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Pregnant Victims of Domestic Violence in Puerto Rico: The Lived Experience

Pedro Vargas Ortiz[1]* and Pamela Aselton[2]

[1]*Faculty of Nursing, Inter American University of Puerto Rico, USA*

[2]*Director DNP Program, USA*

***Corresponding author:** Pedro Vargas Ortiz, Inter American University of Puerto Rico, 104 Turpeaux Industrial Park, Mercedita, PR 00715 1602, USA,*

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Abstract

Domestic violence is defined as a pattern of assaultive and coercive behaviors that includes the threat or infliction of physical, sexual, or psychological abuse that is used by perpetrators for the purpose of intimidation and control over the victim. This study describes pregnant women's lived experience of domestic violence and examines the factors influencing the process of disclosure of domestic violence among pregnant women in the southern region of Puerto Rico. A phenomenological method was used where women who had experienced domestic violence during pregnancy were invited to participate in online semi structured interviews. Data analysis included qualitative coding of the interview identifying emergent themes. In order to ensure trustworthiness and accurate representation of the text the use of a second reader was employed in the thematic analysis. The main themes identified included lack of direct questions from providers, isolation, worsening of abuse by pregnancy, physical, psychological and sexual abuse; support from family, friends and shelter; lack of police support and economic dependence. Implications for nursing are discussed

Keyword: Abuse; Pregnancy; Disclosure; Qualitative research; Phenomenology

Introduction

Abuse of women is pervasive in our society. Much research had been done in the area of domestic violence, however little had been done to explore the factors that result in women disclosing DV during their pregnancy at a prenatal visit. Domestic violence is defined as a pattern of assaultive and coercive behaviors that includes the threat or infliction of physical, sexual, or psychological abuse that is used by perpetrators for the purpose of intimidation and control over the victim [1]. Domestic violence affecting women of childbearing age represents a special case among abused individuals because outcomes are not solely experienced by the woman, but also affect her fetus during pregnancy and her newborn after birth [2].

In Puerto Rico 20,965 incidents of DV were reported to the police department in 2008 of which 17,598 cases were against women resulting in a rate of 871 per 100,000 women [3]. Although these figures do not reflect how many of them were pregnant, they do indicate the magnitude of the problem in Puerto Rico. Valle reported that Puerto Rico has one of the worst rates of intimate partner violence in the world [4].

Despite having an adverse impact upon the health and welfare of women and children, women experiencing domestic violence face a number of difficulties seeking help about their situation from statutory health and welfare agencies [5]. In the Peckover study, women disclosing domestic violence to their health visitors in the United Kingdom did not always receive appropriate support, protection, or information about accessing more specialist services. Frontline healthcare professionals should be offering these services.

Background

Previous studies have shown that the low rates of clinician-patient communication about domestic violence result in part from a lack of direct questioning by many clinicians and women rarely volunteer information about abuse without being asked [6]. A study of clinician-patient communication about domestic violence found barriers significantly associated with a lack of communication on the part of the clinician. Patients perceived that clinicians did not ask directly about abuse and felt that clinicians demonstrated a lack of time and interest in discussing abuse. Victims also reported fears about involving police and courts, as well as concerns about confidentiality.

In a study with women of Mexican descent, many factors hindered disclosure; including protecting their partners, avoidance of worrying their mothers, and fear of losing their children. Fear was the most common cross-cultural factor interfering with disclosure [7]. What made this study unique is that most of the

existing literature examined factors influencing and interfering with disclosure of abuse among white and African-American women [8]. There are few published studies available on Latina women. Pregnant women's experiences of partner abuse are similar to those who are abused outside of pregnancy [9]. Violence often stems from the abuser's emotional insecurity and the need to enforce power and control. However, according to Bowen et al. [10], fewer women reported domestic violence victimization during pregnancy than they did postpartum. Women who reported being victimized during pregnancy also reported significantly higher levels of social adversity during pregnancy, which also predicted postpartum victimization.

Comparable population-based data on the prevalence of domestic violence during pregnancy are lacking in the general population. Available estimates varied widely, from about 3% to 30% [11]. Most studies on prevalence came from small clinical samples in maternity wards, which often serve particular patient groups and communities, such as immigrant or minority groups, rural communities, adolescents, and women from affluent areas. A number of other studies included participants from rural and urban areas of the United States, Canada, Peru, Mexico, Rwanda, Nigeria, Saudi Arabia, Iran, as well as from India, Pakistan, UK, and New Zealand. According to Devries et al. [11] data suggests that domestic violence during a pregnancy is a common experience. The prevalence of DV during pregnancy ranged from approximately 2.0% in Australia, Cambodia, Denmark and the Philippines to 13.5% in Uganda among pregnant women. Half of the surveys estimated the prevalence to be between 3.9 and 8.7%. Prevalence of domestic violence appears to be higher in African and Latin American countries relative to the European and Asian countries surveyed. In most settings the prevalence was relatively constant in the younger age groups (age 15-35), and then appeared to decline slightly after age 35.

Domestic violence during pregnancy is more common than some maternal health conditions routinely screened for in antenatal care [11]. In London, the prevalence of domestic violence was 17%. Domestic violence was highest in the age group 26-30years and boyfriends were the main perpetrators. Punching and slapping were the most common pattern of violence, and 10% of women experiencing domestic violence had forced sexual activity [12]. Murdaugh et al. [13] conducted a study to describe domestic violence in Hispanic/Latino women in the southeastern US, including type and frequency of violence experienced, barriers to obtaining treatment, and services needed by women who have been abused. Among those women who had experienced abuse, almost three-quarters (70%) of women reported victimization by violent acts during the prior 12months. Of these women, 43% indicated they had experienced physical violence many times during the prior year. The most frequent acts of violence were being slapped, pushed, grabbed, or shoved (n=179, 62%), kicked, beat, punched, or choked (n=119, 44%), and forced to have sex against their will (n=154, 42%).

The most frequently reported important barrier that kept women from getting needed services was language, either not being able to speak English or not having a translator [13]. The second most frequently reported important barrier was lack of transportation. Other reported barriers were money, insurance or resources; afraid of husband/boyfriend; afraid children would be taken; afraid of being deported; did not know where to go; and fear of being alone. The women described feelings of shame and embarrassment that combined with language barriers and fear to silence them in patient-provider interactions.

Domestic violence is a serious public health problem that affects the health and well-being of millions of women and families throughout the world. While the risk factors vary across cultures, similar consequences have been observed globally, ranging from psychological problems to death. Globally, abuse by an intimate partner is the most common form of violence against women with great human and economic costs [14]. Approximately one in four women and one in seven men reported some form of lifetime DV victimization. Women evidenced significantly higher lifetime and 12-month DV prevalence and were more likely to report DV-related injury than men. Domestic violence prevalence also varied by state of residence, race/ethnicity, age, income, and education [15].

As part of the routine assessment of the pregnant women in prenatal clinics, there is no questioning about victimization during pregnancy. Health care team members, especially nurses, play a key role for the identification of the women victim of domestic violence during pregnancy and those at risk of victimization. This study gives the opportunity to understand the lived experience of pregnant women and serve the basis for others to establish policies and protocols for high quality nursing care, appropriate screening, and prevention efforts to decrease the problem of domestic violence in this population.

Materials and Methods

The research design consisted of qualitative in-depth interviews via email with semi-structured questions utilizing a phenomenological approach to explore the lived experience. Utilizing email to conduct qualitative interviews has some definite benefits to both the researcher and participant [16]. Email can provide immediate feedback from participants, either through online interviewing, or open-ended questionnaires and information received in digital form does not need labor-intensive transcription that qualitative research often involves [17]. The study was conducted using qualitative online interviews via email in the southern region of Puerto Rico. The prompts were used to start an online discussion in the privacy of either the participant's home computer if they were no longer involved with an abusive partner, or they were recommended to go to a public computer where these online conversations would not be seen to a potentially abusive partner. Alternatives to public computers were public library and internet cafes computer services which are readily available anywhere here in Puerto Rico.

Women who have experienced domestic violence during pregnancy at some point in their lives were recruited through the use of posters and ads placed in a primary health center and hospitals in Ponce, Puerto Rico, posters in local shops as well as

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ads in local newspapers. Women were also recruited by health professional's referrals. Participants had to meet the following eligibility criteria: Female resident of the southern region of Puerto Rico, having had been pregnant and experienced domestic violence while pregnant, have willingness and be able to consent to participate in the study, be 21years old or older and have access to email to respond to questions, and not be in a life-threatening situation where participation will increase the threat of violence.

This study consisted of extended qualitative online interview with women who were identified as suffering from domestic violence while pregnant using a phenomenological approach. The University of Massachusetts' Institutional Review Board approved the study and informed consent was obtained from each participant. A list of open-ended prompts guided the online discussion. This took place using Spanish language, and translation to English by the researcher was required in order for the second reader to review transcripts. An audit trail was kept using Lincoln & Guba's [18] six categories of information that need to be collected to inform the audit process: raw data, data reduction and analysis notes, data reconstruction and synthesis products, process notes, materials related to intentions and dispositions, and preliminary development information. These ensured the study's findings were grounded in the data and inferences are logical [19].

One or two prompts were given during the first email contact with follow up prompts used as the first topics evolve. These prompts were used to guide discussion and the participants' story were explored as it unfolded. The participants were encouraged to write as much as possible and the researcher responded based on their prompts every night. The role of the researcher in the discussion of the participants' story was to elicit information that yield their lived experience [20].

Data Management and Analysis

The translations were made using a Google translator. Both the first and second reader read the interviews and made notes of themes, which they then compared and came to agreement on major themes present in the interviews. In some instances, the Google translations did not come back in perfect English or were difficult to interpret. In this case the first and second reader discussed the implied meaning in the original Spanish version and agreed on an interpretation. Once all the email transcripts were collected and stored on a private password protected computer with identifying codes, the researcher assembled each email trail into one transcript per participant. The researcher then read each transcript using thematic analysis looking for major themes. Thematic analysis as an independent qualitative descriptive approach is mainly described as "a method for identifying, analyzing and reporting patterns (themes) within data" [21].

Result and Discussion

A total of twelve women agreed to participate via email with nine returning the informed consent after it was emailed to them over a 12-month period. The prompts for the online interviews were sent after the consent was returned, and all nine participants returned the interview after several reminders sent via email to the participants. In several cases emails were sent as a follow up in an effort to clarify or broaden the responses, however these participants never returned further emails. Of the nine women who completed the interview, their ages ranged from 30 to 64 years and they all lived in the southern region of Puerto Rico. They answered all the questions of the interview in one sitting and in their own words. The interviews were written in Spanish and read in Spanish initially by the first reader and then translated into English for the second reader to ensure trustworthiness of data.

Several major themes were agreed on by the first and second reader in relation to the research question concerning the lived experience and meaning of disclosure in pregnant women who were victims of domestic violence. The major themes identified from the data were as follows: lack of direct questioning from healthcare providers, isolation, pregnancy making relationship/abuse worse, physical abuse, family and friends support, economic dependence, and lack of support from Puerto Rico police. In the following sections direct quotes are used to illustrate these themes.

Lack of Direct Questioning

Several respondents reported that they did not disclose or receive care of the health care provider because they did not ask whether they were victim of abuse. Others did not feel comfortable talking to health professionals about the abuse or were worried insurance would not cover that type of care. If they went to the prenatal care with their partners, it was likely that the health provider avoided the abuse screening thinking the woman would deny the abuse in front of her partner. Examples of their stories included the following statements: "As I recall, when I visited my gynecologist office almost always the theme focused on how I felt physically with my pregnancy and its development. The emotional aspect, almost none of the medical staff asked me something, which sometimes surprised me. But I did not give it importance because neither I wanted to vent my relationship issues. No one directly asked me questions related to violence or abuse."

"I was constantly threatened by my partner. He told me that nobody had to be aware of our relationship issues. Possibly if someone had asked me directly I would have shared my story."

Other respondents reported that the problem of lack of questioning was related to the work load the health care provider had and the trust the women developed with them. Latina women have a strong relationship with their mother, sisters, or a very close friend. They think sisters and close friends will understand their situation, either because of their knowing them so well or because they themselves were in similar situations. Shame is another factor that may add to the lack of questioning by providers. Many single women will not admit being victims of abuse unless someone asks them directly. They did not want anybody to know about their lived experience and maybe this shame led her back to their abusive partner. Shame is very common for survivors. The following statements reveal this reality as they experienced it:

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"No doctor or nurse asked me anything about domestic violence. I went to my prenatal care visits and they never asked. Perhaps if he had asked me, maybe I had talked to them about the hell that I was living at home."

"Even today it is difficult to speak on the issue. That depends on the trust that you have with your doctor or nurse. At that time, I was afraid that my son would be taken away and, I didn't have any place to go with my son. Today, when one goes to the doctor's office, you see that the office is full. There are times that one must wait hours to be seen. The doctors don't have time to ask about violence unless one says it directly. I wouldn't say I felt fear, rather, shame. In addition, always I was told that one does not speak of what is not asked. Maybe I would have liked to be asked. That would have made easier the process to talk about violence."

Isolation

Some of the participants admitted that they lived in solitude provoked by their intimate partner's violence and attempts to isolate them from their families and friends. In some cases, the abusers would not let the women see their relatives or prevented them from traveling home for support. The following excerpt is an example of her story:

"He began to take out my son who at that time was 6 years old. He took him to his mom's house and to the school and he went for him. I had prohibited him from taking my son from school because no one will give my son to me. He chained me up at home and let me out only when needed with my youngest daughter who was younger. He said that had a neighbor that was watching me and would call him if I try to escape." "After the pregnancy, he told me I was fat, that I did nothing to lose weight. Remained the same attitudes of the blows. Once my aunts came to visit me and the day before he had beaten me so strong, that when they arrived, he told me to get to the bathroom to make them believe that I was taking a bath, so they walk away and this was how I did it and they walked away."

Another one of the participants revealed that the isolation imposed by her partner was because he did not want her to succeed in life as evidenced by the following quote: "During both pregnancies, he pulled my hair, beat me, it broke the clothes over me for I can't came out; He told me that I was fat and ugly, he locked me in the apartment when he was not at home, he didn't leave me study nor succeed in life."

Pregnancy Making Relationship/Abuse Worse

Some of the participants reported changes in the way their partners treated them when they got pregnant because they were unable to keep up with him as illustrated by the following excerpt: "During pregnancy, I felt tired, depressed me greatly, since I did a very big belly and weighed a lot, and he did not understand that; had nausea and vomiting up to the 8th month, and never took me to the doctor to give me something to calm the upset, so most of the time I was vomiting, weak, and tired. I could not do what I used to do before with so much ease…. I needed to be quiet at home and he didn't like to him. He said that I was no longer the same; that if for that I wanted to get pregnant. It was very sad because I was very happy, although sometimes I felt very bad. I had to overcome so that he won't be angry and my mother-in-law who was controlling it all."

According to one of the participants, the physical changes during pregnancy were a determinant factor in the way her partners treated them. The following three quotes are an example of what these participants went through: "When I became pregnant, our relationship began to change. He did not treat me in the same way as before and made me many derogatory comments related to my body. This made me feel very sad and not felt valued as a woman. There were many occasions in which he forced me to have sex in which I felt uncomfortable. He told me that I was getting too fat, that my breasts were no longer attractive as before, that sexual relations were no longer so satisfactory as before…"

"With my pregnancy, my body underwent changes. According to him, I didn't look attractive anymore and unwilling to having sex. If we see it in a simple way, the pregnancy was the trigger for all the abuse that I lived."

"It was a relationship where all the feelings felt before being pregnant, disappeared. With the emotional and verbal abuse came bad looks, the derogatory comments regarding the body and indisposition with other family members living in the same household."

Physical, Psychological and Sexual Abuse

In the lived experience of these women during pregnancy many had to deal not only with all the changes that come with pregnancy, but with the physical, psychological, and even the sexual abuse by their intimate partners. The following quotes are examples of their lived experience:

"When I shared my story with my family, they tried to help me to move to U.S. and even bought me tickets, but he convinced me, and I did not go out of the situation. They were trying to help me, but I fell again and at the end I think they got tired. On one occasion, he was banging and trying to kill me with a knife in the bathtub and my mother came and tried to defend me, but he strongly pushed her and knocked her out."

"The psychological abuse was overwhelming, because he said that I had to dress decently and not look to any man or greet it. I could not use high heel shoes, did not want that I used makeup. In short, nothing that call attention……. The psychological abuse continued, but one day...was physical. We were discussing, and he told me to shut me up. I told him that I was angry, that this situation did not improve, and he slapped me. I tried to slap him pressing his face, but he is very tall and of long arms, he took me by my hair and got me down by the stairs like I was an animal. Then, already on the ground, he spanked me and broke my clothes I have on. He told me this is what you got, and I'm leaving this house before I kill you. I could not believe it. He was a monster. Then he hit the kids. On one occasion, he hit with a piece of wood board in the buttocks because they were arguing outside for a small car, it was child's play and he shouted at us to come in the house. I asked: "Why do we have to go

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inside? We did not obey, and he also hit me with the wood board on my buttocks".

The excerpts shown above are examples of the type of abuse these women suffered. It is important to note that not only them were victims of the abuse, but their families as well. In some cases, the victims of abuse were their mothers and even the children they have with the abuser. The consequences of the constant episodes are evidenced in the following quotes:

"The experience with my partner while I was pregnant was really a nightmare, to not call it a living hell. There was emotional, verbal, and physical abuse. It was a consensual relationship that lasted 10 years bearing a cycle of abuse that increased during the pregnancies, until I could notice of the cycle that was living and took the decision to stop with that cycle. During that relationship, I had four (4) pregnancies of which two (2) ended in abortion, secondary to the abuse that there was in the relationship. In one (1) of the two pregnancies that ended in abortion, I was not aware that was pregnant. Due to a fight where there was emotional, physical, and verbal aggression, two hours later I had a "spontaneous" abortion. I put the word "spontaneous" in quotes because actually, two hours before the abortion I had received a strong blow with a fist in the abdomen from my partner in that time. That experience was very painful, unpleasant and marked my life forever."

"During pregnancy was a total nightmare; he beat me, pushed me, I got under cold water, so I get calm, while he was still hitting me. He scared me, leading me to believe that it would pull the car over a cliff with the two of us inside." "In my first pregnancy, he stayed out up to 3 days out and he returned being aggressive, thinking that I had been with another person and he hit me until left me unconscious and I pass out and let me still. All the times to be with me intimately, he raped me, because I did not want, and he was always drunk for that. I think that every time I was with him were violations, because I believe that if there is no mutual agreement, it is, and I never was in agreement."

"During pregnancy, he had no reaction; and I alone by myself without understanding nothing about relationships or pregnancy. The abuse was such that one night, I "he threw me over the bed, hitting me against the heater as the result of a kick that he gave me while I was sleeping, and I had C-section at 7 months by the blow that he gave me." One participant shared that the abuse was so intense that she put the life of her daughter in danger because she lost interest in her prenatal care as evidenced by this quote:

"During the pregnancy, I received many knockings which forced me to have a poor pregnancy. When my daughter born, had too many consequences. She was at verge of death because I lived so sad that didn't care myself during pregnancy and almost not eat or took me the necessary vitamins, and the she paid the consequences."

Family, Friends and Shelter Support

The participants reported the importance of the support received from family and friends. The family and friends of the victims tried to help them to stop the abuse. They helped financially and offering alternatives. Some of the relatives assumed the abuser's responsibility to provide basic needs as clothing, diapers for small children, and travel tickets to get out of Puerto Rico. These quotes are evidence of one of the participant's responses who had two children and lived with the abuser in Mexico: "My main source of support was my Lord Jesus Christ, who never left me, then my mother, my aunt, and my dad. My mom helped me financially each month and came to see me to Mexico once a year and brought clothing to the baby and we went out to the shops to buy disposable diapers and left me well stocked for a long time, so I never fall short on anything, since my spouse had closed the music school and our income had lowered."

Puerto Rican women keep a close relationship with their families, especially with their mothers. This relationship was very important to the victim because when the participants shared their lived experience, they did not find themselves alone in a difficult situation. This relationship is so strong that some of them took time off from her work to let her daughter finish her college work. This behavior demonstrates the support offered to her daughter in a moment where the victim felt that she needed to look for her personal improvement.

"The sources of support during the pregnancy were family; mainly, my parents, secondly my brothers and finally my in-laws. Over the time, all the support and family company that I received, was useful for me. This allowed me to establish a plan of how I could leave back that relationship doing the least possible damage to both families." "My mother was my greatest support. She decided to take a leave of absence in her work so that I would finish my university studies. If it had not been for her, she would not have succeeded. She inspired me. My mother has eight children and she is a professional."

One of the participants pointed out the importance of a shelter support in her situation. This woman had the need to look for a temporary shelter because her life was in danger at the moment of the abuse. The shelter came to satisfy the need of security for the participant and her young daughter. The shelter offered protection, social services, and tools to manage the abusive situation. The following extract evidenced this:

"Gradually, I was taking away all the pain. I was in shelter for battered women for 1 year. That was my real school. Of course, I was there with my daughter. The father of my children looked for me, even by the radio saying my name and my daughter's. He alleged that we were missing, but he really knew that I was protected and that he could not harm us. Once a week I could see my older son who was with his father supervised by a social worker because I was in a shelter with my daughter. I lacked many material things, but there I was taking classes on the battered woman syndrome. I cried a lot and especially forgave. I took many courses and understood too many things. That experience was very valuable for me."

Lack of Support from Police

Three of the participants shared in these quotes the lack of support from the Puerto Rico Police Department. In some cases,

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the policeman that received the complaint did not support the woman or did not believe what they are telling as evidenced by the following stories: "I did not speak with anyone. But already in PR, I went once to the police station to seek help in an incident I had with him and the police convinced me to not file a complaint, the scared me and I gave up."

The behavior demonstrated by members of the Puerto Rico Police Department does not encourage victims of abuse to report the victimization. The women experiencing abuse expect that the authorities of law and order will protect them from the abuser, but they encountered no solution to their problem. The participants did not find support from the government agencies that was supposed to protect them. The agents did not offer the opportunity to file a restraint order from the abuser as mandated by Law 54 Prevention and Intervention against Domestic Violence Act.

"No one ever asked me anything. I believe that by that time, it was perhaps a taboo. The worst of all was when he broke my nose septum and I went to charge him to court, but he went first and said that I had a problem in the nose that bled and that I caused damages to his car. The police never believed me, and they made fun of me (one of the officers was a female). I went to emergency room and confirmed that he had fractured my septum, that I had no choice but gave me a napkin to clean the blood. Once out of the hospital, went with the doctor's evidence so they would know that it was not a normal problem of bleeding, but a fracture and the police made us ask forgiveness to both, because if we wouldn't, we will get prison both. I knew I was never going to find support with the police. I have a family member who is a policeman and he also did not believe in me, saying that I went give a show at the police station." "Sometimes I felt that he could do me much harm since he worked as a policeman and had a fire gun. That frightened me. I thought if I asked for help to the police they won't help because they were co-workers."

Economic Dependence

Some of the participants reported that they never told a health professional about their abuse because of their economic dependence on their intimate partner as evidenced in the following quotes:

A. "I never went to a health professional by fear. And he had much control over me because I did not work, and I depended fully on him."

B. "My partner was unemployed, and I just graduated from college. Our big picture painted a bit difficult, referring to the economic situation because both of us depended on the help of relatives for normal expenses and lived in my in-laws' house."

C. "… he had much control over me because I did not work, and I depended fully on him."

Some of the participants did not have enough financial resources to meet their personal and siblings needs. The abuser did not allow the women study or work in order to keep their control over them. Sometimes the participants did not have money to buy even food for them and their siblings.

Some of the major themes coming out of the participants lived experiences include the amount of physical and verbal abuse they endured and how it affected the health of their children, their isolation and their desire to be asked about abuse, but fear of disclosure due to economic dependence. The support they received from family, friends, and shelters was very important to help them to deal with their lived experience of abuse. Not only did many of them have to bear the physical abuse, but the psychological and sexual assault as well, making them feel that nobody could help them. The lack of support from the police and lack of questioning from healthcare providers were factors that might be determinants for these women keeping silent as well as the fear that the abuse might become worse.

Summary

Domestic violence is a social problem that has consequences in the lives of the victims, especially during pregnancy. The woman must cope with all the changes that come with pregnancy and deal with the effects of domestic violence. Interviewing women remembering facts that occurred years ago provided some impressive recall of difficult situations in their lives and reflections on what they had learned. The variety of lived experiences shared in these online interviews provided a rich description of the phenomena of domestic violence during pregnancy for these women. The online interviews gave the women the opportunity to reflect back on the meaning of their lived experience with domestic violence during pregnancy. This reflection did not trigger any post-traumatic experience that participants shared during the online interviews.

Lack of Direct Questioning

Most of the women interviewed reported that they did not disclose the abuse because of lack of direct questioning. They expressed that the health care providers did not ask about abuse during their prenatal care. Others shared that they did not disclose the abuse because they felt uncomfortable discussing private matters. The uncertainty about health insurance covering that type of care was another factor that prevented the women from disclosing the abuse. These findings are consistent with studies found on the literature. Cha & Masho [22] found that women who experienced intimate preconception or prenatal partner violence were 30% more likely to have inadequate prenatal care. This was especially true for Medicare recipients as the paper concluded that they were even less likely to be screened for intimate partner violence. In a study completed in Puerto Rico to explore the nature and extent of violence against pregnant women, 51.1% of the abused pregnant women indicated that they did not have health insurance [23].

However, these findings are not consistent with other populations. One study in North Carolina reported that women experiencing violence before or during pregnancy had increased

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odds of intimate partner discussions during prenatal care compared to non-abused women [24]. Puerto Rican women did not follow this standard. Culturally, in dealing with such private matters, Puerto Rican women tend to keep this information to themselves unless a direct questioning is made or confronted with physical evidence of abuse. López Alicea [23] reported that sexual, physical, and emotional abuse were considered private events rarely open to public discussion and found that Puerto Rican women often will not seek either medical treatment or help from others unless the abuse is extremely severe, and even then, are often reticent to seek assistance. De la Cancela [25] reported that while Puerto Rican women may complain of poor treatment by their husbands, they still encourage their sons to develop the supposed positive aspects of machismo and often are proud of their sons' manifestations of the characteristics.

The lack of questioning could be due to health care professionals feeling uncomfortable asking the question or not wanting to take the time during a visit. They may see a direct question of abuse as an intrusive way of dealing with the problem or fear their own ability to competently handle a disclosure of abuse and respond in a fashion that a patient finds appropriate and helpful [26]. Other have found that many doctors and nurses hold the cultural belief that a 'family affair is a private matter and that other people should not intervene' [27]. This may affect provider's compassion, empathy and their approach to intimate partner violence victims.

Still others feel that there is no practical or acceptable universal tool for screening for domestic violence [28]. Although there are evidence-based tools, local community hospitals are not using them and there are no specific questions on the screening forms regarding domestic violence. In Puerto Rico, the same guidelines and standards of care are followed as in the United States. The American College of Obstetricians and Gynecologists recommend the routine assessment of domestic violence to all women. However, the medical record in Puerto Rico, especially the prenatal record, does not evaluate this aspect as part of health care. The doctor may evaluate the woman for domestic violence, but there is no written evidence on the current prenatal care record sheet. Currently there are several tools available for the evaluation of domestic violence such as the Woman Abuse Screening Tool and the Abuse Assessment Screen. None of them is used in Puerto Rico or is part of the medical record.

Bailey [28] cited other studies indicating that the evaluation of domestic violence by health care providers varies widely in whether it actually occurs in prenatal and primary care visits. A survey of primary care residents in the United States revealed that 95% though that screening for domestic violence was important. However, less than 65% of the residents reported that they follow the screening guidelines of the American Academy of Obstetricians and Gynecologists to detect domestic violence during pregnancy. This was evidenced in another study cited by Bailey where 33% of the doctors reported that they evaluated their patients for domestic violence, while only 7% of the women remembered that their doctor asked them about domestic violence.

Sokoloff & Pratt [29] argued that Puerto Ricans were the most likely to report abuse during pregnancy and Cwikel [30] cited culture as another cause for increased risk of domestic violence during pregnancy. Among Hispanics in United States, Puerto Ricans were rated among those who were at increased risk of domestic violence during pregnancy. For Puerto Rican pregnant women, abuse may be embarrassing for them and they prefer to keep their situation private and do not seek medical treatment. Another possible reason that pregnant women are afraid to request medical treatment is because the law has established that agencies have the responsibility to report these cases to the police and women may fear further retribution if the abuse is reported [23]. Intimate partner violence victims are ashamed at disclosing their situation but are willing to discuss their problems if professionals approach them directly with respect and a guarantee of privacy [31].

Isolation

Participants reported that they felt isolated from others, including family members. This state of isolation may have prevented the participants from receiving needed health care. Some of the women reported that the abuser prevented them from seeing their family because they were a "bad influence". Roush & Kurth [32] found that isolation was a defining factor in the lives of these women and prevented them from receiving the support that is so crucial to women who experience intimate partner violence. The isolation that victims often feel may be to help manage the stigma they face. Thomas & Scott Tilley [33] state that like other women's intimate partner violence experiences, one of the tactics abusers used to exert control over the victim was to isolate them from friends or family and to limit or monitor activities. In addition, Reina, Maldonado & Lohman [34] found in their study that isolation and dependency were major factors contributing to undocumented Latinas' experiences of domestic abuse.

Worsening of the Abuse because of the Pregnancy

Pregnancy brings many changes for the woman. Statements from the participants' narratives showed changes in the way their partners treated them when they got pregnant because of their inability to keep up physically with them. Lowdermilk, Perry, Cashion & Alden [35] found that rates of physical abuse among women with a history of recent abuse peaked during the first three months of pregnancy, and then declined. However, in the same study women without a recent history of abuse had low rates of abuse during pregnancy. In the same study, rates of psychological abuse were highest in the first month after the birth, as was sexual abuse [36].

One of the most accepted theories about domestic violence during pregnancy is that pregnancy increases feelings of jealousy. The abuser may see the fetus as competition for the woman's attention. Stress accompanies pregnancy and can exacerbate the tension between the couple. In most cases, violence during pregnancy appears to be a continuation of the violence of the couple's relationship [37]. However, research completed to

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examine the rates of domestic violence reported during and after pregnancy and to assess the importance of family adversity found that pregnancy itself represents a period of comparatively low risk for domestic violence. Thus, pregnancy and the early postpartum period appear to be protective against domestic violence [10].

Physical, Psychological and Sexual Abuse

Participants of the present study reported suffering three types of abuse: physical, psychological, and sexual abuse. The magnitude of the abuse the participants suffered ranged from moderate to severe. These episodes provoked feelings of fear and helplessness among the participants. Some of the women reported that not only were they victims of the abuse, but their families were victims as well. In some cases, the victims of abuse were their mothers and even the children they had with the abuser. Studies from developed countries such as the United Kingdom reported the prevalence of violence during pregnancy to be 2.5% to 3.4% [38]. Reports from United States showed that 21% to 34% of women are physically attacked by an intimate partner during their lifetime including pregnancy [39]. Another study in Iran indicated that 25% of women had suffered physical violence by their husbands during pregnancy [40].

As described in studies of non-pregnant women, control was often achieved using psychological abuse, which engendered feelings of fear, insecurity, and dependency [9]. Women reported being constantly criticized, humiliated, demeaned, and undermined, as well as being verbally abused and threatened with violence. Their independence and freedom of movement were restricted, and many reported a reduced sense of autonomy, self-esteem, and confidence. Other studies in Brussels had reported various types of violence, including physical, sexual, and emotional abuse. It is important to note that only 41% of the abused pregnant women had the presence of violence detected by medical staff during the pregnancy [41].

However, Bailey [28] argued that there is no consensus among researchers regarding whether the prevalence of domestic violence decreases during pregnancy, remains roughly the same, or whether a woman is at greater risk in the time between conception and delivery. In a review of the literature, Bailey concluded that the prevalence of IPV in pregnancy varied from 1%-20%, depending on the way in which the IPV is evaluated and the population studied. Population studies from the Centers for Disease Control and Prevention (CDC) suggested that the intimate partner violence prevalence during pregnancy is only 2.9%-5.7%. Saltzman, Johnson, Gilbert & Goodwin [42] found that the prevalence of abuse before pregnancy varied significantly for all pregnancy-related characteristics except alcohol use during the last three months of pregnancy and was consistently higher when women received Medicaid benefits, delivered a low birth weight infant, had not intended to become pregnant, smoked cigarettes during the last three months of pregnancy, or received prenatal care from a publicly funded provider. These findings are consistent with the characteristics of the women who participated in the present study. All of them were young women, from low socio-economic status and receive prenatal care from the public health system.

Family, Friends, and Shelter Support

Findings from this study revealed the important role that others, especially mothers and close friends played in the lives of these women. Not only did they give them emotional support, but economic assistance as well. The mothers were in most cases the ones they trusted, and in turn the mothers supported their daughters when they needed help. This is consistent with findings from a study by Engnes, Lidén, & Lundgren [43] where mothers were important to women who were exposed to intimate partner violence.

This contrasts with findings from a study conducted in Connecticut to understand the experience of pregnancy, labor, and birth events from the perspective of survivors of sexual abuse [44]. The lack of support survivors experienced from family members when they were being abused led to survivors keeping their pregnancies and/or history of sexual abuse to themselves later in life. Therefore, survivors had nowhere to turn during their pregnancies [44]. This illustrates the tensions associated with the family obligation of helping family members and the belief that family members' behaviors should meet family expectations. Results from another study with sixty-four urban women attending public health services in Mexico City (ages between 20 and 65 years) highlights the fact that the family may not always act as a source of support for women who suffer physical and/or sexual intimate partner violence [45].

Lack of Support from Police

One of the themes that emerged from the narratives of the participants was the lack of support from the law and order officials in Puerto Rico. One of the women surveyed reported that police officers did not take the complaint about the abuse seriously. Others tried to talk the woman out of filing a report. Participants in this study did not believe they could rely on law enforcement for the protection of their rights. This is consistent with the literature that is published on domestic violence. Roush & Kurth [32] found that women did not involve law officers because of fear of triggering increased violence in the face of ineffective legal intervention. In 1989, Puerto Rico's legislature passed Law #54 Prevention and Intervention with Domestic Violence Act in an effort to eradicate domestic violence.

This law clearly establishes the process to follow in case a victim reports an incident of domestic violence and the responsibilities of the law and order officials, but it did not improve reporting practices. Significantly, Law 54 not only sought to apprehend and punish abusers, but also to transform social relations between men and women. It demanded broad community education on domestic violence and the development of social services to meet the needs of women and children, not only through the provision of shelter and psychological counseling, but also through loans and job training programs. It also ordered a reorganization of government service

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agencies that address situations of abuse, to ensure an efficient and rapid response and it empowered the Women's Affairs Commission of Puerto Rico to monitor and evaluate implementation.

Many experts argue that it is a patriarchal practice that replicates the oppression women experience as victims of intimate partner violence and that it endangers women [46]. The literature review reveals that police officers and prosecutors do not fully comply with domestic violence protocols and judges were found to be among the most resilient employees of the criminal justice system. Factors such as "prejudices, preconceived ideas and value judgments" that influence the sentence for domestic violence crimes have been cited [47].

Economic Dependence

One of the problems the women surveyed reported was the economic dependence they had on the abuser or the abuser's family members. On several reported occasions, the abuser did not allow the woman to study or work. One of the respondents lived with her partner in her in-laws' house. This dependence places the women at a disadvantage because it does not allow for personal self-realization and independence from the abuser, perpetuating the dependence and control over the woman.

The literature provides evidence that economic abuse is a distinct, and common form of harm experienced by women in abusive relationships [48]. Economic abuse is part of the pattern of behaviors used by batterers to maintain power and control over their partners. One significant way that abusive men interfere with a woman's ability to acquire resources is by preventing her from obtaining and maintaining employment. Research indicates that abusive men often forbid, discourage, and actively prevent their partners from working outside the home [49]. In addition to demonstrating how abusive men prevent their partners from working, studies show that abusive men also interfere with their partners' efforts to take part in self-improvement activities aimed at increasing their marketability in the labor force and heightening their chance of obtaining a decent job. Interfering with educational pursuits is a common way that abusive men prevent self-improvement [48]. Furthermore, these findings empirically demonstrate that economic abuse is a significant component of the broad system of tactics used by abusive men to gain power and maintain control over their partners.

The experiences of these participants provide us with a look at economic abuse as well as more information about other forms of intimate partner violence such a self-sufficiency. Such abusive tactics may propel survivors toward poverty, if not trapped already by poverty. The combination of abuse and poverty may force women to remain in their abusive relationships as well as keep their focus on basic economic survival [50].

The interviews were written in Spanish and read in Spanish initially by the first reader and then translated into English for the second reader using Google Translate, a free Web-based resource for translation. Translation of quotes can cause challenges, because it may be difficult to translate concepts for which specific culturally-based words are used by the participants. If there was a problem with the translation the second reader checked in with the first reader who is a native Spanish speaker to verify the translation. Balk et al. [51] used Google Translate to compare data extraction of trials done on original-language articles by native speakers with data extraction done on articles translated to English by Google Translate and tracked the time and resources used for article translation and the extra time and resources required for data extraction related to use of translated articles. They found the accuracy of translations were really dependent on the original language of the article. Specifically, extractions of Spanish articles were most accurate, followed by fairly accurate extractions from German, Japanese, and French articles.

This phenomenological design used the participant's own words and investigator bias was not influenced by any experience of this in their own life, but by observing that it was a common problem among Puerto Rican women. The use of an audit trail involved noting all data sources and recording interpretations through detailed notes for review by the investigator including transcribed interviews (raw data), data reduction and reconstruction and coding scheme.

Strengths and Limitations

This qualitative study involving domestic violence during pregnancy in Puerto Rican women is unique in that it turned out to be a retrospective analysis of how these women felt during the experience of being abused in pregnancy, how they coped and the problems they endured. It is important to emphasize that none of the participants continued in an abusive relationship. This contributes to the body of knowledge in nursing on the topic of domestic violence during pregnancy in Puerto Rican women. Understanding the lived experiences these women may help to develop practices that enforce routine questioning to identify women at risk and support services. Interviewing women that were remembering facts of their lived experiences that occurred in their past was an enlightening experience for both the researcher and the participants. The online interviews gave the women the opportunity to reflect back on their lived experiences and share all the feelings and the meaning of those experiences. Some of the participants were remembering events that happened a long time ago in their lives. It was very impressive that they remembered these events with details as if the events happened a few months ago.

Having people respond to requests for online interviews was a challenging task. While using the online format may have avoided the potential women's bias regarding the researcher's male gender in their desire to participate, several of the participants who were initially interested in participating in the study did not return the informed consent despite numerous reminders. The online format did allow for women to remember in the privacy of their own home setting without an outsider in the room, which other researchers have speculated can make them feel more comfortable sharing personal information [52]. Another limitation that might arise from the online interviews was the selection bias due to the

non-representative nature of the respondents. Aselton [16] stated that the selection bias could be present when the individual who respond to a request tend to respond only if the issue has deeply affected them. This may have led to a preponderance of participants who had very difficult situations that they had overcome and felt more motivated to talk about their experiences.

The lack of non-verbal reinforcement such as eye contact could have reduced the complimentary information to gain a broad interpretation of the meaning of their lived experience. Several attempts were taken to minimize this limitation. However, the participants did not take the opportunity to elaborate when asked further questions to broaden the responses given, limiting the interpretation of the lived experience. None of the participants responded to further emails for clarification after submitted the online interview. This suggests they either had said all they wanted to say in the online interview, or that for a more detailed analysis of factors related to abuse in Puerto Rican women who are abused during pregnancy the interview should be in person.

Implications for Future Research

Finding prospective participants was a difficult task. The first step was to obtain permission in the health facilities and gynecology offices to place the invitation poster to participate in the study. The recruitment process was slow with an average of one participant recruited per month. Another visit was made to the health facilities and medical offices to follow up the recruitment. Consent forms were sent to the fifteen women but only nine returned it signed and they completed the online interview. A challenge to future research is to find a way to access this hidden population and engage women to participate.

Understanding their experiences can help to develop policies to enforce the enquiry or screening about domestic violence during pregnancy and may result in better care and screening that address the broad spectrum of domestic violence in this community. To achieve this goal a study with a larger number of participants is needed to have more evidence to generate policy changes in health care settings that ensure all pregnant women are screened for domestic violence during prenatal checks.

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