, Ruiz, Carrasco-Portino, & Alvarez-Dardet, 2008). Furthermore, men who were subjected to family violence of physical abuse as children run double the risk of being involved in pregnancy during adolescence (Anda et al., 2001).

A Norwegian report based on data from a process and outcome study of men undergoing treatment for violent behaviour at ATV, from which the participants in the studies for this thesis were recruited, shows that the majority of the men reported psychological problems. The report show high incidences of severe violence and of potentially violent incidents. It also also shows high incidence of aversive childhood experiences such as emotional abuse, neglect, and physical and/or sexual abuse. A majority of the men had been in therapy either as children or adults (Askeland, 2012).

2.4 The effect of IPV on the health and well-being of women

Violence against women involves human rights violations, and there is increasing evidence that IPV can affect women's health, both individually and as a global challenge. Being exposed to violence during pregnancy can lead to health-related problems throughout the life cycle and even to death (Ellsberg et al., 2008; Espinosa & Osborne, 2002; Martin, Macy, Sullivan, & Magee, 2007; Shay-Zapien & Bullock, 2010).

Studies of violence in connection with pregnancy and childbirth show that IPV is significantly associated with both increased sexually transmitted diseases, miscarriages,and induced abortions (Fanslow, Silva, Whitehead, & Robinson, 2008; Phyllis W. Sharps, Laughon, &

Giangrande, 2007). IPV during pregnancy can also cause mental health challenges such as mental distress, depression, and anxiety (Brown, McDonald, & Krastev, 2008; Howard, Oram, Galley, Trevillion, & Feder, 2013; Lancaster et al., 2010; Rodriguez et al., 2010; Rose et al., 2010) and can affect the woman's bonding and caregiving abilities with respect to her child (Shay-Zapien & Bullock, 2010; Taylor, Guterman, Lee, & Rathouz, 2009). Anxiety and depression can also lead to medication and alcohol abuse (Sarkar, 2008). Experiences of violence may impair women's ability to concentrate and to function in everyday life (Ellsberg et al., 2008). Three studies conducted between eight and 12 month after birth shows that violence in the post-partum period may lead to further maternal psychological distress and depression (Escriba-Aguir, Royo-Marques, Artazcoz, Romito, & Ruiz-Perez, 2013; P. Romito et al., 2009 a; Patrizia Romito et al., 2009 b).

A study from Australia shows that women who are afraid of their partners both before and during pregnancy show signs of poorer physical health in early pregnancy, such as urinary incontinence and faecal incontinence (Brown et al., 2008). Another study from the United States shows that women reporting IPV prior or during pregnancy run a high risk of high blood pressure, severe nausea, vomiting, dehydration, kidney infection, urinary tract infection (J.G. Silverman, Decker, Reed, & Raj, 2006a) and vaginal bleeding (Brown et al., 2008; J.G. Silverman et al., 2006a). According to a cross- sectional, self- reporting survey from Norway, increasing levels of exposure of violence are related to increasing somatic symptoms and reporting of diseases in women (Eberhard-Gran, Schei, & Eskild, 2007), which also is confirmed by Silverman's study in which women reporting IPV during pregnancy had more hospital visits (J.G. Silverman et al., 2006a).

Studies also show that women who have been exposed to a violence and sexual abuse are associated with increased reporting of pregnancy-related physical symptoms (Han & Stewart, 2013; Lukasse, Henriksen, Vangen, & Schei, 2012) have a longer second stage of labour and an increased risk of operative vaginal delivery compared with controls from the general birth cohort (Nerum et al., 2010). Experience of sexual abuse during childhood may lead to retraumatisation during pregnancy and to posttraumatic stress disorder (Yampolsky, Lev-Wiesel, & Ben-Zion, 2010).

Despite the research conducted in this area, the full impact of abuse on the long-term physical and psychosocial well-being of women and their families may not be fully understood. Women who are exposed to violence report higher rates of smoking and substance abuse than other women (L. Bacchus et al., 2004; Beck, 1993; Bhandari et al., 2008; Rosen et al., 2007). IPV also frequently occurs in conjunction with other risk factors such as the parents' substance abuse, unemployment, financial problems, and other adverse circumstances in their immediate environment. The relationship between IPV and health is complex (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008), and it is important to try to understand the different needs of partners subjected to violence and the challenges they face, as these will affect their health and quality of life in different ways.

2.5 The effect of IPV on the health of the unborn and newborn child

During pregnancy, violence may affect the unborn child; either directly through kicks and blows to the stomach, or indirectly through the stress reactions of the mother (Woods, Melville, Guo, Fan, & Gavin, 2010). Violence-related stress may cause lower birth weight (Han & Stewart, 2013; Rosen et al., 2007; Shah & Shah, 2010; Phyllis W Sharps, Campbell, Baty, Walker, & Bair-Merritt, 2008; Yost, Bloom, McIntire, & Leveno, 2005) or premature birth (Meuleners, Lee, Janssen, &

Fraser, 2011; Rosen et al., 2007; Phyllis W. Sharps et al., 2007; Stewart et al., 2013; Yost et al., 2005) and poses a higher risk of death (Hall, Chappell, Parnell, Seed, & Bewley, 2014; Meuleners et al., 2011). Research also shows that women who are victims of violence breastfeed less than other women (Kendall-Tackett, 2007; Lau & Chan, 2007; Shay-Zapien & Bullock, 2010; Jay G. Silverman, Decker, Reed, & Raj, 2006b), although other factors beyond experiences of IPV may also predict a woman's decision or ability to breastfeed. Research indicates that perinatal stress may also lead to structural changes in the brain that may cause cognitive impairment, short-temperedness, and restlessness (Burke, Lee, & O'Campo, 2008; Sandman, Davis, Buss, & Glynn, 2012). A review of 23 studies on the impact of perinatal stress found a small but consistent impact on infant size and early birth, as well as attention-deficit symptoms and decreased cognitive levels (Talge, Neal, & Glover, 2007). An article that synthesises research examined the impact of abuse on women, fetuses, and developing children. This research shows that violence against pregnant women may have both short-term and long-term consequences for the health and quality of life of the unborn child. Even without witnessing the abuse, the child of a woman who has experienced IPV may suffer from its effects, and this may have negative impacts on the child's social, emotional , behavioural, and cognitive developement (Shay-Zapien & Bullock, 2010).

2.6 The Norwegian context

Antenatal care is organised differently around the world; even he Nordic countries differ in the way they organise care during pregnancy and childbirth. In Sweden, Denmark, and Finland, midwives have been the primary caretakers for pregnant women and their families since the 1930s (Norwegian Directorate of Health, 2005). In Norway, however, pregnant women are free to choose if they want to see a midwife, a general practioner or both. An estimated 80% of women receive some from of antenatal care provided by a midwife (Backe, 2001). Antenatal care is provided free of charge, and women are recommended to have eight consultations during their pregnancy. Psychosocial care should be a key concern, and the midwife and doctor, in consultation with each woman, can determine how closely she should be monitored. Expectant fathers are welcome to take part in antenatal care together with the women, but no routines exist for separate consultations with the father. Many fathers attend the ultrasound examinations.

In Guidelines for Antenatal Care in Norway (Norwegian Directorate of Health, 2005), there is no requirement to systematically screen for IPV during pregnancy, but midwives and other health professionals should be aware of individuals who are exposed to violence and should support women who are exposed to IPV. The Norwegian Directorate of Health is currently running a project in several municipalities to screen for violence, substance abuse, and mental health problems. The Norwegian Action Plan against Domestic Violence 2014-2017 states that the guidelines for antenatal care will be amended in 2013 so that health personnel must routinely ask questions to uncover domestic violence during pregnancy (Ministry of Justice and Public Security, 2013).

In its Action Plan against domestic violence 2012, the Norwegian Ministry of Justice and Public Security has announced an educational programme called "Early intervention – mental health, substance abuse and violence" aimed at teaching personnel how to practice early intervention in order to prevent children from growing up in an atmosphere of violence and conflict. The programme includes providing help to pregnant women and families with small

children in order to prevent a negative development over time. The programme is planned for implementation nationwide (Ministry of Justice and Public Security, 2012).

2.6.1 The legal aspect

Perpetrating violence constitutes a violation of human rights and can also be defined as a criminal act. There is no guarantee that women who are subjected to violence will get far in the legal system, since the way in which such violence is defined and judged under the legal framework may differ from the way in which the women perceive and describe it. Health professionals have a duty to protect people who are subjected to violence. This section summarises the legal obligations of midwives under Norwegian law with respect to individuals who are subjected to violence.

Under sections 21 to 29 of the Health Personnel Act, health professionals have a professional duty of confidentiality. In some cases, the issue of confidentiality is turned on its head, and health professionals are bound by a *duty* to disclose information which is otherwise subject to the duty of confidentiality; this duty is referred to as the duty to report. Under section 31 of the Health Personnel Act, midwives and other health professionals who encounter women who are being subjected to violence have a duty to notify the authorities in order to prevent serious injury or damage to individuals or property. This applies in cases where health professionals are convinced that a woman's life or health is in danger because she, for example, returns to live with a man who subjected her to severe violence and where there is a risk of renewed physical abuse (Helsepersonelloven, 1999).

Section 6-4 of the Child Welfare Act imposes a duty to report on health professionals in cases where a child is subject to serious neglect. Serious neglect exists when there are grounds for intervening under section 4-12 of the Child Welfare Act; for example, in the case of serious deficiencies in the personal contact and safety that children need. Children are often present when women are subjected to violence in intimate relationships. This is deemed to be unacceptable caregiving conditions for a child. In some cases the fact that a child witnesses the father's repeated violence against the mother will be deemed such a serious deficiency in the child's care situation that it will justify intervention under section 4-12 of the Child Welfare Act. Such cases trigger the duty to report, regardless of the duty of confidentiality(Barnevernloven, 1992).

In extremely serious cases, everyone has a duty to prevent a felony. Section 139 of the General Civil Penal Code prescribes a duty by everyone to prevent certain serious criminal acts by reporting them in some way or another. The most appropriate way of fulfilling the duty to prevent a felony is to report it to the police. This provision prevails over other mandatory duties of confidentiality. A criminal act must be relatively serious for the duty to report a felony to apply. In many violent relationships, rape is part of the violence to which women are subjected. The duty to report a felony may only prevail over the duty of confidentiality in acute situations where there is a risk of a serious crime being committed(Straffeloven, 1999).

2.7 Women's and men's experiences of IPV during pregnancy

Internationally, we found a few studies, conducted in Sweden, UK, Australia and the United States, about women's experiences of being exposed to violence during pregnancy. A total of 190 women were interviewed. According to these studies, violence gives women the experience of

losing control of their lives, destroys their self-image, and causes shame (L. Bacchus, Mezey, & Bewley, 2006; K. E. Edin, 2006; Goldstein & Martin, 2004; Haggerty, Kelly, Hawkins, Pearce, & Kearney, 2001; McCosker, Barnard, & Gerber, 2004). Exposure to violence gives women experiences such as a sense of being controlled and of destruction (McCosker, et al., 2004). According to studies by Edin (2010) and Lutz, Curry, Robrecht, Libbus and Bullock (2006), women who are exposed to violence during pregnancy have ambiguous and contradictory feelings. Studies show that the phenomenon is experienced as difficult and taboo (Edin, et al., 2010; Lutz, 2005). Edin and Bishop (2005) report that women findit difficult to tell health professionals about their situation.

Only a limited number of international studies exist that describe pregnant women's, needs for important others in terms of help, support, and motivation to change the social network and support system when exposed to IPV. According to Bacchus (2002), women carefully consider the benefits and disadvantages before sharing their experiences. Prerequisites for disclosing their experiences to health professionals are continuity of care and that the health professionals have available time . Lutz (2005a) shows that fear, guilt, and shame make it difficult to share experiences, but women want the support, help, and respect of carers in the support system. Women do not want the support system to fix their situation. They want to participate in their own lives. Seng, Sparbel, Low and Killion (2002) describe the psychological phases of violence, from living with violence to finding a way out of it, based on interviews with women who had abuse-related posttraumatic stress. The study shows that women consider individual respect, and knowledge of and competence in the nature of violence, change, and trauma-related needs as important for providers of antenatal care. Gielen, O'Campo, Faden, Kass and Xue (1994) conducted interviews with women and show that support from friends helps women to leave a relationship with IPV.

One study explores men´s perspectives of their own intimate partner violence in relation to their understanding of manhood. This study is not related to pregnancy or becoming a father, but one participant expresses an explicit resistance to perpetrate violence during pregnancy;'I did smack her a couple of times, but when she was pregnant I never put my hands on her' (Wood, 2004, p. 566).

3.0 Research area and aims of the studies

Men's violence against women is widespread, both nationally and internationally, and it also occurs to a significant degree when women are pregnant, although it is difficult to determine the exact prevalence. Men's violence against women is a widespread and serious human rights problem that presents challenges in terms of health and quality of life in society. Violence has huge consequences for the physical and mental health of both women and the unborn child, and can also affect the quality of the child's later life in terms of cognitive and emotional skills. Although there is broad consensus that domestic violence must be stopped, it remains a taboo subject that is considered difficult to bring up and uncover.

In Norway, pregnancy is a time when most women contact the health care services, to receive pregnancy care. The focus in antenatal care should be on psychosocial factors. Antenatal care can therefore offer an arena for discussing violence and for supporting women who are exposed to IPV.

To be able to offer pregnant women and their partners help and support in changing a

life situation where violence is involved, it is important to have knowledge of how the couple perceive their life situation and what type of help from the support system they think might help.
No studies with a Norwegian context were found that looked at women's experiences of being exposed to violence during pregnancy or at which individuals are significant for them in connection with improving their life situation. Likewise, no studies were found that looked at what type of help and support the women themselves say they need in order to change their life situation. If midwives are to help women who are exposed to violence, this is important knowledge that should be disseminated. After several searches in databases, no studies were found that dealt with men's experiences of pregnancy and change when perpetrating violence.

3.1 Aim of the studies

The overall aim of this study is to describe and interpret women´s experiences of being exposed to IVP during pregnancy and of important others in relation to change, and men´s experiences of becoming a father and of being in change in the context of pregnancy and early parenthood. Such research is important for gaining in-depth knowledge about women's and men's experiences and needs in terms of understanding their life situation and of what they expect from the support services. The thesis consists of four studies, as shown in Figure1.

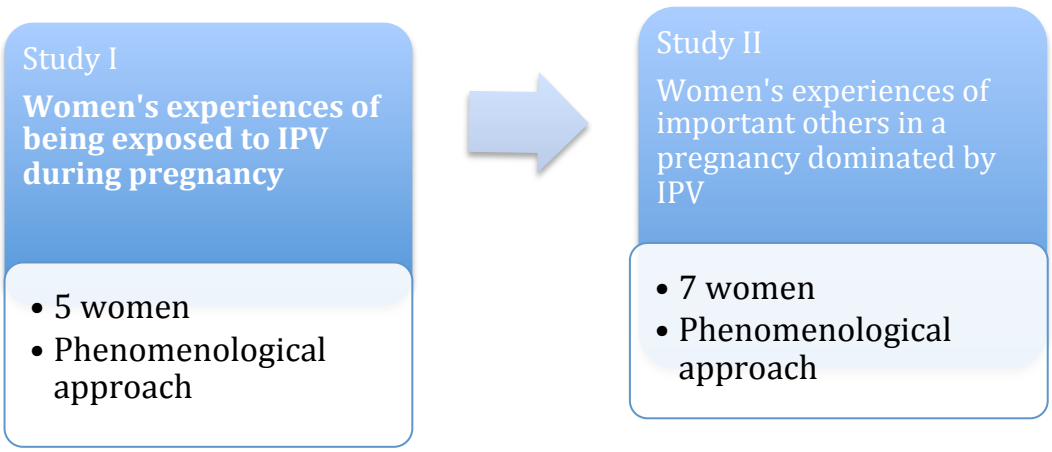
The studies have the following aims:

l To describe and gain a deeper understanding of women's experiences of being exposed to IPV during pregnancy.

ll To describe women´s experiences of important others in a pregnancy dominated by IPV.

lll To illuminate the lived experiences of becoming a father, in men who have subjected their partners to violence.

lV To explore men's experiences of perpetrating IPV and of being in change in the childbearing period.



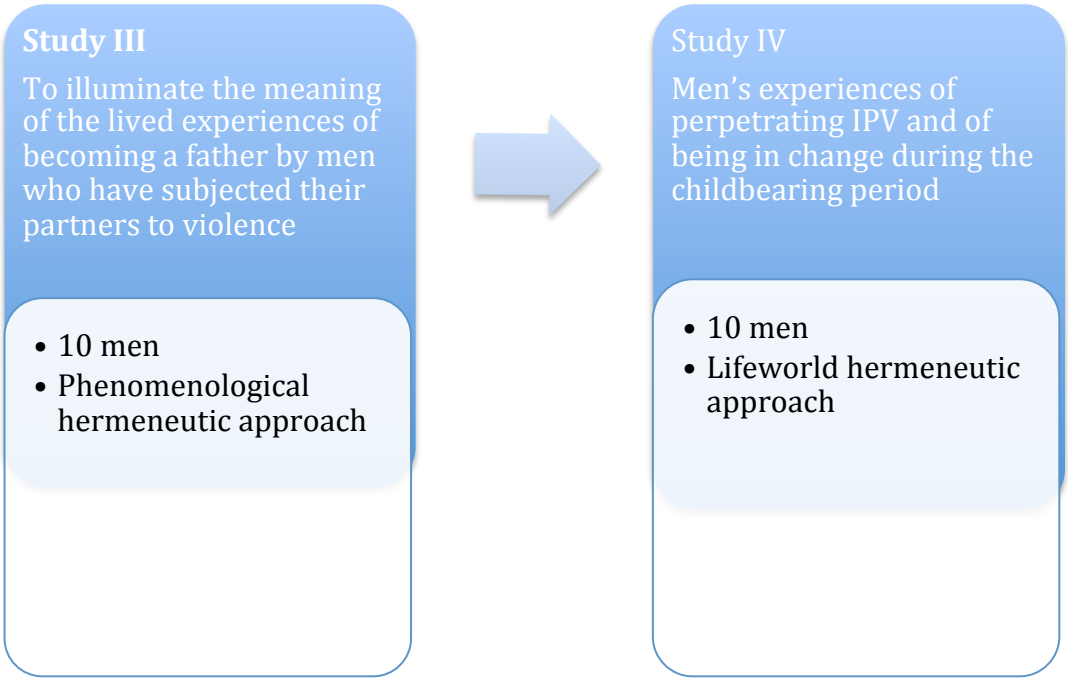


Figure 1. An overview of the articles in the thesis

4.0 Method

This chapter begins with an account of the epistemological frame of reference on which the studies are based. A phenomenological approach (Dahlberg, Dahlberg & Nyström, 2008) is used in Study I and Study II, based on the work of Husserl (1970) and Merleau-Ponty (2002). Study III has a phenomenological hermeneutic approach (Lindseth & Norberg, 2004), based on the the philosophy of Ricoeur (Hermansen & Rendtorff, 2002; Ricœur, 1976). Study IV has a lifeworld hermeneutics based on Heiddeger and Gadamer (Dahlberg et al., 2008).

Qualitative in-depth interviews are used in order to enter deeply into the experience and meaning of the studied phenomena. A step-by-step account is given of the respective methods applied. Pre-understanding is emphasised because of the sensitive and difficult nature of the topic of this thesis, which requires the researcher to tread carefully in this area of research. The chapter concludes with some ethical considerations and a summary.

4.1 Theoretical framework

4.1.1 Phenomenology and lifeworld hermenutics

The lifeworld perspective is the basis for both phenomenology and lifeworld hermeneutics, which share the philosophy that all individuals live in a common world , a world of perception, whereby the world presents itself to us in different ways. Human beings are intentional beings, and always have their consciousness directed at something. We experience the everyday world through the lifeworld and through the 'natural attitude', meaning that we take things for granted, uncritically. What comes to the fore and what remains in the background of our consciousness will vary in line with our experiences and with the context in which we live our lives. We judge and evaluate the world on the basis of our lifeworld and create meaning in our lives on the basis of our lifeworld (Dahlberg, Dahlberg, & Nyström, 2008).

Merleau-Ponty states that human being are in the world as “flesh”, which is an important approach for the ontological understanding of the lifeworld. The body is not only biological but also subjectiv, and all the knowledge we develop is embodied knowing. The body is constant perceiving and perceive. Through our body we are connected with everyone and everything in the world. The world becomes meaningful through our bodies, and we can never free ourselves from this embodiment. As subjective bodies, we are always here and now, and we belong to space and time. The body is the medium of our temporal and spatial communication, and is significant in the function of memory (Dahlberg et al., 2008). This replaces the ontological dualism, of body and soul that has dominated Westerm philosophy (Merleau-Ponty, 1994).

In phenomenology, the focus is on the description of a phenomenon, which is an object as experienced by a subject (Dahlberg et al., 2008). “Phenomenon” is derived from the Greek word “phainomenon”, meaning to show to or to be manifest to the consciousness. Phenomenology is the science of phenomena and its inhabitants; the world of experience (Dahlberg et al., 2008). According to Husserl, the scientist has to go “to the things themselves”, the lived experiences, in order to find the essence of a phenomenon (Dahlberg et al., 2008). The idea behind applying a phenomenological approach to research and thereby problematising and challenging the lifeworld is to develop new knowledge and to describe people's modes of thought and experiences, through their language and their subjective bodies (Dahlberg et al., 2008). In this thesis, we have approached women who were exposed to violence and men who perpetrated violence in connection with the period of childbearing in order to gain knowledge about their lifeworld through in-depth interviewing.

The phenomenon in the first study is *” Women’s experiences of being exposed to IPV during pregnancy”* and the phenomenon in the second study is *” Women´s experiences of important others in a pregnancy dominated by IVP*”. The context in both studies is pregnancy. The phenomenon in the fourth study is *”Men’s experiences of perpetrating IPV and of being in change during the childbearing period*” in thecontext of the childbearing period.

In lifeworld hermeneutics, the goal is to express the hidden meaning and to discover anything new, where openness is a prerequisite (Dahlberg et al., 2008). According to Heidegger, the hermeneutic processes of understanding and interpreting make it possible to reveal the hidden meaning of phenomena. In order to discover something new in the text, one needs to have an open mind. This is in accordance with our “natural attitude” and with the way we belong to the world. The open attitude can thus lead us to a new and deeper understanding (Dahlberg et al., 2008). To confront and critically reflect on the everyday human world in a scientific way makes it possible to expand our understanding of human beings and human experiences. The tacit and implicit of the lifeworld can become explicit. Heidegger states that human beings can share their experiences of world with others, and intersubjectivity is a primordial quality of the human world. However, even if we live in the same world and have much in common, every person has his or her own unique lifeworld (Dahlberg et al., 2008).

According to Gadamer, pre-understanding is an intentional structure of feelings and thoughts which is activated when we regard something as something and which we unreflectively bring with us when reading a text. Gadamer uses the concept of “horizon”, which consists of experienthe prejudices are overcome, the horizons becomes expanded. The meaning is never fixed nor static, but always influenced of context and history, and leads toward new understanding (Dahlberg et al., 2008).

4.1.2 Phenomenological hermeneutics

Hermeneutics is the philosophy of understanding through interpretation. Originally, hermeneutics was used to refer to the interpretation of religious and juridical texts, especially of biblical texts in theology (Lindseth & Norberg, 2004; Thornquist, 2003). It was later further developed within the fields of philosophy and humanism. Schleimacher, and later Dilthey, Heidegger, Gadamer, and Ricoeur, played important roles in developing the hermeneutic tradition (Dahlberg et al., 2008; Lindseth & Norberg, 2004).

According to Ricoeur, in order to understand the human consciousness and actions, phenomenology must be supplemented by hermeneutics. He wanted to define and transcend the phenomenology. People's lived experience of difficult/complex situations in life are often expressed as narratives, and the essence is not explicitly spelled out. By using a phenomenological hermeneutic approach, the stories and text can reveal and make visible the meaning and essence through analysis and interpretation (Lindseth & Norberg, 2004). The symbolic expression, the written language, is important in hermeneutics because it connects humans to the world by describing their experiences and meanings of the world and of human existence. The written text has a surplus of meaning that must be uncovered by interpretation. Ricoeur objectified a text by removing it from the author, thereby allowing the researcher to interpret it beyond the written text. The interpretation should be as truthful and as probable as possible (Geanellos, 2000; Ricœur, 1976). In contrast to a purely phenomenological approach, Ricoeur argued that interpretation and reflection are very close to each other and that intuition always is masked by reflection.

By using the phenomenological hermenetucal approach we sought to illuminate, understand, and explain the phenomenon "*experiences of becoming fathers*" in men who have subjected their partners to violence. The aim of the method is to find new possibilities of living in the world that the interview text open up through the narratives of lived experiences(Lindseth & Norberg, 2004).

4.2 Participants

The participants were recruited via Alternative to Violence (ATV), a professional research and treatment centre for violent offenders and for people who witness or who are exposed to violence. Therapists at ATV informed women who were exposed to violence and men who had perpetrated violence on their partners about the project, both orally and in writing, and asked them to participate. ATV provided the researcher with the names of those women and men who agreed to participate and information about how they wished to be contacted.

Five Norwegian-speaking women aged between 20 and 38 participated in the first study and an addition two women participated in the second. The inclusion criteria for the participants were: women who had experienced intimate partner violence during a pregnancy within the previous two years, and were Norwegian speaking. Two of the interviews were conducted on women who were pregnant and five were conducted on women who had already given birth. Five of the women were first-time mothers, but some of their partners had children from earlier relationships. Two of the mothers had other children. Five of the women who participated were either studying or educated at university level. The women who were pregnant when the interviews took place lived with partners who subjected them to violence. One woman lived with her partner and their children, and four women were separated. All of the interviews were conducted in places where the interviewees felt safe. Four interviews were

conducted in an office at a hospital, and three interviews were conducted in a room at ATV's premises.

Ten men participated in the third and fourth studies. The inclusion criteria for the participants were: men who had exposed their female partners to violence in the childbearing period, who had become fathers within the previous two years. Both the female and the male participants were Norwegian-speaking. This was selected as a criteria so that the interviewer should understand the concept and meaning of the language. The spoken message went directly from the participant to the interviewer, without the need for an interpreter.

Recruiting male participants proved difficult; one reason for this might be that this is a taboo subject, and men may find if difficult to share their experiences and emotions. After six month, only three interviews were conducted. Due to this, the inclusion criteria were changed to involve men who had become fathers up to six years back in time. In the course of a few weeks, a total of ten men agreed to participate. The men had contacted ATV seeking help for their violent behaviour. Some of them had contacted ATV of their own accord, while others had been ordered to attend therapy in order to have contact with their children. They were all in a life situation where the focus was on possibilities for change, which matched the focus in this research. The interviews were conducted in at ATV's premises, where the interviews felt familiar and where the interviewer felt safe.

4.3 Interviewing and transcription

Each participant was interviewed once, for between one and two hours. During the interview, the interviewer and the interviewee talked about the experiences and stories related to the phenomenom which the interviewee chose to share. The interviews with the women consisted of two open questions: "Could you tell me about your experiences of pregnancy and of being subjected to violence by your partner?" and "Can you tell me about important others in your situation?" The interviews with the men contained the following questions: "Can you tell me about your experience of becoming a father?" and "What do you experience as important in changing a violent behaviour when becoming a father?" Their responses were followed up by in-depth questions about various aspects in order to gain a deeper understanding.

This could be achieved by asking: "Could you say more about it ...?"; "What were you thinking while you were experiencing this ...?"; or "What emotions did this create inside you?" Another way of conveying understanding and reflection is to repeat the last thing the interviewee said and then be open and wait for more details. It was important to be conscious about the way I asked the questions and about my non-verbal communication, and to be aware of how my attitude and pre-understanding might affect the answers and results. I tried to have an open and friendly attitude and to avoid expressing negative feelings about what was said, even though some incidents were emotionally difficult to deal with.

All of the interviews were audiotaped and transcribed afterwards. Through transcription, the data were converted from oral speech to written text. They will thus appear somewhat reduced, since human factors such as tone of voice, body language, and gestures were removed (Dahlberg et al., 2008; Ricœur, 1976). Non-verbal forms ofcommunication, such as crying and walking around the room, were noted in the transcription because they add an emotional expression to the interpretation of the text (Lindseth & Norberg, 2004), but they do not replace the overall linguistic expression. No lived experience of another person can be

totally captured in language or transcripts, but it is possible to transfer the meaning of lived experience (Dahlberg et al., 2008; Ricœur, 1976).

4.4 Pre-understanding

During the research process the pre-understanding of the researcher must be discussed and problematized (Dahlberg et al., 2008; Lindseth & Norberg, 2004). More specifically, the thoughts and actions are influenced of the different roles the researcher has as woman, mother, midwife, psychiatric nurse, and researcher. Attitudes and thoughts related to the studied phenomenon and based on these roles may influence the research. Husserl refers to the "natural attitude", meaning an unreflective attitude as a pre-given basis for all experiences. Attitudes we take for granted but with which we subconsciously judge and pre-judge phenomena (Lindseth & Norberg, 2004). This natural attitude is also called "pre-understanding", and two things are required to validate its influence.

Pre-understanding is a complex phenomenon, with several aspects one has to be aware of: historical, cognitive, social and emotiona (Dahlberg et al., 2008). In addition to the roles already mentioned, the researcher is a citizen and participant in various social systems, and is historically and culturally rooted. The researcher also has her own experiences, feelings, and reflections as a human being. Some of these roles were shared by the women interviewed, while others were not. We are individuals with our own life stories and lifeworlds, all of them consisting of multitudes of dimensions and experiences.

The pre-understanding of the female participants in this thesis was that I had met several women who had told me about their experiences of previous abuse but not about ongoing violence. I had not experienced IPV myself, so my experience was limited. My pre-understanding of the women I was to interview was influenced by the research in which I had immersed myself, which consisted of risk factors in women who are exposed to violence: young age (Barbara Parker, McFarlane, Soeken, Silva, & Reel, 1999; Rådestad et al., 2004) single, without regular employement, low economic status, low level of education, belong to a minority group, suffer from a chronic disease, disability or mental illness, and use drugs (Haaland et al., 2005; Rådestad et al., 2004). I therefore felt distanced from these women and could not identify with them. Despite of my pre-understanding, I wanted to meet these women with an open mind, question my pre-justice and bridle it. By bridling is meant to restrain one's personal beliefs, theories, and assumptions that might mislead the understanding of meaning and thus limit the openness of the research. The aim is to be open and to show a respectful attitude that allows the phenomenon to present itself (Dahlberg et al., 2008).

My pre-understanding of the men was not as clear to me. I knew no men who, to my knowledge, used violence against their partners, nor did I have any prior experience in discussing this topic. I was curious to meet them and to hear their experiences of the situations, but at the same time it was important for me to conduct the interviews in a place where I could feel safe. My conscious thoughts about feeling safe probably indicated my concern about being placed in an unpleasant situation by the men. I worried that I might provoke them unintentionally or that they might become angry and lose their temper during the interview situation. Some of the interviews were conducted during the evening, and I was therefore alone with the men at ATV's premises. I had arranged with a friend that if I failed to call her within two hours, she should come to the premises to check that I was safe.

When I met the women who were being exposed to violence, I was suprised by their education level, apparent control, and their coping strategies. I asked a researcher who works in

this area whether this group of women genuinely needed support and help; they appeared so strong and well organised. I was almost irritated by the prospect of spending so much time on women who, on first impression, appeared to be such well-functioning individuals. Dahlberg et al. (2008) states that a productive way to grasp pre-understanding is probably to be provoked. Through in-depth interviews and critical reflection, my understanding expanded and my prejudices changed (Dahlberg et al., 2008).

After interviewing the first man, I was drawn into his story and his perspective. He described a situation in which he presented himself as the victim in a relationship with a woman with a behavioural disorder. He was a handsome and articulate man, and during the interview I felt sympathetic towards him and his story. After the interview, I reflected on my own feelings and attitudes and had to realise that his story probably differed somewhat to the story that had resulted in him being ordered to undergo treatment at ATV. The men differed considerably in terms of manners and body language; some of them gave me the impression of being open and charming, while others seemed more introvert and ashamed. All of them had positive characteristics, and all of their stories had an element of sadness about them. All of them had used violence against their female partners. This interview process might also be understood as a form of self-examination (Fog, 2004). Self-examination consists of outward and inward movements; the outward movement represents attention directed at the women exposed to violence and at the men, who perpetrated violence, but at the same time I directed my attention inwards, to the immediate significance this issue had for me as a researcher. During interviews with some of the men, this inward attention led me to think about my own children; would I have noticed violent tendencies in a man if one of my daughters had a boyfriend who was violent? My pre-understanding changed during the course of the interviews. I viewed the men from a wider perspective; they were people with both good and bad sides, both vulnerable and strong. My fear of provoking them during the interview situation disappeared after the first two interviews. None of the men showed any sign of anger or irritation during the interviews.

After each interview I wrote down my intuitive reflections on my impressions of the participant and their lifestories. I also consulted a mentor, a colleague from the university college with expertise in debriefing and guidance, to share and discuss my feelings and pre-understandings in retrospect.

4.5 Analysis

4.5.1 Phenomenological analysis

The data from the first and the second study of the women's experiences were analysed in line with Dahlberg et al. (2008). The aim is to describe a phenomenon without interpretation, explanation or construction. The researcher must stay close to the data and dwell on it. A cautious and reflective attitude is important. The researcher is herself a tool in the research process and must therefore develop self-awareness. The researcher must try to bridle the pre-understanding she has of the phenomenon being studied to ensure that it affects the findings as little as possible (Jfr. 4.4) The first step was to read the transcripts of the interviews to gain a sense of the whole picture. Openness means being open and carefully listening to the tapes and reading the transcripts (Dahlberg et al., 2008). The next step involved dividing the text into parts, called 'meaning units' by Giorgi (2009). Meaning units should be concrete descriptions of the informant's everyday world that have meaning in relation to the studied phenomenon

(Giorgi, 2009). During the analysis, the text was read and parts that had relevance to the studied phenomena, i.e.: "*Women's experiences of being exposed to IPV during pregnancy*" and the phenomenon in the second study "*Women's experiences of important others in a pregnancy dominated by IPV*".

Next, the meaning units were organised to identify and understand patterns. Similarities and differences were reflected on and clusters of meaning emerged (Dahlberg et al., 2008). This process entails a constant movement between the interviews and the clusters, going from the whole to the parts and back again (Dahlberg et al., 2008). It leads to a reduction where the text is made more concise so that the essence of the investigated phenomena can emerge. Clusters of meaning were synthesised into a structure that bound them together, and an essence of the phenomenon began to emerge (Dahlberg et al., 2008). The essence is the phenomenon's essential meaning, whereas constituents are meanings that make up the essence (Dahlberg, 2006). A phenomenological approach is a slow process, waiting for the phenomenon to show us the meaning. The essence is further expressed by its constituents.

4.5.2 Phenomenological-hermeneutic analysis

The phenomenological-hermeneutic analysis was developed by Lindseth and Norberg (2004) and is based on the philosophy of Paul Ricoeur. The method was developed in order to investigate ethically, i.e. a perspective on morals; difficult care situations (Lindseth & Norberg, 2004), and has been used in several studies (e.g. (Karlsson, Bergbom, & Forsberg, 2012; Lohne & Severinsson, 2005; Tirgari, Iranmanesh, Cheraghi, & Arefi, 2013; Årestedt, Persson, & Benzein, 2014). Thus, this is a suitable for studying the phenomenon in the third study; "*The lived experiences of becoming a father by men who have subjected their partners to violence*". Through a three-step analysis consisting of understanding and finding explanations for the meaning in the data, a new comprehensive understanding can emerge (Lindseth & Norberg, 2004).

The first step is to formulate the first impression of the text; the naïve understanding. The naïve understanding is a pre-understanding that represents the initial, unreflected, spontaneous interpretation of the phenomenon. It conveys our understanding and our emotional link with the lifeworld through the narratives. The naïve understanding is used actively in the analysis. The interpretation is already underway, as it begins during the interview as the participants tell their stories and continues throughout the process. The aim of the naïve reading is to be open to the text, to gain a sense of the whole picture, and to serve as a guide for the structural analysis. The text should be written in a phenomenological language, as close as possible to that of the participant (Lindseth & Norberg, 2004). According to Ricoeur, the author's intention is beyond our reach, so the only way to find the textual meaning is to guess (Ricœur, 1976). However, the naïve understanding points out the direction for this work.

During step two, the structural analysis, the researcher tries to take a more objective and distanced approach to the text, - in contrast to the subjective attitude in the naïve reading. The whole text is read and divided into meaningful units. The meaning units may be part of a sentence, a full sentence, a group of sentences or a paragraph that expresses one specific meaning. These are first condensed and then categorised into sub-themes that are further reviewed and abstracted into themes. The meaning units are reflected on in terms of the background of the naïve understanding, but during the structural analysis the text should simultaneously be viewed as objectively as possible. The naïve understanding are validated og invalidated on the basis of the themes that emerged from the structural analysis. Validation

shows that sometimes our first impressions of a text can emerge from an as objective analysis as possible, while other times the structural analysis can reveal new meanings which one did not see in the first reading. If the naïve understanding is not validated, the researcher needs to repeat the naïve reading in order to find a new naïve understanding, which is more processed and mature. This process continues until the naïve understanding is validated through the structural analysis (Lindseth & Norberg, 2004).

A challenge related to validation is that themes can be ambiguous and contain a plurality of meanings, something Ricoeur accepted, but he also tried to find ways to mediate between competing interpretations. Despite plurality, Ricoeur states that some interpretations are more likely than others (Geanellos, 2000).

In step three a comprehensive understanding of the issues in the text as a whole is expressed. The researcher tries to have an open an attitude as possible and to critically reflect on the naïve understanding, the structural analysis, and relevant literature. This is a phase that allows for creativity at the same time as the literature and the creativity should shed light on different aspects of the phenomenon. The analysis process is like a hermeneutic spiral, commuting between whole and part and, eventually, to a new whole. The literature and the interview text interact with and illuminate each other, creating a new understanding, a new whole. The new whole is an awareness and a deeper understanding of the phenomenon. Simultaneously, the text and the researcher interact with each other; the researcher interprets the text, but the text also interprets the researcher (Lindseth & Norberg, 2004). In this way, Ricoeur's theory of interpretation provides researchers with a method of developing intersubjective knowledge. The analysis provided me with new knowledge and new reflections on men's experiences of becoming fathers, and give me new thoughts, attitudes, and nuances regarding aspects of the role of fatherhood.

However, interpretation is always incomplete, and understanding can change and develop. There is no absolute, unchanging knowledge (Geanellos, 2000). In this way, the hermeneutic spiral is both a movement on different levels and an ongoing process.

4.5.3 Life-world hermeneutic analysis

The fourth study is analysed by life-world hermeneutic method (Dahlberg et al., 2008). The analysis is done by interpreting the transcribed text. According to Gadamer, openness is important, which means having an open mind in order "to discover anything new, to see the 'otherness of something'"(Dahlberg et al., 2008). This means that the researcher must treat the informant's experiences in an unprejudiced manner as well as with a reflective and, not least, a self-reflective attitude (Dahlberg et al., 2008). During the analysis of the data the texts were first read as a whole. In this way the researcher initiates a dialogue with the text in order to discover the meanings that emerge from the studied phenomenon (Dahlberg et al., 2008), in this case: "*Men's experiences of perpetrating IPV and of being in change during the childbearing period*".

Further meaning units were identified and marked. Next, the meaning units were compared to one other and contradictions and similarities were discussed. After a process of visiting and revisiting parts of the text and the text as a whole, themes are derived and a main interpretation developed (Dahlberg et al., 2008). The hermeneutic spiral, or hermeneutic circle, thus provides a basis for interpretation. A main interpretation is formed that goes beyond the context of the study and that serves as a guide for the reader. A main interpretation is developed

through the use of theory. This allows the researcher to gain a new understanding that goes beyond the content of the original text.

Theory is applied to elucidate the findings so that new interpretations, understandings, and explanations can emerge, but the theory must not be applied too early because it may disrupt with the findings. All interpretations must be critically assessed to ensure reliability(Dahlberg et al., 2008). This was achieved by participating in research groups and in discussions with supervisors.

4.6 Ethical considerations

Women who are in a childbearing period and who are exposed to violence are vulnerable, and it might risky for them to disclosure about their situation, especially if they still are living with their partner.Men who are in therapy because of their violent behaviour are also vulnerable. Caution and carefulness are called for when planning a study so as to avoid hurting or offending the people one will meet. Conducting interviews with vulnerable people also requires ethical considerations in order to respect their integrity, security, anonymity, confidentiality. The interviews were anonymised during transcription so that all names were removed. The interviewees will be able to recognise their own voices in direct quotations, but since they come from different places around the country and none of these places is mentioned by name, they will not be recognisable to others. The recorded data were transferred from audio tape to a password-protected audio file, and the audio tape was destroyed immediately afterwards. The recordings on the audio tape will be destroyed once the thesis is completed, in accordance with guidelines issues by the Norwegian Social Science Data Services. Throughout the study process, the guidelines for research on violence against women were followed in order to protect the participants, the researcher, and the data (B. Parker & Ulrich, 1990).

First, it was important to protect the participants. Recruitment of the participants in the studies proved difficult, partly because the study design had to include a system that safeguarded the participants' safety and the participants' potential need to be followed up afterwards. The therapists at ATV helped to recruit women and men who fulfilled the inclusion criteria, and an agreement was made that the therapists could, if requested by the participants, follow them up after the interview. The researcher demonstrated a sensitive attitude towards the needs of the women and the men. If the participants showed signs of discomfort or stress, a break was suggested. At the end of the interviews, the researcher asked all the participants about how they experienced the interview situation and about their thoughts and feelings, and the female participants were asked about their safety and security in daily life. Several of the women and the men said that they found it positive to share their experiences, both because someone listened to them and because they gained a new insight into their own situation. Liamputtong (2007) emphasizes that researchers need to protect their participants, because talking about their lives may force them to relive their painful experiences. All of the participants, who were recruited by ATV, had shared some of their experiences with therapists before, so this was not their first experience of disclosing details about their situation. Sharing experiences of IPV may give the participants an opportunity to work through their trauma and in this way the interview may have a positive therapeutic effect (Liamputtong, 2007). Several of the women also expressed the hope that their experiences would help other women who are victims of IPV. After the interviews, both the women and the men were given an opportunity to participate in follow-up conversations with experts at ATV.

The researcher had a special responsibility to protect the women who still lived with their partners when the interview took place. She had to ask them about what kind of strategies they had to keep themselves safe, have a focus on security planning and establish contact with important persons who could support the women. If it considered becoming dangerously to return at home, she had responsibility to help the woman go to e.g. a crisis centre. The researcher had experience and knowledge about security planning from her previous job. The researcher was also sensitive to the men's mood, especially whether they seem to be angry or provoked. It was important that they didn't leave the interview situation in a mood that could provoke violent actions after.

Second, the researcher had to be protected (B. Parker & Ulrich, 1990). The protection of the researcher was most significant when planning and carrying out the interviews with the men. In order to make the researcher feel safe, the interviews were held in the consulting room at ATV. The therapists, who knew the participants, made themselves available None of the men behaved threateningly. They clearly had confidence in the therapists and ATV, and placed confidence in the researcher, too. They said that it was okay to tell their stories, and showed an interestin the project. Several of them said they wanted to read the article. The researcher promised to send it to ATV so that they could pass it on to the participants.

Third, the data had to be protected(B. Parker & Ulrich, 1990). The consent obtained from the participants and the tapes were kept in a locked filing cabinet, and during transcribition any names and data that could identify individuals were removed. The computer on which the text was password-protected and stored in a secure place. At the end of this project, the tapes and consent forms will be erased.

The Regional Ethics Committee of South-Norway (2010/1107) approved the study. The ethical guidelines for midwives (International Confederation of Midwives, 2008), and the Helsinki Declaration were adhered to throughout the study. Together with the invitation to participate, the women and the men were notified verbally and in writing that if the researcher was made aware of any children at home who were being exposed to violence, it would be her duty to report the matter to the Child Welfare Service.

5.0 Results

This chapter presents the results of the studies and, finally, a summary of all the results in the articles combined.

5.1 Women's experiences of being exposed to IPV during pregnancy

The essence of being exposed to IPV during pregnancy, is characterised by difficult existential choices and ambivalence. By existential choices is meant questioning one's own existence, the meaning of life as well as the responsibility for oneself and for others. The existential choices are related to the women's entire life, both before and during pregnancy. By ambivalence is meant feelings of uncertainly about one's own feelings, self-esteem, and abilities. By ambivalence in relation to others is meant conflicting feelings for and confusion over how to relate to the other. The future life with the child is experienced as a possibility for existential change in the women themselves and in others.

The essential structure can be further explained by its five constituents: living with unpredictability; the violence is living in the body; losing oneself; feeling lonely; and being pregnant leads to change.

5.2 Women´s experiences of important others in a pregnancy dominated by IPV

The essence of important others in a pregnancy dominated by IPV implies striving for control in an uncontrolled situation, where other people may be experienced as representing both rescue and risk. By control is meant women's wish to take part in choices and decision-making processes. By uncontrolled situation is meant that others make decisions and take measures in relation to changes in the woman's life situation which she neither wants nor agree. Two persons were identified as particularly important to the women. The first was the unborn child, who represented power and motivation for change and gave the woman a sense of responsibility. The second was the woman's mother, who held a unique role in terms of possibilities for change because one's mother represents continuity and honesty.

Important others could represent rescue, as they support the women, are available, have the time and knowledge, show them respect, and motivate them for change. A common definition of violence and clear communication are vital factors for creating a secure relationship on which the women can depend. Other persons may be associated with risk if the women cannot find sympathetic understanding for their situation and for the violence to which they are exposed. Furthermore, experiencing others as a risk may destroy friendships and isolate the women even more. Another aspect of risk may be that the women are afraid to be considered bad mothers and therefore be in danger of losing the child.

The essence is further described by means of four constituents: the child needs protection; my mother is always present for me; an exhausted run for help; and a reduced but important social network.

5.3 The lived experiences of becoming a father by men who have subjected their partners to violence

The naïve understanding of *becoming a father by men who have subjected their partners to violence* shows that becoming and being a father when exposing the partner to violence is a demanding transition and is affected by men's experiences with their own fathers. Becoming a father forces men to grow up and to take responsibility. It seems that men are struggling hard to keep control of their thoughts and actions. Being a father implies being able to protect the child and to having a desire for one's own safety. It also includes feelings of fighting against shame and condemnation and, at the same time, involves acknowledgement that someone loves you anyway.

The four themes developed in the analysis are: being forced to take responsibility: being afraid that the violence will continue in subsequent generations; striving to stay in control; and being a good enough father. The themes reflect aspects of the lived experiences as described by the participants in their narratives about becoming and being a father.

5.4. Men's experiences of perpetrating IPV and of being in change in the childbearing period

The main interpretation of *perpetrating IPV and of being in change in the childbearing period* is based on interpretation using the concept "the face of the other" by Levinas, where the face of the other creates an ethical demand for consideration. To be seen by others and to be perceived

as a multifaceted individual is a prerequisite for finding the motivation for change. An important motivator for change is the face of the child, and the men express a need for support in learning how to becomen good fathers. It is important for them to acknowledge that they are inflicting violence. Men's experiences of being in change is about seeing oneself through the eyes of others. The child is crucial as a motivator for change. During pregnancy, the man's relationship to the child is vague, but his motivation rises in concrete encounters with the child.

Four themes developed in the analysis that highlight different aspects of violent fathers' experiences of being in change during pregnancy and early parenthood are: beginning to acknowledge that one is inflicting violence; receiving confirmation that one is more than just a perpetrator of violence; becoming aware of one's child; and a desire for support in learning how to become a good father.

5.5 Summary of the results

The summary of the results of the articles show that pregnancy is a time when both men and women experience many changes at different levels. These entail both experiences that are common to both men and women and experiences and modes of thought that differ. The mothers describe these changes as existential in nature; a fundamental change.

The results of the thesis show that the starting point for the women and men who took part in these studies were somewhat different. The women clearly expressed that, even if they have been in relatively short-lived relationships with the men, they had a strong desire for pregnancy and felt that they were ready to become mothers (Study I). Most of the men experienced the beginning of the pregnancy as an unpleasant surprise. They did not feel ready for fatherhood, and some say they felt they had been duped (Study II). The women worried about what life would be like living with men who were violent. Despite the fact that the violence affected their self-image and presented them with existential challenges and decisions, they still held high hopes that the violence would disappear once the child was born (Study I). The men also experienced the pregnancy as stressful, particularly because the women were so unstable due to hormonal changes. For most of the men, the women gradually became less important, and after the birth their focus shifted to the child (Study III).

Formation of the roles of motherhood and fatherhood afford the women and men a new identity. This identity is formed through, among other things, relationships with other people who may come from the past, the present, or the future (Study II). With respect to role models from the past, the women refer to their mothers (Study II) and the men to their fathers (Study III). For the women, their mothers are important support persons, even though some describe experiences of negligence, when they had to be responsible for younger siblings. Despite the fact that the women's mothers did not always step up, the women characterise them as the best mothers anyone could wish for (Study II). The men's relationships with their fathers are associated with wishes of not wanting to adopt the same violent behaviour. Pregnancy and the new role of fatherhood seemed to create an awareness of their own childhood where fear of and violence perpetrated by their fathers was all part of their everyday life (Study III). The findings indicate that the women take their mothers as role models (Study II) while the men have a need to learn how be become fathers because they lack good role models (Study IV).

In addition to family members and friends, the support system is important for the men and women in the present. For both the men and the women, the idea of approaching others and discussing their situation is associated with risk. Both genders acknowledged feelings of inadequacy and shame (Studies II and IV). The women describe an exhausting process of

running from one public service agency to another to seek help. This demands considerable courage and energy. Having people to step up and to care is a prerequisite for breaking out of a violent relationship (Study III). The men's experience of the support system is more limited to ATV. Receiving treatment at ATV made them reflect on their own role and, gradually, on their responsibilities (Study IV).

While the women have no wish to assume the role of the victim (Study II), the men have no wish to assume the role of abuser (Study IV). The women find that the role of the victim leaves them passive and without the strength to participate in decisions concerning their own lives (Study II). For the men, on the other hand, it is important that they are not condemned but instead seen as complex individuals who also have positive characteristics (Study IV). Both the women and the men want others to treat them with respect and acknowledge them as human beings so that they are not identified exclusively in terms of their violent behaviour (Studies II and IV).

For the parents, their children represent the future. The women experience their children through pregnancy, both physically and mentally (Study I). For the men, it is different; they have no physical experience of pregnancy, and express no appreciation of any connection between the mother's mental health and fear during pregnancy and the welfare of the child. The men experienced a distinct change once the child is born, sometimes as early as in the delivery room. Seeing the child creates a desire to be a father, to protect it and to be together with it (Studies III and IV). The child is a motivating factor for getting the men to seek help for their violent behaviour (Study III). Both women and men want to be good parents for their children (Studies II and III).

6.0 Discussion

Based on the findings from our studies of men's and women's experiences, this chapter contains a discussion of the results of the thesis from the perspective of whether the childbearing period offers an opportunity for change. Antenatal care is a meeting place between men, women, and the health professionals when women become pregnant and may therefore provide opportunities to discuss and possibly intervene in situations of domestic violence. Although antenatal care in Norway, as in other countries, is performed by both physicians and midwives, the focus of the discussion will be on the role of the midwife.

This is followed by a discussion of some of the challenges of conducting research on vulnerable individuals. While working on this thesis, I discovered how demanding it was to share in the lives and pain of vulnerable individuals. This became particularly evident during the work on transcribing the interviews. My reflections on this pain are drawn into the discussion on the role of the midwife; can midwives deal with hearing stories of violence and abuse without becoming wounded healers? The chapter concludes with some methodological considerations and clinical implications.

6.1 Does the childbearing period present an opportunity for change?

The results of the thesis show that both the men and the women wanted help with changing their domestic situation in terms of use of violence once they became parents. They had not managed to end the violence themselves. Pregnancy is a time when most women seek health care. Antenatal care presents opportunities to support women who are exposed to violence. Despite this, discussing violence during pregnancy is not a routine procedure. Several studies shows that women do not mind being asked about violence during pregnancy (L. Bacchus et al.,

2002; Keeling & Birch, 2004; Stenson et al., 2001; Webster, Stratigos, & Grimes, 2001). However, women do not usually disclose their situation unless asked directly (L. Bacchus, Mezey, & Bewley, 2003; Dufty & Hardacre, 2005; Jeanjot et al., 2008; Rubertsson, Hildingsson, & Rådestad, 2010). The experience of the women in our studies was that violence was not discussed during prenatal care. Consequently, neither the men nor the women thought of the midwife as a resource in terms of finding help for their problems in this connection. They did, however, have experience of ATV, and both the men and the women found that the staff had knowledge of violence and that they were able to acknowledge, support, and help them. All the women had contacted ATV directly in connection with their pregnancy, a fact which indicates that they were concerned with change and with the possibility of finding help during this period. The men had found it difficult to visit ATV for their first consultation because they felt stigmatised and ashamed about the situation they found themselves in, but their experience of ATV turned out to be positive, despite the fact that some of them had been ordered to undergo treatment if they wanted to have contact with their own children. Many indicated that they wanted to continue receiving treatment over time, and they believed that all parents would benefit from discussing parenthood and their reactions and feelings with other people. The women considered it important that the men could get help, for the women's sake and for the sake of the child.

The women in the study expressed a view that health professionals should ask about violence during pregnancy. The men also said it would be acceptable if midwives asked about violence, and in the interview situation they gave the impression that they would not be provoked or angered if this was done. Some of the men believed that they would have talked about the violence if they had been asked in a well intentioned way, whereas others were more uncertain as to whether they would have admitted their violent behaviour. This is were our results differ with other studies and with guidelines, which clearly advise that if health professionals in antenatal care want to ask a woman whether they are being exposed to violence, they should do so on the condition that the woman attends the consultation without her partner. The reasoning behind this is consideration for the women's safety, to avoid her being exposed to further danger afterwards (Loraine Bacchus, Bewley, & Mezey, 2001; Stewart et al., 2013; Stockl et al., 2013). A review article on the screening of violence against women shows that no descriptions exist of any injuries sustained by women after being asked about violence, but only one article in the review had actually studied this issue directly (Taft et al., 2013). Because the men in this thesis are in a process of changing their behaviour with the help of ATV, their views cannot be assigned to all men who perpetrate domestic violence without taking this factor into account. Nonetheless, it is interesting to note that, according to current regulations, if one is to uncover men's violence against women and to inform of the injuries this behaviour can cause, the men may not be involved. The men were concerned about protecting their children after their birth, and they also had a barrier that stopped them from hitting their partners in the stomach during pregnancy. One clear motivating factor for change that emerges from this thesis is the child’s presence, and the men's ability to function as a father. If fathers are to to choose to receive help, it may be significant for them to be made aware of the consequences of their violent behaviour. Do routines that are based on the need to protect women place additional responsibility on the women's shoulders? Should the woman have responsibility for informing the man about the consequences of his violent behaviour when she comes home after a consultation with the midwife, or should the midwife provide the man with this information? Could discussions about violence be conducted in a respectful way with both the woman and the man present? It is extremely important not to expose women to further risk and to help her plan

safety measures for herself, the unborn child, and any siblings there might be; but are we being unduly cautious? These are difficult ethical questions, and discussion of them should perhaps be elevated to the level of the wider societal perspective.

The women and men's views of what support measures they need in order to change their life situation differed somewhat, but both expressed a need for help in talking about and receiving guidance from others regarding their life situation. One argument against expecting health professionals to uncover violence as a routine procedure in prenatal care is that not enough is known about what types of intervention might work in ending the violence. A systematic review about screening for and intervention in domestic violence during antenatal care shows that routine screening for domestic violence may increase identification of women who are exposed to violence, but there is limited evidence for the effectiveness of the interventions. However, only four studies on interventions were included in the review, searched between January 1995 and November 2009 (O'Reilly, Beale, & Gillies, 2010). Two studies indicate that intervention such as counselling sessions after screening and an advocacy programme seem to be useful for preventing the recurrence of IPV (Kataoka, Yaju, Eto, Matsumoto, & Horiuchi, 2004; McFarlane & Wiist, 1997), and the screening itself may also create awareness and may contribute to reducing IPV (Cook & Dickens, 2009; McFarlane, Groff, O'Brien, & Watson, 2006).

A recent review articles, which summarise interventions and evaluations in connection with IPV, show that home visits, psychosocial support, psychotherapy, and guidance for pregnant women may lead to fewer incidents of IPV during and after pregnancy, but these do not appear to have any direct impact on the number of premature births (Jahanfar, Janssen, Howard, & Dowswell, 2013; Van Parys, Verhamme, Temmerman, & Verstraelen, 2014). Although it is difficult to determine with certainty that specific interventions have a guaranteed effect, research indicates that interventions that are implemented appear neither to lead to injuries nor to have any negative impacts (Jahanfar et al., 2013). Research shows that we ought to think in terms of individual solutions for these women (O'Reilly et al., 2010). This is consistent with the views of the women who participated in the studies in this thesis. They want to be involved in deciding which measures should be implemented. The women have a need for control over how health professionals think and act if violence is uncovered. They also wish that health professionals had knowledge about violence and its consequences. The women have a diversity of needs; legal, financial, and health-related, and may therefore need help from different bodies. One important finding in the thesis is the need among women for someone who can help them coordinate the help they require. The midwife could play the role of coordinator, but at the same time her presence in the lives of these women is limited. Once the pregnancy and the postnatal period is over, the women must refer to other health professionals, doctors, and public health nurses.

Pregnancy is a time of inner change in both women and men; they assume a new identity as mothers and fathers (Brodén, 2004), something which was also apparent in our studies. The men and women reflected on their own lives and particularly on the relationship they had with their parent of the same gender; the women with their mothers and the men with their fathers. One important result in the studies is that the men clearly expressed a desire to learn how to become fathers, since their own fathers were poor role models. Many of the men had themselves grown up with domestic violence, and for some of them anger was the dominant emotion they had in their emotional repertoire. Anger was the emotion they expressed when they felt disappointed, sad, afraid, under pressure, inadequate or insecure.

No intervention studies were found that dealt with how to help fathers to change their violent behaviour during pregnancy. The same applies to information on teaching programmes focusing on forming the role of the father and simultaneously changing violent behaviour. If domestic violence is to be asked about and uncovered during prenatal care, does the midwife's knowledge of and willingness to discuss paternal identity and parental competence with fathers who use violence present a challenge? A study from Pennsylvania, a cross-sectional survey of 85 staff members who worked with fathers in community-based parent organisations, explored fathering interventions in barriers and behaviour related to the perpetration of domestic violence. The findings suggest that many in the staff consider asking about violence, but few actually do it. Those who did ask about violence had longer work experience and more training than those who did not. The female staff members were more likely to report concerns about their own safety and less interested in working with a client if identified as a perpetrator, while the male staff members were more likely to report no interest in knowing whether their clients were perpetrators (Cronholm et al., 2011). According to these findings, IPV still seems to be a taboo subject that arouses emotional resistance, and there may also be gender-related differences in how it is handled. We need more knowledge about midwives' attitudes to and possibilities for helping expectant fathers who perpetrate violence. We also need interdisciplinary discussion about which professional groups can best address the needs of both men and women. At ATV in Stavanger, Norway, a new project is currently running in which parenting courses are provided for couples where at least one partner has grown up with domestic violence. The purpose is to break down the pattern of violence that is passed down from one generation to the next. The project is called *"I was afraid of my parents – My child is not going to be afraid of me!"*(Alternativ til vold, 2014). The evaluation of this project will prove important to future planning of measures.

For the men who participated in the studies, seeing their child's face represented a turning point that made them want to change their behaviour. A review article on qualitative studies which looks at turning points for men who perpetrate violence shows that the key motivating factors for the man are the realisation that they are beginning to resemble their fathers – who they despise – and the fear of losing their wife and family (Sheehan, Thakor, & Stewart, 2012). The child is not mentioned specifically. With respect to the results of our studies, making the child 'visible' during antenatal care may present an opportunity to motivate fathers who perpetrate violence to change their behaviour. Information about the positive aspects of foetal development as well as on foetal vulnerability and – not least – involvement in the ultrasound examination, where they get to see their child on the ultrasound monitor, may have a preventive effect on men's violence against women

Another significant and new finding in the thesis is that the women exposed to violence regard their own mothers as their most important support person. No accounts of mothers as resource persons was found in previous research in connection with violence against women. Should grandmothers or others close to the women be invited to take part in consultations during pregnancy? The women expressed a sense of deep loneliness, which could also present a barrier that stopped them from escaping the violence. Could the midwife play a key role in helping and encouraging women to build up a network during their pregnancy and thus contribute to change? Simply asking about violence may trigger an awareness-raising process in the women that may initiate a change process. Regardless of what specific type of follow-up provided, a study shows that simply by asking questions about violence, women exposed to

violence assume better safety behaviours and make more use of the support services (McFarlane et al., 2006).

IPV presents a complex and difficult challenge, but what is best for the child? What is it like for children to grow up with a mother who is stressed and afraid because of violence? Can men who use violence against women be good fathers for their children? Antenatal care may be an arena for asking questions about experiences of violence, but it is important for health professionals to possess knowledge, exercise caution, and have access to the interdisciplinary cooperation necessary to help families with this problem and that the best interests of the child are carefully considered in each individual case.

6.2 Conducting research on vulnerable people

The interviews with the women exposed to violence and the men made a strong impact on me. They created a sense of intimacy between two people – the women exposed to violence and me – which had unforeseen consequences for me. This became particularly clear to me while working on the transcriptions.

6.2.1 Transcription – and unexpected bodily pain

I chose to transcribe the interviews myself because I thought it might offer up new discoveries and perspectives. This proved to be a powerful experience. I sat at home, alone, with my earplugs connected to my computer. I could hear the women's voices loud and clear without any other impressions to distract me and could now hear the women in a different way. I could hear their loneliness, fear, insecurity, and intense pain. Although they were no longer sitting in front of me, I could see them in my mind's eye. I could see their facial expressions, their breathing movements, their agitation, and other physical expressions such as arms gestures and restless pacing around the room.

Transcribing conversations with vulnerable individuals with difficult stories to tell can cause emotional stress, anger, grief, exhaustion, and headache and even cause sleeplessness and nightmares. (Liamputtong, 2007) The words that are uttered and the text that is written down are embodied in the listener and transcriber. From a phenomological perspective of embodiment, the body carries within it the history of mankind and is simultaneously interwoven in meaningful relationships with its environment and with other people. Human beings have an effect on each other via their bodies; they live in relational coexistence. This reciprocal effect, or intersubjectivity, weaves our lives and experiences together (Bengtsson, 2001). I became affected by the women's emotional anxiety and pain and found myself unable to sit still. I, too, had to get up and pace around the room; a few minutes' transcription, then up and pace. I have no idea how many laps I walked around during those days. The tears came, too; I was moved by their loneliness.

I worked intensely to be finished with the transcription, which took many late nights to complete. The material was rich, and contained powerful stories and sensitive statements. The stories and the pain belonged to the women, but I recognised the nuances and gained an understanding of their pain and of the context of the meanings. By the time the summer holidays arrived, I had completed the transcriptions and could enjoy a much longed-for break that put a little distance between me and the faces of the women and enabled me to study the material with new eyes.

When I transcribed the interviews with the men, the focus of my attention shifted; I could picture the men's body language during the interview situations in my mind's eye. Some of

them had an open attitude, leaning back in the chair with their arms and legs in a relaxed position, looking at me with a relaxed facial expression, and making eye contact. Some of them gave a clear impression that their responsibility for the violence was limited, whereas others were plagued by shame. Their bodies were more tense, they tended to look away, and only occasionally did they make eye contact. I saw a change when I asked them about their children; in one particular case this was patently obvious. This man, who had been crying and agonising over his life of violence, suddenly sat ut straight and made eye contact. His body adopted a new posture, and he began telling stories about his child. His speech became faster and more animated. He broke into a smile, our eyes met, and we both laughed at the story he had told. He told more stories, all dealing with happy moments together with his child, how he had been determined to acknowledge the child,and how he thought the child acknowledged him as a father. He felt that they meant something to each other. Merleau-Ponty's philosophy of how humans exist in the world as bodies, where subjective perceptions and experiences manifest themselves, also became evident in this situation. Speech and body became one, reinforcing the message conveyed (Dahlberg et al., 2008). The message entailed a movement from shame to pride, and the movement was full of contrasts. It would have been interesting if the interviews had been filmed so that the physical experiential expressions of the men and women could be seen and could demonstrate some of the energy and experiences in what became the written word, the transcribed data.

Qualitative research conducted on vulnerable individuals will influence the researcher's everyday life to different degrees. One source of motivation for my work is what Levinas referred to as "seeing the face of the other" (Levinas, 1993). Seeing the face of the other, seeing the suffering and the fear, creates an ethical imperative to act. The pain and the joy served as a reminder that human beings are complex. According to Leer-Salvesen (Hammerlin & Leer-Salvesen, 2014), acknowledgement is important, particularly for those who have perpetrated violence. Someone who has done something wrong needs an opportunity to do something good, often through concrete actions. Humans yearn to be acknowledged as good beings, not just acknowledged as inadequate, failures, and even evil. The happy stories the men shared about their children provided us with a common arena that dealt with the positive aspects of parenthood. It felt good to be able to share some of the men's positive experiences and to show them that I could also see that there were sides to them other than that of a perpetrator of violence. I found the emotional contrasts powerful.

The researcher needs someone with whom the can share these feelings; a mentor. It is valuable if the mentor can not only supervise the academic performance but can also provide therapeutic debriefing. It could also help significantly if more people are involved in conducting the research and the transcription. In this way one can share one's thoughts and reflections with others who have access to the material and who are also bound by the duty of confidentiality (Liamputtong, 2007). I have made active use of my supervisors, who were individuals with both academic competence and knowledge about violence and about exposure to violence. This has allowed for deeper reflection and mental relief.

Transcription also entails giving ethical consideration to the way in which one chooses to present the interviewees. Because I both conducted the interviews and transcribed them, I still have a clear picture of the context, but during the transcription process, oral data is decontextualised and reconstructed in written form. An analysis of an interview is thereby placed between the original story told in the interview and the product communicated by the researcher from her project (Kvale, Brinkmann, Anderssen, & Rygge, 2009). Along with body

language and gestures, the vocal pitch, intonation, and breathing are lost in transcription. Transcription can be performed at different levels, and which level is used depends on what the research intends to impart. In my material, it was important to convey the emotional tone of the interviews, the women and men's own perceptions and experiences. This meant that pauses and interjections such as "eh" and "hm" held significance and had to be included in the written text. At the same time, disconnected speech, when transcribed directly, leads the reader to believe that the interviewee is confused or has a poor command of language. The interviewees may feel uncomfortable seeing their oral utterances transformed into writing, as it may make them appear incoherent, give an impression of low intelligence, and have a stigmatising effect. An ethical dilemma may therefore be how interviewees can be presented with respect and dignity by the researcher at the same time as the researcher gives a faithful interpretation of utterances without changing the meaning in the written text.

The meetings with interviewees was not as I had anticipated. Initially, I thought that violence did not concern me, and that these men and women were very different from me. But I was wrong; the interviewees were more like me than I expected. Through the interviews, I was almost drawn into their lifeworlds and gained a deeper understanding of different aspects of life with a partner who perpetrates violence. I recognised some of the women's expressions of pain from pain experienced in my own life at times when I felt small and vulnerable, and was thereby confronted with my own vulnerability. Most of the men demonstrated despair and grief over how life had turned out so differently to how they had hoped and planned. Life had presented them with more challenges than they had managed to deal with. All of them had positive sides and displayed vulnerability, yet they were also responsible for destroying something in the lives of others; they had perpetrated violence. The topic began to concern me in a new way that felt closer to home. This was something I was not prepared for. My focus had been on attending to the men and woman as interviewees, not on the pain and resonance these meetings would create in my own life, and this presented me with some challenges.

One such challenge is to find out how close this contact between researcher and interviewee should be. Liamputtong (2007) writes about conducting research on vulnerable individuals. She believes that a clear prerequisite is the researcher's willingness to get close to the person to be interviewed in order to give the interview material depth and quality. The researcher ought to play an active and open role that allows the researcher share her experiences and make her attitudes known to the person being interviewed. This may give the interviewee a sense of security and may lead to formation of the new knowledge that emerges through co-creation between researcher and interviewee. Berg (2005) uses the terms "medreisende" (fellow travellers) and medtenkere (co-thinkers). The researcher is a fellow traveller and the interviewee is described as a co-thinker. The knowledge being sought does not lie buried and waiting to be uncovered; it is created together during the course of the interviews.

This point in the methodological wandering marks a turn into a difficult borderline landscape between closeness to and distance from the interviewee, and between the researcher's role as participator or onlooker. Although there are two people engaged in the dialogue, the researcher nonetheless holds a position of power in terms of purpose and interpretative choices. The researcher must make various choices throughout the research process, some of which can be planned in advance while others must be made on the spot during the interview situation. One example was that women spontaneously told me about their births, which I did not ask about in the first place. Nevertheless, I decided to let them talk about this, and these stories revealed experiences of violence, which were relevant to the research. This

makes the qualitative method complex and difficult, but exciting too. The reflections and choices that are made should, as far as possible, be transparent and clearly defined so that others can see and understand the path the researcher has taken throughout the research process.

Another challenge is how the researcher should deal with her own vulnerability. Any meeting between people is, essentially, vulnerable. One way of protecting oneself against one's own vulnerability is by objectifying the other person. Unfortunately, however, this may prevent the stories from coming to light or, in worst case, may violate the other person. The risk of rejection or violation is always present when two people meet. This demands ethical reflection, where the researcher must evaluate what details of her own life and attitudes she will share and what purpose this has in terms of the research study. It also demands self-reflection and a sorting-out of feelings; which are mine and which are the other's? Thoughts and feelings were written down, reflected on, and discussed with the other researchers. According to Kvale (2009), the researcher is a research instrument. Using the metaphor of researcher as research instrument, he describes the researcher as the instrument used in meetings with the study participants. To be able to use an instrument, it is important to know it in the sense of knowing its possibilities and limitations. To understand the other, therefore, I had to be willing to acknowledge the feelings and thoughts which violence and pregnancy aroused inside me and which, to greater or lesser degrees, might influence both my being in my meetings with the men and women and the various reflections which these meetings would immediately generate. This was also important for the subsequent analytical perspectives that had to be developed of the lifeworlds of the interviewees.

6.3 Receiving vulnerable life experiences

The results from the studies show that becoming a parent creates potentials for change in men and women who live with domestic violence. By virtue of her examinations, the midwife will come into contact with the women's lives through dialogue and through physical touch. The men in our studies want to talk about becoming fathers. Will midwives and other health professionals providing antenatal care be willing to assist expectant parents who live with domestic violence?

A review from 2000 shows that the barriers that stop health professionals from asking women about violence are lack of training, time, and effective interventions. Health professionals are also concerned that women would find it unacceptable and do not want to talk about violence (Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). A more recent review article from 2012 shows that the same barriers exist: lack of time, knowledge, training, practical training in discussing violence, and lack of opportunity to follow up. Health professionals also fear and feel uncomfortable about entering the private sphere if the individuals are not exposed to violence, and some health professionals do not consider issues of violence to fall under their area of responsibilities (Sprague et al., 2012). Several studies show that women do not mind being asked questions about domestic violence (Roelens, Verstraelen, Van Egmond, & Temmerman, 2008; Stockl et al., 2013). It therefore seems as if the biggest fear of discussion domestic violence lies with the health professionals. A follow-up study of midwives through five years, shows that mandatory training over time in asking questions about violence increased midwives' confidence (Baird, Salmon, & White, 2013).

In a report on the screening project in Telemark (Chapt 1.0), by NKVTS, some of the midwives were interviewed after the project ended and reported that when they asked about violence they had heard many life stories which they previously would not have heard. These

were stories of abuse, violence, family conflicts, and neglect during childhood. The midwives regarded this development as positive, but it also gave rise to despair in cases where the women were in the 'grey zone', by which was meant cases where women told of difficult life stories but did not want any help or where there was no help available to offer them (Hjemdal & Engnes, 2009).

It is important that health professionals are taken care of if they are expected to uncover violence in antenatal care and to help men and women to change. Interdisciplinary cooperation, reasonable time frames, educational provision, and opportunities for referral for treatment are important external factors, but internal factors such as the midwives' experiences and handling of their own feelings are also important. Experiences like these, which can come about when one is conducting research on vulnerable individuals (Chapt.5.2.1) can also be made by personnel who work with people exposed to violence. Feelings, attitudes, and expectations which, for example, women have experienced in connection with a partner who has perpetrated violence, may be transferred to health professionals. Reactions to clients' stories and behaviour may give rise to body sensations, feelings, thoughts, and interpersonal reactions and may trigger internal processes in health professionals. This phenomenon is called counter transferral. Encountering other people's total pain, such as in relation to domestic violence, may create a feeling of impotence, grief, and loneliness and may also touch on one's own life story. If health professionals hear multiple stories of violence over time and are not given opportunities to process them, they may risk developing secondary trauma and burnout (Bang, 2003). The opportunity to stop and reflect on their own feelings and on their professional viewpoint and responsibility may become a positive element in their personal development. An awareness of processing and emotional strain and an understanding of the influential processes that play out between client and health professional are very important (Bang, 2003). Guidance by health professionals may be necessary to create a space in which violence can be discussed in antenatal care.

6.4 Methodological considerations

The strength of a qualitative study is the opportunity to enter deeply into a phenomenon and grasp the meaning or the essence (K. Dahlberg et al., 2008; Lindseth & Norberg, 2004). The ontological basis for the studies is derived from the lifeworld. The experiences and interviews have provided understanding and in-depth knowledge of people's lives and have revealed complex aspects of the phenomena. Other theories may have offered other perspectives of the data material; for example, a power–powerlessness or feminist perspective. No one theory is currently recognised as the definitive explanatory model, and the research field is characterised by contradiction and controversy (Hammerlin & Leer-Salvesen, 2014). In the context of pregnancy and the role of the midwife, discussing/uncovering domestic violence will deal with people's existence in everyday life and with their "natural attitudes"; see chapter 4.1.1) (K. Dahlberg et al., 2008). The lifeworld perspective may therefore bring to light knowledge that can be applied in clinical practice. The interviews bring to light knowledge that originates in the perspectives of lived experiences and need of people who possess the studied phenomena.

The results of our studies must be viewed in light of the fact that the interviewees are in a particular context in that they receive help from ATV. The women had contacted ATV of their own accord because they wanted help with changing their life situation with a man who perpetrates violence, and the men were receiving treatment to help them change their behaviour. The results must therefore be used with caution when transferring to other

situations. Nonetheless, the results do offer knowledge that may be clinically applicable for individuals exposed to violence, perpetrators of violence, and other expectant parents. Examples of this could be exercising caution when touching pregnant women, who physically carry their life stories in their bodies, or providing courses on fatherhood for expectant fathers.

The participants were not asked about drugs or psychiatric diagnoses. This may have provided an expanded understanding of how people's experiences are interwoven with different experiences, such as violence and substance abuse. On the other hand, diagnoses may have led to a more reductionist and categorical view of individuals in that the diagnosis might become an explanatory system that might have overshadowed the nuances in an individual's unique life experiences. Describing different types of violence may present another risk, that of simplifying the issue of violence and causing the complex interaction to disappear. An incident of violence consists of multiple forms of violence, and it is the collective incidents that lead to the experience of pain and suffering (Hammerlin & Leer-Salvesen, 2014).

One weakness in the studies is the fact that each interviewee is interviewed **once** only. If they had been interviewed on more occasions, they could have elaborated on and clarified their statements and meanings to a greater extent and thus further validated the content of the interviews. Out of ethical considerations for the interviewees in terms of causing as little stress as possible, permission from the Regional Ethics Committee to conduct only one interview per person was applied for. After the interviews, some of the interviewees spontaneously expressed their willingness to participate in more interviews. This was not followed up, but it may show that allowing themselves to be interviewed had not been particularly stressful for them; see chapter 4.7. Another weakness in the studies is that no participants with minority background were included.

During a research process it is of great importance that the researcher describe the steps in the work as clearly as possible and make them transparent so that others can evaluate the validity. Objectivity is aspired to through reflection and critical thinking (K. Dahlberg et al., 2008). This applies both to the way in which the data material is treated and to how I as the researcher have gained self-awareness of and applied my pre-understanding.

According to phenomenology, the researcher should try to problematise, recognize, and reflect on the pre-understanding of and on the attitudes to the phenomenon. It might be impossible to know oneself fully, but it is important to try to make subconscious attitudes conscious to avoid them interfering with the results(K. Dahlberg et al., 2008). Before I began conducting the interviews, I wrote down some reflections of my pre-understanding. During the process, I reflected on them with my supervisors. After each interview, I wrote down new reflections based on the impressions I formed of the interviewee. While I was analysing the material, my supervisors asked me repeatedly – particularly during my work on the first two articles –: “Is this the voice of the participants or is it yours?” I had to stop and reflect on this, and sometimes it was quite clear that it was my pre-understanding, which emerged in the text. Through this awareness, the pre-understanding – which I before had taken for granted – became explicit and bridled (K. Dahlberg et al., 2008). The researcher should be able to reach new understanding by a more unconditional and open approach and should avoid merely confirming what is already known (K. Dahlberg et al., 2008).

In Lindseth and Norberg's (Lindseth & Norberg, 2004) phenomenological hermeneutic method, pre-understanding is formed on the basis of the naïve understanding. I wrote down the naïve understanding and kept it close to hand throughout my work on the analysis. The naïve understanding should be used as a guideline and should be reflected on throughout the

structural analysis (Lindseth & Norberg, 2004). Pre-understanding is thus used far more actively and reflectively throughout the analysis. If the structural analysis no longer corresponds with the naïve understanding, a new one is formulated (Lindseth & Norberg, 2004). The naïve understanding changed several times during the course of the work on the analysis of the study. This is all part of validating the study. The structural analysis shows that the content of the data material is not what it appeared to be at first sight. The analysis uncovered and brought to light knowledge that lay hidden in the surplus of meaning (Lindseth & Norberg, 2004).

According to a lifeworld hermeneutic approach, it is impossible to interpret unless you already have a pre-understanding. The pre-understanding is a prerequisite for understanding (K. Dahlberg et al., 2008), but as with the phenomenological analysis, Dahlberg et al. believe that the pre-understanding should be bridled. The pre-understanding ought to be reflected on as a part of a process of developing new understanding. It is important that the researcher be open to finding new aspects of the data, ones that have not previously been described, and that the data material be included in the analysis in its entirety. Theoretical perspectives in this study were derived from the literature and discussions. The relationships between meaning units were discussed and reflected on so that the most likely interpretation could emerge. This process is called the hermeneutic spiral, or hermeneutic circle, a process whereby the interview text (the whole) is analysed (broken down into parts and meaning units) until it leads to a new whole. This is an ongoing process(K. Dahlberg et al., 2008).

7.0 Conclusion

The childbearing period is experienced as a period of change both for the women and the men, involving the past, the present, and the future. Change has to do with the new roles of motherhood and fatherhood and about a desire for a new life situation with respect to IPV. The women report that violence and pregnancy lead to fundamental existential questions dealing with choices and responsibilities. It is important to be treated with respect; this is particularly important for the women in relation to their bodies and to the life experiences manifested in them. To be seen by others as multifaceted individuals and not just be associated with the role of victim or perpetrator of violence is important. Both the women and the men have a need for control and predictability, both in their relationship with each other and with others. The women's mothers played a special role as support persons. The men who mentioned their fathers had strained relationships with them, since they themselves had been subjected to violent perpetrated by their fathers during childhood. The child represents a key motivating factor for change, and both the men and women want to be good parents. The childbearing period is a significant time in terms of meeting women who are being exposed to violence because the women are concerned about their life situation and about what life with their child will be like. The men in the study would also like to talk to the midwife, but for them their child plays a clearer role in terms of motivation for change of violent behaviour after they have actually seen it. More knowledge is needed about how discussions with men could be conducted, but with respect to the results of the study it may be meaningful if the child could be rendered more prominent to expectant fathers as an independent individual with its own needs. Both men and women need support and help with changing their life situation and in their role as parents.

In discussions with expectant parents, it may be important to be aware of the knowledge that expectant parents are in a context of past, present, and future, where past experiences are

important in the new role as parents. If the expectant parents are in lack of good role models as mother and father, it might be important to find other persons who had given them positive experiences in their own childhood, which they might pass on to their own children.

8.0 Future perspectives

Violence against women in the childbearing period is a complex issue that affects people's lives in different ways. The men and women who participated in these studies were interviewed separately, and knowledge about people's lifeworlds were brought to light. We need more research conducted on which interventions may be effective when violence is uncovered, not least in relation to how interventions can safeguard children's needs for safety and peace.

We need knowledge about whether – and how – health professionals can conduct discussions about violence with women and men together, so that the fathers are also informed about the consequences of violence for the unborn child and for any siblings, without jeopardising security and safety. Fathers have been invited to support women during pregnancy and to participate in the delivery, yet no tradition or explicit expectation exists for discussing the fathers' needs and experiences. The men in these studies show that they want to be, and to learn how to be, good fathers for their children. It is important that knowledge to developed about how to conduct discussions with men about the role of fatherhood from the perspective of violence prevention.

To some extent, violence is passed down from one generation to the next. Knowledge about the dynamics in acts of violence and about how to break socially inherited IPV in the broader perspective of family and generations is important in terms of prevention. Can antenatal care provide an arena where the generational perspective is rendered more prominent? What thoughts do grandparents have about their role in terms of having children who are exposed to or who perpetrate domestic violence during the childbearing period?

The women in the study reported feelings of isolation and loneliness. We need more knowledge about network building and protective factors against violence from a societal perspective. If antenatal care health professionals are expected to enquire about domestic violence, it is also important to gain knowledge about strategies for dealing with issues of violence, interdisciplinary cooperation routines, and about addressing the feelings and reactions of the health professionals who receive information on these life situations.

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References

Alternativ til vold. (2014). *"Jeg var redd for mine foreldre,– mine barn skal ikke bli redde for meg!"* ["I was afraid of my parents, - my children will not be afraid of me!"] Retrieved from http://atv-stiftelsen.no/

Anda, R. F., Felitti, V. J., Chapman, D. P., Croft, J. B., Williamson, D. F., Santelli, J., . . . Marks, J. S. (2001). Abused boys, battered mothers, and male involvement in teen pregnancy. *Pediatrics, 107*(2), e19-e19.

Askeland, I. R. (2012). *Kjennetegn hos menn som har oppsøkt Alternativ til Vold (ATV) for vold i nære relasjoner: Alternativ til Vold-terapiprosjektet* [Characteristics in men who have contacted Alternative to Violence for domestic violence: Alternative to Violence therapy project] (Vol. 4/2012). Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress.

Bacchus, L., Bewley, S., & Mezey, G. (2001). Domestic violence in pregnancy. *Fetal and Maternal Medicine Review, 12*(04), 249-271. doi: doi:10.1017/S0965539501000420

Bacchus, L., Mezey, G., & Bewley, S. (2002). Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service. *BJOG: An International Journal of Obstetrics & Gynaecology, 109*(1), 9-16.

Bacchus, L., Mezey, G., & Bewley, S. (2003). Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health & Social Care in the Community, 11*(1), 10-18.

Bacchus, L., Mezey, G., & Bewley, S. (2004). Domestic violence: prevalence in pregnant women and associations with physical and psychological health. *Eur J Obstet Gynecol Reprod Biol, 113*(1), 6-11. doi: 10.1016/S0301-2115(03)00326-9 S0301211503003269 [pii]

Bacchus, L., Mezey, G., & Bewley, S. (2006). A qualitative exploration of the nature of domestic violence in pregnancy. *Violence Against Women, 12*(6), 588-604.

Backe, B. (2001). Overutilization of antenatal care in Norway. *Scand J Public Health, 29*(2), 129-132.

Bailey, B. A. (2010). Partner violence during pregnancy: prevalence, effects, screening, and management. *Int J Womens Health, 2*, 183-197.

Baird, K., Salmon, D., & White, P. (2013). A five year follow-up study of the Bristol pregnancy domestic violence programme to promote routine enquiry. *Midwifery*.

Bang, S. (2003). *Rørt, rammet og rystet: faglig vekst gjennom veiledning*. Oslo: Gyldendal akademisk.

Barnevernloven. (1992). Lov om barneverntjenester (barnevernloven) [Child Protection Act;]. from http://www.lovdata.no

Beck, C. T. (1993). Critique of Correlates of battering during pregnancy. *Nursing Scan in Research, 6*(1), 6.

Bengtsson, J. (2001). *Sammanflätningar: Husserls och Merleau-Pontys fenomenologi* [Intertwinings: The phenomenology of Husserl and Merleau-Ponty]. Göteborg: Daidalos.

Berg, E. (2005). *Det skapende mellomrommet: i møtet mellom pasient og lege* [The creative space: The encounter between patient and physician]. Oslo: Gyldendal akademisk.

Bhandari, S., Levitch, A. H., Ellis, K. K., Ball, K., Everett, K., Geden, E., & Bullock, L. (2008). Comparative analyses of stressors experienced by rural low-income pregnant women experiencing intimate partner violence and those who are not. *Journal of Obstetric, Gynecologic, & Neonatal Nursing: Clinical Scholarship for the Care of Women, Childbearing Families, & Newborns, 37*(4), 492-501.

Bishop, S. E. (2005). *The meaning of labor, birth, and the immediate postpartum period for women who have experienced intimate partner violence in the perinatal period*. Dissertation Abstracts International: Section B: The Sciences and Engineering.

Brodén, M. (2004). *Graviditetens möjligheter: en tid då relationer skapas och utvecklas [Possibilities in pregnancy: a time when relationships are created and developed]* [Graviditetens möjligheter: en tid då relationer skapas och utvecklas]. Stockholm: Natur och Kultur.

Brown, S. J., McDonald, E. A., & Krastev, A. H. (2008). Fear of an intimate partner and women's health in early pregnancy: Findings from the maternal health study. *Birth: Issues in Perinatal Care, 35*(4), 293-302.

Burch, R., & Gallup, G. (2004). Pregnancy as a Stimulus for Domestic Violence. *Journal of Family Violence, 19*(4), 243-247. doi: 10.1023/b:jofv.0000032634.40840.48

Burke, J. G., Lee, L.-C., & O'Campo, P. (2008). An exploration of maternal intimate partner violence experiences and infant general health and temperament. *Maternal and Child Health Journal, 12*(2), 172-179.

Cook, R. J., & Dickens, B. M. (2009). Dilemmas in intimate partner violence. *Int J Gynaecol Obstet, 106*(1), 72-75.

Cronholm, P. F., Ellison, W., Mazzella, S., Witherspoon, M., Bowman Lim, J., Lapp, T., & Coleman, G. (2011). Fathering Agency Staff Members' Perspectives on Domestic Violence Perpetration. *American Journal of Men's Health, 5*(1), 47.

Dahlberg, K. (2006). The essence of essences. The search for meaning structures in phenomenological analysis of lifeworld phenomena. *International journal of qualitative studies on health and well-being, 1*(1), 11-19.

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective Lifeworld Research*. [Lund]: Studentlitteratur.

Devries, K. M., Kishor, S., Johnson, H., Stockl, H., Bacchus, L. J., Garcia-Moreno, C., & Watts, C. (2010). Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. *Reprod Health Matters, 18*(36), 158-170. doi: 10.1016/s0968-8080(10)36533-5

Dufty, J., & Hardacre, S. (2005). Why men abuse, why women don't leave: what midwives need to know. *MIDIRS Midwifery Digest, 15*(4), 555-559.

Dunn, L. L., & Oths, K. S. (2004). Prenatal predictors of intimate partner abuse. *JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 33*(1), 54-63.

Eberhard-Gran, M., Schei, B., & Eskild, A. (2007). Somatic Symptoms and Diseases are more Common in Women Exposed to Violence. *JGIM: Journal of General Internal Medicine, 22*, 1668-1673.

Edin, K., Hogberg, U., Dahlgren, L., & Lalos, A. (2009). The Pregnancy Put the Screws On. *Men and Masculinities, 11*(3), 307.

Edin, K. E. (2006). *Perspectives on intimate partner violence, focusing on the period of pregnancy*: Epidemiology adn Public Health Sciences, Department of Public Health and Clinical Medicine.

Edin, K. E., Dahlgren, L., Lalos, A., & Hogberg, U. (2010). "Keeping up a front": Narratives about intimate partner violence, pregnancy, and antenatal care. *Violence Against Women, 16*(2), 189-206.

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H., Garcia-Moreno, C., Health, W. H. O. M.-c. S. o. W. s., & Domestic Violence against Women Study, T. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet, 371*(9619), 1165-1172.

Escriba-Aguir, V., Royo-Marques, M., Artazcoz, L., Romito, P., & Ruiz-Perez, I. (2013). Longitudinal study of depression and health status in pregnant women: incidence, course and predictive factors. *Eur Arch Psychiatry Clin Neurosci, 263*(2), 143-151. doi: 10.1007/s00406-012-0336-5

Espinosa, L., & Osborne, K. (2002). Domestic violence during pregnancy: implications for practice. *J Midwifery Womens Health, 47*(5), 305-317. doi: S1526952302002878 [pii]

Ezechi, O. C., Kalu, B. K., Ezechi, L. O., Nwokoro, C. A., Ndububa, V. I., & Okeke, G. C. E. (2004). Prevalence and pattern of domestic violence against pregnant Nigerian women. *Journal of Obstetrics and Gynaecology, 24*(6), 652-656.

Fanslow, J., Silva, M., Whitehead, A., & Robinson, E. (2008). Pregnancy outcomes and intimate partner violence in New Zealand. *Australian & New Zealand Journal of Obstetrics & Gynaecology, 48*(4), 391-397.

Fog, J. (2004). *Med samtalen som udgangspunkt: det kvalitative forskningsinterview* [The conversation as a starting point: The qualitative research interview]. København: Akademisk Forlag.

Garcia-Moreno, C., Jansen, H., A. F. M., Ellsberg, M., Heise, L., & et al. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet, 368*(9543), 1260.

Geanellos, R. (2000). Exploring Ricoeur's hermeneutic theory of interpretation as a method of analysing research texts. *Nursing Inquiry, 7*(2), 112-119.

Gielen, A. C., O'Campo, P. J., Faden, R. R., Kass, N. E., & Xue, X. (1994). Interpersonal conflict and physical violence during the childbearing year. *Social Science & Medicine, 39*(6), 781-787.

Gil-Gonzalez, D., Vives-Cases, C., Ruiz, M. T., Carrasco-Portino, M., & Alvarez-Dardet, C. (2008). Childhood experiences of violence in perpetrators as a risk factor of intimate partner violence: a systematic review. *J Public Health (Oxf), 30*(1), 14-22. doi: 10.1093/pubmed/fdm071

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: a modified Husserlian approach*. Pittsburgh: Duquesne university press.

Goldstein, K. M., & Martin, S. L. (2004). Intimate Partner Physical Assault Before and During Pregnancy: How Does It Relate to Women's Psychological Vulnerability? *Violence and victims, 19*, 387-398.

Haggerty, L. A., Kelly, U., Hawkins, J., Pearce, C., & Kearney, M. H. (2001). Pregnant women's perceptions of abuse. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 30*(3), 283-290.

Hall, M., Chappell, L. C., Parnell, B. L., Seed, P. T., & Bewley, S. (2014). Associations between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis. *PLoS medicine, 11*(1), e1001581.

Hammerlin, Y., & Leer-Salvesen, P. (2014). *Voldens ansikter: en dialog om ondskap, ansvar og håp* [Faces of violence: a dialogue on wickedness, responsibility and hope]. Oslo: Cappelen Damm akademisk.

Han, A., & Stewart, D. E. (2013). Maternal and fetal outcomes of intimate partner violence associated with pregnancy in the Latin American and Caribbean region. *Int J Gynaecol Obstet*. doi: 10.1016/j.ijgo.2013.06.037

Heise, L., & Garcia-Moreno, C. (2002). Violence by intimate partners. In E. G. Krug (Ed.), *World report on violence and health* (pp. XXII, 346). Geneva: World Health Organization.

Hellmuth, J. C., Gordon, K. C., Stuart, G. L., & Moore, T. M. (2013). Risk factors for intimate partner violence during pregnancy and postpartum. *Arch Womens Ment Health, 16*(1), 19-27. doi: 10.1007/s00737-012-0309-8

Helsepersonelloven. (1999). Lov om helsepersonell m.v. [Health Personnel Act;]. from http://www.lovdata.no

Hermansen, M., & Rendtorff, J. D. (Eds.). (2002). *En hermeneutisk brobygger: tekster af Paul Ricæur*. Århus: Klim.

Herrenkohl, T. I., Sousa, C., Tajima, E. A., Herrenkohl, R. C., & Moylan, C. A. (2008). Intersection of child abuse and children's exposure to domestic violence. *Trauma, Violence, & Abuse, 9*(2), 84-99.

Hjemdal, O. K., & Engnes, K. (2009). *Å spørre om vold ved svangerskapskontroll: rapport fra et forsøksprosjekt i fire kommuner* [To ask about violence in antenatal care: Report from a pilot project in four municipalities]. Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress.

Howard, L. M., Oram, S., Galley, H., Trevillion, K., & Feder, G. (2013). Domestic Violence and Perinatal Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS medicine, 10*(5), e1001452.

Huth-Bocks, A. C., Levendosky, A. A., & Bogat, G. (2002). The effects of domestic violence during pregnancy on maternal and infant health. *Violence and victims, 17*(2), 169-185.

Haaland, T., Clausen, S.-E., & Schei, B. (2005). *Vold i parforhold - ulike perspektiver: resultater fra den første landsdekkende undersøkelsen i Norge* [Intimate Partner Violence - different perspectives: results from the first nationwide survey in Norway] (http://www.nibr.no/uploads/publications/8c7695745995ffcac1e73e454d17e63a.pdf ed.). Oslo: NIBR.

International Confederation of Midwives. (2008). International Code of Ethics for Midwives Retrieved 26.10.2011, from http://www.internationalmidwives.org

Jahanfar, S., Janssen, P. A., Howard, L. M., & Dowswell, T. (2013). Interventions for preventing or reducing domestic violence against pregnant women. *Cochrane Database of Systematic Reviews*(2).

James, L., Brody, D., & Hamilton, Z. (2013). Risk factors for domestic violence during pregnancy: a meta-analytic review. *Violence Vict, 28*(3), 359-380.

Jeanjot, I., Barlow, P., & Rozenberg, S. (2008). Domestic violence during pregnancy: survey of patients and healthcare providers. *Journal of Women's Health, 17*(4), 557-567.

Johnson, J. K., Haider, F., Ellis, K., Hay, D. M., & Lindow, S. W. (2003). The prevalence of domestic violence in pregnant women. *BJOG, 110*(3), 272-275. doi: S1470032803029264 [pii]

Johnson, M. P. (2006). Conflict and control gender symmetry and asymmetry in domestic violence. *Violence Against Women, 12*(11), 1003-1018.

Johnson, M. P. (2010). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*: Upne.

Karlsson, V., Bergbom, I., & Forsberg, A. (2012). The lived experiences of adult intensive care patients who were conscious during mechanical ventilation: a phenomenological-hermeneutic study. *Intensive and Critical Care Nursing, 28*(1), 6-15.

Kataoka, Y., Yaju, Y., Eto, H., Matsumoto, N., & Horiuchi, S. (2004). Screening of domestic violence against women in the perinatal setting: a systematic review. *Japan Journal of Nursing Science, 1*(2), 77-86.

Keeling, J., & Birch, L. (2004). Asking pregnant women about domestic abuse. *British Journal of Midwifery, 12*(12), 746-749.

Kendall-Tackett, K. A. (2007). Violence against women and the perinatal period: The impact of lifetime violence and abuse on pregnancy, postpartum, and breastfeeding. *Trauma, Violence, & Abuse, 8*(3), 344-353.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (Eds.). (2002). *World report on violence and health*. Geneva: World Health Organization.

Kvale, S., Brinkmann, S., Anderssen, T. M., & Rygge, J. (2009). *Det kvalitative forskningsintervju* [The qualitative research interview]. Oslo: Gyldendal akademisk.

Lancaster, C. A., Gold, K. J., Flynn, H. A., Yoo, H., Marcus, S. M., & Davis, M. M. (2010). Risk factors for depressive symptoms during pregnancy: a systematic review. *American Journal of Obstetrics and Gynecology, 202*(1), 5-14.

Lau, Y., & Chan, K. S. (2007). Influence of intimate partner violence during pregnancy and early postpartum depressive symptoms on breastfeeding among chinese women in Hong Kong. *J Midwifery Womens Health, 52*(2), e15-20.

Levinas, E. (1993). *Den annens humanisme [Humanisme de l'autre homme]* [Humanisme de l'autre homme] (A. Aarnes & H. Kolstad, Trans.): H. Aschenhoug.

Liamputtong, P. (2007). *Researching the vulnerable: a guide to sensitive research methods*. London: SAGE.

Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences, 18*(2), 145-153.

Lohne, V., & Severinsson, E. (2005). Patients' experiences of hope and suffering during the first year following acute spinal cord injury. *Journal of Clinical Nursing, 14*(3), 285-293.

Lukasse, M., Henriksen, L., Vangen, S., & Schei, B. (2012). Sexual violence and pregnancy-related physical symptoms. *BMC pregnancy and childbirth, 12*(1), 83.

Lutz, K. F. (2005a). Abused pregnant women's interactions with health care providers during the childbearing year. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 34*(2), 151-162.

Lutz, K. F., Curry, M. A., Robrecht, L. C., Libbus, M. K., & Bullock, L. (2006). Double binding, abusive intimate partner relationships, and pregnancy. *Canadian Journal of Nursing Research, 38*(4), 119-134.

Martin, S. L., Macy, R. J., Sullivan, K., & Magee, M. L. (2007). Pregnancy-associated violent deaths: The role of intimate partner violence. *Trauma, Violence, & Abuse, 8*(2), 135-148.

McCosker, H., Barnard, A., & Gerber, R. (2004). A phenomenographic study of women's experiences of domestic violence during the childbearing years. *Online Journal of Issues in Nursing, 9*(1), 11p.

McFarlane, J., Groff, J., O'Brien, J. A., & Watson, K. (2006). Secondary Prevention of Intimate Partner Violence: A Randomized Controlled Trial. *Nursing Research, 55*(1), 52-61.

McFarlane, J., & Wiist, W. (1997). Preventing abuse to pregnant women: implementation of a "mentor mother" advocacy model. *Journal of Community Health Nursing, 14*(4), 237-249.

Merleau-Ponty, M. (1994). *Kroppens fenomenologi [Phenomenology of Embodiment]* Oslo: Pax.

Meuleners, L., Lee, A., Janssen, P., & Fraser, M. (2011). Maternal and foetal outcomes among pregnant women hospitalised due to interpersonal violence: A population based study in Western Australia, 2002-2008. *BMC pregnancy and childbirth, 11*(1), 70.

Ministry of Justice and Public Security. (2012). *Handlingsplan mot vold i nære relasjoner 2012* [Action Plan against Domestic Violence 2012] Retrieved from http://www.regjeringen.no/

Ministry of Justice and Public Security. (2013). *Et liv uten vold: Handlingsplan mot vold i nære relasjoner 2014–2017* [A life without violence: Action Plan against Domestic Violence 2014-2017]

Nerum, H., Halvorsen, L., Øian, P., Sørlie, T., Straume, B., & Blix, E. (2010). Birth outcomes in primiparous women who were raped as adults: a matched controlled study. *BJOG: An International Journal of Obstetrics & Gynaecology, 117*(3), 288-294.

Norwegian Directorate of Health. (2005). *A national clinical guideline for antenatal care*. Oslo: Sosial- og helsedirektoratet.

O'Reilly, R., Beale, B., & Gillies, D. (2010). Screening and intervention for domestic violence during pregnancy care: A systematic review. *Trauma, Violence, & Abuse, 11*(4), 190.

Parker, B., McFarlane, J., Soeken, K., Silva, C., & Reel, S. (1999). Testing an intervention to prevent further abuse to pregnant women. *Research in nursing & health, 22*(1), 59-66.

Parker, B., & Ulrich, Y. (1990). A protocol of safety: research on abuse of women. Nursing Research Consortium on Violence and Abuse. *Nursing Research, 39*(4), 248.

Ricœur, P. (1976). *Interpretation theory: discourse and the surplus of meaning*. Fort Worth, Tex.: Texas Christian University Press.

Rodriguez, M. A., Valentine, J., Ahmed, S. R., Eisenman, D. P., Sumner, L. A., Heilemann, M. V., & Liu, H. (2010). Intimate partner violence and maternal depression during the perinatal period: A longitudinal investigation of Latinas. *Violence Against Women, 16*(5), 543-559.

Roelens, K., Verstraelen, H., Van Egmond, K., & Temmerman, M. (2008). Disclosure and health-seeking behaviour following intimate partner violence before and during pregnancy in Flanders, Belgium: A survey surveillance study. *European Journal of Obstetrics & Gynecology and Reproductive Biology, 137*(1), 37-42.

Romito, P., Pomicino, L., Lucchetta, C., Scrimin, F., Turan, J. M., Romito, P., . . . Turan, J. M. (2009 a). The relationships between physical violence, verbal abuse and women's psychological distress during the postpartum period. *Journal of Psychosomatic Obstetrics & Gynecology, 30*(2), 115-121.

Romito, P., Turan, J. M., Neilands, T., Lucchetta, C., Pomicino, L., & Scrimin, F. (2009 b). Violence and women's psychological distress after birth: an exploratory study in Italy. *Health Care for Women International, 30*(1-2), 160-180.

Rose, L., Alhusen, J., Bhandari, S., Soeken, K., Marcantonio, K., Bullock, L., & Sharps, P. (2010). Impact of intimate partner violence on pregnant women's mental health: mental distress and mental strength. *Issues Ment Health Nurs, 31*(2), 103-111. doi: 10.3109/01612840903254834

Rosen, D., Seng, J. S., Tolman, R. M., Mallinger, G., Rosen, D., Seng, J. S., . . . Mallinger, G. (2007). Intimate partner violence, depression, and posttraumatic stress disorder as additional predictors of low birth weight infants among low-income mothers. *Journal of interpersonal violence, 22*(10), 1305-1314.

Rubertsson, C., Hildingsson, I., & Rådestad, I. (2010). Disclosure and police reporting of intimate partner violence postpartum: a pilot study. *Midwifery, 26*(1), e1-5. doi: 10.1016/j.midw.2008.01.003

Rådestad, I., Rubertsson, C., Ebeling, E., & Hildingsson, I. (2004). What Factors in Early Pregnancy Indicate that the Mother Will Be Hit by Her Partner during the Year after Childbirth?A Nationwide Swedish Survey. *Birth, 31*(2), 84-92.

Sandman, C. A., Davis, E. P., Buss, C., & Glynn, L. M. (2012). Exposure to prenatal psychobiological stress exerts programming influences on the mother and her fetus. *Neuroendocrinology, 95*(1), 1-14. doi: http://dx.doi.org/10.1159/000327017

Sarkar, N. N. (2008). The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *J Obstet Gynaecol, 28*(3), 266-271. doi: 10.1080/01443610802042415

Seng, J. S., Sparbel, K. J. H., Low, L. K., & Killion, C. (2002). Abuse-related posttraumatic stress and desired maternity care practices: women's perspectives. *J Midwifery Womens Health, 47*(5), 360-370.

Shah, P., & Shah, J. (2010). Knowledge Synthesis Group on Determinants of Preterm/LBW Births. Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. *J Womens Health (Larchmt), 19*(11), 2017-2031.

Sharps, P. W., Campbell, J., Baty, M. L., Walker, K. S., & Bair-Merritt, M. H. (2008). Current evidence on perinatal home visiting and intimate partner violence. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 37*(4), 480-491.

Sharps, P. W., Laughon, K., & Giangrande, S. K. (2007). Intimate partner violence and the childbearing year: Maternal and infant health consequences. *Trauma, Violence, & Abuse, 8*(2), 105-116.

Shay-Zapien, G., & Bullock, L. (2010). Impact of intimate partner violence on maternal child health. *MCN, American Journal of Maternal Child Nursing, 35*(4), 206-212.

Sheehan, K. A., Thakor, S., & Stewart, D. E. (2012). Turning points for perpetrators of intimate partner violence. *Trauma, Violence, & Abuse, 13*(1), 30-40.

Silverman, J. G., Decker, M. R., Reed, E., & Raj, A. (2006a). Intimate partner violence victimisation prior to and during pregnancy among women residing in 26 U.S. States: associations with maternal and neonatal health. *American Journal of Obstetrics and Gynecology, 195*, 140-148.

Silverman, J. G., Decker, M. R., Reed, E., & Raj, A. (2006b). Intimate Partner Violence around the Time of Pregnancy: Association with Breastfeeding Behavior. *Journal of Women's Health, 15*(8), 934-940.

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. (2012). Barriers to screening for intimate partner violence. *Women & Health, 52*(6), 587-605.

Stenson, K., Heimer, G., Lundh, C., Nordström, M., Saarinen, H., & Wenker, A. (2001). The prevalence of violence investigated in a pregnant population in Sweden. *Journal of Psychosomatic Obstetrics & Gynecology, 22*(4), 189-197.

Stewart, D. E., MacMillan, H., & Wathen, N. (2013). Intimate Partner Violence. *Canadian Journal of Psychiatry, 58*(6), 1-15.

Stockl, H., Hertlein, L., Himsl, I., Ditsch, N., Blume, C., Hasbargen, U., . . . Stockl, D. (2013). Acceptance of routine or case-based inquiry for intimate partner violence: a mixed method study. *BMC pregnancy and childbirth, 13*(1), 77.

Straffeloven. (1999). Almindelig borgerlig Straffelov (Straffeloven) [Criminal Code]. from http://www.lovdata.no

Taft, A., O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L., & Feder, G. (2013). Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev, 4*(4).

Talge, N. M., Neal, C., & Glover, V. (2007). Antenatal maternal stress and long-term effects on child neurodevelopment: how and why? *Journal of Child Psychology and Psychiatry, 48*(3-4), 245-261.

Taylor, C. A., Guterman, N. B., Lee, S. J., & Rathouz, P. J. (2009). Intimate partner violence, maternal stress, nativity, and risk for maternal maltreatment of young children. *American Journal of Public Health, 99*(1), 175-183.

The Norwegian Ministry of Justice and the Police. (2005). Domestic violence (2004-2005) (J.-o. politidepartementet, Trans.). [Oslo]: Justis- og politidepartementet.

The United States Department of Justice. (2011, 08.01.2012). National Domestic Violence Hotline, 2011

Thoresen, S., & Hjemdal, O. K. (2014). *Vold og voldtekt i Norge. En nasjonal forekomststudie av vold i et livsløp* [Violence and rape in Norway: a national study of violence in a course of life]. Oslo: Nasjonalt kunnskassenter om vold og traumatisk stress.

Thornquist, E. (2003). *Vitenskapsfilosofi og vitenskapsteori: for helsefag* [Philosophy of science and epistemology]. [Bergen]: Fagbokforl.

Tirgari, B., Iranmanesh, S., Cheraghi, M. A., & Arefi, A. (2013). Meaning of spiritual care: Iranian nurses' experiences. *Holistic nursing practice, 27*(4), 199-206.

Van Parys, A.-S., Verhamme, A., Temmerman, M., & Verstraelen, H. (2014). Intimate Partner Violence and Pregnancy: A Systematic Review of Interventions. *PLOS ONE, 9*(1), e85084.

Webster, J., Stratigos, S. M., & Grimes, K. M. (2001). Women's responses to screening for domestic violence in a health-care setting. *Midwifery, 17*(4), 289-294.

WHO. (2013). Responding to intimate partner violence and sexual violence against women – WHO clinical and policy guidelines (Vol. ISBN: 978 92 4 154859 5).

Wilson, L. M., Reid, A. J., Midmer, D. K., Biringer, A., Carroll, J. C., & Stewart, D. E. (1996). Antenatal psychosocial risk factors associated with adverse postpartum family outcomes. *CMAJ Canadian Medical Association Journal, 154*(6), 785-799.

Wood, J. T. (2004). Monsters and victims: Male felons' accounts of intimate partner violence. *Journal of Social and Personal Relationships, 21*(5), 555-576.

Woods, S. M., Melville, J. L., Guo, Y., Fan, M.-Y., & Gavin, A. (2010). Psychosocial stress during pregnancy. *American Journal of Obstetrics and Gynecology, 202*(1), 61.e61-61.e67. doi: http://dx.doi.org/10.1016/j.ajog.2009.07.041

Waalen, J., Goodwin, M. M., Spitz, A. M., Petersen, R., & Saltzman, L. E. (2000). Screening for intimate partner violence by health care providers: barriers and interventions. *American journal of preventive medicine, 19*(4), 230-237.

Yampolsky, L., Lev-Wiesel, R., & Ben-Zion, I. Z. (2010). Child sexual abuse: is it a risk factor for pregnancy? *Journal of Advanced Nursing, 66*(9), 2025-2037.

Yost, N. P., Bloom, S. L., McIntire, D. D., & Leveno, K. J. (2005). A prospective observational study of domestic violence during pregnancy. *Obstetrics & Gynecology, 106*(1), 61-65.

Årestedt, L., Persson, C., & Benzein, E. (2014). Living as a family in the midst of chronic illness. *Scandinavian Journal of Caring Sciences, 28*(1), 29-37.