Living Two Lives:

Women's Experiences of Intimate Partner Abuse During Pregnancy

A Dissertation

by

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represented the reality of abuse that the woman recognizes, but does not want to publicly acknowledge. She hopes the abuse diminish because of the pregnancy. She hesitates to reveal the abuse to anyone for fear of public scrutiny and the stigma of being considered an abused woman.

The primary condition women engaged in was a process of guarding and revealing the intersection between the private and public lives. The secondary condition was pregnancy. Women engaged in five actions or processes: 1) Pursuing the dream; 2) Enduring for the family's sake; 3) Engaging in a dynamic balance; 4) Reconciling dreams with reality; and 5) Revealing and integrating two lives. Seven intervening conditions and three crystallizing events emerged as having a direct or an indirect effect on the processes women engaged in.

Women experienced diverse personal, social, and legal consequences of living two lives and revealing the abuse in the periods of pregnancy, postpartum, and beyond. Pregnancy provided the impetus for reinvesting in the abusive relationship and constructing the family. Thus, leaving the abusive relationship during pregnancy was not considered unless the partner ended the relationship or the woman perceived an increased danger to herself or significant others.

Abstract

Title: Living Two Lives: Women's Experiences of Intimate Partner Abuse During Pregnancy

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The purpose of this qualitative investigation was to generate a theoretical understanding of the women's experiences of intimate partner abuse during pregnancy. The specific aims of this investigation were to: 1) Explore women's perceptions of the meaning of experiencing abuse during pregnancy; 2) Describe the effect of abuse on decisions make during pregnancy; 3) Generate the development of an initial grounded theory of the effects of abuse on pregnancy and on women's decision's made during pregnancy. Twenty-one interviews were conducted with 12 participants over a one-year time period. Participants were either 1) currently pregnant or in the postpartum period and had experienced abuse by an intimate male partner or 2) had been abused during pregnancy or postpartum by an intimate male partner sometime in the past. The sample was comprised of an ethnically, socioeconomically, and chronologically diverse group of women. This study used Dimensional Analysis, a grounded theory method. The research design included intensive in-depth interviews. Results indicated that the organizing perspective was that of living two lives. The contexts of the lives were public, reflecting the pregnancy, and private, reflecting the abusive relationship. The public life represented an external, idealized view of the woman's life and family. The private life

represented the reality of abuse that the woman recognizes, but does not want to publicly acknowledge. She hopes the abuse diminish because of the pregnancy. She hesitates to reveal the abuse to anyone for fear of public scrutiny and the stigma of being considered an abused woman.

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Chapter 1: Introduction

Evidence from research and clinical practice has led to an increased awareness of the seriousness, complexity, and universality of woman abuse (U.S. Department of Health and Human Services, 1990, 1995). Studies of abuse and pregnancy suggest that abuse may be initiated or escalate in the prenatal period and may negatively impact maternal and infant outcomes, women's general health, and health services utilization Campbell, Pugh, Campbell, & Visscher, 1995; Curry & Harvey, 1998; Curry, Perrin, & Wall, 1998; Dye, Tolliver, Lee, & Kenney, 1995; A. S. Helton, J. McFarlane, & E. T. Anderson, 1987; McFarlane, Parker, & Soeken, 1995; 1996a; 1996b; McFarlane, Parker, Soeken, & Bullock, 1992; Parker, McFarlane, & Soeken, 1994; Schei, Samuelsen, & Bakketeig, 1991). These studies provide empirical data about the incidence and prevalence, correlates, and the actual and potential maternal and infant health outcomes of abuse during pregnancy. However, there is little known about the meaning of experiencing abuse during pregnancy. Pregnancy involves many decisions about health behaviors, prenatal care, and relationships. Given the current knowledge base, it is uncertain what effect abuse has on those decisions (Campbell, 1995).

Although there has been some research conducted with mothers who have been abused by their intimate male partners, the investigations have been conducted primarily with shelter-based populations and women with older children. To this author's knowledge, although a large number of investigations have examined the effects of intimate partner abuse during pregnancy, there have been no qualitative studies published to date that provide contextual information about the impact of abuse on the process of becoming a mother from the perspective of women who have been pregnant and abused.

How is the process of maternal role development affected when an intimate male partner abuses the woman during pregnancy, while she is engaged in the early process of becoming a mother? Conversely, what is the impact of maternal role development on abused women's decision making during pregnancy? It is currently unknown how the experience of abuse impacts women's development and attainment of a maternal identity.

Pregnancy involves myriad changes for women. In addition to the physiological changes that occur due to the developing infant, numerous changes also occur within her emotional, cognitive, and psychosocial contexts while she engages in the process of becoming a mother. Becoming a mother is a challenging developmental process for women demanding a shift in the woman's self-concept. Prior to becoming pregnant, the woman thinks of herself as an individual person. As a pregnant woman, she begins the journey to motherhood that results in a changed perception of her self as mother with the attendant role responsibilities and transformations.

The voices of women who have been abused during pregnancy will provide an important missing link from the current knowledge about abuse and motherhood. Their perspective will provide essential contextual information about their experiences of pregnancy and abuse as well as the impact of such experiences on decisions made routinely during the course of pregnancy.

Clinical experience as a women's health care nurse practitioner and an emergency nurse combined with volunteer experience in domestic violence shelters and a comprehensive review of the literature have led this researcher to identify a gap in the current knowledge base about woman abuse. Specifically, what are the effects of abuse on women's experiences of pregnancy and on their decisions about health behaviors,

health care, and leaving or remaining in the abusive relationship? Therefore, this research study examined the effects of abuse on women's experiences as well as on decisions made during the prenatal period.

The Specific Aims of the Research Study

1. Explore women's perceptions of the meaning of experiencing abuse during pregnancy.
2. Describe the effects of abuse on decisions women make during pregnancy.
3. Generate the development of an initial grounded theory of the effects of abuse on pregnancy and on women's decisions made during pregnancy.

This study focused on women's perceptions of the experience of abuse during pregnancy, and built on the author's previous research (Lutz, 1996). Long-term objectives of the program of research are to contribute to the existing theoretical knowledge on maternal identity development, add to the knowledge base on violence against women, and to develop effective clinical interventions with abused women.

Significance to Nursing

The science and art of nursing is concerned with the human responses to actual and potential health problems. Specific to caring for abused, pregnant women, nurses have been on the forefront of providing direct patient care to pregnant and non-pregnant abused women as well as conducting research with women who have been victims of intimate partner abuse. Whatever setting a nurse practices in, given the high prevalence of violence against women, it is likely that he or she will interface with one or more abused women on a daily basis.

According to a recent investigation of nurses' reasoning in the assessment of family violence, the majority of participants had little or no education related to child, spouse, or elder abuse (Limandri & Tilden, 1996). In addition to a lack of knowledge about various forms of abuse, nurses also expressed a lack of awareness and understanding of the complexities inherent within the context of an intimate, partnered relationship that was abusive and "...intolerance for adults who were perceived as participating in their own abusive situation" (p. 251). Clearly, nurses' lack of understanding of the contextual reality of living in an abusive relationship could profoundly impact their ability and willingness to intervene with victims of intimate partner abuse.

Nurses need to understand not only what the actual and potential consequences of abuse during pregnancy are in terms of maternal and neonatal outcomes, but in order to provide responsive and effective care, they must also appreciate how living within the context of abuse effects women's experiences and decision making during pregnancy. An abusive relationship is fraught with contradiction and complexity and that is increased when pregnancy is introduced to the situation. Without this understanding, however, it is unlikely that nursing interventions with abused, pregnant women will be positive or successful. The current study will provide important contextual information that may improve nurses' understanding of the complexities and ambiguities that comprise the life experiences of an abused, pregnant woman.

Chapter 2: Background and Significance

The purpose of this chapter is to provide the background and significance for the proposed investigation by reviewing pertinent research and literature. In qualitative research using Dimensional Analysis (DA) methods, the literature review is initially employed to sensitize the analyst to possible issues, questions, and areas of inquiry related to the proposed investigation. Initial topics addressed within this section will include a discussion of the phenomenon of abuse and pregnancy, maternal behavior, and maternal identity. This will be followed by information about the prevalence of abuse and negative pregnancy outcomes associated with abuse. Building on this topical area, research and theory that has explored the effects of abuse on actions that normally women engage in during pregnancy including health behaviors and seeking of health care services will be presented. The decision to leave or remain in an abusive relationship has been examined by researchers and this body of work will also be addressed. Therefore, literature on woman abuse, abuse during pregnancy, and the development of maternal identity will be reviewed, the findings summarized, and significant gaps in knowledge about this phenomenon identified.

Physical, sexual, and emotional abuse of women during pregnancy is a social and health problem with significant consequences for the women who are abused, their unborn infants, health care providers, health policy, and society. Each day, thousands of women are physically or sexually assaulted by their spouses, ex-spouses, or intimate male partners (Plichta & Weisman, 1995; Tjaden & Thoennes, 2000b). However, health care professionals frequently do not know how to address this complex issue (Limandri & Tilden, 1996). As a consequence, health care professionals may feel uncomfortable and

avoid discussing abuse with their patients (Sugg & Inui, 1992), or they may screen for abuse in a cursory manner that is not conducive to patient disclosure or that effectively assists patients in any way. As a result, when these situations occur, both patients and providers feel frustrated. More importantly, it may constrain abused patients' access to helpful resources, leaving them to continue living in a dangerous setting that may adversely affect their psychosocial and physical health, or if they decide to stay in the relationship, lead them to feel more ostracized and alone.

Abuse during pregnancy presents additional medical and psychosocial complications that may go undetected, despite frequent health care. These complications increase the economic costs of pregnancy. Frequently associated with abuse during pregnancy, lack of health insurance, economic constraints, and social isolation add to the myriad issues contributing to and confounding the effects of abuse. Therefore, the consumption of health care and social service resources and the associated costs from abuse impacts all health care consumers and has implications for health policy (Straus & Gelles, 1990; Webster, Chandler, & Battistutta, 1996).

Phenomenon of Woman Abuse

Woman abuse is a complex phenomenon based on coercion, power, and control and comprised of interrelationships between physical, sexual, verbal, emotional, and psychological abuse (Smith, Tessaro, & Earp, 1995). Unlike an occurrence of random violence or accidental trauma, the experience of partner abuse occurs within the context of an interpersonal relationship with a partner that one is committed to and has chosen to love. Intimate partner abuse is affiliated with a person who is supposed to provide love, support, and protection. Thus, within the context of an intimate relationship, abuse is

juxtaposed with love and affection. This contradiction between love and fear, family ties and abuse is difficult to reconcile. Although women want the abuse to end, most often they want the relationship to continue and their family to remain intact.

Women who are abused within the context of an intimate relationship are affected by the abuse in many ways and on many levels. In addition to the direct physical injuries and trauma that may be experienced by a woman who is abused, an abused woman frequently experiences hidden trauma such as social isolation, emotional trauma, fear, depression, and anxiety. A woman's experience of abuse is something that shapes her perceptions of and responses to her environment and experiences (Landenburger, 1989, 1993). However, her perceptions of the abuse and the abusive relationship are frequently contradictory and change throughout the duration of the abusive relationship.

In part, measurement issues have fostered the development of instruments that emphasize physical and sexual acts of abuse. As a result, in addition to being more easily measured, sexually and physically violent acts are more commonly accepted as "abuse". Moreover, instruments that are designed to measure physical and or sexual acts of violence frequently fail to account for other equally damaging forms of abuse such as emotional or verbal abuse. Essentially, these instruments neglect the hostile, dangerous, and undermining contextual reality that occurs on a daily basis within an abusive relationship. Clearly, when using statistical analysis it is more efficient and expedient to measure the severity or frequency of physical violence than it is to measure the less tangible and more indirect effects of living within the context of an abusive relationship. And, valuable information can be gleaned from well-designed, large-scale quantitative studies of women who are abused. However, it is imperative to remember that woman

abuse is a phenomenon that is more complex and multidimensional than simple acts of physical violence. Furthermore, a comprehensive understanding of this phenomenon is not possible without inclusion of women's perceptions of the abuse, acknowledgement of various forms of abuse, and analysis of the contradictory context in which abuse occurs.

Abuse rarely is an isolated event, and generally increases in severity and frequency over time (Stark & Flitcraft, 1996). Physical abuse specifically includes the acts or threats of hitting, slapping, kicking, punching, shoving, torture, sexual assault, and any use of weapons. It also incorporates and or may be preceded by emotional and psychological battery and trauma (Campbell, Poland, Waller, & Ager, 1992). Verbal, emotional, and psychological abuse may occur in relationships without physical or sexual abuse; however, physical and or sexual abuse rarely occurs without concomitant emotional or psychological abuse. Therefore, it is assumed that emotional abuse and psychological abuse occur within physically and sexually abusive relationships.

To conclude this section, it is self-evident that the language and terminology that one uses to describe a phenomenon inherently reflect one's underlying theoretical assumptions about the phenomenon. The language associated with a particular phenomenon also helps to create a perception of the problem for others and has important implications for solutions to the problem (Dobash & Dobash, 1990). Whatever definition one attaches to a particular phenomenon also has particular meaning and implications for the research methods. By employing woman abuse and intimate partner abuse against women as the terms to describe this phenomenon, it is intended to call attention to the gender of the victim/survivor and to include abusive actions that may not result in physical injury but are also injurious and detrimental to the general health and well-being

of women. Presenting woman abuse as a complex phenomenon also implies the assumption that measures designed to screen for abuse or tally physically or sexually abusive acts are generally inadequate to capture the meaning and complexity of this experience. As a complex and difficult problem, it is believed that the use of qualitative interviews with abused women and analysis using DA as a research method provided a more complete understanding of this complex and multidimensional problem.

Pregnancy, Maternal Behavior, and Maternal Identity

Pregnancy is a time of many biological, psychological, social, and transitional changes (Mercer, 1986, 1995; Rubin, 1970, 1975, 1984; Tilden, 1980). Reva Rubin presented one of the first nursing theories to describe maternal behavior and the cognitive work used by pregnant women engaged in the process of structuring a maternal identity in pregnancy and the early postpartum period (Rubin, 1970, 1975, 1984). Based on her research utilizing participant observation, Rubin's early efforts served as a foundation for her later theoretical writing. Her research was the first to present maternal role attainment from the perspective of the women experiencing it. In addition, her theory provided major theoretical concepts upon which later work would be based (Mercer, 1995). Rubin described four maternal tasks of pregnancy. The first task is seeking and ensuring safe passage for mother and infant. Included in this task are such actions as obtaining prenatal care and acquiring knowledge about what to expect through observation, literature, and sharing the personal stories of other women. The second task is securing and assuring acceptance of the pregnancy and the infant by significant others. According to Rubin, the quality of the relationship with the father of the baby influences the course of the pregnancy, the execution of maternal tasks, and the attainment and

formation of a maternal identity (Rubin, 1984). The third task, binding-in to the child, is a process of attachment to the theoretical image of the child that becomes transformed to knowing the child as a person and committing to that child as the mother. In the fourth task, the mother gives of herself to the dependent, valued child. As the pregnancy progresses, this task becomes more demanding and complex. Incorporated with this task is the taking in of food and nutrients and giving up of detrimental substances such as cigarettes and alcohol.

According to Rubin, the environment or context is important to maternal role development (Rubin, 1984). Throughout pregnancy, the person or self enlarges in scope and complexity while assuming a maternal identity. Although it is commonly accepted that each woman will negotiate and fulfill these tasks in her own individual style that may be different for each pregnancy, it is unknown how the context of abuse impacts women's achievement of these tasks.

Mercer (1995) expanded Rubin's (1984) theory of maternal role and acquisition of maternal identity by extending her concepts to include the first year following childbirth. Based on her research, she maintains that maternal role identity may not be achieved until well into the first postpartum year. Components of the mothering role include attachment to the infant by identifying, claiming, and interacting with the infant, increasing competence in maternal behaviors, and expressing gratification in the infant-mother interactions (Mercer, 1995). Mercer describes mothering as:

> The maternal behavior learned in interaction with a particular child, beginning in the process of achieving a maternal role identity and continuing to evolve

> throughout the child's development...[it] is derived from the mother's resources and extensive knowledge of each individual child (Mercer, 1995, p. 1).

Lederman contributed to the content area of maternal adaptation by focusing on seven psychosocial dimensions of pregnancy experienced by women (Lederman, 1996). She used this framework to examine the broad range of women's psychosocial experiences during pregnancy through the development of the Prenatal Self-Evaluation Questionnaire II. A 79-item tool with 4 response categories, this instrument measures seven psychosocial dimensions: 1) acceptance of pregnancy; 2) identification with a motherhood role; 3) relationship to the mother; 4) relationship to the husband or partner; 5) preparation for labor; 6) prenatal fear of loss of control in labor; and 7) prenatal loss of self-esteem in labor (Lederman, 1996). Lower scores suggest better adjustment, while higher scores are equated with increased conflict.

What remains unclear is how women fulfill or attain maternal tasks when their intimate male partner (an integral part of the family), is abusive, and thereby, jeopardizing the family unit, her safety, as well as the safety of the unborn child. What are the decisions that women make to promote fulfilling these maternal tasks of pregnancy within the context of a violent relationship? What trade-offs do abused, pregnant women make and how do they compare with those described in the literature?

Prevalence of Woman Abuse

Woman abuse is a common health and social problem. According to the National Violence Against Women (NVAW) Survey, almost 25 percent of women surveyed reported having been raped and or physically assaulted by a current or former partner at some time in their lifetime (Tjaden & Thoennes, 2000a). Based on data from three

nationally representative studies, it has been conservatively estimated that 1.5 million (Plichta & Weisman, 1995; Tjaden & Thoennes, 2000a) to 6.75 million (Straus & Gelles, 1990) women are exposed to one or more physically abusive acts by their partner or spouse annually. Of those women, between 1.6 million (Plichta & Weisman, 1995) and 1.8 million (Straus & Gelles, 1990) experienced severe abuse. In the first study, data from the 1985 National Family Violence Resurvey were used (Straus & Gelles, 1990). A telephone survey was conducted with 4032 randomly selected households that were oversampled for African-American and Hispanic participants. Male and female adults, aged 18 years or older were interviewed. The Conflict Tactics Scale (CTS) was used to measure abuse. Results indicated that one out of eight male partners carried out one or more violent acts against their female partners during the year of the study and 3.4% of those women were severely abused by their partners.

In the second study, also a cross-sectional, nationally representative telephone survey that oversampled for African-American and Hispanics, the participants were 1324 females who were married or cohabiting with a male partner and between 18 and 64 years of age (Plichta & Weisman, 1995). In that study, 8.4% (n = 112) of the respondents reported being physically abused by their partner or spouse in the past year, and 3.2% (n = 42) reported severe abuse in the past year as measured by the CTS.

The third, and most recent investigation was the NVAW survey, the sample for which was generated by random-digit dialing from a database of households with telephones in the United States and District of Columbia (Tjaden & Thoennes, 2000a, 2000b). A total of 8000 women and 8005 men over 18 years of age or older were interviewed about their experiences as victims of violent acts including intimate partner

violence. The investigators defined intimate partner violence as "rape, physical assault, and stalking perpetrated by current and former dates, spouses, and cohabiting partners, with cohabiting meaning living together at least some of the time as a couple" (Tjaden & Thoennes, 2000a, p. 5). It included same-sex and opposite-sex couples. The definition resembled the definition put forth by the Centers for Disease Control, but is not limited to rape and physical assault. The measurement of physical assault included a modified version of the CTS.

According to the NVAW survey, of those women surveyed, 7.7 % reported having experienced rape or attempted rape by a current or former intimate partner at some time in their lifetime; 22.1 % had been physically assaulted by a current or former intimate partner at some time in their lifetime; while 4.8 % had been stalked by a current or former intimate partner at some time in their lifetime. The reported findings indicated that intimate partner violence is more common for women than men, whether it is rape, physical assault, or stalking and whether the timeframe is over the past twelve months or over a lifetime. Additionally, violence by a male intimate against his female partner was often accompanied by emotionally abusive and controlling behavior.

Prevalence of woman abuse among non-pregnant women.

Investigations examining the prevalence of abuse in clinic settings with samples of non-pregnant women have also been reported. For example, two recent studies examined the abuse status of female emergency department patients (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; McFarlane, Greenberg, Weltge, & Watson, 1995). In one of the studies, using a randomized block sample of 648 women and a self-completed, written survey instrument developed for the study, current abuse (physical,

sexual, or emotional) was reported by 11.7% (n = 47) of the sample (Abbott et al., 1995). However, only 23% (n = 11) of those currently abused women had presented during 30 randomly selected 4-hour time blocks for treatment at an emergency department with a traumatic injury. For the other study, a convenience sample of 416 women was drawn from patients who had presented with the primary symptom of vaginal bleeding to two public or one private emergency departments (McFarlane, Greenberg et al., 1995). They were screened for abuse by an interviewer using the Abuse Assessment Screen (AAS). Thirty-eight percent (n = 153) of the sample reported a history of abuse. Of the women who had experienced any abuse, for 93 women (61%) the last episode of abuse had occurred within the last 12 months. For both studies set in emergency department settings, the lifetime prevalence rate for abuse ranged from 38% (McFarlane, Greenberg et al., 1995) to 54.2% (Abbott et al., 1995).

Two studies set in primary care internal medicine clinics reported similar prevalence rates for women's current physical or sexual abuse ranging from 5.5% (McCauley et al., 1995) to 14% (Gin, Rucker, Frayne, Cygan, & Hubbell, 1991). However, lifetime physical and sexual abuse prevalence rates for women were lower than those reported in emergency settings and ranged from 21.4% (McCauley et al., 1995) to 28% (Gin et al., 1991). The first study used a cross-sectional survey design with a self-administered anonymous questionnaire that incorporated abuse items from the AAS to measure abuse. The purposive sample was comprised of 1952 women of varying ages, marital, educational, and economic status (McCauley et al., 1995). In the second study, all patients presenting for care at three internal medicine clinics on randomly selected days were approached and asked to participate (Gin et al., 1991). The sample of 453

English- and Spanish-speaking men and women were asked to complete a self-administered anonymous questionnaire about domestic violence. The 47-item questionnaire was specifically developed for the investigation, with some items on abuse based on the CTS. Domestic violence was loosely defined as being hit or hurt by the live-in significant other but also included "nonviolent intimidation".

Similarly, using a four-question self-report format of the AAS as part of a self-administered social history form, a study set in four outpatient women's clinics with a sample of 793 women reported a lifetime prevalence of physical abuse of 8.2% (n = 65) (Bullock, McFarlane, Bateman, & Miller, 1989). Another study also set in women's clinics examined whether abuse prevalence rates were different when women self-reported compared to women who were interviewed by a nurse (McFarlane, Cristoffel, Bateman, Miller, & Bullock, 1991). For the self-report group, screening for abuse was accomplished by including a four-question format of the AAS as part of the standard social history that each participant completed. For the interview group, the same abuse questions were used, except that the nurse interviewed the participants and recorded their answers. The investigators found that abuse prevalence rates varied considerably. In that study, abuse prevalence rates by self-report were much lower than abuse rates reported following a nurse interview (7.3% compared with 29.3%)(McFarlane et al., 1991).

Prevalence of woman abuse during pregnancy.

Abuse is also common during pregnancy, and by most calculations, is 3 to 15 times more common than other health problems that are routinely screened for in prenatal care such as gestational diabetes and preeclampsia (Cunningham, MacDonald, Gant, Leveno, & Gilstrap, 1993). Research suggests that 0.9% to 65% of women experience emotional,

verbal, physical or sexual abuse during pregnancy (Bullock & McFarlane, 1989; Curry & Harvey, 1998b; Curry, Perrin et al., 1998; Dye et al., 1995; Gazamararian et al., 1995; Gazmararian et al., 1996; Gelles, 1975, 1988; Gielen, O'Campo, Faden, Kass, & Xue, 1994; A. Helton, J. McFarlane, & E. Anderson, 1987; A. S. Helton et al., 1987; Martin, English, Clark, Cilenti, & Kupper, 1996; McFarlane et al., 1991; McFarlane, Parker et al., 1995; McFarlane, Parker, & Soeken, 1996b; McFarlane et al., 1992; O'Campo, Gielen, Faden, & Kass, 1994; Stewart & Cecutti, 1993; Walker, 1984). Of women who were battered prior to pregnancy, 34% to 60% report continued physical abuse during pregnancy (Campbell, Oliver, & Bullock, 1993; Campbell et al., 1992; A. S. Helton et al., 1987).

In a prospective study, researchers interviewed 1243 low-income, primarily African-American, primagravidas in the prenatal and post partum period (Amaro, Fried, Cabral, & Zuckerman, 1990). Participants who experienced violence by an intimate partner were identified by scores on the CTS reflecting physical and sexual abuse. Of the sample, seven percent (n = 92) of the women reported physical or sexual violence during pregnancy, and three percent (n = 37) reported violence three months before pregnancy but not during the pregnancy. Less than one percent of the total sample, but 12% of the abused women (n = 11) reported violence occurring three months before pregnancy and continuing into the pregnancy. Women reporting abuse were more likely to be white, born in the United States, and single.

In a retrospective study of the relationship between physical abuse and low birth weight outcomes, a nurse interviewed a sample of 589 women within 24 hours of delivery (Bullock & McFarlane, 1989). In this study, battering was defined as physical

assault by a woman's male partner occurring during or before pregnancy but within the current relationship. Four undescribed questions assessed the women's history of battering, presence of verbal abuse, and threats of physical abuse. A positive response to any of the four questions classified the participant as abused. Of the sample, 20.4% reported being battered before or during pregnancy.

Campbell et al. (1992) conducted a retrospective investigation to identify correlates of abuse during pregnancy with a convenience sample of 488 low-income women. Women were interviewed one time 2 to 5 days following childbirth in any of 5 hospitals. In the hour-long interviews using open-ended and fixed choice questions, women were asked about the experience of pregnancy and prenatal care, the content of prenatal care, health behaviors before and during pregnancy, demographic information, support, and anxiety, depression, hopefulness, and physical violence. Fifty-six (11.2%) of the women reported physical abuse (as measured by the AAS) at some time during their current relationship. Of the sample, 35 women (7% of the total sample) reported abuse during pregnancy. Therefore, nearly two-thirds (62.5%) of the women who were abused at some time in their current relationship (n = 56) were abused during pregnancy. Twenty-one women (4.2% of the total sample) reported abuse before but not during their pregnancy (37.5% of women who were abused). Of the 35 women battered during pregnancy, 28.6% (n =10) reported an increase in violence during pregnancy.

Another retrospective study was designed to discover why men physically abuse women during pregnancy from the women's perspective (Campbell et al., 1993). The convenience sample was comprised of African-American and white battered women (n = 79) who were recruited by newspaper advertisement and bulletin board postings from two

demographic areas for an investigation of women's responses to battering. The abuse measure used was the CTS. Fifty-one women were pregnant by their intimate partner. They comprised the subsample for this investigation. Women who were physically and or sexually abused by an intimate male partner during the prior year were asked if they were beaten by their partner during pregnancy. Forty-seven percent (n = 24) of the women who were pregnant by their partner were beaten during pregnancy. The remaining, 53% (n = 27) of those women who were pregnant by their partner were not beaten during pregnancy. For these women, pregnancy was protective from physical abuse. The group of women who were not beaten during pregnancy used as a comparison group. The women battered during pregnancy also experienced more frequent and severe abuse throughout their relationships and had been more severely injured than the women who had never been abused during pregnancy.

Women were asked why they thought they had been beaten by their intimate male partner during pregnancy. Thematic analysis identified four themes to the responses to that question: 1) jealousy of the unborn child, 2) pregnancy-specific violence that was not directed toward the unborn child, 3) anger toward the unborn child, and 4) anger against the woman or "business as usual".

Campbell and colleagues used focus group methodology to investigate the relationships of abuse of intimate partners and unintended pregnancy (Campbell et al, 1995). The sample was comprised of 23 currently or retrospectively pregnant abused women who were staying at a shelter for female victims of domestic abuse. Thematic analysis revealed five themes: 1) Male partner control, 2) relentless abuse, 3) lack of consistency and jealousy in the partner's relationship with the woman and with offspring,

4) definition of manhood, and 5) health problems. Participants were interviewed about their experiences with prenatal care. The majority reported being accompanied by the abusive partner to prenatal visits and that they would lie about the abuse if asked in front of the partner. Their recommendations for health professionals included: screening for abuse by use of a written questionnaire; talking to the woman as another woman, not as a health care provider; being aware that women who were abused knew they were abused, but acknowledging the desire to have a family; and screening for abuse as a way to let women know they can seek the help of the health care provider.

In a prospective study, the impact of violence on pregnancy outcomes was examined (Dye et al., 1995). In the sample of 364 low-income women, 15.9% (n = 58) reported abuse during pregnancy. For this study, abuse was assessed by two questions asked by prenatal care coordinators during an in-person prenatal interview: 1)"Since you were pregnant, were you involved in a physical fight?" 2)"Since you were pregnant did someone physically hurt you?" A positive response to either question, or a clinician's documentation of abuse in a participant's medical chart classified the participant as abused. Women who were teenagers, whose partners were teenagers, or who were primigravidas were significantly more likely to be abused during pregnancy.

In a study set in public health and low-income clinics, 502 pregnant white, Hispanic, and African-American women were surveyed to determine whether they delayed prenatal care due to battering during pregnancy (Taggart & Mattson, 1996). In this sample, abuse was common with 43.8% reporting one or more occurrence of physical abuse by their partner or someone important to them; 26.1% reported that this

had occurred in the past year. One-fifth of the sample reported being physically hurt since pregnancy, and 25% said they had been forced to have sex in the past year.

Another study was designed to determine whether pregnancy intention was associated with abuse (Gazamararian et al., 1995). Using a 14-page mailed questionnaire, researchers surveyed a stratified random sample of 12,612 new mothers in four states, three to six months after the birth of their infant (Gazamararian et al., 1995). Most of the women were high school educated, over 24, married, middle-income, and had entered prenatal care in the first trimester. Physical violence was determined by asking each participant if her "husband or partner physically hurt (her)" during the year before delivery. Prevalence of being physically hurt by a partner or husband during the 12 months preceding delivery ranged from 3.8% to 6.9%. Nearly 70% of the women reporting physical abuse had unwanted or mistimed pregnancies.

In a descriptive study of a national probability sample of 6002 households, the rates of violence in homes with pregnant women and homes without pregnant women were compared (Gelles, 1975, 1988). Violence was measured by the CTS. Pregnant women had a 23.8% greater risk of minor violence (i.e., pushing, shoving, and slapping), a 60.6% risk of severe violence (i.e., kicking, hitting, and using a weapon), and a 35.6% higher risk for any form of violence when compared with non-pregnant women. Overall, risk of violence was higher for pregnant than non-pregnant women. However, when pregnancy and age were controlled, no statistically significant relationship was found. Data collection methods (phone interviews of both males and females), use of the CTS and researcher bias may have affected the validity of the data.

Helton et al. (1987a, 1987b) conducted a study of pregnant women at private and public prenatal clinics. Using a 19-item questionnaire (that incorporated the AAS) in an interview format, eight percent of the 290 women reported abuse during their pregnancy, while another 15% reported battering before their current pregnancy. No differences in the demographic variables of race, ethnicity, age, employment status, marital status, or level of education were found between women who were and those who were not abused. Of those women physically abused during pregnancy, 87.5% had experienced violence prior to pregnancy. Therefore, previous abuse was predictive of abuse during pregnancy. Twenty-nine percent of the women reported the abuse had increased after they had become pregnant. One-third of those battered during pregnancy sought medical care for injuries; however, none of the women reporting abuse had been identified as battered in medical records by their health care providers, nor had any of the women been provided with resource information for victims of abuse.

A sample of 2092 primarily low-income, African-American and white health department prenatal patients was screened for physical or sexual abuse. Screening for abuse using the AAS was conducted by the health care providers as part of the initial prenatal visit (Martin et al., 1996). Of the women, 550 (26%) experienced one or more episodes of lifetime violence, 486 (23%) experienced violence before but not during their current pregnancy, 49 (2%) experienced violence before and during the current pregnancy, and 15 (<1%) experienced violence only during the current pregnancy.

In a stratified, prospective, cohort analysis of 691 pregnant, low-income Hispanic, African-American, and white women at public prenatal clinics, McFarlane et al. (1992), found a 17% prevalence rate of physical or sexual abuse during pregnancy. In a private

setting, primary care providers assessed the women for abuse by using the AAS, the CTS, the Index of Spouse Abuse (ISA), and the Danger Assessment Screen (DAS) during each trimester of pregnancy. Recurrent abuse was common, with greater than 60% of the abused women reporting two or more episodes of abuse during pregnancy.

In an extension of the previous study (McFarlane et al., 1992), an investigation was conducted with 1203 low-income, young African-American, Hispanic, and white women at public prenatal clinics (McFarlane, Parker, & Soeken, 1996a; Parker et al., 1994). Investigators found that 24% of the sample (n = 293) reported physical or sexual abuse within the past year at their first prenatal visit as measured by the AAS. At interviews during the remaining two trimesters, five percent of the nonabused women reported abuse during the second or third trimester. The aggregate rate of abuse during pregnancy for the entire sample was 16%. The incidence rate for abuse during pregnancy was higher for teens than adults (20.6% versus 14.2%) and abuse rates also varied by race/ethnicity with African-American women reporting the most abuse (18%), followed by white (17%) and Hispanic women (13%). In contrast to the findings of previous studies (A. Helton et al., 1987; A. S. Helton et al., 1987) this study found significant differences in abuse frequency, severity, and homicide risk between racial/ethnic groups. Abuse frequency, severity, and homicide risk were each significantly worse for white women compared to African American and Hispanic women. Additionally, abused women were twice as likely to enter prenatal care during the third trimester. Although the abuse prevalence was higher than other studies with pregnant women, reassessment for abuse in each trimester may have uncovered abuse that was not reported in the first interview or that started later in the pregnancy. Further, assessment for abuse via

interview by a health care provider known to the woman may also have facilitated disclosure of abuse.

In a prospective study of 358 predominantly African-American, low-income women seeking prenatal care at a university clinic, investigators found that 65% had experienced verbal or physical abuse during pregnancy as measured by the CTS (O'Campo et al., 1994). Twenty percent of the women experienced moderate or severe physical violence during their pregnancy. Moderate violence included the following acts: "throw something at you," "push, grab, or shove you" or "slap you." It also may have included the experience of negative verbal interaction. Severe violence included the following items: "kick, bite, or hit you with a fist," "hit or try to hit you with something;" or "use a knife or fire a gun." Women who experienced severe violence may also have experienced moderate violence and or negative verbal interactions.

In a secondary analysis of survey data from 940 antenatal patients in private CNM and MD practices, Sampselle and colleagues described the prevalence of past and current abuse of pregnant patients (Sampselle, Petersen, Murtland, & Oakley, 1992). The researchers used two items on a written questionnaire to assess for past or current abuse. Participants were asked, "Have you ever been physically, emotionally, or sexually abused or mistreated?" And, "Are you currently being abused or mistreated in any of these ways?" A history of sexual, physical, or emotional abuse was reported by 9.7%, while eight women (0.9%) reported current abuse. Current abuse was more prevalent among lower income and less educated women. A positive history of abuse was also associated with lower educational levels for women. Lower prevalence rates may be related to the use of a written questionnaire versus a verbal interview as supported by previous research

(McFarlane et al., 1991). In addition, the grouping together of physical, sexual, and emotional abuse limits the descriptions of specific forms of abuse.

Using a self-report questionnaire, a sample of 548 women, 20 or more weeks gestation drawn from prenatal clinics and a university hospital were interviewed about abuse to determine the prevalence of physical abuse in late pregnancy (Stewart & Cecutti, 1993). The study instrument asked 12 questions about abuse including when the abuse occurred. In this sample, 36 women (6.6%) reported physical abuse during the current pregnancy, 60 women (10.9%) experienced physical abuse before the pregnancy. Of the women who experienced abuse during pregnancy, 23 women (63.9%) reported the abuse increased during their pregnancy.

Curry and colleagues conducted a prospective investigation of adult and adolescent pregnant women to estimate the incidence of physical and sexual abuse and to determine the relationship between intimate partner abuse, maternal complications and infant birth weight (Curry, Perrin et al., 1998). Using the AAS, 513 of the 1897 women (27%) reported physical or sexual abuse in the past year and or physical abuse during pregnancy. Sexual abuse during the past year was reported by 4.5% of the sample. Adolescents were more likely to report abuse than adults (37.6% compared to 22.6%; $\chi^2 = 44.94$, $df = 1$, $p < .001$). Women who identified themselves as black, Native American or "other" race also reported significantly higher rates of abuse than did other ethnic groups ($\chi^2 = 15.16$, $df = 5$, $p < .01$).

In a related investigation, the incidence of abuse among pregnant teens was described and the relationship between abuse, pregnancy planning, participation in high school, substance use during pregnancy, pregnancy complications, and birth weight were

explored (Curry, Doyle, & Gilhooley, 1998). Of the 559 English-speaking primarily Caucasian (52%) or African American (30%) pregnant, adolescents between 13 and 19 years of age, more than 37% reported abuse. Significantly, the middle adolescents (ages 14-17) reported the highest incidence of abuse, followed by the early adolescents (ages 10-13), and the late adolescents (ages 18-21). In each age group, the incidence of low birth weight was higher for those who were abused, but the differences were not statistically significant.

Recently, a summary article examining the methods and findings of studies on the prevalence of violence during pregnancy studies was published (Gazmararian et al., 1996). The authors examined 13 studies and extracted data to compare studies by description, methods, and results. The authors found a wide range of reported prevalence rates of physical violence during pregnancy of 0.9% to 20.1%. Studies also varied in the measures of violence, populations sampled, and study methods. Those studies that asked about violence more than once during in-person interviews or later in pregnancy reported higher abuse prevalence rates, and the lowest reported prevalence rate was in a study using a written self-report questionnaire.

Summary of abuse prevalence literature.

As illustrated by the findings of the reviewed studies, the reported prevalence of abuse against women varies considerably from 0.9% to 65%. In addition to standard research design issues (i.e., sampling, validity and reliability of measures, and data analysis) that are important to evaluate for any research investigation, several specific methodological issues plague research in the substantive area of woman abuse and domestic violence and have direct implications for reported abuse prevalence rates. For

example, variations in the way that abuse is assessed, whether by a written survey, an unknown interviewer, or the woman's health care provider, may effect a woman's willingness to disclose her abuse status – which will directly impact reported abuse prevalence rates (McFarlane et al., 1991). Furthermore, use of an untested assessment instrument instead of a sound, valid and reliable instrument and a single versus repeated assessment for abuse may all result in falsely low reported rates of abuse (Gazmararian et al., 1996; McFarlane et al., 1991). Another important issue related to abuse prevalence rates is the wide variation in what constitutes abuse and how and when it is measured. Whereas some researchers report lifetime prevalence of any physical, sexual, emotional, or verbal abuse, others measure physical and or sexual abuse only while others allow study respondents to self-define abuse. Therefore, one must carefully read the report to determine how abuse is defined and measured.

For example, although abuse was common in the nationally representative studies (Plichta & Weisman, 1995; Straus & Gelles, 1990); Tjaden & Thoennes, 2000), it is important to note how the studies defined and measured abuse and how data were collected. The first two studies only measured actual physical acts of violence, use of weapons, or threats of physical violence or use of a weapon and did not include sexual, emotional, or verbal abuse (other than threats). The third study did include a measure for stalking, but otherwise did not include emotional or verbal abuse. Furthermore, while sampling a nationally representative sample promotes generalizability of the findings, the use of a telephone interview may actually limit the rate of disclosure of abuse due the interviewer being someone unknown to the respondent or the potential for lack of privacy from an abusive partner.

These points are also important to consider in evaluating, comparing, designing and conducting research of abuse during pregnancy, however, there are also important issues that may be unique to this area. Specific to research on the prevalence of abuse during pregnancy, research findings suggest that violence may be initiated at different times in pregnancy (McFarlane et al., 1996a). Therefore, prevalence rates based on a single assessment for abuse at an initial or early prenatal visit may underreport the actual occurrence of abuse during pregnancy. This phenomenon may actually be represented by the differences in abuse prevalence rates reported by studies assessing abuse status early in the pregnancy or at only one point (Sampselle et al., 1992; Stewart & Cecutti, 1993) and those measuring later in the pregnancy or at multiple times (Campbell et al., 1992; O'Campo et al., 1994; Parker et al., 1994). However, other studies that made repeated, late pregnancy, or postpartum assessments also reported lower abuse prevalence rates (Amaro et al., 1990; Campbell et al., 1992).

In conclusion, the variation in prevalence rates for woman abuse drawn from nationally representative samples and samples from health care settings reflects inconsistent assessment methods, varying operationalization of abuse, and differing terminology, making comparisons between studies and across settings and populations difficult. Despite these discrepancies, abuse is acknowledged as a major public health problem for women and children (USDHHS, 1990; USDHHS, 1995). It has been suggested but not established that pregnancy may increase women's risk of abuse, and that pregnant women experience abuse at higher rates than non-pregnant women (APA Task Force, 1996; Gelles, 1988; Stark & Flitcraft, 1996). Additionally, for some women the severity and frequency of abuse may escalate during pregnancy (Campbell, 1989b;

Campbell et al., 1993; A. S. Helton et al., 1987; McFarlane et al., 1992; Stewart & Cecutti, 1993). Therefore, a relationship that is abusive before pregnancy may become more abusive and dangerous during pregnancy or in the postpartum. Consequently, abuse during pregnancy is an issue of significance to nursing and other health professionals. Accordingly, the American Nurses Association (ANA), the American Academy of Nursing (AAN), the American College of Nurse Midwives (ACNM), the American Medical Association (AMA) and the American College of Obstetrics and Gynecology (ACOG), have identified abuse during pregnancy as a major priority for provider education and research.

Negative Pregnancy Outcomes Associated with Woman Abuse

Several studies concerned with pregnancy and abuse have focused on pregnancy outcomes. In general, more maternal and fetal complications occur to women abused in pregnancy than to women who were not abused, including higher rates of preterm births, lower mean birth weights, prolonged labor, spontaneous abortions (SABs), and prolonged hospital stay for infants (Curry et al., 1998; Dye et al., 1995; McFarlane et al., 1996b; Parker et al., 1994; Schei et al., 1991).

In a retrospective study, Bullock and McFarlane (1989) found a statistically significant correlation between physical battering and low birth weight (LBW, weight less than 2500 grams), when a stepwise partial correlation was conducted (controlling separately and simultaneously for the variables of race, smoking, alcohol consumption, prenatal care, prior abortions, maternal complications, and specific hospitals). Overall, women who were battered were two times more likely than nonbattered women to give birth to LBW infants. In private hospitals, battered women were four times more likely

to have LBW infants. In contrast, no statistically significant difference was found between abuse during pregnancy and LBW for women at public hospitals. However, battered women in both public and private settings delivered more premature LBW infants. An important limitation of this study is the lack of description of the specific abuse assessment questions.

In a prospective study, researchers conducted interviews with 364 low-income women to examine the impact of violence on birth outcomes (Dye et al., 1995). Results from the structured interviews were then compared with perinatal records and birth and death information. In this sample, women abused during pregnancy were also more likely to have had fetal distress or fetal death than other women were. No significant differences were found in the incidence of LBW and preterm delivery, although the mean birth weight was 165 grams less in abused women, and this difference was statistically significant. In addition, infants born to women who were abused in pregnancy were significantly more likely not to be discharged from the hospital when their mothers were.

To determine the effect of abuse on pregnancy, investigators studied 1203 low-income, young African-American, Hispanic and white women using a stratified prospective cohort analysis (McFarlane et al., 1996a; Parker et al., 1994). Although the incidence rate for abuse during pregnancy was higher for teens than adults (20.6% to 14.2%), adult women reported more severe physical and non-physical abuse using the ISA. In addition to age, abuse rates also varied by race/ethnicity with African-American and white women reporting similar rates of abuse (18% and 17% respectively) followed by Hispanic women (13%). However, white women reported the most episodes and greatest percentage of severe episodes of abuse. Using factor analysis, race/ethnicity was

not a statistically significant predictor variable for abuse during pregnancy. Overall, abused women entered prenatal care later than nonabused women did. Abuse during pregnancy was a significant risk factor for LBW and maternal complications of low weight gain, infections (such as symptomatic bacteriuria, rubella, cytomegalovirus), and anemia. In this study, since almost all the participants were low income, the effects of poverty were controlled.

In a study designed to examine whether pregnancy and neonatal outcomes differed between abused and nonabused women, 1014 women completed an abuse prevalence survey and an interview during the postpartum period (Webster et al., 1996). For this sample, spontaneous abortions and elective terminations were significantly more common in the medical histories of abused women than nonabused women, and there was an increasing trend in the incidence of stillbirths. Women who were abused had infants with lower mean birth rates than women who were not abused. However, when other variables such as maternal age, cigarette and alcohol use, education level, ethnicity, marital status, parity, number of TABs, number of antenatal visits, and gestational age were considered, this difference was not statistically significant.

In a retrospective cohort study, investigators examined the relationship between women living in a physically abusive relationship and adverse pregnancy outcome with a sample of 180 women (Schei et al., 1991). Women were interviewed using a structured guide about their abuse status, however the abuse assessment questions were not described. An index cohort drawn from an emergency clinic and a woman's shelter was comprised of 66 women who were currently in an abusive relationship. The control cohort of 114 young women was randomly selected from women residing in the

community who had not been in an abusive relationship in the previous 12 months. Women in the index cohort reported a history of 192 pregnancies and the women in the control cohort reported 230. However, the index cohort had fewer completed pregnancies (66.7% versus 77.4%). Significantly, the cohort of abused women reported a higher incidence of spontaneous abortions (16.1% versus 9.6%) and LBW infants (8.6% versus 2.2%) and lower mean infant birth weights (3329 grams versus 3482 grams) than did the women who were not abused. However, there were no significant differences between the groups relative to gestational age at birth or number of legal abortions. Of the 40 pregnancies exposed to violence, infant mean birth weight was significantly lower (3219 grams to 3482 grams) than infant mean birth weight of unexposed pregnancies. Although pregnancy complications of preeclampsia, hemorrhage, premature labor, proportion of LBW infants, and hospital admissions were more common among women abused during pregnancy, the differences between groups were not statistically significant. In a regression model violence during pregnancy had an impact on infant birthweight that was close to being statistically significant. However, information on smoking during pregnancy, which may also adversely affect pregnancy outcomes, was not collected.

Another retrospective study was conducted to determine if there were differences in psychosocial and medical risk factors among 65 matched pairs of low-income women with LBW infants and normal birth weight (NBW) infants (Lia-Hoagberg, Knoll, Swaney, Carlson, & Mullett, 1988). Data collection included a retrospective record review using a 40-item psychosocial assessment instrument developed by the investigators and categorization of eight risk factors related to LBW in the population

(age less than 20, education less than 12 years, out-of-wedlock pregnancy, age less than 18 at first pregnancy, underweight at conception, cigarette smoking during pregnancy, history of a previous LBW infant, and spacing since last pregnancy of less than 6 or 12 months). After controlling for the eight risk factors, only two factors, hospitalization and street drug use during pregnancy, were significantly related to LBW. There were no significant differences between the groups in medical and lifestyle characteristics. Although approximately 20% of the women in both groups reported emotional abuse, while more than 10% described physical abuse by family members or the father of the baby, neither form of abuse was significantly related to LBW.

In a prospective study of 358 predominantly African-American, low-income women (O'Campo et al., 1994), investigators found that 65% experienced verbal or physical abuse during pregnancy. Furthermore, 20% experienced moderate or severe violence during pregnancy. However, no relationship between abuse (physical or verbal) and low birthweight or preterm birth was found.

In a previously described prospective investigation (Curry, Perrin et al., 1998), abused women were more likely to have initiated prenatal care after 20 weeks and or to have unsure dates and less likely to have a planned pregnancy. However, there was no significant difference in the total number of prenatal visits between abused and nonabused women. There were no significant differences in initiation of prenatal care, pregnancy planning, or total number of prenatal visits between abused and nonabused adolescents. Abuse was significantly associated with low birth weight for adults (9.0% compared to 5.7%; $\chi^2 = 3.59$, df = 1, $p < .05$), but not for adolescents. However, the rate of low birth weight was higher among abused (8.1%) versus nonabused (6.4%)

adolescents. Abused women were more likely to have a poor obstetrical history, to smoke, and to use drugs or alcohol during pregnancy. Limitations to the study included a one-time assessment for abuse; limiting the abuse to sexual and physical violence; lack of screening about the perpetrator, severity, and frequency of the abuse; and use of a low-income population.

Another prospective investigation examined the relationship between abuse during pregnancy and adverse pregnancy outcomes among 403 participants (Curry & Harvey, 1998). Sixty-nine participants (17%) reported experiencing stress related to current abuse. Women who were abused had significantly lower incomes than nonabused women. Abused women also had infants that weighed significantly less than the infants of nonabused women (M = 3239 grams versus M = 3486 grams, $t(2,70)$ = 81.6, $p < .008$. The low birth weight rate was 4.4% for nonabused women and 8.2% for abused women. Significantly, abused women reported more stress, less support from partner, less support from others, and lower self-esteem than nonabused women. Significant predictors of birth weight included: age, education, number of prenatal visits, stress due to abuse, stress due to recent loss of a loved one, and stress due to problems with friends.

In an investigation of physical and nonphysical abuse and other risk factors for low birth weight, a multiethnic case-control design was used (Campbell et al., 1999). A purposive sample comprised of 1004 women who were Mexican American, Puerto Rican, Cuban American, Central American, African American, or Anglo was interviewed within 72 hours after delivery. Cases and controls were matched by age group, ethnicity, gestational age, and delivery setting. Participants were drawn from multiple sites. Abuse

was determined by the AAS and the ISA. The overall prevalence of abuse during pregnancy was 5.6% (according to the ISA) and 5.2% (according to the AAS). Full term and preterm infants were analyzed separately. Both physical and nonphysical abuse, as measured by the ISA, were significant risk factors for low birth weight for full term infants, but not for preterm infants. With the addition of other known risk factors for low birth weight into the model, however, the significance decreased.

In an extension of the previously described investigation (Campbell et al., 1999), an examination of the impact of cultural norms and acculturation on women's experience and reporting of abuse during pregnancy was undertaken (Torres et al., 2000). Women who spoke only Spanish were less likely and English-only speakers were more likely to report physical abuse. The woman's ethnicity and reported childhood sexual abuse was strongly associated. Sociodemographic measures of income and educational level were significantly related to physical abuse, with lower income women and women with less than a high school education having higher rates of physical and emotional abuse. Unemployment was associated with high rates of emotional abuse. Puerto Rican women were most likely to report abuse during pregnancy as compared to other ethnic groups. The other three Latina groups reported lower rates of abuse during pregnancy than did Anglo and African American women. However, ethnic group differences disappeared when socioeconomic variables were controlled for. The partner's ethnicity did affect the prevalence of abuse during pregnancy, even after controlling for sociodemographic variables, with Cuban American and Central American men being significantly less likely to physically abuse their partners than all other groups of men. The partner not being the father of the baby and being unmarried were significantly associated with both physical

and nonphysical abuse. Cuban American women were at lower risk of being sexually and emotionally abused and abused during pregnancy compared to the other ethnic groups. African American women were three times more likely to report a history of physical abuse than Anglo American women, even after controlling for sociodemographic variables. The group having African American partners were also more likely to report physical abuse during pregnancy than those women having Anglo American partners. Women with partners who believed the most important role for a woman was that of a wife and a mother were more likely to report physical and emotional abuse on all scales. While women who believed strongly that pregnant women should be taken care of rather than doing their usual activities reported more physical abuse and abuse during pregnancy. Cultural beliefs about the acceptability of men hitting women was related to physical, emotional, and sexual abuse.

Three review articles have been published addressing the problem of abuse during pregnancy. The first provides a review of the research examining abuse of pregnant women and adverse birth outcomes and describes numerous methodological problems in research studies (Newberger et al., 1992). Primarily, small sample sizes and nonrandom sampling techniques have limited the generalizability of research findings. In addition, there have also been limited descriptions of the actual abuse incurred by women and of the interventions provided for their injuries. As well as a lack of corroboration with infant findings, multiple confounding variables, and possible recall bias with retrospective designs. Inadequate validity and reliability of study instruments and potential statistical error due to inadequate power are also common limitations. However, the authors noted that limited funding opportunities for research on abuse

during pregnancy have prevented the institution of large studies. The authors' recommendations included interviewing women to assess for abuse (versus using a self-report questionnaire) and linking medical services with services provided by battered women's advocacy groups.

A second article also reviewed the phenomena of physical and sexual abuse during pregnancy and the evidence suggesting the association with negative pregnancy outcomes (Campbell, 1995). In contrast to the first article, this author addressed cultural issues and proposed potential interventions for health care providers derived from research.

Another paper also reviewed and developed recommendations for future research (Petersen et al., 1997). From this review of seven studies on violence during pregnancy, no pregnancy outcome was consistently found to be associated with physical abuse during pregnancy. However, the ability to assess for a relationship between abuse during pregnancy and negative outcomes may have been hampered by methodological limitations like the timing of data collection and sampling, inadequate control of confounding variables, and lack of information about site of injury. For example, studies frequently failed to control for potential interacting variables that may also impact birth outcomes, such as those studies that failed to control for smoking status (Parker et al., 1994; Schei et al., 1991) or race (Dye et al., 1995) both of which have been known to be related to LBW infants. The authors suggested that research using qualitative and quantitative methods would be required to adequately understand the dynamics of physical abuse during pregnancy and the potential for adverse pregnancy outcomes.

Summary of pregnancy outcomes research.

Research examining the effects of abuse during pregnancy on pregnancy outcomes has looked at both infant and maternal complications, with infant birth weight being the most common pregnancy outcome studied. In general, research data suggest that abuse during pregnancy is a risk factor for lower infant birth weights (Curry & Harvey, 1998a, 1998b; Curry, Perrin et al., 1998; Dye et al., 1995; McFarlane et al., 1996a; Parker et al., 1994; Webster et al., 1996). Additionally, other studies have reported that women who are abused during pregnancy have more LBW infants than nonabused women (Bullock & McFarlane, 1989; Curry, Doyle et al., 1998; Curry & Harvey, 1998b; McFarlane et al., 1996a; Parker et al., 1994; Schei et al., 1991). However, other investigations have found no differences in the frequencies of LBW infants between abused and nonabused women (Dye et al., 1995; O'Campo et al., 1994).

An increased risk of preterm birth may also be related with abuse during pregnancy, but that has not been consistently found. One study described higher rates of preterm births for abused women compared with nonabused women (Bullock & McFarlane, 1989), whereas two others found no differences (Dye et al., 1995; Schei et al., 1991). Other investigators have examined differences between the number of spontaneous abortions (SABs), fetal demises, or elective abortions (TABs) for abused and nonabused women. Several studies have found that abused women reported higher frequencies of SABs (Schei et al., 1991; Webster et al., 1996), fetal demises or stillbirths (Dye et al., 1995; Webster et al., 1996), and TABs (Schei et al., 1991; Webster et al., 1996). However, this has not been a consistent finding. A higher frequency of SABs and fetal demises may be due to physical trauma during pregnancy; however, the lack of

information about the severity and location of injuries has prevented any conclusions from being reached. An increased frequency of TABs may reflect the abused woman's ambivalence about her relationship or about bringing a child into the relationship. Conversely, the abusive partner may have insisted on a TAB due to jealousy or conviction that the child was not his. Without additional contextual information, however, these reasons are only speculative.

The risk of maternal morbidity associated with abuse during pregnancy has been examined by additional studies. Low maternal weight gain, infections, vaginal bleeding, and anemia have been reported as maternal complications positively associated with abuse during pregnancy (Curry, Doyle et al., 1998; Curry, Perrin et al., 1998; McFarlane et al., 1996a; Parker et al., 1994). Another study found an increased risk of preeclampsia and maternal hemorrhage for women who were abused during pregnancy (Schei et al., 1991). As demonstrated, there has not been one clear maternal complication that has been consistently linked with abuse during pregnancy. However, the number of maternal complications found in the various studies support the conclusion that abuse during pregnancy increases maternal morbidity.

Although statistically significant relationships between abuse during pregnancy and negative pregnancy outcomes are not consistent across studies, this may be primarily due to methodological limitations, not the absence of an association. For example, most studies have failed to show a statistically significant association between abuse and LBW infants among women of low socioeconomic status (Bullock & McFarlane, 1989; Dye et al., 1995; A. Helton et al., 1987; Lia-Hoagberg et al., 1988; O'Campo et al., 1994; Schei et al., 1991). These findings support the previous assumption about the methodological

limitations of some studies. The findings also suggest that abused women of low socioeconomic status may have multiple intervening and confounding variables (i.e., sociodemographic or psychosocial variables) that have a more powerful effect on pregnancy outcomes. Comparatively, in several studies with large samples that allow multivariate analyses, other investigators have reported significant associations between abuse during pregnancy and LBW infants in samples of low-income women (Curry & Harvey, 1998; McFarlane et al., 1996a; Parker et al., 1994). In those studies, since the samples were primarily comprised of low-income women, the effects of income were controlled.

As described by the review articles on abuse and pregnancy outcomes, investigations have been hampered by methodological problems that limit analysis of the effects of abuse during pregnancy. Inability or failure to control for known confounding variables such as poverty, parity, or education with LBW is but one example of common problems in this area of research. What's more, there is little information about the impact of abused women's perceptions of the abuse during pregnancy, how those perceptions influence decisions made during pregnancy, and how they impact pregnancy outcomes. Consequently, further information is necessary to understand what mechanisms – physiologic, stress, or others – actually mediate the relationship between abuse and pregnancy outcomes.

Woman Abuse, Health Effects, and Decisions About Health Behaviors

Possible physical health responses to women's experiences of abuse have also been investigated. Research has found numerous negative alterations in the physical and psychological health of women thought to be associated with abuse. For example, abuse

has been related to an increased risk for chronic pain disorders including pelvic pain, gastrointestinal illness, and non-migrainous headaches; depression, anxiety, and somatization; increased need for and decreased access to health care services; and increased suicidality and homelessness (Campbell, Pliska, Taylor, & Sheridan, 1994; Drossman, Talley, Leserman, Olden, & Barreiro, 1995; Fisher, Hovell, Hofstetter, & Hough, 1995; McCauley et al., 1995; Plichta & Weisman, 1995; Stark & Flitcraft, 1995; Walling, Reiter, O'Hara, Milburn, Lilly, & Vincent, 1994; Walling, O'Hara, Reiter, Milburn, Lilly, & Vincent, 1994). Consequently, abused women who may experience physical trauma that is directly caused by the abuse, but they may also have indirect, chronic, physical, emotional, and psychological manifestations of abuse.

Psychosocial health effects of woman abuse.

There has been extensive examination of the psychological effects of abuse on women. Research has focused on the effects of abuse by an intimate male partner on women's self-esteem, self-concept, body image, depression, anxiety, stress, and grief. According to early research with 400 women who had been battered (Walker, 1984), battered women rated themselves high on a self-esteem measure but experienced anxiety, depression, cognitive disorders, re-experiencing of traumatic events, and the disruption of interpersonal relationships. Recent studies have reported altered self-concept, decreased levels of self-esteem, and body image alterations among women abused by their partners (Campbell, 1989b; Landenburger, 1989; Smith et al., 1995; Trimpey, 1989). In addition, higher levels of depression, anxiety, and increased frequency of stress and grief have been described by abused women (Campbell, 1989a; Campbell, Kub, Belknap, &

Templin, 1997; Campbell, Pliska, Taylor, & Sheridan, 1994; Cascardi, Langhinrichsen, & Vivian, 1992; Gleason, 1993; Trimpey, 1989).

Depression is probably the most common mental health response to ongoing abuse by an intimate partner. A study of the prevalence of mental disorders in a sample of 62 battered women receiving services from an agency for battered women was conducted (Gleason, 1993). There were two groups of battered women – one group was drawn from residents of an abuse shelter while the other group was drawn from the community. The prevalence of mental disorders was compared with the two battered groups and 10,952 women randomly sampled in a national epidemiological study of mental disorders. The prevalence rates of all mental disorders measured (except alcohol abuse or dependence and schizophrenia) were higher in both samples of abused women than the comparison group. Significantly, based on DSM-III diagnostic criteria, major depression, post-traumatic stress disorders, generalized anxiety disorder, and obsessive compulsive disorder were experienced by the majority of battered women.

Another study determined the prevalence, impact and health correlates of marital aggression in a psychology clinic sample of couples seeking psychological treatment (Cascardi et al., 1992). A sample of 93 consecutively presenting maritally discordant couples and 16 maritally satisfied matched controls from the community were studied. Aggression was common in the clinic sample, with 71% reporting aggression. Although aggression was reciprocal among 86% of the clinic sample couples, women were more likely than men to be negatively affected by their partner's aggression and to sustain severe injuries. Women who experienced aggression in their relationships reported

significantly more depressive symptoms than did women from the matched control group or women who experienced marital discord without aggression.

A study using a convenience sample of 164 battered women recruited through publications from the community was conducted to identify correlates and predictors of depression in battered women (Campbell et al., 1997). Women were screened for abuse using the CTS. Of the sample, 39% met the DSM criteria for major depression – 28% were moderately to severely depressed and 11% were severely depressed using the Beck Depression Inventory. Depression was significantly related to the frequency and severity of physical abuse. In regression analysis, physical violence was the only form of abuse that was a significant predictor of depression. Through multivariate analysis, childhood physical abuse, lack of self-care agency, physical abuse by partner, and daily hassles were found to be significant predictors of depression.

A study to determine perceptions of battered women regarding their treatment in emergency departments was conducted (Campbell et al., 1994). Using a mailed survey of 74 battered women temporarily residing in any of 31 shelters, nearly 40% (n = 26) reported having mental health problems. Nearly half of those women reporting mental problems experienced depression (n = 10, 45.5%). In another study, abused women reported more health factors that reflected an increased need for health care services (Plichta & Weisman, 1995). In this sample, compared to nonabused women, women who had been abused were more likely to: perceive their health status as fair or poor, have one or more chronic health conditions, have been diagnosed with anxiety or depression, have depressive symptoms, and have suicidal thoughts in the past year.

Two particularly disturbing phenomena have been reported as associated with abuse – suicidality and homelessness. As reflected in the previous study, suicidal thought occurs significantly more often with abused women than nonabused women (Plichta & Weisman, 1995). In addition to having more suicidal thoughts, several studies have suggested that women who are abused are more likely to attempt suicide than nonabused women. In the first study, designed to retrospectively investigate the association between abuse and attempted suicide, a review of the full medical records of all women who had attempted suicide and presented at the emergency department of a hospital during a one year period was conducted (Stark & Flitcraft, 1995). A sample of 176 women was identified. The Adult Trauma History Screen (ATHS) was used to determine the probability of abuse. Fifty-two (29.5%) of the women were classified as battered 22.2% (n = 39) had at least one documented incidence of domestic abuse and 7.3% had at least one injury that resulted from assault by an unnamed assailant. For abused women, race and pregnancy status were significantly associated with suicidality. Black women who attempted suicide were significantly more likely than whites (48.8% versus 22.2%) to have been battered. Battered women were also significantly more likely than nonbattered women were (19.2% versus 5%) to be pregnant when they attempted suicide.

In another study also set in emergency department settings (Abbott et al., 1995), women who were currently in an abusive relationship or had a history of abuse were more likely than nonabused women to have attempted suicide (26% compared to 8%). Similar findings were also found in a previously described study set in community-based, primary care internal medicine clinics designed to identify clinical characteristics associated with current domestic violence (McCauley et al., 1995). In that study,

currently abused women were more likely than not currently abused women to ever have attempted suicide.

Another investigation examined risks associated with long-term homelessness among women (Fisher, Hovell, Hofstetter, & Hough, 1995). Using cluster sampling, 53 young, primarily white or African-American, English-speaking women who had been homeless at least three months were interviewed. Women were classified as battered if they answered "yes" to the question, "Have you ever been beaten or battered?" Nearly all (91%) of the women had been battered at some time. Thirty-eight percent had been battered when they had been domiciled, 48% had been battered when they had been domiciled and homeless, and 4% only when homeless. Being hit eight or more times per month was reported by 15% of the women. Over half (56%, n = 29) of the women had been raped in their lifetime, with 15% of the rapes occurring in the past year.

In a previously described study set in emergency department settings (Abbott et al., 1995), women who were currently in an abusive relationship or had a history of abuse were more likely than nonabused women to report excessive alcohol use (24% compared to 13%). Similar findings were also seen in a study that identified clinical characteristics associated with current domestic violence with a sample from community-based, primary care internal medicine clinics (McCauley et al., 1995). Investigators reported that currently abused women were more likely than nonabused women to be using street drugs, to have ever used street drugs, to ever have had a drinking problem, to abuse drugs or alcohol, or to have a partner with a drug or alcohol problem.

Pregnant and non-pregnant women share many of the same psychosocial correlates of abuse. Similar to non-pregnant, abused women, pregnant women

experience depression, increased stress, lower levels of self-esteem, and decreased support from others (Campbell et al., 1992; Curry, 1998; Curry & Harvey, 1998b; Dye et al., 1995; Stewart & Cecutti, 1993). Abused, pregnant women are more likely to report housing problems, lower incomes, lower educational levels, younger age, and decreased social support than nonabused, pregnant women (Amaro et al., 1990; Campbell et al., 1992; Curry & Harvey, 1998; Dye et al., 1995; Gazamararian et al., 1995; Gielen et al., 1994; Stewart & Cecutti, 1993; Young, McMahan, Bowman, & Thompson, 1989).

A study explored the relationship between pregnancy intendedness and physical violence and the mediating factors for this association (Gazamararian et al., 1995). Women who reported physical abuse were more likely to: have less than 12 years of education, be single, be a race other than white, live in crowded conditions, have had participated in WIC during pregnancy, and to have delayed or had no prenatal care. Pregnancy intendedness was categorized as unwanted, mistimed, or intended. An unintended pregnancy was reported by nearly 43% of the women (11.6% unwanted, 31.1% mistimed). Prevalence rates for physical abuse were highest for women with an unwanted pregnancy, and lowest for women with an intended pregnancy. Nearly 70% of the women reporting physical abuse had unwanted or mistimed pregnancies.

In a previously described study of primarily low-income, African-American young, high school educated women, the frequency and severity of interpersonal conflict and violence during prenatal and postpartum periods and psychosocial correlates of moderate and severe violence were examined (Gielen et al. 1994). A sample of 275 women was interviewed four times, at three prenatal and one postpartum visit. Researchers examined the variables of social support, conflict, locus of control, drug use

by partner, as well as demographic variables. Seventy-five percent of the sample reported conflict or physical violence (measured by the CTS) during the childbearing year. Moderate or severe violence occurred among 19% of the sample prenatally and 25% in the postpartum period. Of the women who experienced moderate or severe violence by their male partner in the prenatal period, 41% continued to experience this level of violence in the postpartum period. Women who experienced violence by their intimate partner were more likely to be younger, have less social support, and to report that a sexual partner had shot drugs. Women who experienced violence by a perpetrator other than their partner were more likely to have less education, and report not having a confidant. For violence perpetrated by a partner, being better educated or having a sex partner who shot drugs was associated with an increased risk of violence. Being older, having a confidant (other than the partner), and having social support were protective mechanisms. For women experiencing violence by other perpetrators, none of the demographic variables were significant; however, the presence of a confidant was protective. Use of the CTS as well as using interviewers other than the women's health care providers may have underrepresented women who were abused.

Campbell, Poland, Waller, and Ager (1992), conducted a retrospective investigation with a convenience sample of 488 low-income women in an effort to describe the factors that correlated with violence in pregnancy. Ten of the 35 women battered during pregnancy reported an increase in violence during pregnancy. The AAS, the Kessner Index (used to measure the adequacy of prenatal care), and chart reviews were used. No significant correlations were found with demographic variables and abuse, except those women battered during pregnancy were more likely to have less

household possessions, and were the most likely to have housing problems. Women battered during pregnancy were also most likely to be depressed and anxious, and least likely to have adequate prenatal care or social support. Statistically significant correlations were found between substance use and abuse.

Amaro, Fried, Cabral, and Zuckerman (1990) also examined the correlates of abuse during pregnancy in a prospective study with 1243 pregnant women. Among the women in the study, women reporting abuse were more likely to be white, born in the United States, and single. They were also more likely to be on Medicaid, have a history of sexually transmitted diseases, and to have had an elective abortion in the past. Battered women were more likely to be unhappy about their current pregnancy, perceived their partner or family as unhappy about their pregnancy, and to have had a history of depression or attempted suicide. Abused women also reported more depressive symptoms and negative life events in the past year. Abused women were at greater risk of being heavy users of alcohol and illicit drugs and of having a male partner who used marijuana and/or cocaine. Weak positive associations were found with the experience of violence in pregnancy and negative birth outcomes such as infant size or gestational age. When possible confounding variables such as race, age, marital status, and history of violence before pregnancy were controlled through multivariate analysis, a woman's alcohol use during pregnancy and her partner's drug use were independently associated with abuse during pregnancy.

In a prospective investigation, the interrelationships between abuse during pregnancy, substance use, and psychosocial stress were explored (Curry, 1998). Abuse was measured by the AAS, while psychosocial stress was measured by the Prenatal

Psychosocial Profile (PPP), a 44-item instrument measuring current stress, support from partner, support from other, and self esteem. Substance use was measured by a confidential self-report of tobacco, marijuana, alcohol, and illicit drug use. Although 27% of the study participants reported abuse as measured by the AAS, only 14% of the participants reported abuse stress as measured by the PPP, so not all of the women reporting abuse reported abuse stress as well. Similarly, of the 272 women reporting abuse stress, 38% of those women had responded "no" to all three of the AAS questions. Therefore, it is possible that the respondents did not feel that the AAS questions captured their experience of abuse, perhaps, because they were experiencing emotional or sexual abuse. The total number of women who were classified as abused – responding positively to the AAS or abuse stress on the PPP – was 616 or 32% of the sample. African American women and adolescents reported higher levels of abuse. Abuse was significantly associated with an increased incidence of tobacco smoking and alcohol and or drug use among white women, but there was no difference between abused and nonabused African American women. Significant psychosocial stress was reported by the abused women. Abused women had significantly higher stress, lower partner support, lower support of other, and lower self-esteem on each of the 44 items.

In a previously described investigation, the relationships between abuse, pregnancy planning, participation in high school, substance use during pregnancy, pregnancy complications, and birth weight were explored (Curry, Doyle et al., 1998). Statistically significant relationships were discovered between abuse, high school participation, substance use, and pregnancy complications. Abused adolescents were more likely to drop out of high school than were nonabused teens (55% compared to

42%, $p < .01$). They were also more likely to smoke at all ($p < .01$), and were two times as likely to report smoking more than 10 cigarettes per day. Abused teens were significantly more likely to have experienced second trimester bleeding ($p < 0.5$). There were no differences in pregnancy planning between abused and nonabused teens, nor were there significant differences in marijuana, alcohol, or drug use, but the reported use rates were low.

Physical health effects of woman abuse.

Numerous negative alterations in the physical health of women have also been associated with abuse. A mailed survey of 74 battered women residing in domestic violence shelters was conducted to determine the perceptions of treatment of battered women in emergency departments (Campbell et al., 1994). Nearly forty percent of the sample (n = 27) reported having physical problems. The most common physical health problems identified by the battered women included chronic back or neck problems (29.2%) and chronic headaches (12.5%).

Using a structured interview and purposive sampling from chronic pain clinics, investigators compared the prevalence of childhood and adult physical and sexual abuse in women with chronic pelvic pain, other chronic pain (headache), and pain-free women (Walling, Reiter et al., 1994). Abuse status was assessed using an inverted-funnel structured telephone interview (i.e., asking questions in a pattern from most severe to least severe abuse and then excluding any abuse reported in a previous question in successive questions). Women in the chronic pelvic pain group had a significantly higher lifetime prevalence of major sexual abuse than the other groups (53% versus 33% versus 28%). In addition, women with chronic pelvic pain and chronic headache had a higher

lifetime prevalence of physical abuse compared to women who were pain free (50% versus 38% versus 30%). Overall, women with chronic pain reported higher prevalence rates of the four categories of abuse (i.e., childhood sexual abuse, childhood physical abuse, adult sexual abuse, and adult physical abuse) than women in the comparison groups.

Building on the previous study with the same sample, a study was conducted to determine the potential role of childhood and adulthood physical and sexual abuse and complaints of chronic pain in explaining psychiatric symptoms in adult women (Walling, O'Hara et al., 1994). Sexual abuse, physical abuse, depression, anxiety and somatization were assessed in three groups: women with chronic pelvic pain, chronic headache, and without chronic pain. Using regression analysis, childhood physical abuse was a significant predictor of depression, anxiety, and somatization. Physical and sexual abuse in adulthood was a significant predictor somatization, while adulthood sexual abuse was a predictor of anxiety.

Drossman and colleagues (1995) wrote a review article summarizing existing data on abuse history and gastrointestinal illness. In this article, a theoretical model for the association between abuse and gastrointestinal illness was proposed. In this model, abuse is described as a traumatic event with long-lasting psychosocial effects which may produce symptoms of psychological distress, predispose women to psychiatric illness, and may promote ineffective coping in the presence of inadequate or poor social support. Susceptibility to gastrointestinal illness combined with psychological disturbances may lead to the development or exacerbation of symptoms.

A study which identified clinical characteristics associated with current domestic violence was conducted with 1952 women seen at 4 community-based, primary care internal medicine clinics (McCauley et al., 1995). Currently abused women reported more physical symptoms than did women who were not currently abused. Patients who reported 6 or more symptoms were almost five times as likely to report abuse as those with 0 to 2 symptoms. Current abuse was associated with the following symptoms: loss of appetite, frequent or serious bruises, nightmares, vaginal discharge, eating binges or self-induced vomiting, diarrhea, broken bones, sprains or serious cuts, pain in the pelvic or genital area, fainting or passing out, abdominal or stomach pain, breast pain, frequent or severe headaches, difficulty in passing urine, chest pain, problems with sleeping, shortness of breath, and constipation.

A study of the prevalence of mental disorders previously described found that most battered women in the sample reported sexual difficulties (Gleason, 1993). Nearly 90% of the sampled battered women reported psychosexual dysfunction. These women identified one or more of the following symptoms: non-interest in sex, painful sex, inability to orgasm, or lack of pleasure with sex.

Summary of research on health effects of woman abuse.

Studies indicate that a history of abuse may lead to multiple acute and chronic physical and psychological health problems. For example, abuse has been related to an increased risk for chronic pain disorders including pelvic pain, gastrointestinal illness, and non-migrainous headaches (Campbell et al., 1994; Drossman, Talley, Leserman, Olden, & Barreiro, 1995; McCauley et al., 1995; Walling, O'Hara et al., 1994; Walling, Reiter et al., 1994). In addition, data also suggest that pregnant and non-pregnant women

who are abused are more likely to experience depression, anxiety, decreased self-esteem than nonabused women (Campbell, Rose, & Kub, 1997; Campbell, 1989b; Campbell et al., 1994; Cascardi et al., 1992; Gleason, 1993; Walker, 1984). These data suggest that not only do women experience direct physical injuries, they also experience indirect effects from the abuse that may be manifested in somatic or psychologic manners. As such, the extent of injury from an abusive may not be immediately discernable.

Studies indicate that a history of abuse may lead to multiple acute and chronic physical and psychological health problems. For example, abuse has been related to an increased risk for chronic pain disorders including pelvic pain, gastrointestinal illness, and non-migrainous headaches (Campbell et al., 1994; Drossman et al., 1995; McCauley et al., 1995; Walling, O'Hara et al., 1994; Walling, Reiter et al., 1994). Although several studies have described associations between different types of abuse and specific illness manifestations (Campbell, 1989b; Walling, O'Hara et al., 1994), that has not been consistently found. Further, although an explanatory model for the association between sexual and physical abuse and gastrointestinal illness has been proposed (Drossman et al., 1995), additional research will be needed to test the proposed mechanisms.

Data also suggest that pregnant and non-pregnant women who are abused are more likely to experience depression, anxiety, decreased self-esteem than nonabused women are (J. Campbell et al., 1997; Campbell, 1989b; Campbell et al., 1994; Cascardi et al., 1992; Gleason, 1993; Walker, 1984). These data suggest that not only do women experience direct physical injury they also experience indirect effects from the abuse that may be manifested in a somatic or psychological manner.

The associations between abuse and suicidality and homelessness underscore the dangerousness and the seriousness of living in an abusive relationship (Abbott et al., 1995; Fisher et al., 1995; McCauley et al., 1995; Plichta & Weisman, 1995; Stark & Flitcraft, 1995, 1996). Findings from one retrospective study suggested that women who were abused were more likely to have been pregnant when they committed suicide (Stark & Flitcraft, 1995). These findings raise important issues related to the development of a maternal identity and possible ambivalence about the pregnancy or the woman's attempts to escape the abuse and protect the infant. Although the women's intent may not be known, these findings reinforce the assertions about the difficulty in living in an abusive context and underscore the importance of prenatal care that is attentive to women's changing emotional, physical, and psychological needs – regardless of abuse status.

Effects of woman abuse on health habits.

Abuse during pregnancy has been correlated with multiple negative health habits that may reflect women's coping strategies to mediate the stress and trauma of abuse. Abuse during pregnancy has been correlated with increased frequency of cigarette smoking, alcohol use, and prescription and non-prescription medication use compared to non-abused, pregnant women (Amaro et al., 1990; Campbell et al., 1992; Curry, 1998; Dye et al., 1995; Gazamararian et al., 1995; McFarlane et al., 1996b; Parker et al., 1994; Stewart, 1994; Stewart & Cecutti, 1993; Young et al., 1989).

A study of violence and substance among pregnant women found that substance use decreased dramatically with pregnancy (Martin et al., 1996). For women who used substances before pregnancy, violence was significantly associated with alcohol and cigarette smoking, but not with recreational drug use. Substance use during pregnancy

was significantly related to violence, with women who were abused being significantly more likely to smoke cigarettes (46% versus 20%), to drink alcohol (14% versus 6%) and to use drugs during pregnancy (8% versus 2%). Using multivariate analysis, a significant association was found between number of substances used during pregnancy and violence – women who were abused used more substances. In addition, abused women were more likely than nonabused women were to continue their substance use during pregnancy.

In a study designed to examine whether pregnancy and neonatal outcomes differed between abused and nonabused women, 1014 women completed an abuse prevalence survey and a postpartum interview (Webster et al., 1996). In this sample, 29.7% reported past or current abuse. Abused women smoked more cigarettes, took more prescription medications, and used more antidepressants than nonabused women. Alcohol use was significantly higher for women who were severely abused used than for women who were not abused or those women who experienced less severe physical and or emotional abuse.

Summary of research on health habits associated with abuse.

Women who are abused are more likely to use substances such as alcohol, cigarettes, and recreational drugs that may negatively affect their health (Abbott et al., 1995; McCauley et al., 1995). For abused, pregnant women, this relationship has also been found, which may have negative consequences for the health of their unborn child (Curry, 1998; Curry, Perrin et al., 1998; Martin et al., 1996; McFarlane et al., 1996a, 1996b; Parker et al., 1994; Webster et al., 1996). Abused, pregnant women are also more likely to use prescription medications and antidepressants than nonabused pregnant

women are (Webster et al., 1996). Although it is postulated that women self-medicate with these substances as a way to cope with the trauma of abuse, this has not been studied (Campbell et al., 1992). Obviously, the physical and emotional trauma of abuse combined with maladaptive health habits during pregnancy may lead to negative outcomes for an abused woman and her infant. However, it is not known how the experience of abuse affects women's decisions to choose an unhealthy behavior during pregnancy. What are the trade-offs in terms of seeking safe passage, especially in the context of current health messages regarding the dangers of smoking and alcohol use to maternal and fetal health? If abuse leads to lower levels of self-esteem would making an unhealthy choice further lower women's self-esteem? Do abused women choose negative health behaviors as coping methods to mediate the stress of abuse? Finally, what experiences lead women to decide to engage in negative health behaviors? These research findings suggest that women who are abused experience direct physical trauma, but they may also have indirect, chronic, physical, emotional, social, and psychological manifestations of abuse as well. These indirect manifestations of abuse often present as factors influencing maternity and other forms of health care. As the meaning of these experiences is illuminated, care provided will be able to be more effective and useful to abused, pregnant women.

Decisions about health care: seeking care and disclosing abuse.

Findings from several studies suggest that abused, pregnant women may be more frequent consumers of health care and social service resources when compared to pregnant women who are not abused (Stewart, 1994; Stewart & Cecutti, 1993; Webster et al., 1996). In a nationally representative study, an increased need for and decreased

access to health care services has been reported among abused women (Plichta & Weisman, 1995). In this sample, compared to nonabused women, women who had been abused were more likely to be receiving Medicaid or were uninsured, to have no regular health care provider, and to use emergency department services as their regular source of health care. There were no significant differences in the mean number of physician visits or the mean number of physicians seen in the past year between abused and nonabused women. However, women who had been abused were three times more likely as other women to report having had an unmet need for medical care in the past year (37.6% versus 12.2%). Although access to the health care system may be limited for these women due to their insurance status or lack of a regular health care provider, there may be other factors that also inhibit abused women's access to health care. Among these factors could be psychosocial factors or constraints imposed by the abusive partner.

Seeking care.

In a prospective study designed to examine whether pregnancy and neonatal outcomes differed between abused and nonabused women, 1014 women completed an abuse prevalence survey and a postpartum interview (Webster et al., 1996). In that sample, 29.7% reported past or current abuse. Although the number of prenatal visits and the number of weeks gestation at the initial prenatal visit were similar between abused and nonabused women, abused women tended to have more hospital admissions during pregnancy. In addition, abused women were significantly more likely to have a social worker involved in their care than were nonabused women. However, there were no significant differences in median length of hospital stay or intensive care nursery stay between abused and nonabused women.

In a study conducted to determine the prevalence of physical abuse in late pregnancy, 548 pregnant women were surveyed (Stewart & Cecutti, 1993). Of the sample, 6.6% (n = 36) reported physical abuse in the current pregnancy. Although two-thirds of the abused women (66.7%, n = 24) had received medical treatment for the abuse injuries, only one woman (2.8%) had told her prenatal care provider about the abuse. Building on this study, the women were who physically abused during pregnancy (n = 36) were surveyed in the postpartum to determine whether they had experienced an increase in physical abuse after birth (Stewart, 1994). Thirty of the women agreed to participate, of those women, 27 (90%) reported a total of 57 incidents of abuse in the postpartum. There was a significant increase in the mean number of incidents of abuse in the postpartum period (3 months after delivery) compared to the three trimesters in the prenatal period. Over half of the women (51.9%, n = 14) who were abused in the postpartum had obtained medical treatment for injuries sustained in the abuse. However, none had volunteered information or remembered being asked the cause of their injuries.

In contrast to those studies finding more frequent health care use among abused women, several other studies have found that abused, pregnant women may delay the initiation of prenatal care or seek inadequate health care (Dye et al., 1995; McFarlane et al., 1992; Taggart & Mattson, 1996). In a previously described prospective study, abused women were more likely than nonabused women to have received late prenatal care (34.5% versus 25.2%), to have gone to a physician for sickness (34.5% versus 24.2%), to not have received WIC at their initial prenatal visit (48.3% versus 35.9%) (Dye et al., 1995). However, these differences were not statistically significant. Abused women

were significantly more likely than nonabused women to have an infant that was not discharged with them (21.9% versus 7%).

McFarlane and colleagues examined the initiation of prenatal care in a stratified, prospective, cohort analysis of 691 pregnant, low-income Hispanic, African-American, and white women (McFarlane et al., 1992). Women who were abused during pregnancy were almost twice as likely as nonabused women were to enter prenatal care at the third trimester (21% versus 11%).

In a previously described study set in public health and low-income clinics, 502 pregnant women were surveyed to determine whether they delayed prenatal care due to battering during pregnancy (Taggart & Mattson, 1996). Overall, 13.7% of the women (n = 68) said they had delayed seeking health care because of injuries. However, researchers found that greater than 50% of the women who were abused during pregnancy chose to delay prenatal care because of injuries. The delay in care averaged 6.5 weeks. Approximately 35% of the sample did not seek care until after the 32nd week of pregnancy.

Research examining self-reported maternal reasons for delayed entry into prenatal care was undertaken by Young and colleagues (1989). A sample of 201 women who entered prenatal care in a county health system in the third trimester was interviewed. These women were more likely to be single, under 20 years old, a member of a minority group, not to be high school graduates, and to be unemployed. Adult women attributed delayed entry to prenatal care to numerous social problems including unemployment, single parenthood, stress, family crises, and interpersonal conflicts with the father of the baby. Although family crises and conflicts with the father of the baby were described by

the women as barriers to prenatal care, the researchers failed to explore the details of the crisis and conflicts. Based on the research of Campbell et al. (1992) and Amaro et al. (1990), it might be hypothesized that the some of the conflicts and crisis in these women's lives were related to abuse.

Disclosing abuse.

Disclosing or concealing one's abuse status to a health care provider is another decision that abused, pregnant women must make. Research suggests that women's level of self-esteem, self-identification as an abused woman, safety concerns, and the response of the health care provider are factors influencing women's decisions regarding health care use and the disclosure of abuse (Fishwick, 1993; Limandri, 1987).

In an investigation designed to determine patient preferences regarding inquiry about abuse and physician practices, a sample of 164 patients and 27 physicians were surveyed at private and public primary care clinics (Friedman, Samet, Roberts, Hudlin, & Hans, 1992). Findings indicated discrepancies between patient and provider expectations, preferences, and experiences. Although the majority of patients favored routine inquiry about physical and sexual abuse (78% physical abuse, 67% sexual abuse), very few had ever been asked about physical or sexual abuse (7% and 6%) by their health care provider. However, 16% of the sample reported a history of physical abuse and 17% a history of sexual abuse. Significantly, the majority of patients believed that a physician could help address either abuse and would answer truthfully if asked directly about abuse. The majority of patients also responded that they would volunteer a history of abuse (67% physical abuse and 61% sexual abuse). Patients with a positive history of physical or sexual abuse were more likely to favor routine inquiry about abuse but less likely to

volunteer a history of abuse compared to nonabused patients. This relationship was statistically significant for sexual abuse but not physical abuse.

In contrast, in the same study (Friedman et al., 1992), the majority of physicians believed that routine inquiry about sexual and physical abuse should not occur at annual examinations (70% and 67%). Most physicians did not inquire about physical or sexual abuse at the first patient visit or at their annual exam. Although routine inquiry was not practiced by this sample, the majority reported that they would be able to help patients with the emotional issues of physical and sexual abuse (81%).

Sugg and Inui interviewed 38 primary care physicians to determine their experiences with abuse victims and barriers to problem recognition and intervention (Sugg & Inui, 1992). The image of opening "Pandora's box" was evoked by almost one-fifth of the respondents. Close identification with patients, fear of offending patients and discomfort with areas considered private, frustration and feelings of inadequacy, loss of control over the situation, and time constraints of a practice were identified as barriers. Only two of the participants seemed comfortable with abuse as a problem in their clinical practice, routinely screened for abuse, and identified abuse cases in their practice. Unlike the others in the sample, these providers saw their role as facilitating change, validating patients' feelings, and discussing safety issues and referral. These providers perceived change in abuse status as a process, and were realistically not concerned with finding a quick fix.

In another study of abuse screening practices of physicians and barriers to screening, Parsons and colleagues surveyed a national random sample of obstetrician-gynecologists (Parsons, Zaccaro, Wells, & Stovall, 1995). Only 14.6% (n = 962)

responded to this mailed survey. In this study, provider gender, age, education on abuse, familiarity with a professional organization's technical bulletin (ACOG or AMA) were all significantly associated with screening behavior. Providers who were female, younger, educated on abuse, and familiar with the ACOG technical bulletin were all more likely to routinely screen for abuse. Almost half (48.9%) reported feeling inadequate in dealing with abuse due to lack of training, which was associated with a lower incidence of routine screening. Common potential barriers to screening included lack of education or training (71%), type of patient (46%), lack of time to screen for and deal with abuse (39.2%), and frustration because they cannot do anything about the patients' problems (34.3%).

In another mailed survey a random sample of clinicians (n = 1521) in six disciplines was queried about their experiences with and attitudes toward family violence (Tilden et al., 1994). One third of the total sample reported no education in child, spouse, or elder abuse. Focusing on spouse abuse, the majority of nurses, physicians, dental hygienists, dentists, and psychologists did not commonly suspect physical or sexual spouse abuse. Although most social workers did not commonly suspect sexual spouse abuse, most social workers commonly suspected physical spouse abuse among patients (53.3%). Providers who had received education on abuse were more likely to indicate they commonly suspected abuse. Although the majority of nurses, physicians, psychologists, and social workers agreed that it was a professional responsibility of their discipline to deal with family violence, almost half of the dental hygienists (45.9%) and dentists (47.3%) did not agree.

In another study of provider barriers to interventions for abuse, a sample of 207 staff from three emergency departments and urgent care sites participated in an anonymous survey (McGrath et al., 1997). For the majority of the physicians (never = 55% or rarely = 68%) and nurses (never = 64% or rarely = 80%) screening for physical or sexual abuse rarely or never occurred. None of the physicians or nurses reported always screening for abuse. Although many of the nurses and physicians (49% and 61% respectively) reported having some training in abuse, 45% of the nurses and 34% of the physicians reported having no abuse training and 5% in each group reported extensive training. Furthermore, approximately one-third of the nurses and physicians (36% and 26%) reported no training in forensic evidence collection for sexual assault. Training in abuse was significantly associated with screening for abuse. Most of the respondents reported frustration that abuse victims would return to their abusive partner as a barrier to intervention with physical abuse victims (78%) and sexual abuse victims (52%). Lack of time was also identified as a common barrier to intervention (60% physical and 55% sexual abuse). Other barriers to intervention/screening cited included lack of experience (80%), concern about misdiagnosis (74%), personal discomfort (63%), concern about invading family privacy (57%), unavailability of access to social worker (48%), lack of police response (53%), and reluctance to become involved in the judicial system (40%). However, 93% of the staff believed that it was their role to get involved in physical and sexual abuse cases.

However, other studies indicate abused women frequently experience negative interactions with health care providers (Campbell et al., 1994; Fishwick, 1993). Negative interactions with health care providers included being humiliated, being blamed for their

abuse, having their experience of abuse minimized, being given inadequate referral information, and not being identified as a woman who was abused or battered (Campbell et al., 1994; Fishwick, 1993).

Fishwick conducted a qualitative grounded theory study to explore abused women's perceptions of health care services, to identify factors that affect disclosure or nondisclosure of abuse within a health encounter, and to develop a conceptual understanding of the processes, behaviors, and interactions as women live in an abusive relationship (Fishwick, 1993). The behavior of an abused woman in any health encounter was a reflection of her perception and goals at that particular time. Protecting personal identity was identified as the core process. This process includes immediate and long-term goals of physical safety, emotional security, and maintaining a positive living environment that fostered development and growth for herself and her children. The process is composed of the phases of sustained personal integrity, jeopardized personal integrity, erosion of personal integrity, and reclaimed personal integrity. Transition through the four phases is overlapping, gradual, and non-linear. Prior to, during, and after any health care encounters, abused women engage in a complex series of decisions where potential risks, benefits, and contingencies were considered and closely monitored throughout the visit. The abused woman's disclosure or concealment of abuse within the health care exchange was based on her changing perceptions of the abuse and her role in the abuse, her experiences with formal and informal sources of assistance, and the perceived risks and benefits of disclosing abuse within the encounter. The four phases of protecting personal integrity provide the context for women's perceptions and the behaviors that occur in health care interactions.

In a study using a qualitative, descriptive-correlational design, 40 white, abused women were interviewed about their help seeking for the abuse (Limandri, 1987). Major factors influencing the women's efforts to seek help included: the level of the woman's self-esteem, the extent to which the woman identified herself as abused, and the helper's response to her disclosure. Women described greater motivation to seek help with rising self-esteem. Specific facilitating helper responses were described, such as the helper asking the woman if abuse is occurring, identifying behavior as abusive, acknowledging the seriousness of abuse, expressing belief, acknowledging the woman does not deserve the abuse, being directive in exploring resources, telling the man to stop the abuse, helping the woman consider all of her options, avoid telling her what to do, aiding to assess her internal strengths, suggesting resources, offering support groups with other abused women, and actively listening and empathizing. Responses that were inhibitory included demonstrating anger or irritation with the woman, blaming her, advising her to accept the abuse, refusing to help her until she leaves the relationship, aligning with the abuser, disbelieving the woman, not responding to her disclosure of abuse, and advising her to leave the abuser.

Other investigations of health care provider reasons for not assessing for intimate partner abuse found victim-blaming attitudes and or belief that the resources to help victims are not available to them (Garimella, Plichta, Houseman, & Garzon, 2000). Another study conducted with a sample of obstetrician-gynecologists discovered the process of struggling between approaching domestic abuse as a legitimate medical problem and feeling overwhelmed by it as a social issue. Moving from trying to fix the problem to supporting the patient resolved the struggle for those providers (Rittmayer &

Roux, 1999). While another investigation of a random sample 2600 women with neonates found that only 37% of the sample reported being screened for partner violence during pregnancy (Clark et al., 2000).

Summary of research on decisions about health care.

Research findings about abused women's behaviors relative to the seeking of health care and prenatal care are contradictory. Several studies have found that women who were abused during pregnancy used health care services more frequently (Stewart, 1994; Stewart & Cecutti, 1993; Webster et al., 1996). In contrast, other studies have suggested that women abused during pregnancy are more likely to delay or have inadequate prenatal care (Dye et al., 1995; McFarlane et al., 1992; Taggart & Mattson, 1996; Young et al., 1989). Another study has described an increased need for health care and a higher frequency of unmet needs for abused women compared to nonabused women in a nationally representative sample (Plichta & Weisman, 1995). Building on these findings, both increased health service use and delayed prenatal care among abused pregnant women may reflect a discrepancy between health needs and the meeting of those needs. Delayed or inadequate prenatal care may result from the abuser controlling woman's choices regarding health care or transportation, or the woman's decision not to risk discovery of the abuse and subsequent disapproval of her and or her relationship by the health care provider. Given the discrepancies in study results, it is unclear why some abused women seek prenatal care while others choose to avoid it. What are the common causes of delayed prenatal care or frequent seeking of health services? It has been proposed that pregnant women seek hospitalization as a refuge from abuse, but this has not been researched (Stewart, 1994).

Two studies (Fishwick, 1993; Limandri, 1987) have found that abused women's actions in health care settings and health seeking behavior occur as a result of women's perceptions of their situation, the risks and benefits, as well as the responses of health care providers. These studies provide valuable contextual information that promotes a better understanding of the motivations behind women's disclosure or nondisclosure of abuse or behaviors that may be considered unhealthy or pathologic.

Although many patients favor routine inquiry about abuse (Friedman et al., 1992), health care providers are often uncomfortable about abuse, uneducated about effective abuse assessment techniques, unaware of available community resources or feel that resources are unavailable to them (Friedman et al., 1992; Garimella et al., 2000; Limandri & Tilden, 1996; McGrath et al., 1997; Parsons et al., 1995; Sugg & Inui, 1992; Tilden et al., 1994). Another investigation reported that few pregnant women are routinely screened for abuse in the course of their prenatal care (Clark et al., 2000). Additional information is needed to understand how the context of pregnancy impacts women's decisions about disclosing abuse to health care providers, and what provider responses are considered helpful and supportive by abused, pregnant women.

Decisions About the Abusive Relationship

Leaving an abusive relationship has been described as a process that is non-linear, complex, and difficult (Campbell et al., 1997; Fishwick, 1993; Landenburger, 1989, 1993; Limandri, 1987; Merritt-Gray & Wuest, 1995; Ulrich, 1991, 1993). In a qualitative study using a purposive, convenience sample of 51 formerly abused women, Ulrich (1991) explored the women's reasons for leaving a physically abusive male partner. Through two interviews utilizing open-ended questions women were asked to remember

what happened that had caused them to leave the abusive relationship. Through content analysis 86 reasons were identified and leaving was described as a process. Safety of self, children, others or the abuser, and the children's emotional safety were all reasons. Dependency was described as another entity making the decision for them. Personal growth included a cognitive change or new knowing, some women described reaching a personal limit, while others expressed a concern for reaching their own potential. Mixed reasons were described by 14 women who cited both safety and personal growth reasons, and one woman described dependency and personal growth. Less than half of the women focused on safety as a reason to leave, whereas personal growth was cited by almost half of the women. Dependency issues may not be a major barrier to leaving for those who actually get out.

Drawing on data from previous research, Ulrich (1993) described what helped women most in leaving an abusive relationship. Women learning about themselves, the relationship and the presence of social support were identified as reasons for leaving. Changes in awareness about the abusive situation, their abusive relationship or about themselves. Availability of social support was important to many women – especially for those women who had lower self-esteem. Women with higher self-esteem tend to ascribe their leaving to their own efforts than do those who attribute leaving to support from others.

In another retrospective study using feminist, grounded theory, 13 English-speaking rural survivors of abusive relationships were interviewed to discover a substantive theory about the process of leaving the abuse (Merritt-Gray & Wuest, 1995). Abuse was self-defined by the participants. A process of counteracting abuse began with

the initiation of the abuse. Subprocesses included relinquishing parts of self, minimizing abuse, and fortifying defenses. Relinquishing parts of self, the initial and ongoing response to being abused included wondering about and trying to reconcile the image of herself that was created by the abuser, defining themselves as abused, and giving up the image of a happy relationship. Minimizing the abuse occurred through such strategies of protecting, reasoning, and fighting back. The third subprocess, fortifying defenses was necessary in preparation to breaking free of the abuse. Creating space, distancing, enhancing capability, experiencing a caring relationship, making a plan to leave, and surviving crises were components of this subprocess. Breaking free was the transitional stage between counteracting abuse and not returning. This research and resulting theory provided evidence that women engage in active strategies to fortify their defenses to leave, that may be considered passive or even pathologic.

A triangulated qualitative-quantitative study with 30 young, predominantly white women who were currently or previously involved in an abusive relationship was conducted (Landenburger, 1989). The purpose of the investigation was to describe the experience of being abused within the context of a significant relationship and explain how the abusive relationship influenced the choices women make over time. For the quantitative component, abuse was measured by the ISA and was categorized by duration, frequency, and severity of abuse. The mean duration of all the abusive relationships was 7.6 years (range: .5 to 19 years). For most women (63%) abuse occurred daily. There was no significant relationship between the frequency and severity or duration of abuse. Based on the qualitative data, a model of the process of entrapment in and recovering from an abusive relationship was proposed. This model is a four phase

process of binding, enduring, disengaging, and recovering that emphasizes the cumulative influence of experiences of woman abuse on women's views of "self." In the binding phase the initial development of the relationship and the beginning of abuse occurred. Desire for a loving relationship, overlooking warning signals, working on the relationship and questioning what it is about her that provokes the abuse are components of binding. In the enduring phase the woman perceives herself as putting up with the abuse. The good in the relationship is valued and is used as a mechanism to block out the abuse. Placating, feeling responsible, covering the abuse, and shrinking of self occur during this phase. During the disengaging phase the woman begins to identify with other women in similar situations. Labeling, seeking help, breaking point and emerging self are subprocesses of this phase. The final stage, recovery, is a time of initial readjustment after leaving her abuser that continues until the woman regains balance in her life. Struggling for survival, grief for the relationship, and searching for meaning occur in this phase.

In a second qualitative study designed to describe the process of leaving an abusive relationship and to determine factors that inhibit or enhance leaving, the sample was comprised of 70 women recruited from a shelter for abused women (Landenburger, 1993). All of the women participated in focus groups and ten women participated in three open-ended interviews that occurred over a six-month period. Focus groups were conducted monthly for 10 months. Data were analyzed using constant comparative analysis. A process of leaving an abusive relationship is an integral part of the model previously explicated. The model of entrapment in and recovery from an abusive relationship was expanded upon. The alteration in self-identity experienced by battered

women influences decision making about the abuse relationship as well as other aspects of the women's lives. Isolation, powerlessness, loss of control, and the woman's separation from "self" are all effects of abuse. The stage of recovering from the abusive relationship, feelings of control or lack of control, isolation from "self" and others, and sociocultural expectations combine to influence a woman's response to her environment and to decision making. Although abuse is often conceptualized as a physical event, it impacts not only the woman's physical self but also her self-identity and self-integrity. According to Landenburger, "A woman who is abused lives in two conflicting realities. One reality encompasses the good aspects of the relationship with her partner. The other reality embodies the abusive aspects of her relationship...while in an abusive relationship, a women tries to make sense of her skewed reality and in the process loses a sense of who she is" (1993, p. 379). In the process of trying to make sense of her situation and of herself, the victim of abuse may become separated from her true "self." As a victim of abuse, she perceives that she has little control over her life and her body.

In a previously described study using a descriptive, correlational design, 40 white, abused women were interviewed about their help-seeking for the abuse (Limandri, 1987). In that study, a wave-like manner of attempting to end the violence occurs in a fashion that progresses and recedes through multiple health seeking events.

A prospective study using in-depth structured, semi-structured, and open-ended interviews and feminist action methodology was conducted with a community sample of 31 primarily African-American women randomly selected from a larger sample of 96 battered women (Campbell et al., 1997). Women were screened for battering by the CTS and severity of abuse was measured by a modified ISA. Participants were interviewed

three times over a three-year period. The overall theme was a picture of initiating and sustaining a process of achieving nonviolence through active problem solving. Unlike many other theories that describe leaving the abusive relationship, this process is one of achieving nonviolence – leaving the relationship and ending the violence were frequently independent. The process of dealing with the abuse is nonlinear and complex comprised of active problem solving driven by and interplays between internal attributes, mental status, personality traits, coping styles and external events. Pivotal events for the women were related to her abuser's general behavior, how the she labeled and conceptualized the violence, an awareness of the possibility of death, her level of violence, her degree of commitment to and hope for the relationship, concerns for the children, financial issues, and what factor(s) seemed to help the most in improving the relationship and minimizing the abuse.

In a qualitative investigation, older adolescents' experiences of abuse in the year prior to and during pregnancy were explored (Renker, 2002). In a prospective study employing structured and focused interviews, the stories of 40 young women who were 18 to 20 years of age were analyzed using content analysis. Women were considered abused if they screened positive for physical abuse using the AAS. Participants were interviewed prior to a prenatal visit. Interviews lasted between 30 and 90 minutes and were conducted in a private area. Seven themes were identified through analysis: seeking safety, losing faith, experiencing loss, living on the edge, taking the next step, crying out for help, and changing and temporary relationships. Nearly one-third of the participants reported being pregnant in the year before their current pregnancy with 11 of the pregnancies having ended in miscarriage, elective abortion, or fetal demise. The author

stressed the importance of assessing for multiple perpetrators including perpetrators other than the intimate partners as well as employing developmentally appropriate interventions.

Two intervention studies conducted with abused, pregnant women have recently been reported (McFarlane, Soeken, & Wiist, 2000; Parker, McFarlane, Soeken, Silva, & Reel, 1999). In the first investigation, 329 pregnant, physically abused, Hispanic women were recruited through two urban, public prenatal clinics (McFarlane et al., 2000). All prenatal patients were screened for abuse using the March of Dimes protocol (McFarlane & Parker, 1994). Women who reported abuse in the year prior to or during the current pregnancy by a current or former intimate male partner were referred to a bilingual project counselor. The Severity of Violence Against Women Scale (SVAWS), a community resource use assessment and a sociodemographic form were completed. The effects of three different levels of intervention on decreasing physical abuse were compared in a longitudinal study over an 18-month post-delivery follow-up at 2-, 6-, 12-, and 18 months after delivery. The first level of intervention, the "brief" intervention, consisted of providing women with a wallet-sized resource card listing local agencies supporting victims of domestic violence and supplying information about personal safety planning. Women were also offered a brochure (that was not described). The second level of intervention, "counseling", consisted of unlimited access to a bilingual professional counselor experienced in domestic violence services. The counselor was available at the prenatal clinic on a "drop-in" or scheduled basis. They could also contact the counselor via telephone and pager. Supportive counseling, education, referral to services for ending abuse, and assistance with other desired services were the support

services provided by the counselor. The third level of intervention, "outreach", consisted of the same unlimited access to the counselor as well as the services of a "mentor mother". The "mentor mother" were nonprofessional, bilingual, Spanish-speaking mothers who were trained to help abused, pregnant women through in-person visits, telephone contacts, and by conducting prenatal education classes that included information on abuse. The mentors resided in the communities served by the prenatal clinics.

Physical violence scores at 2-months post-delivery were significantly lower for women who received both counseling and mentoring than for the women who received counseling alone. Their scores were not significantly lower than the women who received the "brief" interventions. Over time, threats of violence and physical violence scores decreased for all the women, regardless of their level intervention or their gestational age at study initiation. Use of community services was low for all groups and neither the use nor the number of agencies used differed significantly by intervention group at any time. Use of community resources, was, however, correlated with severity of violence.

In another intervention for abuse during pregnancy, a sample of 199 pregnant, abused African American, Hispanic, and Caucasian women was recruited at public health clinics providing services to women and children in Texas and Virginia (Parker et al., 1999). Women were classified as abused via the AAS. Only abused women who were in a relationship were eligible. The ISA and the SVAWS were used to measure the severity of abuse experienced. Measures were administered on entry to the investigation, twice more during pregnancy, and at 2-, 6-, and 12 months post-delivery. The intervention was

administered to each woman in the intervention group three times during pregnancy (usually at the first prenatal visit and then at two subsequent sessions). The intervention was one-on-one interview conducted by nurses with a master's or doctorate. The intervention consisted of development of a safety plan, making copies of house and car keys, establishing a code with family and friends, hiding extra clothing, and identifying behaviors by the abuser indicating increased danger. The intervention included: providing information on the cycle of abuse, information on applying for legal protection orders or filing criminal charges, and community resource phone numbers. The protocol took approximately 30 minutes to complete, and all of the women in the intervention group received all three interventions. At the conclusion of the intervention protocol, women were offered a brochure that was specifically designed for the study, reinforcing the information provided. Half of the intervention group was invited to attend three additional counseling and information sessions taught by workers at the local shelter. Just over half (51%) of those women invited attended at least one class. A wallet-sized card with information on community resources for victims of abuse was provided for the comparison group. Results indicated that the comparison group experienced more ongoing physical and non-physical abuse than the intervention group. On all four measures, women in the intervention group reported less violence at 6 and 12 months post delivery, but the differences were not statistically significant. Mean scores for physical abuse were higher for African American and Caucasian women than Hispanic women, but the mean scores for non-physical abuse were higher for Hispanic women compared to African American and Caucasian women. Women in the intervention group

engaged in more safety behaviors than women in the comparison group, $t(197) = 4.33, p < .001$.

Summary of research on decisions about the abusive relationship.

Overall, research suggests that women's decisions about the abusive relationship are mediated by internal and contextual variables (Campbell et al., 1997; Fishwick, 1993; Landenburger, 1989, 1993; Limandri, 1987; Merritt-Gray & Wuest, 1995; Ulrich, 1991, 1993). In most studies, abused women describe changing perceptions of the abuse and the abusive relationship. This includes the ability to label the relationship as "abusive" and an altered sense of, giving up, or loss of the self (Campbell et al., 1997; Fishwick, 1993; Landenburger, 1989; Merritt-Gray & Wuest, 1995). Other abused women articulate conscious trade-offs made to maintain acceptable levels of non-violence within their relationships (Campbell et al., 1997).

Many of the studies of women's responses to the abusive relationship have been conducted retrospectively with primarily white women drawn from shelter samples, most of whom have left the abusive relationship (Landenburger, 1989, 1993; Merritt-Gray & Wuest, 1995; Ulrich, 1991, 1993). Although they provide useful information, given their limited variation in sample characteristics they may not be representative of the experiences of women who choose to remain in the relationship, who do not seek the assistance of domestic violence services, or who are of other races or ethnic groups. Further research will be needed to extend these theories with other groups of abused women. One study, using a community sample, primarily comprised of African-American women, has described the creative strategies that women use decrease the level of violence within their abusive relationship (Campbell et al., 1997) which has

contributed to the further development of the other theories. Although two intervention studies have recently been reported (McFarlane et al., 2000; Parker et al., 1999), further testing and refinement of potential interventions is necessary.

Only one study has examined women's perceptions of the influence of pregnancy on their partner's responses and abuse (Campbell et al., 1993). However, the effect of pregnancy on the process of leaving the relationship was not studied. How does pregnancy effect the decisions abused women make about the relationship? When juxtaposed with the maternal tasks of pregnancy, how are decisions made about whether or not to remain in an abusive relationship?

Summary

Women who are physically or sexually abused by their intimate male partner during pregnancy are affected by the abuse in many ways. In addition to the acute physical injuries and trauma, they also experience social isolation, emotional trauma, and fear, as well as recurrent or chronic physical and emotional problems. However, women who are abused during pregnancy have been primarily studied in terms of pregnancy outcomes. Research foci have included the proportion of LBW infants and SABs, use of health care and social services, frequency and duration of hospitalization, and other physical and economic consequences of abuse during pregnancy. From the review of literature, a major gap in the knowledge about woman abuse during pregnancy is evident. That gap in knowledge is an understanding of the meaning for women of the concurrent experience of abuse and pregnancy and the consequences to the development of a maternal identity. This investigation will promote an understanding of the pathways (depression, level of self-esteem, anxiety, and substance use) that may lead to the

negative outcomes. Consequently, although intimate partner abuse against women has been studied by numerous researchers, the current understanding is incomplete because the meaning of abuse experiences from women's perspective have not been thoroughly examined. The proposed study, utilizing the voices of women who are abused to reflect and describe their perspectives of the experiences of abuse in pregnancy and the effects of abuse on decisions made during pregnancy and the development of a maternal identity, will provide valuable information for health professionals.

Pregnancy has been described as a time of opportunity for health care providers since women often are in frequent contact with their health care providers (Campbell, 1995; Helton et al., 1987; McFarlane et al., 1992). Perhaps more than at any other time in their lives, women have regular interactions with a specific health care provider or group. As such, pregnancy presents an ideal time for interventions aimed at the prevention and reduction of the occurrence of abuse. In a broad sense, this research program will contribute to the knowledge and information about abuse of pregnant and non-pregnant women. Specifically, this study will provide information from the woman's perspective about the effects of abuse on the experience of pregnancy and on the development of a maternal identity reflected by her decisions about health behaviors, the abusive relationship, and health care. Examination of this problem from the perspective of the women experiencing the phenomenon will lead to a more thorough understanding of this complex phenomenon. Without a complete understanding of abuse health care providers will continue to be frustrated and bewildered by abuse and women and families will continue to go without adequate intervention. Better understanding of this problem will facilitate the development of effective interventions that will help

decrease the prevalence and the tremendous human and economic cost of this problem, and promote development of provider skills to help abused women make healthy decisions during pregnancy.

Chapter 3: Research Design and Methods

The purpose of this chapter is to describe the design and methods employed in this research investigation. This study used Dimensional Analysis (DA) method to focus on abused, pregnant women's perceptions of the meaning of abuse during pregnancy and the influence of the context of abuse on maternal identity development. Maternal identity is an internal process that women undergo. The process begins in pregnancy and is social in nature. Therefore, the development of a woman's maternal self is the product of interactions between the woman and her social context and is constructed psychologically and socially.

The investigation explored the effects of the concurrent experiences of abuse and pregnancy on maternal role attainment reflected by women's decisions about health behaviors, prenatal care, and the abusive relationship. In this chapter, the study design, methods and rationale for their use will be discussed. Dimensional Analysis method will be reviewed and a historical overview of the development of DA provided. In addition, the target population, setting, sampling method and rationale will be presented. Data collection procedures, interview scheduling, questions, and lines of inquiry, data storage, and the specific analytic process will be described in detail and quality and credibility issues will be reviewed. Finally, the protocol for insuring the safety of this vulnerable population will be provided.

Dimensional Analysis

Dimensional Analysis (DA) is a method of generating grounded theory from qualitative data. This method was chosen because it emphasizes the meaning of interactions within a given social context, and provides a useful model that frames the

essential analytic processes of grounded theory research (Robrecht, 1995). For the current study of a complex problem, DA was seen as the most appropriate research method. In this section, a brief historical overview of symbolic interactionism, which provides the philosophical underpinnings of DA as well as the theory of natural analysis that is central to DA will be presented. Finally, specific research procedures will be discussed.

Symbolic Interactionism

The tradition of inquiry known as symbolic interactionism had it's origins in the beginning of the 20th century. This historical context provides useful insight to the development of this intellectual tradition. In the early 1900s, the myriad industrial and social changes were occurring in the United States and Europe at an unprecedented rate. This era of tumultuous change motivated many scholars to attempt to make sense of these changes. In the academic community, science was dominated by quantitative methods and the assumption that all things (e.g., objects, animals, and people) were governed by natural laws and, consequently, that all behavior and action occurred in predicable and orderly ways. Academicians within the human sciences began to challenge this perspective and borrow from philosophy, arguing that the laws that governed natural science were not directly transferable to the study of human science. Along this vein, academic sociologists at the University of Chicago developed a unique perspective of humans and their behavior that was derived from the philosophical tradition of American Pragmatism.

George Herbert Mead, John Dewey, Charles Horton Cooley, William Isaac Thomas, Robert E. Park, and William James were among those scholars at the "Chicago

School" who used or contributed to the intellectual approach known as symbolic interactionism. The American Pragmatist tradition that formulated the social theory of intelligence and the mind was the result of the intellectual activity of George Herbert Mead and John Dewey. It was Mead who attempted to demonstrate that language provided the mechanism for social construction of the mind and through which the self-conscious and self-aware self emerges. Further, Mead argued that human action was different from other animals since human beings possessed a rational mind (Mead, 1934). Scholarly debate over the development and meanings of social interactions formed the basic constructs of symbolic interaction. The perspective of symbolic interactionism viewed humans and human behavior as having the ability to determine and control their actions and through negotiation, to construct society (LaRossa & Reitzes, 1993; Mead, 1934). However, it was a later scholar, Herbert Blumer – a former student of Mead's – who actually coined the term "symbolic interactionism". Consequently, symbolic interactionism was developed as a unique and distinctive approach to the study of human life and behavior that stood in contrast to the study of inanimate objects and other non-human animals.

According to Blumer, there are three premises upon which symbolic interactionism is based: 1) Human beings act toward things on the basis of the meanings that things (i.e., objects, beings, groups, institutions, principles, others' activities, and situations of life) have for them; 2) The meaning of such things is derived from, or arises out of, social interactions; 3) These meanings are handled in and modified through an interpretive process used by the person in dealing with things s/he encounters (Blumer,

1969, p. 2). Symbolic interactionism provides the philosophical underpinnings of traditional grounded theory and Dimensional Analysis.

Traditional Grounded Theory.

Reflecting the dominant positivist perspective of the 1930s and 1940s, quantitative methods for social science were considered the most rigorous of research methods. Through the application of quantitative methods, scientists were able to test theories and facts. In contrast, qualitative methods were deemed less rigorous. Although many social scientists attempted to articulate qualitative research methods and analytic procedures, qualitative methods were generally regarded as conjecture until sociologists Barney Glaser, who had a quantitative background, and Anselm Strauss, who was from the tradition of symbolic interactionism, developed grounded theory method in response to this critique.

Because they considered qualitative research methods to be equally useful, and at times, more appropriate than quantitative approaches to inquiry in social sciences, Glaser and Strauss constructed the qualitative method called "Grounded Theory" (1967), to counter this perception and enhance the credibility of qualitative research. Their book, *The Discovery of Grounded Theory: Strategies for Qualitative Research* was published in 1967. Through the application of original Grounded Theory method, they proposed to organize the research process by systematic collecting, coding, and analyzing of qualitative data used to generate theory (Glaser & Strauss, 1967). In original grounded theory method, the processes of data collection, coding, and analysis are done concurrently. Through comparative analysis of data – also called constant comparison – a theory that is grounded in data will be discovered (Glaser & Strauss, 1967). The goal

of the original grounded theory is the generation of a substantive or formal theory "that accounts for the pattern of behavior that is problematic for those involved" (Glaser, 1978).

The association between the tradition and development of Grounded Theory and nursing research has been a long and productive relationship. Glaser and Strauss were faculty and colleagues in the Sociology Department located within the School of Nursing at the University of California – San Francisco in the 1960s-1970s. They were collaborators in research as well as in the development of grounded theory method. In later years, however, the colleagues began to collaborate with others and to have differing perspectives of and approaches to grounded theory method. A student of Glaser, Phyllis N. Stern RN, DNS, suggests that the differences in Strauss and Glaser's approaches to grounded theory method were always present and actually evolved through the years (Stern, 1994). According to Stern, their difference can be summarized by their approach to analysis. She suggests that Strauss examines each word and asks "What if?" while Glaser focuses on the data and asks, "What do we have here?" (Stern, 1994, p. 220). In contrast, Schatzman, the originator of Dimensional Analysis asks, "What all is involved here?" (Schatzman, 1991, p. 310). Although these questions are similar, there are subtle distinctions that influence the direction and substance of the research process. For the purposes of this research project, the focus will be on the question posed by Schatzman (1991).

The development of Dimensional Analysis.

As a colleague of Glaser and Strauss, Leonard Schatzman taught field research to graduate students of nursing and sociology in the same department at the University of

California – San Fransisco. Although generally agreeing with many of the tenets and goals of grounded theory, Schatzman, while working with students on their research, noticed that many of them had great difficulty with the analytic techniques proposed in the original grounded theory method (Schatzman, 1991). As a consequence of these observations, he endeavored to develop a way to deal with their analytic problems. It was at that time, that Schatzman began to think of the explanatory matrix as the central feature of analysis – providing both a frame and a methodological perspective to analysis (Schatzman, 1991, p. 308).

Explanatory matrix.

For Schatzman and DA, the explanatory matrix provides a procedural and structural form for analysis (Schatzman, 1991, p. 309). Although traditional grounded theory (Glaser & Strauss, 1967) and later revisions (Strauss & Corbin, 1990, 1994; Strauss, 1987) describe various analytic tools including a matrix, the description and proposed functions of the model and matrix within the generation of grounded theory is different. For example Strauss and Corbin (Strauss & Corbin, 1990, 1994) describe two models or analytic tools: the conditional matrix and the paradigm model. The conditional matrix is represented as a set of concentric circles that correspond to differing conditions that impact the phenomenon under investigation. The paradigm model is employed during the process of axial coding and is used to relate categories and subcategories (Strauss & Corbin, 1990, 1994). Although bearing some resemblance to the explanatory matrix of DA, they do not serve as the central feature providing a procedural and structural form for analysis.

DA seeks to answer the question, "What all is involved here?" (Kools, McCarthy, Durham, & Robrecht, 1996). This question closely reflects the symbolic interactionist foundation in which thinking is understood to be governed by and reflective of one's interaction with others (Schatzman, 1991). The product of DA is a theory that is grounded in the data and provides theoretical and explanatory form to a complex social phenomenon. This theory reflects the perspective of the research participant's natural analysis of their experience of the phenomenon as interpreted by dimensional analysis of the researcher (Kools, 1997; Robrecht, 1995; Schatzman, 1991).

As described, although DA is informed by the ideas and practices of traditional grounded theory method (Glaser & Strauss, 1967), it has a unique methodology, logic, and underlying epistomologic assumptions (Kools et al., 1996; Robrecht, 1995). The traditions of pragmatism, structuralism, postpositivism, and symbolic interactionism as described by members of the Chicago School, Mead, and Blumer provide the philosophical foundation of DA. Therefore, the corresponding epistemological and ontological assumptions include the following: reality is imperfectly known and contextually bound and objectivity is ideal, but dualism is unnecessary (Guba & Lincoln, 1994). A primary distinction of between DA and traditional grounded theory is the assumption of the theory of natural analysis that is essential to both common and scientific problem solving (Schatzman, 1991).

A theory of natural analysis.

Natural analysis is a theory of thinking. Humans gain the ability to perform natural analysis via the acquisition of language skills. During language acquisition, meanings and values are assigned to objects through one's interactions with others. More

abstract concepts such as differentiation are also learned in this manner (e.g., good vs. bad) (Kools et al., 1996; Robrecht, 1995). A person's ability to differentiate is called *dimensionality*. *Dimensionality* is a theoretical concept of natural analysis that refers to an individual's cognitive ability of addressing the complexity of a phenomenon by noting its attributes, context, processes, and meaning (Kools et al., 1996; Robrecht, 1995). In DA, *natural analysis* is seen as an "...intrinsic subprocess of thinking learned early in social life, along with language, and practiced whenever experience is problematic and action is required" (Schatzman, 1991, p. 305). Scientific thinking is highly self-reflective and undertaken with a defined intention. Analytic actions one ordinarily uses in natural analysis are intentionally employed within the operations of theory development (Kools et al., 1996; Robrecht, 1995; Schatzman, 1991). Consequently, in scientific inquiry using DA method, the investigator uses his or her own ability to dimensionalize along with careful and deliberate natural analysis in an explicit and self-conscious manner to analyze the research participants' own natural analysis of the meaning of their situation.

DA recognizes that people naturally work with and from prior knowledge (Schatzman, 1991). As such, research questions asked and the defining of problems are based on one's cumulative experience. Correspondingly, the basis for initial interview questions is drawn from this cumulative experience that promotes entrée into the field of study as well as revealing the investigator's biases. Natural analysis is a normal cognitive process used to interpret and understand a phenomenon.

Dimensional analysis research process.

The key process in DA is the construction or novel reconstruction of multiple components of a complex social phenomenon. Although the qualitative design of

dimensional analysis is a cyclical inductive-deductive process, for purposes of explanation a simplified, numerically ordered process will be elucidated. It is derived from the processes described by Schatzman (Schatzman, 1991), Kools and colleagues (Kools et al., 1996) and Robrecht (Robrecht, 1995).

1) The process of initial coding (data expansion) occurs subsequent to initial data collection. It begins with *dimensionalizing* and concurrent designation or naming of concepts. Data expansion serves to reveal the multiple properties and attributes involved in phenomena without considering the relationship of identified dimensions.

2) *Data limitation* refers to the clustering of early-identified dimensions into more abstract categories. Through data limitation the researcher develops an abstract analysis that allows consideration of the magnitude and relative importance of the dimensions. Perspective selection and theory development utilizes the explanatory matrix (See Figure 1). The organizing *perspective* is the dimension that is most central to the developing theory (Kools et al., 1996). It best answers the question "What all is going on here?" The *context* is comprised of dimensional categories that provide the boundaries for inquiry. It is the situation or environment in which the dimensions, representations, conditions, actions/processes or consequences are embedded. *Conditions* are salient dimensions that exert a direct or indirect influence on interactions by facilitating, blocking, or in some other way shaping them. An *action or process* is an intended or unintended response impelled by specific conditions. Outcomes or results of actions or processes are designated *consequences*. After identifying the organizing perspective, and tentatively placing structural components within the matrix, theoretical sampling continues. This allows the researcher to clarify, test, and modify conceptual linkages of

the developing theory (Robrecht, 1995). Once a high level of repetition of the dimensional themes is present, the process of data collection and analysis will be ended. At this point, a dense theoretical statement or grounded theory of the phenomena is offered that represents the participants' experience and meaning of interactions from the articulated perspective and within the given context (Kools et al., 1996; Robrecht, 1995).

Study Design

This investigation utilized a qualitative design and the DA research method to explore women's perspectives of the meaning of abuse during pregnancy as well as the effects of abuse on maternal role attainment as reflected by maternal decision making during pregnancy.

Setting.

Participants were sought from two prenatal clinics located in a metropolitan area in the Pacific Northwest. To protect participant confidentiality, only a limited description of the recruitment sites will be provided. Both clinics were staffed by certified nurse-midwives (CNMs) who were assisted by registered nurses (RNs) and nursing or medical assistants (NAs or MAs). Obstetrician-gynecologists (OB/GYNs) and perinatologists served as consultants to the CNMs as needed for the care of high risk patients. In addition, both settings had access to a clinical social worker to help with case management for patients who were considered high risk for psychosocial, physiological, or other reasons – including women who were identified as being in an abusive relationship. Both settings were accessible by public transportations. The nurse-midwives in the first practice delivered approximately 40 patients per month. Half of those patients were seen at the main clinic and half were seen at satellite clinics. Thus, in

2001, approximately 480 patients were seen on an annual basis. In 2001, the midwifery staff at the second practice attended the deliveries of 360 women. Thus, a total of approximately 840 were seen over the past year.

The clinics were chosen as recruiting sites for several reasons. First, the PI knew the staff through their collaboration on prior research studies with the PI and two of her faculty advisors. Secondly, there was a high level of commitment expressed by the clinicians to the patients' safety and well being which was an important consideration when dealing with such a vulnerable population. Third, the providers were interested in working with the PI on an investigation of domestic violence during pregnancy. Finally, and perhaps most importantly, the health care providers and these clinics were knowledgeable of resources for women who were victims of intimate partner violence and had the professional support of and access to clinical social workers with whom they could refer patients as needed. This final consideration was something that the PI and her advisors felt was integral to providing quality care and promoting safety for the women.

Study participants.

In an effort to interview women who initiate prenatal care during different trimesters, participants were sought from prenatal clinics. Since 99.0 percent of Oregon women receive some form of prenatal care, it is unlikely that any potential participants would not be receiving prenatal care (Oregon Health Division, 1997). Therefore, the PI originally proposed to recruit participants from prenatal care settings. Based on data from a recent prospective study of pregnant women living in Oregon it has been estimated that more than 20 percent of pregnant women in the Portland metropolitan area experience abuse during pregnancy (Curry, Doyle et al., 1998; Curry, Perrin et al., 1998).

Considering that the combined annual number of patients seen at the two clinic sites was approximately 840 patients, the PI anticipated that at least 84 to 168 abused women were likely to be included the combined prenatal patient panel and that a sufficient number of potential participants would be referred to the PI.

Initially, inclusion criteria for the study sample were: 1) pregnant women older than 18 who were currently in an abusive relationship with an intimate male partner; 2) willingness to participate in the study; and 3) English speaking with the ability to articulate their perspective of the experience and meaning of abuse. It was proposed that women would be screened for abuse during their routine prenatal care and their care provider would inform them of the opportunity to participate in this research investigation. Abuse screening would consist of a valid and reliable question for detecting abuse that is part of the Abuse Assessment Screen (AAS): Since you've been pregnant, have you been hit, kicked, slapped, or otherwise physically hurt by your partner? (Helton et al., 1987; McFarlane et al., 1991; McFarlane et al., 1992). This screening question for abuse during pregnancy, which is on the standard obstetric history and physical forms used by most health care providers in Oregon, was to be asked by one of the professional clinic staff. The standardized state obstetrical form with the abuse screening question was used by the providers at the two study settings. The abuse screening question was generally asked at the initial prenatal appointment. However, according to the clinic-referred participants in the study, many of the participants had initially responded negatively when screened for abuse at their first prenatal visit, using the standard questions. Instead, they had disclosed their positive abuse status at another point during their pregnancy. This finding will be discussed in the findings chapter. In

addition, because community participants would not have been screened for abuse by a health care provider who would then refer the potential participant to the PI, potential participants who were drawn from the community were screened for abuse by the PI at their first contact. At that time, the potential participant was asked whether she had experienced physical, sexual, and or emotional abuse by an intimate male partner during pregnancy or in the postpartum. If she responded affirmatively, she was considered eligible to be included in the sample and was invited to participate in the study. Potential community participants were primarily recruited via snowball sampling and word-of-mouth. Potential participants learned of the investigation through other study participants, the PI's discussion about her investigation in several nursing courses, and personal or professional contacts with the PI or someone known to the PI who shared information about the PI's investigation.

Emergent design.

Emergent design is commonly used in DA method as well as other qualitative methods. In this investigation, alterations in the design were made from those that had originally been proposed as were deemed necessary and appropriate to the investigation. Specifically, modifications were made to the proposed sampling plan and the inclusion criteria were expanded for the project. The alteration in sampling was deemed necessary in order to allow the PI to complete the research project in a timely manner. Because there were so few referrals to the PI during the first three months of recruiting, instead of limiting the sample to women who were currently physically abused and pregnant or postpartum, the PI, in consultation with her faculty advisors, decided to include retrospective participants (i.e., women who were no longer pregnant or in the immediate

postpartum period, but who had experienced abuse during pregnancy or postpartum) and to broaden the definition of abuse to include emotional and sexual abuse, as well. Additionally, snowball and word-of-mouth sampling from the community was also utilized. The expanded inclusion criteria and additional sampling strategies were proposed to and approved by the two Institutional Review Boards involved with this project in June and July 2001. Additionally, the Department of Health and Human Services was notified of the alterations to the design for the purposes of the confidentiality certificate for the project.

An excerpt from one of the PI's theoretical and process memos dated June 11, 2001 about the expansion of sample inclusion criteria and sampling strategies provides information about the considerations given to the changes in the design:

> Research suggests (see Landenburger and others) that women who are currently experiencing abuse may not even label an abusive relationship as "abusive"; and that it takes, perhaps, several times being asked for a woman to feel comfortable disclosing abuse to her health care provider (see Nancy Fishwick's dissertation). As such, there will be some self-selection as to those participants who have screened positive (i.e., they are ready and feel comfortable disclosing their abuse status). Thus, distance from the experience may help women be able to articulate some of their decision-making process. This has also been seen in Gail Houck's clinical practice with abused women - gaining ability to articulate their experience and attach meaning after they have some distance from the experience. I also proposed using word-of-mouth sampling. While this may muddy the water of sampling strategies and also limit describing the sample as a clinical sample, it

may pick up some women who did not disclose their abuse during their pregnancy. It will be interesting to compare and contrast the women's experiences and decision-making.

Broadening the inclusion criteria did add an interesting element to the research process. The perspective of women who described their experience of abuse during pregnancy retrospectively was different from the prospective participants and allowed the PI to explore the differences. It also revealed important contextual information about the interface between the trajectory of the abusive relationship and the pregnancy timeline and significant information about the abusive relationship for women who have more than one pregnancy with their abusive partner. Including participants from the community also revealed differences in the prenatal services received by abused, pregnant women and exposed inadequacies of many services provided in the community. Finally, including women who were emotionally or sexually abused during pregnancy revealed important information about the abuse trajectory. These issues will be discussed in the findings and discussion chapters.

Convenience and theoretical sampling.

Convenience and theoretical sampling techniques were used. Informants were sought through prenatal clinics and in the community who could articulate their individual perspective of the meaning of their concurrent experiences of pregnancy and abuse by their intimate partner. After initial interviews, the process of theoretical sampling was utilized, following the accepted procedures for grounded theory (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1994). In theoretical sampling, data collection, coding, and analysis occur simultaneously. Through this process, the analyst

determines which data to collect next according to the developing theory – this is theoretical sampling. As such, the process of theoretical sampling guided the direction of the inquiry, the acquisition of later data, and subsequent interview content and questions. At times, it was difficult for the PI to stay ahead of the theoretical sampling during data collection and analysis. Data collection continued until theoretical saturation occurred. Theoretical saturation occurs when data from different informants reveals the same themes and theories and no new data emerges in the salient categories. Consequently, at the proposal stage, it was not possible to predict the final sample size required. It was initially estimated that a sample of 20 – 25 women would be required to yield theoretical saturation of salient categories. After interviewing the first nine participants, beginning theoretical saturation was evident. Further recruiting and theoretical sampling continued until theoretical saturation occurred and no new themes or categories emerged. Eventually, 21 interviews were conducted with 12 participants.

Gender and minority inclusion.

Since this study examined a phenomenon unique to women, study participation was limited to females. To enhance the opportunity to sample a wide range of social and cultural dimensions, clinics with cultural densities greater than that of the Portland metropolitan area (5.3 % African-American, 1.2 % Native American, 3.2 % Hispanic, 5.3 % Asian/Pacific Islander, 82.6 % Caucasian, and 2.4 % Other) were used (Curry, Perrin et al., 1998) (See Table 1 for breakdown of clinics' cultural/ethnic composition). The actual sample consisted of Caucasian (n = 6), African American (n = 3), Arab American (n = 2) and Ethiopian (n = 1) women. There were no Hispanic, Asian or Pacific Islander participants referred or recruited.

Table 1. Cultural/Ethnic Composition

	African-American	Native American	Hispanic	Asian/ Pacific Islander	Caucasian	Other	Total
Clinic 1	6 %	3 %	4 %	2 %	79 %	6 %	100 %
Clinic 2	34 %	4 %	3 %	4 %	50 %	5 %	100 %
Portland	5.3 %	1.2 %	3.2 %	5.3 %	82.6 %	2.4 %	100 %
Study	25 %	0	0	0	50 %	25 %	100%

Data collection.

Data collection was generated toward the development of a conceptual understanding of the phenomenon of women's experiences of abuse during pregnancy. Data collection occurred through one or two interviews with each participant. Given the sensitive topic of research and vulnerability of prospective research participants, ensuring the safety and confidentiality of the participants was of utmost concern. To promote the safety of the research participants, guidelines developed by The Nursing Research Consortium on Violence and Abuse (NRCVA) for conducting research with abused women were used to promote participants' safety and autonomy (Parker, Ulrich, & NRCVA, 1990). See Appendix A for specific protocol information.

Interviews.

Individual, in-depth, face-to-face interviews were conducted for the purpose of understanding women's experiences of abuse during the childbearing year. Participants' perspective and understanding of their experiences provided the guidance for the inquiry in meaningful and important ways.

Recruiting of participants began in March of 2001 and concluded in March 2002. Interviews were conducted over an eleven-month period: the first interview was conducted in May 2001 and the final interview was conducted in March 2002. Twenty-

one in-depth interviews were conducted with 12 participants. The interviews lasted from 45 minutes to nearly 4 hours. The average interview usually took approximately 2 hours. There were five potential participants referred to the PI from one of the clinic sites. All of the referred potential participants met the inclusion criteria and participated in the study. There was only one potential participant referred from the other site and that referral occurred after data collection had ended. Although the PI contacted the midwifery staff from that clinic numerous times over the recruiting year, staff at that setting reported that there were no patients who met the inclusion criteria for the study. Thus, five of the twelve participants were from clinic settings.

The research plan proposed two interview sessions with participants. Following positive identification as an abused woman by a prenatal care provider, the PI contacted potential participants interested in participating in the research project were in the manner they specified. All of the potential participants who were referred by clinic staff had either returned a stamped, addressed post card to the PI or gave permission to the clinic staff to notify the PI of their interest. As discussed previously, self-referred potential participants from the community were screened for abuse by the PI at the initial contact. After the purpose of the research study was described and eligibility ascertained women were invited to participate in the study. To ensure the safety and confidentiality of each participant, individual interviews were conducted in a private area at the clinic, an office at the University, or in a place chosen by the participant, at a time convenient to the participant.

It had been anticipated that most women would be interviewed twice – at least once during pregnancy and in a later trimester or in the postpartum. The majority (75 %)

of the participants were interviewed two times. Although it may have been ideal to interview participants during each trimester of their pregnancy as well as in the early postpartum period to adequately capture change over time, previous research and clinical experience suggested that abused women may delay prenatal care, or attend care in a sporadic manner (Dye et al., 1995; Parker et al., 1994; Taggart & Mattson, 1996). In addition, women who were pregnant and abused or who had left the relationship, had many difficulties to deal with and the PI wished to make sure that their participation in this investigation was not unduly stressful or overwhelming to them. Consequently, women were interviewed when they were available. The first interviews were scheduled at the initial contact with participants. Scheduling of the second interviews was discussed at the conclusion of the first interview.

Initial interviews were broadly structured and based on review of pertinent literature and the clinical experience of the PI and her dissertation advisors (Kools et al., 1996; Kools, 1997). After obtaining informed consent, the PI generally started the interviews by making the following statement: "Abuse is very common in women's lives whether they're pregnant or not pregnant and what I'm interested in is what your experience has been. Could you tell me about your pregnancy?" Open-ended questions ensued about their experiences of abuse during pregnancy and postpartum and explored how the participants' perceived those experiences as impacting their pregnancy decision-making (See Appendix B for interview topics and questions). According to practices for theoretical sampling, additional questions and lines of inquiry emerged as suggested by analysis of the accumulating data and developing theory (See Appendix B for subsequent questions and topics).

Later inquiry was more directive and specific. As directed by the practice of theoretical sampling applied within DA method, questions for the second interviews focused on exploring the important dimensions discovered through the analysis of initial interview data according to the principles and procedures of DA (Kools et al., 1996). Data collection occurred until no new information salient to the major dimensional categories was revealed (theoretical saturation).

Field notes and theoretical memos were utilized (Schatzman & Strauss, 1973) to provide a record of the PI's analytical thinking and dimensionalizing. In addition, recorded field notes and theoretical memos were employed to ensure the quality and credibility of data and provide an audit trail to substantiate the trustworthiness and confirmability of the study (Lincoln & Guba, 1985; Rodgers & Cowles, 1993). Each of the interviews were audiotaped and transcribed. Both the transcriptions and the audiotapes were stored in a locked file accessible to the PI and her research advisor. All identifying data were removed, and code numbers were used to promote the participant's safety and confidentiality.

The principal investigator.

In qualitative inquiry, the PI is the primary instrument for data collection. The PI had extensive training and experience as a registered nurse, working in a variety of settings including emergency nursing and outpatient women's health. Additionally, she had advanced training and experience as Nurse Practitioner specializing in women's health care. The PI had also worked as a research assistant on another investigation of abuse during pregnancy. Through educational, clinical, and research experiences, she had interviewed and provided nursing care to many individuals dealing with sensitive or

stigmatizing issues – including intimate partner abuse. Furthermore, she worked in shelters for female victims of domestic violence since 1987, which complemented her professional training and experience. In addition, during the course of the study, prior to the initiation of the data collection phase, she experienced pregnancy and motherhood, which further sensitized the PI to the experience of pregnancy.

As the interviewer, the PI utilized practices for active listening. Consistent with the philosophical underpinnings of this inquiry, she affected an instrumental, relativist stance and attempted to be as non-judgmental as possible during interviews. In order to avoid altering the meaning of the perspective shared and stories told, leading questions were avoided and participants were instructed that she was interested in learning what they felt was most important about their experiences of abuse during pregnancy. Additionally, points were clarified and stories paraphrased in order to insure accuracy and to be certain that an accurate understanding of the information they had shared was achieved. Thus, women provided the direction for the interviews as well as the developing theory.

Data analysis.

Using DA method, analysis is neither linear nor sequential, but like other grounded theory methods, it can be most easily described as involving two phases: a data expansion phase and a data limitation phase (Robrecht, 1995). Data expansion, the earliest phase, involves data collection, dimensionalizing, and designating. Data gleaned from the earliest interviews and observations are expanded by identifying each dimension – its attributes and properties. Designation is the analytic process of naming or labeling a dimension or concept, which becomes an abstract symbol with specific meaning to the

data and the analytic process (Kools et al., 1996; Kools, 1997; Robrecht, 1995). As data collection proceeds, identified dimensions are sorted into categories based on their analytic meaning. At this point, a "critical mass" of data has been collected and analyzed. The basis of the data limitation phase of analysis is category identification. With category formation, the analyst evaluates each category as the potential guiding perspective of the investigation. The perspective is then selected from all other categories based on its explanatory power – that is, from that perspective a more complete story can be told – one that accounts for variation within the phenomenon (Kools et al., 1996; Robrecht, 1995).

Theoretical sampling and selection of the organizing perspective.

In the course of data analysis for this investigation, early data collection identified "abuse within family of origin," "shifting perceptions," and "evolving values" as several of the important dimensions. Theoretical sampling among those topics led to the discovery of the interrelatedness of those dimensions, but none of those dimensions offered the explanatory power required of the organizing perspective. In addition, through early interviews, the dimension of women's violent or abusive actions emerged. At first, the investigator was troubled about what to do with such potentially stigmatizing information. After discussing the issue with her dissertation advisor, she continued to conduct theoretical sampling around the issue. While several participants described their own abusive behavior, the majority of the participants described defensive acts that were primarily verbal in nature. Theoretical sampling around women's use of violence ultimately revealed a continuum of actions – from drawing a weapon, to striking out, to throwing a clock. Initially, the PI thought that women's responses were primarily

influenced by a lifelong exposure to abuse – that is, those women who grew up in a family or social context where violence was common would be more likely to engage in violent acts, themselves. However, with further theoretical sampling in interviews with other participants – it became clear that prior exposure to violence was not the only variable influencing women's use of violence because several women who grew up in violent homes or who had been abused as a child or an adult did not report using physical violence against their abusive partner. Additionally, each of the women who reported using physical violence also reported using substances during pregnancy, but not every woman who used substances during pregnancy also reported engaging in violence against the abusive partner. Instead, through further theoretical sampling, it became apparent that a constellation of factors including the woman's and her partner's substance use, prior exposure to violence, cultural values regarding violence in the family, as well as the woman's personal value system influenced her decision to use or not use violence against her abusive partner. Theoretical sampling around cultural values also provided important information.

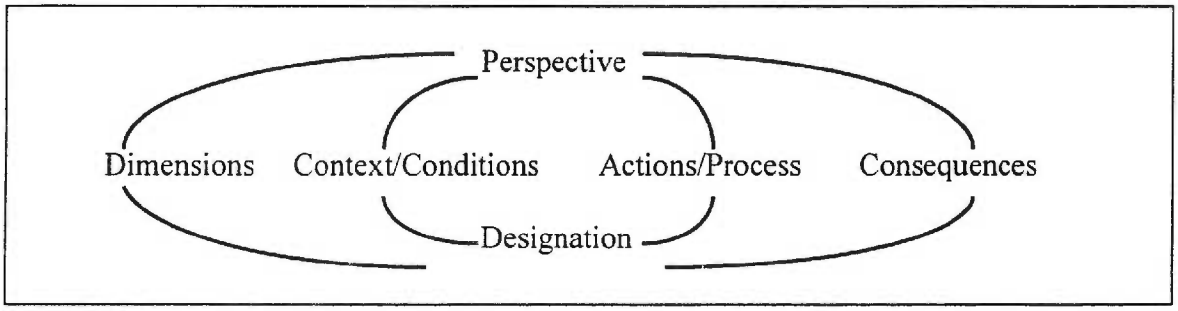
"Choosing family, pregnancy, or child over the abusive relationship" was auditioned as an early organizing perspective after several interviews. However, it was discarded as being inadequate for capturing the variation and complexity of the phenomenon of abuse during pregnancy. Instead, as a result of further theoretical sampling with subsequent participants around the dimension of "family", it became obvious that at least throughout much of the pregnancy, that the women considered family as intimately connected with and inseparable from the abusive partner. Through additional interviews with participants, it was revealed that women engaged in a process

of evolving perceptions of the constellation of the family and what she valued. The definition of "family" that women held at the beginning of the pregnancy – which for all of the participants was a reflection of the values of their larger sociocultural context – generally changed over the course of the pregnancy. The change in definition and values was profoundly influenced by their experiences of abuse by the intimate male partner as well as growing dissatisfaction with the relationship, discordance between their vision of the family and the reality they experienced, and profound emotional pain.

After interviews with two different participants featured descriptions of their "private" and "public" personas or lives and the tension between the two lives, the PI decided to conduct theoretical sampling around that dimension. Initially, the investigator thought that the women were describing the phenomenon of separated self that has been written up extensively in the literature on abused women. However, theoretical sampling around the dimension revealed that the women considered the phenomenon as something different that was unique to and compounded by pregnancy and the additional interest of society in the pregnancy and developing family. Theoretical sampling around the division between the private and public life ultimately revealed "living two lives" as an integral dimension to the phenomenon of abuse during pregnancy that was ultimately chosen as the organizing perspective that captured the complexity of the experience. Once the organizing perspective was selected, the remaining categories fell logically into place with further interviewing, analyses, and member checking. Through further investigation of the two contexts and theoretical sampling along the dimensions "private" and "public" lives, the conditions: guarding and revealing the intersection between the private and public lives and pregnancy emerged as the primary and secondary conditions.

Once the organizing perspective was selected, the remaining categories of context, condition, process/action, or consequence were placed in the explanatory matrix (see Figure 1). As the categories were assigned within the logic of the matrix, theoretical sampling continued to enable to investigator to differentiate, refine, and test the conceptual linkages of the theory. When no new dimensions were identified, sampling was ended and the grounded, theoretical statement refined (Schatzman, 1991).

Figure 1. Dimensional Analysis Explanatory Matrix



Criteria for Evaluation

Since this study used a qualitative design, quantitative issues of internal and external validity and reliability are not directly applicable. In DA, the theoretical statement offered should be interpretable from the data or alternatively stated and a clear evidence trail should point toward the "validity" of the theory. However, consistent with its symbolic interactionist underpinnings it is recognized that each social theory is a tentative theoretical offering, and in a sense, never complete. This acknowledges that human behavior is more complex than what is observable, and that interactions are contextually and historically dependent and change, depending on the actors (Schatzman, 1991). Although debates exist regarding the applicability and utility of criteria evaluating validity within qualitative inquiry (Lincoln & Guba, 2000; Sandelowski, 1993), there

does exist a responsibility by the researcher to assure that the investigative process was rigorous and that the results are trustworthy and useful.

Procedures for verification of qualitative research.

A classification of eight procedures for verification derived from a review of the literature has been presented (Creswell, 1998, pp. 201-203). Those eight procedures are as follow:

1) Prolonged engagement and persistent observation in the field. This includes building trust with participants, learning the culture, and checking for misinformation.

2) Triangulation of sources, methods, investigators, and or theories to provide confirming evidence.

3) Peer review or debriefing to provide an external check of the research process.

4) Use of negative case analysis to refine the working hypotheses in light of negative or disconfirming evidence as the investigation continues.

5) Clarifying researcher bias from the outset of the study to present to the reader the researcher's position and any associated biases or assumptions that impact the inquiry.

6) Use of member checks. Soliciting informants' views of the credibility of the findings and interpretations through the process of sharing data, analyses, interpretations, and conclusions with informants so they can judge the accuracy and credibility of the account.

7) Rich, thick description allows the reader to make decisions regarding transferability because the writer describes in detail the participants or setting under study.

8) External audits allow an external consultant, to examine the process and the product of the account, accessing their accuracy.

Creswell recommends that qualitative researchers engage in at least two of the eight procedures in any given study.

As described, Creswell (1998) put forth eight procedures for ensuring quality and verification for qualitative investigations in the constructivist traditions. He recommended that researchers engage in at least two of the eight procedures for a given study. For this research investigation, the PI participated in prolonged engagement and persistent observation. The PI conducted two interviews with the majority of the study participants and was in the field for approximately one year. She kept careful memos of observations and insights gained during the interviews as well as throughout the research process. Theoretical memos were maintained throughout the research process. The memos documented the development of designated categories from early dimensionalizing through final integration into the theoretical statement (Kools et al., 1996). In addition, by virtue of having multiple informants, triangulation of sources was another process engaged in by the investigator. Peer debriefing occurred throughout the research process with the PI's dissertation chair, her dissertation committee, and nursing faculty and students in a qualitative research forum. Interview transcripts, theoretical memos, and ongoing issues were brought forth, analyzed, and critiqued in the various forums. Finally, member checks were used throughout the research investigation. Early

in the process, member checking was of a more general nature, but occurred in the majority of the interviews. Near the end of the investigation, member checking was used to verify the proposed theoretical model and organizing perspective. Participant's responses were used to confirm and to modify the proposed model as needed.

Criteria for evaluating grounded theory research.

In addition to the general criteria for qualitative research there are also criteria for evaluation that are specific to grounded theory research (Strauss & Corbin, 1998). These criteria are primarily concerned with the adequacy of an investigation's research process and the grounding of the findings. Strauss and Corbin presented seven evaluative criteria related to the research process (1998, p. 269).

1) How was the original sample selected? On what grounds?

2) What major categories emerged?

3) What were some of the events, incidents, or actions (indicators) that pointed to some of these major categories?

4) On the basis of what categories did theoretical sampling proceed? That is, how did theoretical formulations guide some of the data collection? After theoretical sampling was done, how representative of the data did the categories prove to be?

5) What were some of the hypotheses pertaining to conceptual relations (i.e., among categories), and on what grounds were they formulated and validated?

6) What were the instances in which hypotheses did not explain what was happening in the data? How were these discrepancies accounted for? Were hypotheses modified?

7) How and why was the core category selected? Was this collection sudden or gradual, and was it difficult or easy? On what grounds were the final analytic decisions made?

Strauss and Corbin (1998, pp. 270-272) also generated eight criteria for evaluating the empirical grounding of a study.

1) Are concepts generated?

2) Are the concepts systematically related?

3) Are there many conceptual linkages and are the categories well developed? Do categories have conceptual density?

4) Is variation built into the theory?

5) Are the conditions under which variation can be found built into the study and explained?

6) Has process been taken into account?

7) Do the theoretical findings seem significant, and to what extent?

8) Does the theory stand the test of time and become part of the discussions and ideas exchanged among relevant social and professional groups?

Detailed explication of the grounded theory will be provided in Chapter 4 and evaluation using the Strauss and Corbin (1998) criteria will be presented in Chapter 5.

Protection of Human Subjects

The Nursing Research Consortium on Violence and Abuse (NRCVA) developed guidelines for conducting research with abused women (Parker et al., 1990). The guidelines describe specific safety issues in contacting and interviewing abused women, and stress the importance of maintaining the confidentiality of data. These guidelines

were used to promote and ensure an ethical approach to the safety and autonomy of participants and researchers throughout the research process (Parker et al., 1990). See Appendix A for specific protocol.

Removal of identifying information.

In research with battered women, the primary safety risk to participants is the potential for retaliatory violence from the abusive partner or ex-partner. Therefore, interviews were scheduled at a time and location that was safe for the participant. A means to safely contact each participant was established at the first interaction, and verified at subsequent interactions. All identifying information was removed from raw and analyzed data. Women were offered the use of pseudonyms (to protect anonymity). All transcribed and recorded data were identified by "code" numbers and pseudonyms. All data were stored in a locked file accessible only to the researcher and her advisor. These measures were employed to guard and ensure participants' safety and confidentiality (Parker et al., 1990).

Potential for emotional stress.

Another potential risk of participation was that of emotional stress related to revealing a stressful situation. However, since the investigator had extensive experience working with and supporting abused women in crisis and non-crisis situations, it was anticipated that this risk would be minimal and if emotional distress was experienced by participants, that the PI would be able to manage the situation effectively. At each encounter, participants were reminded that their participation was voluntary, they could refuse to answer any question, could stop the interview at any time, and they could

withdraw from the study at any time. No one chose to stop an interview or withdraw from the study because of emotional distress.

Providing resource and mandatory reporting information.

Additionally, each participant was given a card listing local resources for women in abusive situations, the national domestic violence hotline number, and the name and phone number of the investigator. There were no instances of suspected or disclosed child abuse. Each participant was verbally informed of the PI's legal obligation as a state mandated reporter of child and elder abuse before the onset of each interview. This information was also provided in written format on the consent form that each participant signed. Also, if other conditions that were considered potential harmful to the participant's life (e.g., suicidal ideation) or the life of other's had been discovered, the appropriate referrals would have been promptly made.

Potential benefits of research participation.

There were also potential benefits from participating in the proposed study. Although there may be risks associated with emotional stress in talking about a stigmatizing and stressful situation, many research participants have reported relief and catharsis from sharing their stories (Brannen, 1988; Cowles, 1988; Eby, Rumptz, & Sullivan, 1997; Lee & Renzetti, 1993; Sieber & Stanley, 1988). There was also the possibility that the interview process served as an intervention that may have influenced the natural history of the phenomenon.

IRB approval and confidentiality certificate.

Before data collection, the researcher submitted a research proposal to the Internal Review Boards (IRBs) overseeing the associated institutions that were settings for the

investigation. The recommended changes were promptly made. In consideration of the vulnerable nature of the participants and the sensitive nature of the investigation, an application was made for a certificate of confidentiality from the Department of Health and Human Services. The confidentiality certificate was obtained.

After IRB approval, prospective participants were approached, the potential risks and benefits of participation reviewed, and written consent obtained. Along with a copy of their signed consent, participants were offered a 1-page abstract of the study, if they believed it would be safe for them to have it. Participants were informed that the interviews would be tape recorded, and their consent was sought. At each interaction, participants were reminded that participation was voluntary, they had the right not to answer any question, and that they were able to withdraw from the study without consequence as previously described.

Summary

Although there is a large amount of data about women's experiences of abuse, there is a significant gap in available information. Specifically, what are women's perspectives of the meaning of abuse during pregnancy, what effects does abuse have on decisions made during pregnancy, and what are the consequences to the process of maternal identity formation? The study was designed to provide additional information about the meaning of abuse during pregnancy, and the consequences of abuse on maternal role attainment as reflected by decisions about health behaviors, health care, and the abusive relationship. Dimensional analysis, a naturalistic, qualitative method of generating grounded theory was used to guide data collection and analysis. This investigation built on the author's previous research and will contribute to a program of

research on women's health, maternal identity development, and violence against women (Lutz, 1996). It is the next step in a logical progression to decrease the occurrence and negative sequelae of intimate partner abuse against women. The study provides important contextual data that will inform the development of interventions and health policy that will promote the health and well being of pregnant, abused women. Without this information, the potential for developing costly, inappropriate, and ineffective interventions to address this complex and pressing problem is ever present.

Chapter 4: Findings

This research study examined the effects of abuse on women's experience during the childbearing year as well as on decisions made during that time period. The specific aims of the investigation were to: 1) Explore women's perceptions of the meaning of experiencing abuse during pregnancy; 2) Describe the effects of abuse on decisions women make during pregnancy; 3) Generate the development of an initial grounded theory of the effects of abuse on pregnancy and on women's decisions made during pregnancy. The purpose of this chapter is to elucidate and describe the elements of the grounded theory proposed to explain women's experiences and decisions made during pregnancy within the context of an abusive relationship as revealed by the research. The initial grounded theory will be presented as will an explanation of the integral theoretical elements.

The Woman on a Bus

A participant, Hannah, shared the following story of an encounter that she had with another abused woman on a public bus. Through her story, Hannah conveyed the isolation and sadness that abused women experience:

> I was on the bus one day and there was a girl on the bus with a baby and she kind of had her head down and she was crying. And I just reached down and I put my hand on hers – I was standing, [the bus] was packed – and she looked up at me and she had a bloody nose and there was blood on her shirt and her tooth was chipped and [she was] just very sad. I asked her if she was ok and she said, "No." She said, "My husband isn't very nice. He's not a nice guy." I said, "You know, mine wasn't either." And I knelt down next to her and held her hand. She was

> meeting her father – she had left…and I helped her off the bus with her stuff. And you know, everybody else on the bus just sat there and ignored what she was going through and that was sad for me – nobody would reach out to her or help her. And I think, when it's happening to you, you feel very isolated – like you're the only one and that nobody cares – and that's what everybody on the bus was showing her…I mean she was obviously, there was blood on her clothes and her face and her hands were cut and nobody would look at her. That's how you feel.

Participants in this investigation gave voice to the loneliness, isolation, embarrassment, shame, guilt, and despair that are emotions commonly experienced by an abused woman. According to the women in this study, pregnancy compounds those feeling. When a woman is pregnant as well as abused, those emotions are magnified and entangled with feelings of hope for the future, investment in the relationship and family, excitement, and ambivalence that are brought about by her pregnancy. Her contradictory feelings are also counterbalanced by the growing realization that the relationship with her partner and her dreams for her family are quite different from the reality of her life. These contradictory and conflicting emotions were common to all of the participants in this study. By sharing their difficult and often, horrendous experiences of intimate partner violence during pregnancy and postpartum, study participants have provided important contextual information about the phenomena of abuse during pregnancy and the influence these seemingly incongruous phenomena have on women's lives and the decisions made during pregnancy.

Sample

Twenty-one interviews were conducted with 12 adult women who were either 1) currently pregnant or in the postpartum period and had experienced abuse by their intimate male partner sometime during the current pregnancy or postpartum or 2) had been abused during pregnancy or postpartum at some previous time. At the first interview, participants were asked to share their experiences of abuse by an intimate male partner. First interviews with the participants recruited in the early part of the investigation provided direction for additional questions and lines of inquiry in subsequent interviews. A significant portion of the initial interviews dealt with each woman telling her story. Depending on the declamatory style of the woman and also, her personal history, the story could be fairly short or quite long. For many of the participants, the sharing of her story was an emotional experience for the participant as well as the PI.

Second interviews were utilized to gain additional information on emerging themes, to clarify information obtained in the previous interview, and also served as a form of member checking. Twenty-one interviews were conducted; nine of the 12 participants were interviewed two times. Three participants were interviewed only one time because they became lost to follow-up. One of the participants moved and left no forwarding contact information. One participant failed to show up to a scheduled appointment with the investigator and then did not return phone calls from the PI. The other participant informed the PI that she was withdrawing from the study because of time constraints.

As previously stated, interviews were conducted at a private, safe place of the participant's choosing. Interview sites included the principal investigator's office, participants' offices, a clinic room, an in-patient hospital room, a hospital café, and various participants' homes. All of the interviews were conducted and audiotaped by the PI. The PI or a professionally trained transcriptionist transcribed the taped interviews verbatim.

Sample demographics.

Demographic information for the participants is presented in Table 2. Twelve adult women between the ages of 18 to 43 years comprised the sample. The mean age was approximately 30 years. Half of the participants (n = 6) were Caucasian, one-third (n = 4) were Black, non-Hispanic, and one-sixth (n= 2) were Arab-American. There were no Hispanic, Asian, or Pacific Islander participants. The sample was well educated; ten of the participants had graduated from high school or had attained a higher educational level.

Originally, the investigator had proposed that all of the prospective participants would be drawn from two prenatal clinics. After three months of recruiting, however, only one participant had been referred to the project and was enrolled in the study. According to clinic personnel from both clinics at that time, no other potential participants had been identified from their panel of pregnant patients. As a result, inclusion criteria and sampling strategies were expanded to: 1) allow for participation by women from the community, 2) broaden the abuse definition to specifically include emotional and or sexually abuse women, 3) add in retrospective participants from the community or clinics, and 4) utilize snowball sampling and word-of-mouth recruiting.

Nearly 60 percent of the participants (n = 7) were recruited from the community, while about 40 percent of the participants (n = 5) were from one of the participating prenatal clinics. There were no participants recruited from the other prenatal clinic and only one potential participant was referred to the investigator by that clinic, however, the study had been closed to participant enrollment at that time.

One third of the participants (n = 4) were primaparous, though all of the women reported experiencing abuse during their first pregnancies that resulted in a live birth. Nearly 60 percent of the participants (n = 7) were retrospective participants, while approximately 40 percent of the participants (n = 5) prospective participants, and thus, were either currently pregnant or in the immediate postpartum period and had experienced abuse during that pregnancy or postpartum period. Eighty percent of the prospective patients (n = 4) had also experienced abuse by an intimate male partner during a prior pregnancy.

The twelve participants shared their experiences of abuse by an intimate male partner during 37 pregnancies. Two participants reported one pregnancy that did not occur within the context of an abusive relationship; they are not included in the total. Three of the participants described terminating pregnancies because of their abusive relationship, while four women described spontaneous abortions that occurred within the context of an abusive relationship.

Table 2. Demographic Characteristics for Study Participants

	Demographic Characteristics	
Age	Range: 18-43 years, mean: 29.7 years	
Race	Black, non-Hispanic:	4 (33.3 %)
	Caucasian:	6 (50.0 %)
	Arab-American	2 (16.7 %)
Educational Status	College graduate or higher:	6 (50.0 %)
	College or trade school attendee:	3 (25.0 %)
	Completed high school/GED:	1 (08.3 %)
	Did not complete high school/GED:	2 (16.7 %)
Employment Status	Currently Employed:	6 (50.0 %)
	Unemployed:	6 (50.0 %)
Recruitment Site	Prenatal Clinic:	5 (41.7 %)
	Community:	7 (58.3 %)
Abuse/Pregnancy Status	Current abuse in pregnancy/postpartum:	5 (41.7 %)
	Past abuse/pregnancy:	7 (58.3 %)
Abuse Type	The majority of the participants experienced a combination of emotional, physical, and or sexual abuse during their pregnancies.	
Pregnancies	Range: 1-9, mean: 3.1	
Children	Range: 0-5, mean: 2.0	

Organizing Perspective: Living Two Lives

Two seemingly disparate situations – abuse by an intimate male partner and pregnancy – are inextricably linked in the life of a woman who is pregnant and abused. Because of the disparities between the two phenomena, an abused, pregnant woman feels as though she is living two different lives. Although women who are abused and not pregnant describe a separation of self, data from participants in this study indicate that the experience of pregnancy compounds the division.

Pregnancy is accompanied by a level of sociocultural investment and interest in the woman's personal life and activities that is considerably different from her non-pregnant state. An aspect of this intensified social interest in the pregnant woman's private life is the surveillance and judgment about her private life and the actions or processes occurring in her private life. This is true for women who are not living in the context of an abusive relationship during pregnancy as well as for those women who are abused during pregnancy. However, due to the pregnancy and the associated sociocultural scrutiny and potential ramifications, the stakes for revealing any abuse are extremely high. Any decision that she makes has negative consequences. As explained by one participant, "And then when you try to make the best out of a bad situation, well, you don't have any good choices. What are you supposed to do?"

An additional, complicating factor for women who are abused during pregnancy is recommitment to the intimate partner and relationship that is accompanied by hopes and dreams that are unique to pregnancy. This re-investment in the relationship and hope for the developing family is experienced by women who are pregnant and is considered a natural component of women's process of becoming a mother. However, this has not

been considered as a process or normal, for women who are abused during pregnancy. In fact, all of the study participants – even those who were unhappy or disillusioned with their intimate, partnered relationship or acknowledged that the relationship was not working for them or labeled the relationship as abusive – experienced a renewed commitment to the relationship and hope for the future. Even women for whom the pregnancy was unplanned or unwanted or who had left the relationship, entertained those same desires, at least for a time. Although a woman may have left the abusive relationship, upon discovering that she was pregnant, she would try reconciling with her abusive partner because she hoped that things would change for the better because of the pregnancy and she felt that it was the best choice for her family. This phenomenon was designated as "hopes and dreams of pregnancy". Women's hopes and dreams of pregnancy are a reflection of and are supported and magnified by the socially constructed myth of the happy pregnancy and the intensified interest in pregnancy that occurs within society, and consequently, in the woman's public life. Thus, the potential risks and costs of revealing the private life, the abuse, are significant during pregnancy.

LIVING TWO LIVES: WOMAN ABUSE DURING PREGNANCY

CONTEXT: PUBLIC LIFE
Pregnancy – A time-limited opportunity

The social importance of pregnancy

- I'm just going to play this role
- I feel like a goddess pregnant – it's such a cool experience
- I'm happy about being pregnant 'cause somebody's going to love me for me

CONTEXT: PRIVATE LIFE
Abuse – Good times and bad

The social importance of father/partner

- I didn't want to be alone
- Pregnancy was like a nail in the coffin
- It would have killed me eventually – it would have just eaten me up inside

CONDITION:

- Guarding-revealing the intersection between public & private lives
- Pregnancy

ACTIONS/PROCESSES:

- Pursuing the dream
- Enduring for the family's sake
- Engaging a dynamic balance
- Reconciling dreams with reality
- Revealing and integrating two lives

CRYSTALLIZING EVENTS

- Partner Ends Relationship
- Increased Danger to Self or Others
- Birth

INTERVENING CONDITIONS

- Commitment to Relationship
- Abuse Trajectory
- Abuse History & Exposure
- Alcohol & Drug Issues
- Social Support
- Sociocultural & Religious Values/Influences
- Age/Developmental Stage

CONSEQUENCES: PREGNANCY, POSTPARTUM AND BEYOND:
Revealing may lead to various legal, social, and personal consequences for women

	Pregnancy	Postpartum	Beyond
• **Priority**	Relationship & family	Baby	Baby & self
• **Family**	Hopes & dreams – looking for normalcy	Confronting dichotomy between dreams/reality	Relinquishing the dream
• **Relationship**	Leaving not considered	Leaving is considered	Leaving versus reconciling to stay
• **Self/Maternal Identity**	Unable to focus on	Delayed/alternative process of development	Appreciates motherhood
• **Pregnancy/child**	Stressed; unable to focus on or enjoy	Feels overwhelmed; loves child	Loves child; mourns pregnancy

The Context of the Public Life: A Pregnant Woman

In the context of her public life, the abused, pregnant woman is seen first and foremost as a pregnant woman because the abuse is usually not evident because of the private nature of intimate partner violence. In the woman's public life, people are enthusiastic about and interested in her pregnancy and developing child. Those people who are closest to her and strangers, as well, offer advice about the pregnancy and parenting and reach out to touch her pregnant abdomen. As a member of larger social, cultural, and or religious groups, she is aware of the groups' assumption that there are two parents involved in the pregnancy and concomitantly, because there is a pregnancy, the assumption that the couple's relationship is a strong and positive relationship. The pregnant woman may struggle to deal with the myriad physical and emotional changes that are a dynamic feature of pregnancy and the transition to motherhood, but often, those struggles are not publicly acknowledged or expressed. Ambivalence, vulnerability, and excitement are characteristic emotions of the pregnant woman.

Nevertheless, even when the pregnancy is a planned, desired occurrence, because of the abuse in her life or – when she is unable or unready to identify her partner's actions as abusive – the nagging feeling that something is not quite right with her relationship with her partner, she wonders whether it is the right time for her to be pregnant. She contemplates whether or not to terminate the pregnancy. Because of the social expectations associated with pregnancy and the risk of negative social appraisal and labeling, however, the expectant mother rarely discloses her doubts and ambivalence about being pregnant whether she is in an abusive relationship with her intimate partner or not.

The Context of the Private Life: An Abused Woman

In the context of her private life, abuse consumes most of the emotional, intellectual, and physical resources of the abused, pregnant woman. As a woman who is abused, she feels frightened, isolated, and alone. She is painfully aware of the sociocultural and religious assumptions and values concerning a positive relationship between partners when they are pregnant. Reflecting the values of the larger context in which she lives, she desires a positive relationship with her partner, the father of her unborn baby. Often, she is unable or unwilling to disclose the abuse to anyone because she is utterly embarrassed by the situation with her partner, feels ashamed of his treatment of herself and others, and suffers guilt for her participation in the abuse. When she reveals the abuse in her relationship to someone, she does so apprehensively, fearing that she will either disappoint that person by not doing what it is that he or she wants her to, or that he or she will fail to understand her choices and consequently, will judge her or her choices as foolish, irresponsible, or inadvisable. For an abused, pregnant woman, there is no clear or easy choice relative to the abusive relationship and her developing family because the two are entwined and interact with the larger sociocultural context in which she lives. Thus, she carefully guards her privacy, attempting to maintain a respectable public face by concealing the abuse that is taking place in her intimate, partnered relationship.

As a result, when a woman is pregnant and in an abusive relationship with her intimate partner, she lives two lives, the life of a pregnant woman and the life of a woman who is abused. One life is public and the other is private. Her two lives are never truly separate and she never fully resides in either world. The physical and emotional demands

in each life consume a great deal of energy. Their combined demands are exhausting; her exhaustion is further exacerbated by her desire to keep the two lives and the individuals associated with them separate. Although she tries to prevent people from her two lives from interacting in order to maintain her public face, her efforts eventually fail. The separation in lives has multiple consequences for the woman, her pregnancy and unborn child, and the abusive relationship. Her decision to guard or reveal her private life is not made lightly. Over time, the risks and benefits of revealing the abuse change, as will her appraisal of the entire, complex situation, and the pros and cons of guarding and revealing.

When a woman experiences intimate partner abuse during pregnancy, she creates two different contexts for herself: a public life as a pregnant woman and a private life as a woman in an abusive relationship. The next section will describe the conditions that influence her actions and interactions from the two previously described viewpoints as a pregnant woman and as a woman in an abusive relationship.

Conditions

As described in the previous chapter, conditions are the most important dimensions that exert a direct or indirect influence on interactions by facilitating, blocking, or in some other way shaping them. Conditions are those dimensions that impact women's actions and reactions in some manner. Within either context – the public life as pregnant woman or the private life as an abused woman – the same two conditions are influential. The primary condition is guarding-revealing the intersection between her public and private lives, while the secondary condition is pregnancy. Each of these conditions will be elaborated.

Guarding/revealing the intersection between public and private lives.

In guarding her public life as a pregnant woman, a woman engages in a variety of strategies to present a positive impression of herself as a pregnant, capable woman to the general public and those persons who are important to her – including her family, friends, and prenatal care providers. She is ashamed and embarrassed that her partner is abusing her – especially because she is pregnant. The pregnant, abused woman engages in guarding because she fears the potential negative ramifications of revealing the abuse such as negatively impacting perceptions of who she is as a person; the possible involvement of children's services division (CSD) with punitive actions; her perceived inadequacies as a mother and a person that are partially related to the detrimental effects of the abuse by her partner and part of the normal maternal transition; and on-going doubts and confusion about herself, the abusive relationship, and the situation. She continuously wonders what is the best course of action. Ultimately, she wants to meet the expectations of others – especially of those persons who are important in her life. As articulated by Libby:

> …Everybody expects you to be – I mean, pregnancy is a beautiful thing – and they expect you to be happy. And…they expect there to be a partner where, you know, if he was such an ass, excuse me, why [would you have a baby with him]? Once you're pregnant, it's like oh. I was embarrassed because I'm pregnant and he's gone…. I think you're totally two different people.

Another factor influencing the condition of guarding-revealing for the majority of the women was a strong sense of responsibility for the abuse that was occurring within her private life. Because she is embarrassed and ashamed about the abusive relationship

and feels some sense of responsibility for the abuse, the abused, pregnant woman feels the need to conceal the abuse that was occurring in her life. Therefore, a pregnant, abused woman engages in guarding the private life because she is afraid of what could happen if the abuse was discovered by others; guilt over her perceived role in the abuse and fighting back; worry about what her partner might reveal about her; and fear about her partner's response. For many of the women, the conviction that no one – including health care providers – could do anything to end the abuse or make a difference in the situation strongly influenced her decision to guard rather than reveal her private life.

Pregnancy.

Pregnancy is the other condition common to both the public and private life. As stated earlier, it is not the primary condition; pregnancy plays a secondary role. During pregnancy, the process of becoming a mother is initiated. Through this maternal process, the woman begins developing a relationship with the unborn child and forging a new identity as a mother, which is a different identity from the one she holds of herself as an individual who is not a mother. When her intimate, male partner is abusive during pregnancy, the profound and negative effects on a woman's sense of self are juxtaposed with her developing maternal attachment and identity.

A woman's choices are strongly influenced and structured by her relationships with others and the larger sociocultural context. During pregnancy, a woman must contend with the demands and expectations of many people. When she is abused, her choices are constrained by the abusive context in which she lives. A woman's appraisal of a given situation – especially a situation that somehow touches on the abuse, even tangentially – differs when she is pregnant as compared to when she was not pregnant.

While it influences her strategies, for the abused woman pregnancy does not hold the same meaning as it does for a woman for whom the demands of pregnancy do not have to be balanced against the uncertainty and chaos of living in an abusive relationship. For the abused woman, pregnancy is an experience that she is generally unable to fully enjoy, celebrate, or appreciate. Rather, for many abused women, pregnancy is something to be endured. To women who are abused prior to the pregnancy, pregnancy is yet another condition constraining her from ending the abusive relationship. Durriya, a 37-year-old, remarried, Arab-American, Muslim woman who was abused throughout her first marriage and had three pregnancies, retrospectively describes the perceptions she had of her first pregnancy:

> ...what I do remember about being pregnant was that it seemed like it was like a nail in the coffin. It was like, like being buried alive and you're trying to get out but then someone puts another nail in your coffin. It's like its God doing it to you or it's your body. It's your body or it's God or it's both and they're plotting, teaming up against you, and so I began to feel depressed and I think that I felt hopeless when I was pregnant that I would ever have a decent life.

Sometime after her child is born, the woman who has been abused during pregnancy experiences profound regret and sadness about her pregnancy and feels a significant sense of loss because she did not have the pregnancy that she had hoped she would have and because the abusive partner had engulfed and overshadowed her pregnancy.

Intervening Conditions

Intervening conditions were those dimensions that altered the perspective of the pregnant, abused woman. Seven intervening conditions were identified: the woman's

commitment to the relationship with her intimate partner, the abuse trajectory, the woman's history of and exposure to violence, alcohol or drug abuse issues, social support, sociocultural and religious values and influences, and the age and developmental stage of the woman. Three additional intervening conditions caused a remarkable alteration in the woman's perspective, resulting in a dramatic and often, immediate shift in her perspective, from focusing on the hopes and dreams of pregnancy to confronting the reality of the abusive nature of the intimate, partnered relationship and the actual and potential effects of the ongoing abuse on herself and her children. Because of their dramatic influence they were designated as "crystallizing events". The three conditions that served as crystallizing events were: the abusive partner ending the relationship, increased dangerousness to herself, her child, or important others, and the birth of the baby.

Two crystallizing events dealt specifically with the abusive relationship: the termination of the relationship by her abusive male partner and the woman's perception of increased danger which often took the form of an abusive event that was characteristically different from the usual pattern of abuse, and was either perceived to be life-threatening to the woman or endangering her child, children, or some other important people in her life.

Abusive partner ends the relationship.

The two youngest participants, who were unmarried, had partners who ended their intimate relationship shortly after they had been informed about the pregnancy. As a result, those participants were forced to develop a new conceptualization of what their family would be. The women were confused and ambivalent about their partner ending

the relationship. They wondered how their child would fare without a father in his or her life. However, their partner's act of ending the relationship also made the women see the abuse in a different light. Beth, a 20-year-old, single woman described how she found out that her partner was ending their relationship:

> He had some girl call me yesterday and tell me…that that's not his baby. He don't want nothin' to do with me. And that if I call him again, this, this, and this – all this stuff. And I'm like, where the hell did this come from?

Debbie, an 18-year-old participant described the negative reaction of her abusive partner to her announcement that she was expecting a baby:

> When I told him I was pregnant, he didn't believe me. And then he left me. And then he said he'd see me in nine months, and that he was going to get custody of the baby because I'm unfit – but you can't prove a mother unfit before they're even a mother but…I don't know.

Both women were confused and angry by their partner's termination of the relationship. Although their partner may have ended the intimate relationship, some form of the relationship continued since they were expecting a child together. The on-going relationship with an abusive ex-partner had many consequences for the women that will be discussed later in the section addressing consequences.

Perceived increased danger.

When the abused, pregnant woman was confronted with an increased level of dangerousness in the relationship that was perceived to be potentially life-threatening even if she had not been planning to end the relationship, the qualitative change in abuse

propelled her to leave the relationship because of the apparent imminent danger to herself, her child or children, or others.

Although physical and emotional abuse was a constant in all three of her pregnancies with her abusive partner, Juji, a divorced, Ethiopian mother of three left her partner in the midst of her third pregnancy. She describes her responses to her husband's horrific attack after he had irrationally become convinced that she was involved with another man. During his brutal attack, her husband verbally assaulted her, stripped her of her clothing, tied her up with a rope, beat her with a steel rod, jumped up and down on her pregnant abdomen, urinated on her, and threatened to kill her while their children were asleep in their beds. After hours of terrorizing her, her husband untied her, and ordered her to get dressed and then, to go to sleep. He threatened to kill her and her alleged lover after their children left the house. Juji followed his orders, barely able to walk or dress her self after the attack. When her husband had finally fallen asleep, she dialed 9-1-1 and hung up the phone. Once the police arrived, they noticed the obvious injuries to her face:

> I told them [the police officers] to take me [sic] and my kids to the shelter, because I didn't know what they were going to do to him. They said, "We are going to take him to jail." I said, "No, no, no, just take me." Because still I thought if they take him to jail, that he's going to come out and he's really going to hurt me. I said to them, "Don't touch him just take me somewhere that he can't find me."

When asked whether she thought she would have ended the relationship if not for that episode of severe violence and the resulting fear that she would be killed, she responded: "Probably I would have waited...."

Similar to Juji, Karima, a 40-year-old Arab-American, Muslim woman left her first abusive husband while she was pregnant immediately after an abusive episode that was different from his "normal pattern" of abuse. In Karima's case, the abuse she was usually subjected to was primarily emotional abuse, controlling behavior, and sexual abuse. During the precipitating incident, Karima's partner restricted her ability to leave their bedroom in order to go to work and subjected her to a several hours' long emotionally abusive tirade – spitting on her, and slapping her multiple times across the face. The incident finally ended when her mother and a co-worker arrived at their home to see why Karima was late to work. She describes her decision to leave her abusive husband during her pregnancy as follows:

> ... I packed my things and left and never went back... I was so frightened. I was willing to put up with all of the emotional things that had come along before just because divorce was so looked down on [in her cultural community], but I was really frightened by not being able to leave when I needed to leave. And at that point I just decided I needed to go away.

When asked to explain why she thought there was an increased level of dangerousness and how she determined that it was time to end the relationship with her partner, she replied:

> I think that maybe being 27 helped out some. I mean I was able to look at these things logically.... But as far as a male-female relationship, I didn't have a good

> concept of what was normal. My father was an abusive parent and abusive husband, physically and emotionally. And so when I got married, I knew that it wasn't good, but I didn't know exactly what good was. And it took getting to the point of being physically forced to sit down and take this abuse that made me realize, "No, I can't accept this." And I think, even that, it's probably only because my sister experienced such violence in her marriage and rebelled against it that I was able to identify physical violence as a marker as to when enough is enough... It's possible that I might have said well, just because I can't leave the room doesn't mean he's hurting me. But I think she provided such a strong example of saying, these little things – maybe I don't have a broken arm, maybe I don't have a black eye, but this is abuse. And I think that was really helpful for me to be able to identify this as abuse. And I don't think I identified the emotional stuff as really abusive until later on, maybe, but it was.

Her age and a history of violence in her family of origin as well as her sister's experience with intimate partner abuse were important to Karima's assessment of increased danger from her partner. Other participants similarly described the process of comparing prior experiences of abuse within the intimate relationship as a whole to the current situation as the benchmark guiding their assessments of increasing danger. However, growing up in a family where the father was abusive inhibited Karima's ability to know what was "normal" in an intimate partnered relationship. All of the participants who had experiences in their family of origin – either with substance abuse or domestic violence – described a similar impact on their understanding of normalcy within an intimate relationship with a partner. This will be discussed under intervening conditions.

Birth.

The crystallizing event labeled birth actually occurred at a time following the birth of the child – during the first part of the postpartum period up to a period of approximately 18 to 24 months following the birth of the child. At that time, the reality of the situation – that the abuse has continued or perhaps, escalated even after the baby was born – sharply contradicts the hopes that the woman held during pregnancy. That is, if the abuse had abated during the pregnancy that that peace would continue; or if the abuse continued or escalated during pregnancy or after the birth, that the birth of the baby and the resulting development of their family would be the impetus for a new, violence-free time in their relationship. It is during this period that an abused woman begins to re-evaluate her previous choices and start making new priorities, with her primary consideration shifting from that of meeting the expectations and demands of the abusive partner and maintaining "the family" at whatever cost to re-evaluating the needs of her child or children and themselves – even if that goes against religious and sociocultural values held by the woman and her significant others. As such, her image of the family unit has changed from a family constellation that includes the abusive partner as a central (if not the central) figure to a family constellation without her partner. According to Hannah, a 31-year-old, divorced, Caucasian woman:

> When you're in the pregnancy and your expectations – what you think will happen – it's all your ideal picture because you don't have any reality to base it on…so you make a picture of what it's going to be like. And that's how you get through the pregnancy and still think it's a good thing when all this other stuff's going on. But then, when you have the baby and have the reality you still have

> the hopes and dreams, but they don't match this. It's like the shapes don't fit in the box, so you have to re-do all that. And I think when people realize that, "This is what I thought and this is what's happening." Then that's when they start having problems. You know, it didn't work out and it didn't make everything better. I don't know if it's at birth or postpartum or two years down the road, but it doesn't happen during pregnancy – at least that first pregnancy for mothers.

Similarly, Faith, a 35-year-old, Caucasian, divorced mother explains how her feelings about the abuse and her partner changed dramatically shortly after her son was born:

> Well, I know definitely after I had him, my tolerance for chaos and for crap definitely got much, much less.... It's not just me any more – there's more. I wasn't just thinking about me any more. I was really worried about my son and I wanted him to have a good upbringing. And I didn't want him to be around a lot of crap, so there was definitely...a mind shift when I became a parent.

Level of commitment to the relationship.

A woman's level of commitment to the intimate, partnered relationship influenced the strategies she engaged in. Those women who were married and or lived with their partner described a differing level of sociocultural and religious expectations and repercussions for ending the partnered relationship as compared to the women who were not married or living with their intimate, male partner. An abused woman who was married to and or living with her partner was also more likely than the woman who was not married to or living with her partner to struggle with a greater sense of responsibility

for their partner's abusive actions toward herself and others. Because they were married or living together, his actions reflected upon her. Durriya explained:

> I was ashamed that I was in that situation, and that I was being treated that way, and that I was married to someone who would treat other people like that… because I wasn't the only person that he was harmful to. He was harmful to my sisters and my mother and I felt like that was my fault and I felt that I was responsible for his behavior. And so I was ashamed of that.

Abuse trajectory.

The abuse trajectory within the partnered relationship also influenced women's strategies, actions, and processes. The frequency and severity of the abuse influenced women's perceptions of the risk of danger to herself, her unborn child, other children, and others. It also influenced how hopeful she was about the future of the abusive relationship. When the abuse decreased or de-escalated during pregnancy, she became more hopeful about the abuse ending permanently, whereas when the abuse increased or escalated, she was more likely to disclose the abuse, consider leaving the relationship, or seek assistance. Karima had two pregnancies with her second husband. She ended the relationship sometime after the birth of the first child only to discover that she was pregnant with their second child. She reconciled with her partner, but only on the condition that they attend counseling.

> …he was on his better behavior for a while. Pretty much during most of the pregnancy we were in the counseling. And within two weeks of leaving the counseling, I would say, he went back to the way he was before. I think he was pretty much just putting on a front so that we could get back together. But during

> that pregnancy, I mean, things were not too bad, mostly because that was when we were in counseling and he was trying to behave himself, probably just long enough for the baby to be born.

When asked whether she had hope that their relationship would improve she replied:

> I certainly did during that period. And I would say with my first daughter with him, so it would be my second child, I think I did. At first I thought well, you know, now we're going to have a baby and he's going to be really happy about that. And, you know, for a while that did help, but he didn't stop doing his manipulative emotional kinds of things.

Alcohol or drug abuse by woman or partner.

Alcohol and drug abuse issues were problematic for several of the participants. With the exception of one woman, all of the participants for whom drug or alcohol use was problematic, had partners with drug and or alcohol use problems. Substance use and abuse by an abusive male partner was also seen without the female partner's using drugs or alcohol as well. A participant found out that her abusive partner was also abusing cocaine while she was pregnant. She focused her attention and concern on her partner's substance use and assumed that addiction was the cause of his anger, controlling behavior, and abuse. If he would seek help and commit to resolving his substance abuse problem, then, she presumed that his abusive behavior would end as well and their family would be restored. However, that was not the case.

A woman who used drugs during pregnancy used drugs before she became pregnant – it was not a habit that was initiated during pregnancy. However, the abuse in the intimate, partnered relationship frequently caused the woman to utilize drugs or

alcohol frequently. At times, she engaged in drug or alcohol us as a form of self-medication. Other times, the use of drugs or alcohol was a way to pacify or placate her partner. Two of the participants who were recovering addicts attributed their drug use to a lifelong exposure to violence. Frequently, the abusive partner would use drugs in front of the pregnant woman. The male partner often would taunt or ridicule her for using or not using drugs while she was pregnant. An excerpt from Beth:

> And then my baby's dad, you know, we were staying together, he'd come home with two grams [of marijuana] and smoke it all in front of me and think its funny, you know. And I'm like, "That's not funny." "I'm not going to smoke with a pregnant person." And, I'm like, "Ok, whatever. Well, I'll put up on it." You know, show him ten dollars or something. [Then] he'll let me smoke with him. I'm like, "That's real messed. You'll take my money."

Abuse history and exposure.

Similarly, a woman's prior exposure to violence within the family and home she grew up in, substance abuse in the family of origin, childhood sexual abuse, and or violence in her immediate cultural and social community further mediated the strategies she engaged in. Ten of the twelve participants grew up in families where domestic abuse and or substance abuse were present. One participant did not share information about her family of origin and did not have a second interview to follow up on the topic. The resulting environment of childhood exposure to some form of abuse was a home and relationships that were confusing and chaotic with long-term effects for many of the participants. As one participant, Elle a single, black woman, age 24, explained:

> So all in all, I've had abuse my whole entire life, and it's something I'm used to, but it's something that I wouldn't want done to me any more (sic). And so I've been working on not spanking my kids because it didn't feel good.

Additionally, participants perceived their religious, cultural, or social community as sanctioning or at least, not condemning intimate partner abuse which compounded the problem and when they were in their own intimate partnership with an abusive man, they felt deserted and persecuted by the very groups whose assistance, affiliation, and support they sought. In addition, one-quarter of the participants reported experiencing childhood sexual abuse. Women who experienced childhood sexual abuses considered that form of abuse as having a profoundly negative impact on their lives. Each of these abuse dimensions contributed to women's sense of confusion about what was "normal" and what was abusive within an intimate, partnered relationship. They reported difficulty distinguishing between fighting and abuse. Some women felt they had a higher tolerance for violence and abuse because of their prior exposures. They reported that it also led them to have difficulty in deciding what was acceptable behavior and with boundary setting within an intimate relationship. Women also described the problematic behavior of taking responsibility for other people's actions or co-dependency that they had developed in response to their childhood experiences.

For other women, family and social norms sanctioning abuse and fighting between partners that occurred during formative years made abusive exchanges feel normal and acceptable to them. For several women, the violence was even interpreted as a sign that their partner cared about them. Abby, a 32-year-old, African American

woman who is the single mother of five children explains the influence of growing up in an abusive home on her perceptions of violence in her own intimate relationships:

> At the time, I was married, and, even before I got married, the domestic violence was there and I believe that was what I was shown. My parents, they fought, so that's what I wanted to be like. I found a man like my dad and I thought that it was the way – how things went. That's the way it was supposed to happen if they really cared about you – you fought. Gosh, that sounds…but that's how I seen [sic] it. And, it wasn't unusual to fight – whether I was pregnant or not – because it seemed like the problem was always there – whether I had a baby or if I didn't have a baby… And, I never did think about how stressful or how much stress that caused on the baby. It wasn't even a thought.… I thought of it (the abuse) as "that's the thing to do". That was normal, for me. And, until recently, I realized that's not normal; that's not ok.

Social support.

Social support was also influential to women's assessment of the situation and informed her decision to leave or stay in the abusive relationship. Most frequently, significant social support was offered by the woman's mothers, sister, and or female friends. Reassuring the woman that the abuse was not her fault or after her partner had left her, strengthening her resolve and boosting her spirits by telling her that he was not worth her pain were two comments from participants. Listening to them and being there for them were the most useful and frequently described supportive acts. An excerpt from an interview with Libby:

> At first I worried about what everybody thought except my sister. I worried about what everybody thought. My sister, you know, she has a huge role. I mean, she's the one who..."You're doing the right thing. It doesn't matter what anybody thinks. You know what happened. You know what he did was wrong, and that's all that matters. You know what happened." So, supporting me.

Several of the women recruited from one of the clinic settings also described the helpful support offered by the health professionals at the clinic as important to them. As with her personal support system, professional support such as listening in a supportive, non-judgmental manner that conveyed respect and concern were greatly appreciated by the women. More instrumental support offered by a clinical social worker through the prenatal clinic was also considered very helpful by 80 % of the clinic participants. Assisting with housing and utilities, referral to appropriate substance abuse and other community resources, and intersecting with the legal system were some of the aspects of support offered by professionals in the context of the health care system.

Sociocultural and religious values.

The values held by the woman, her partner, her family of origin, and or her identified social, cultural, and religious community were described as influential by half of the participants. This was consistent across racial, ethnic, religious, and social groups. Illyse, a 43-year-old, divorced, Caucasian woman with two children explains about the influence of her fundamental Christian background on her choice of strategies:

> I think when I think of myself as a woman back then, I lived two very different internal lives, so to speak. I was involved with a fairly fundamental Christian church that I had been raised in that had a fairly specific dogma about behavior

> and how women are in relation to men and that kind of thing. So it was really in my background for men to be decision-makers, to be the authority, et cetera. Being raised in a very fundamental church, you are literally taught to not think on your own. This is the belief set that you have. If you are outside of that, you, burn in hell… You don't make decisions on your own. You're told what to do, what to think, and so on. And that was true both in my family of origin as well as that culture. So it was just kind of this natural or unnatural way of being. Whatever it was, it was the way that I behaved in that time….

A similar sentiment was expressed by Durriya, a remarried, Arab American, Muslim woman:

> …There was just this tremendous pressure to stay in the marriage because that was the right thing to do and it wasn't a matter about personal happiness. That wasn't what it was about. It was about fulfilling your religious duties and your role as wife and mother. That was what was supposed to be important and if you wanted to be happy and in order to be happy that meant getting rid of them – that was wrong and selfish. And so I felt that I was selfish and I felt that I was a bad mother and I felt I was selfish cause I wished that I wasn't in that situation. And I blamed myself for being in the situation, but still, you know, my fundamental feelings of dislike for him were very consistent.

Although the remaining women did not attribute any influence of specific cultural or religious values on their decision-making about the relationship or guarding the private life, they did articulate the desire and hope for the "ideal family" and the perceived stigma associated with single mothers. These images were interpreted as a reflection of

women's internalization of a common social value of the western, society in the United States. When asked what she considered as the main reason for deciding to stay in her abusive relationship during pregnancy, Faith replied, "The main reason – if I had to choose one reason – I would say fear and then, social stigma, too. My picture of a single mother…I didn't want to be that person…"

Age and or developmental stage.

The age and developmental stage of the woman also served as an intervening condition influencing her actions or processes. Several of the retrospective participants described their age and relative maturity or immaturity at the time they were pregnant and abused as contributing to their level of self-awareness, their awareness of relationship dynamics and abuse, as well as facilitating or hindering their educational or professional opportunities or barriers, which impacted their perceived options. Primarily, the younger a woman was during her simultaneous experience of abuse and pregnancy, the less options she felt she possessed. An excerpt from Durriya:

> So after the first child was born, it was only nine months and then I got pregnant with the second child. That was really devastating to me. Because by that time I was no longer in public schools, I was trying to take correspondence courses to graduate and it was just like – it felt like I was sinking deeper and deeper into this mire that I would never be able to get out of and that I probably wasn't supposed to get out of. That God didn't want me to get out of, because why else would I keep having these kids. I had used birth control; I used the diaphragm, and got pregnant anyway. So I was very depressed.

In summary, there were ten conditions identified by participants that directly or indirectly influenced the strategies, processes, and actions of an abused, pregnant woman. They include the following: 1) partner ends the relationship; 2) increased danger to self or others; 3) birth; 4) commitment to the relationship; 5) abuse trajectory; 6) abuse history and exposure; 7) alcohol and drug issues; 8) social support; 9) sociocultural and religious values or influences; and 10) the woman's age or developmental stage. Three conditions have a dramatic, and often, immediate effect on the strategies engaged in by an abused, pregnant woman, they have been designated "crystallizing events". The partner ending the relationship, increased danger to self or others, and birth are considered crystallizing events.

Processes

Processes or actions are the intentional or unintentional responses that are impelled by specific conditions. Five processes emerged from the data: pursuing the dream of the loving, peaceful family; enduring for the sake of the family; evolving perceptions of family, self, and abusive relationship; reconciling dreams of pregnancy with reality; and revealing and integrating two lives. These strategies are not linear, discrete, or time-specific, instead they were woven together.

Although pregnancy has a relatively predictable timeline and trajectory and an abusive relationship tends to become more abusive over time, the two conditions combined complicate one another. As a result, the condition of guarding and revealing the intersection between the public and private lives is less predictable because of multiple, varying intervening conditions. Consequently, the processes and strategies described do not occur in a linear, orderly fashion or for that matter, in a predictable

manner. Nor do the processes inevitably correspond with the pregnancy trajectory – except that the process of pursuing the dream does initiate early in the pregnancy with the discovery that the woman is pregnant. Additionally, the conditions influencing the processes and the resulting consequences, inform subsequent actions and processes. As a result, the woman may go through the processes in varying progression or engage in one strategy or process for a prolonged period of time. At other times, the woman will progress quickly from one strategy to the next. In the following section, each of the five processes and the associated sub-processes will be described and examples from the transcribed interviews provided as supporting evidence.

Pursuing the Dream of the Loving, Peaceful Family

The process of *pursuing the dream of the loving, peaceful family* is distinguished by the following features: the commitment to maintaining family unity; positive illusions of partner, family, and home life; and the priority is on guarding and maintaining a separation between the private and public lives because the stakes are considered too high to reveal the private life. At this point, the woman believes – or her desire to believe is so strong – that the situation can be transformed into a positive situation, that peace and love will mend the relationship with her partner, and the abuse can and will end.

Confronting the reality of pregnancy.

An integral sub-process of *pursuing the dream* is *confronting the reality of pregnancy*. In this sub-process, the woman comes to terms with the fact that she is pregnant. Whether the pregnancy was desired or undesired, planned or unplanned, is no longer important because she is pregnant and that is a fact. As stated by one of the participants with an unplanned, undesired pregnancy, "Well, I'm going to be a mom – I

better deal with it." In contrast, the partner's response to this information and his feelings about her pregnancy and their unborn child are very important and influential at this stage.

Reinvesting in the relationship with partner.

Reinvesting in the relationship with partner is a second sub-process. When engaged in this sub-process, the hopes and dreams for her family and the life with her partner begin to surface and take precedence over any individual hopes and dreams. *Reinvesting in the relationship* is considered by the woman to be beneficial for the entire family – especially for the unborn baby or other children. The strategy *playing the role* is one of the primary ways that the woman is able to *reinvest in the relationship* and to guard the intersection between her public and private lives.

Playing the role.

Playing the role is another sub-process of *pursuing the dream.* Many of the women described themselves as *playing the role* of the happy, pregnant woman. If she *plays the role* well enough, then her desire may be fulfilled and her dreams for the happy and abuse-free family and pregnancy will come true. The woman attempts, with varying success, to suppress and ignore any doubts she has about the relationship and suspicions that the relationship is abusive. Faith described her response to finding out she was pregnant when she had some concerns about her relationship and her use of the strategy *playing the role*:

> [I was] scared to death, I think. I mean most people do feel that way, even when you want to be pregnant. It's the shock that it's actually happening. And, also, since I knew my relationship was not going well, pretty freaked out by that, but

> overall excited. And, I think, maybe you always have some hope that it will just be a fresh start. And you always have your pictures of what you think your pregnancy or your life is going to be like, or your marriage is going to be like.... I thought, "I'm just going to play this role. I'm going to be this happy person, happy pregnant person, and everything is just going to work itself out." Knowing that that's unrealistic...

An excerpt from an interview with Illyse also illustrates the sub-process of *playing the role*:

> And so I played my part, in those things.... And I had this Pollyanna – well, I mean, this happy little family pretend life rather than really waking up and saying, you know, something is really screwed here. So that was that duality.... I had really shut down my instincts.... I spoke a lot about isn't this fun, isn't this a nice, happy family, but really deeply knowing something is way off here, but just keeping that down, feeling ashamed of that.

Women described playing the role as a strategy with the possibility of effecting change in the relationship. That is, if they acted in a certain way, then that would be the way things would turn out.

Understanding the rules.

Another sub-process is *understanding the rules*. In this sub-processes, the woman attempts to discover and understand the unspoken rules set by her abusive partner that are constantly changing within the context of the abusive relationship. She holds the assumption that the rules are understandable and if she understands the rules, then she will know what is expected of her, will do what is expected of her, and hence, peace and

happiness will ensue. Illyse explained, "Maybe if I behaved differently, it would be different, maybe if I switched this."

Negotiating the tasks of pregnancy.

Another sub-process that is intrinsic to the process of *pursuing the dream* is *negotiating the tasks of pregnancy*. This sub-process begins in the first process and continues throughout the pregnancy and the year following the birth. See Appendix F for a summary table of maternal tasks within an abusive relationship. Seeking safe passage for the baby, developing a relationship with the unborn child, ensuring acceptance of the child, and developing a maternal identity are all incorporated in *negotiating the tasks of pregnancy*. From Faith:

> I always wanted a baby. And, you know, it's funny because I think right when I found out I was pregnant and then a few days later I started having bleeding and I was, like, oh. I think that just – for me, anyway, just makes you, like, oh, God, you've got to get serious about this. You have to know what a gift you're getting and, you know, like, you get really scared that you're going to lose the pregnancy, and then everything changes, kind of, or just becomes more intense; like, maybe your feelings about the pregnancy, or it did for me.

Confusion and contradiction are hallmarks of this sub-process. Messages from her self, her partner, and important others regarding the abusive relationship and or the pregnancy are contradictory. She wonders, "What is the reality of my situation?" Others may express their opinions about her pregnancy, her suitability as a parent, the timing of the pregnancy, and her choice of father. Because the opinions of others often are different from her own experience, she is unsure of what is real or true. Her desire to

have the dream family, leads her to suppress of any doubts raised by others, which often echo her own inner voice.

Enduring for the Family's Sake

Enduring for the family's sake is the second process. As reflected by the processes designation, "the family" is the key consideration for the woman at this time. As explained by Libby:

> I tried everything because I wanted that family. I wanted, you know, us to be together, and then – so I could put up with a lot – and then when I got pregnant, I just couldn't do it any more. It was too much on me. I was a wreck inside. So, yeah, I think you do put up with a lot. Every woman wants that family when they are pregnant. You know, they don't want to be alone…

In this process, the woman endures the abuse because she perceives staying in the relationship and working within it to create the home and family of her dreams is considered the best thing to do for her own children and family or for her larger, extended family. Her individual needs or desires are secondary to those of the important others in her life, however, she continues to hope and dream that the situation will improve and the abuse will end. However, her hope has dulled a bit and the emphasis has been shifted, albeit, often unconsciously, on enduring the pregnancy and surviving within the relationship and the family. Illusions about family and home life continue to be of high value and import. She has the growing suspicion that things are not right with her intimate, partnered relationship, but she continues to hope the situation will resolve and the relationship will improve over time. Her priority continues to be guarding and maintaining the separation between the private and public lives. According to Faith, "It's

just like you are constantly hiding.... and then for me, to have all this stuff getting discovered and then to kind of get dinged for that, there's a certain amount of fear that's practical fear for your kid." Because of the emotional pain she is enduring and the need to validate her experiences, she may reveal the abuse to someone she feels closest to – often a family member like her mother, sister, or a female friend. Data from Libby, who was raped by her ex-partner during pregnancy:

> When I got home from the hospital I called my brother in Idaho and told him [that her ex-partner had raped her], and I made him swear not to tell anybody because I was embarrassed. My brother and I are really close. And so I didn't want to tell my mom and dad because they were up there, you know. I didn't want them... So Monday, before I talked to him [her ex-partner], I went and talked to my sister. And she asked what was wrong with me because I was just – I couldn't maintain my composure – I was just, it was awful. And so I told her, and she told me to tell mom and dad. I couldn't face them, so she called them and told them.

The abused pregnant woman wonders what would happen if her private life were fully revealed.

Doing whatever is needed to maintain the family unit.

Doing whatever is needed to maintain the family unit is a sub-process of *enduring for the family's sake.* In this sub-process women resolve themselves to staying in the relationship as it is. For some, the pregnancy is considered a sign that this is the way her life is supposed to be – even if it is not the life that she pictured or wanted for herself. Intensifying feelings of vulnerability and embarrassment make her unlikely to disclose abuse lightly. Her vulnerability is in part a component of her emotional journey as a

mother, but it is also related to her developing awareness of the abuse and a growing inability to ignore her sense that something is wrong with her intimate, partnered relationship. Karima described her sense of vulnerability as a pregnant woman in an "unhappy" situation:

> I had a lot of mixed feelings about it (the pregnancy). I was glad because that was sort of proof to me that, yes, everything was working: I was fertile; things were going well. And of course I wanted children. I was 27 years old. But, on the other hand, I knew that this marriage was not going well. I didn't at that time have thoughts of leaving, because, coming from an Arab background, once you're married and divorced, you really have no worth anymore.... As far as being pregnant, I think the main feeling I had was at that point I felt really helpless because now I'm pregnant. I'm expecting a baby. I don't want to do this by myself.

Balancing demands and expectations.

Balancing demands and expectations becomes an integral sub-process as women attempt to maintain equilibrium despite conflicting expectations and demands between her public and private lives. She works at balancing conflicting expectations and demands about her behavior, responses, time, energy, and feelings. Within the context of the public life, women balance expectations – her own, her partner's, and others' for her behavior, responses and feelings. There are expectations that she holds about being pregnant, having a family, being a partner, being a parent, and having a partner. Her abusive partner also has expectations of her. Faith describes her perceptions of the

contradictory expectations from others about her relationship with her abusive partner and her own fears about people's perceptions of her and her decision-making:

> .... I think you feel like maybe people are gonna be critical and that, you obviously you should just leave. And then like from his parents or his mom, she never would have ever advised me to leave. So I knew where people stood, just on the grain. And, you know, if there was any pressure from her, it would have been, just to work it out, you know, everybody goes through hard times. But you do, you feel like, "Oh, what will people think about me? Am I a big wimp because I'm still in this relationship?" Or, you know, that I should leave, or that's the thing that you do and you're not doing it, and, " I wonder if people think I'm weak"...

As reflected by the previous two interview excerpts, abused, pregnant women perceive individuals such as family, friends, interested community and religious members, health care providers, and others as holding expectations for how she and her family should behave. Because of these expectations, women feel ambivalent about what how they should respond to the situation. Very often, these expectations are influenced by the sociocultural value that the group places on pregnancy and family and the myths associated with pregnancy, family, and violence.

Negotiating opposing expectations and demands.

The pregnant woman also engages in the sub-process of *negotiating opposing expectations and demands*. Being in an abusive relationship is very demanding for a woman. Likewise, pregnancy is also emotionally and physically demanding for a woman. To compensate for the contrast between opposing demands, women negotiate

between the opposing expectations and demands that are associated with pregnancy and abuse. Hannah describes her efforts to *negotiate opposing demands.* Hannah's partner expected that she would smoke marijuana – in spite of her pregnancy. Hannah wanted to quit using marijuana because of her desire to do something healthy for her pregnancy; however, the stress of the on-going abuse was difficult for her to cope with:

> I smoked marijuana before – probably from the time I was about 18. I was pregnant when I was 23 and at the time I got pregnant I quit and I had some negative repercussions from him from that. He treated me differently. He didn't want to hang out with me because I wouldn't do it with him. And I didn't smoke until I was about five months pregnant when all this started going on and the stress was – I don't know, whatever got to me, and I started doing it again. I thought of it kind of as a way that maybe he would want to be there, or that part of it would go away, but it didn't.

Engaging a Dynamic Balance

In this process, the abused, pregnant woman continues to hope that things will change, but she has begun considering other options. She is becoming more disillusioned with her dreams and hopes for family and home life, but feels unable to change the situation. She continues to hope for the best. She worries about her ability to "make it on her own". The pain that she feels as an abused woman increases and her ability to silence her inner voice is weakening. She may reveal the abuse to people she feels closest to. She may also disclose the abuse to a health care provider if she feels they are genuinely concerned about her as an individual or if her need to seek help outweighs her feelings of embarrassment about the situation and the potential for negative outcomes. Although she

may divulge the abuse to others, she remains sensitive to their responses – especially the responses of significant others. She worries about the consequences if her private life is revealed.

Examining contradictions.

Examining contradictions is a sub-process of *engaging a dynamic balance.* In this sub-process, the abused, pregnant woman critically and carefully begins to examine the contradictions within her life – especially those contradictions pertaining to her hopes for the intimate, partnered relationship and the reality of the relationship, but also include the perceptions that she holds of her self and family as well as the paradoxical demands and expectations that she and others hold. As a result of the declining ability to silence her inner voice in light of her growing pain, she begins to consider the contradictions between her perceptions of the relationship with her partner, her definition of family structure and constellation. At this time, she starts tentatively labeling her partner as abusive, if only to herself.

Libby, a 28-year-old Caucasian woman actually was in the process of ending an abusive relationship when she discovered she was pregnant. Libby tried to reconcile with her partner, the father of her unborn baby, several times because of the pregnancy. Following an incident where her partner beat her school-age child, and that child pleaded with her, Libby decided that the relationship would not work that she could not expose her children to the abuse and that her partner was not going to follow through with the promises that he had made to end the violence, stop drinking, and attend an anger management course. Libby described this process as follows:

> When you're in a personal relationship, you're not looking outside the box, you're in the box, and sometimes you need someone from the outside to look in and say, "Hey." Towards the end I was doing that. I was stepping outside and examining everything.

Evolving perceptions.

As a result of her scrutiny of the contradictions in her life, the pregnant, abused woman becomes aware of her *evolving perceptions* of her sense of self, the relationship, and her child. Her *evolving perceptions* are also influenced by the process becoming a mother, as well as the interactions that she has with her larger social, cultural, and religious group. In her evolving perception of self, she begins to see herself as a mother. This is differentiated from being a pregnant woman or as a woman who is an individual. Although her intimate partner and family is integral to her construction of her self as a mother, she is troubled by the inconsistencies and inequities between what she considers a family and a father and partner should be and what her experience has been.

As a result, she begins to consider her partner as less important to the family because of the negative effect he has had on their family. She begins allowing for a family without him at the head. At this time, she starts prioritizing her own and the needs of her child or children. Although she continues to consider the values and influence of important others – including her abusive partner – they become less important to her as her pain and the contradictions increase. Thus, she moves from listening and weighing others' influence and silencing her own voice to hearing her own voice. According to Faith:

> "...the reality of the situation and living through it, you can't deny how scary it is and how confusing it is, and how your being pregnant on some hand that makes you put up with more because you're afraid to be by yourself because everybody – you know, you're supposed to have a mom, a dad and a baby – that's the way it's supposed to be anyway. So it makes you put up with more, but then it also makes you put up with less because I think, ultimately, becoming a mom – I don't know if it made me respect myself more or it made me realize there's more to life than just me and thought, I really wanted my son to have a better life than what I was living, what we were living, so it was weird because it made me put up with more for a long time. It's the fear, and then it made me – having him made me ultimately say, "No way." And I think knowing myself, that I would have gotten to that point, but maybe it would have taken me longer because I – and when you're in the middle of a situation it's really hard to make decisions and your ability to think rationally is affected – and so I could see that it's a scary thing to leave a marriage, that it could have taken me a lot longer.

Reconciling the Dreams of Pregnancy with Reality

The process of *reconciling the dreams of pregnancy with reality* is characterized by the abused woman's focus on surviving and taking care of herself and her child or children. At this point, she definitely knows that something is wrong with her intimate relationship – even if she does not definitively or publicly identify her partner as "abusive". She continues to worry about her ability to "make it on her own". Her fear and depression increase. The costs of guarding the private life are too high to her. She judiciously discloses the abuse to others, mainly following an abusive incident. She

continues to be embarrassed, ashamed, and sensitive to other's responses – especially those of significant others. She begins listening to her inner voice to determine the right path for her. She worries about the consequences of revealing her private life to all. She worries about the impact of the chaos, violence, and abuse on her baby and other children. She feels overwhelmed, scared, depressed and anxious. Either she reconciles herself to endure the abuse and continue in the relationship as it is or with new rules or she begins making plans to leave the relationship.

Surviving.

In the sub-process of *surviving*, the woman relinquishes some of her long-held hopes and dreams of pregnancy as well as the associated expectations of others. Instead, she focuses on surviving: surviving for the duration of the pregnancy. She focuses on the birth as a foreseeable deadline. When asked about whether she was able to enjoy her pregnancy at all, Libby responded:

> I hated it.... My whole body changed, my whole – I mean, I was sick, I was – they put me on Paxil, they put me on all these medications. I wasn't me. I wasn't happy. I didn't have that glowing that women get. I didn't have that. He robbed me of that again, so it was like, I don't know, I didn't enjoy it. I wanted her out. I'm glad she's here now. I mean I wouldn't change it.

After the baby is born, she will re-evaluate the situation. By letting go of some of her hopes and dreams, she allows herself to focus on her child. If she has the necessary emotional reserves, she develops a new appreciation for her child and her role as mother and engages in educating herself about the baby and it's development.

Trying to understand the abuse.

She commences the sub-process of *trying to understand abuse.* She asks herself such questions as, "What is abuse? Why did it happen to me? Why didn't I recognize it when it started happening?" Within this sub-process she also begins to try to understand how her past choices brought her to the current situation. Through this process she comes to understand that her partner's weaknesses and problems are his own and accordingly, that he is the one who is responsible for his abuse – not her. Abby describes the process of understanding that she began after she sought treatment for her addiction to cocaine in the midst of her pregnancy:

> I would love to be able to have been with or to have made a life and a new start and been a family with one of my kid's dads, but I'm looking at all of my choices and me not getting to know myself and how I keep picking the same kind of abusive men. That's a factor I find in all the men – they're abusive. Whether it's mentally, physically abusive, emotionally or economically, they are. And that's why it's so important for me to be looking at this issue of my domestic violence because that's what took me into using. That's what took me into the choices that I've made. And it really worries me because by me doing that I have also made choices for my children and they have been exposed to that – like I was. So, you know, and then I have my old stuff, where my parents are still together and I'm like, "Why couldn't I make it work?" But I know that I want more and that it wasn't meant to be.

Revealing and Integrating Two Lives

Revealing and integrating two lives is the final process identified in this investigation. At this point, her focus has completely shifted to her own survival and taking the best care of her child or children. At this time, she labels her intimate relationship "abusive". Although she continues to worry about her ability to "make it on her own" she feels that where she is now is better than where she was. According to Juji:

> ...I used to think that a man is not just for sex only, that he can (sic) do everything for me. But actually I've been doing it by myself, but I didn't notice that until now; that I don't need a man in my life or in my kids' life to do things for me when I know how to do it.... They told me that, "You need to marry a man who will give you this and that." I don't believe it because I've got a job. I go out there and work like people. Even like I said, I'm not a millionaire or have a lot of money in my bank, but at least I'm happy and my kids [are] happy.... And so that's what matters to me now.

Mental health issues such as depression, anxiety, and PTSD continue, but it is likely that she is receiving support and services to help her deal with them. She discloses the abuse to others, but continues to be embarrassed, ashamed, and sensitive to other's responses. The doubts that she holds about the relationship begin to surface. As a mother, she worries about the impact of the chaos, violence, and abuse on her baby and other children. At this point, she has ended the relationship or has a plan to do so.

She may reveal her abuse history to her health care provider if she feels it is relevant or if they have a positive and trusting relationship. As the pain of living two lives grows to be unbearable or begins to outweighs her embarrassment about the

situation and the potential consequences. If her partner is involved with their children, often some level of his abusive behavior continues and her life continues to be complicated and frightening. She worries about keeping her children safe when they are with their father and she is not with them. Legal concerns may surface. Common problems include child custody and visitation as well as criminal and civil issues. She dreams of and begins to act on providing a different future.

Consequences

Outcomes or results of actions, strategies, or processes are designated consequences. Consequences were organized into three time periods: the prenatal period, postpartum, and beyond. The pregnancy/child, self/maternal identity, and abusive relationship were the primary foci of the consequences. Overall or global consequences were categorized as legal, social, and personal consequences. Legal consequences included such issues as custody of children. Rejection by family or friends and homelessness were social consequences, while personal consequences were increased violence or mental health problems.

Prenatal Period

The prenatal period was classified as the period of time from the presumptive self-diagnosis of pregnancy to the delivery of the baby. Consequences in the prenatal period relative to the pregnancy/unborn child, self/maternal identity, and the abusive relationship will be presented.

Considering pregnancy termination.

Nearly all of the participants considered terminating one or more of their pregnancies with their abusive, intimate partner. For some participants, coercion by their

abusive partner to terminate a pregnancy was another example of his abusive action and desire to control her. Even women with religious and spiritual values opposing pregnancy termination contemplated whether or not to consider terminating the pregnancy. Somewhat surprisingly, women who had planned, desired pregnancies, often considered termination because of their growing awareness of the abuse within the relationship. All of the participants described their ambivalent feelings about becoming pregnant while they were in an abusive relationship. Three of women terminated pregnancies while in an abusive relationship and another participant utilized emergency contraception to prevent a pregnancy following unprotected intercourse with her abusive partner. Two of the participants who terminated pregnancies did so under considerable duress from their abusive partners. They felt coerced into that decision which went against their own desires and reported later regretting making that choice. According to Abby:

> Then I had feelings around him, about him not wanting to have the baby.... This time I said, I am not – no matter what has happened – I am not going to do that because I didn't want to go through that the first time. I chose to do that and that didn't feel good then and it doesn't feel good now and you're going to have to deal with me being pregnant.

Another participant, Illyse, chose to terminate a third pregnancy rather than having another child with her partner. She did not regret her decision. Instead, she saw pregnancy termination as her only option if she ever was going to be able to leave the abusive relationship:

> I had one pregnancy after Jon (her son). And I knew I would not have another child with that man. I knew it. I had to do something about it. And I went and had an abortion. I've never felt so sick in my life, but was very clear I was not going to do this again because I felt like it kept me in a place of dependency. If I had an infant, how am I going to handle three kids on my own? You know, I guess I gave some of my power away, certainly, but there are areas in which I am clear. Women talk about being affected by abortions, and I have never once thought I would make a different decision. I've been thinking about this since the last time I talked with you. And, on the other hand, I adore my two children and I would have adored a third. They don't know. I don't think it's right – I wouldn't tell them – some day they may know that, or not. But I didn't have the same commitment, if you will, to the fetus – to the fetus – to that child as I do to my born children. And I wanted it out. Primarily, I wanted to get myself out.

One of the participants, Elle, experienced abuse by a man she described as her "fling" as well as by her mother during her first pregnancy when she was 16 years old. Over time, she became addicted to crack cocaine and used drugs throughout the second pregnancy primarily because she did not care about the pregnancy. She regretted her actions immensely after her daughter was born. Another participant elected to use emergency contraception to prevent an undesired pregnancy with her partner – just one month before she ended the abusive relationship.

Focusing or not focusing on the developing baby.

Due to the demands of living in an abusive context, initially, the pregnancy and developing baby are not the woman's primary concern. Physical symptoms and even the

unborn baby's movements may be distressing or overwhelming to her – another sign that her life is out of control as well as one more thing to cope with. Beth, a 20-year-old African American woman whose abusive partner ended the relationship described how she was feeling midway through her pregnancy:

> Physically, I hurt. I hurt everywhere. Usually, sometimes, I always feel that the baby moves all the time. It's really irritating. The doctor told me not to say that about the baby. I don't know I get bored – or sleepy. I'm very sleepy all the time. Emotionally, I just wish that he was (sic) here to go through it with me.

In contrast, several women described their enjoyment of the pregnancy and focusing on the pregnancy in order to avoid thinking about the abuse or the situation with their partner. Illyse explains:

> I was very excited about being pregnant. And I love being pregnant, you know, big ripe belly and all of that kind of thing. But it was almost as if I was in a bubble in my relationship; that I was in a relationship with a child, not in a larger normal relationship.

Although the pregnancy and her child may not be her primary focus, the abused, pregnant woman tries to do the best thing for her baby during the pregnancy, but because of her limited control over her life and her desire to keep the peace, she is not always successful. Like women who are pregnant, but not in an abusive relationship, women who are abused during pregnancy develop a growing attachment to their unborn child.

Heightened vulnerability.

Women expressed a heightened vulnerability during pregnancy that was different from their non-pregnant state. As explained by Karima, "But as far as being pregnant, I

think the main feeling I had was at that point I felt really helpless because now I'm pregnant. I'm expecting a baby. I don't want to do this by myself." Fears about being alone or single parenting were described and influenced the pregnant, abused woman's growing sense of dependency on the abusive partner. The woman wonders whether the pregnancy or her partner's negative feelings about the unborn baby cause his abuse. Correspondingly, she questions whether the end of the pregnancy and the birth of the child will end the abuse.

Women also feel vulnerable about the potential fall out from any decisions that she may make. For example, if she leaves the relationship, she worries about how she will make it as a single parent both economically and in providing the necessary day-to-day care for the child. She also is worried about the harm that will come to her child if that child is raised without a father. She also worries about disclosing the abuse and the negative potential consequences that will follow her disclosure. Fear of losing her child to her partner or foster care, being seen negatively, and other punitive acts were all expressed.

Constant change – wanting the baby out.

Ongoing physical and emotional change over trimesters are a given in pregnancy but they are intensified by the immense emotional and physical challenges associated with the abuse. As the pregnancy went along, they wanted it done with. They were tired, stressed, overwhelmed, in pain, and uncertain about the future. According to Hannah:

> I – as my pregnancy progressed – I was excited about it in the beginning, and I remember, probably by the time I was about five months, that it was just a hassle, but I wasn't excited about it, and I didn't really care. It kind of patterned his

> behavior when he was no longer excited about it. It's hard to be excited about it when the person in the room with you doesn't care, like nobody to share it with. I was three hundred miles away from my family, so I just had my husband. And kind of as time went on I was more uncomfortable, and I believe that all the aches and pains I had, and then not sleeping, was directly related to the stress of the relationship effect on the pregnancy. I think I would sleep like two hours a night, be up and not be able to go back to sleep, stuff like that. I hurt all the time. I was just – I wanted the baby out. I was done. And I wasn't eating right. I didn't eat a lot of crap, but I just didn't eat when I was hungry, or eat what I was craving, or really pay attention to my body, so that I shut it off.

Several participants described significant abdominal pain or other unusual pain during their pregnancy that seemed out of proportion to what one would expect during pregnancy. Multiparous women compared the pain they were experiencing to their experiences in the first pregnancy. Participants who voiced their concerns to their prenatal care provider felt as though their concerns were not taken seriously. Gillian described her experience with pain during pregnancy and her health care provider's response in the following way:

> I don't remember being like that with my first child, when the baby moves it hurts. When I touch her and she's in certain spots, it hurts, I mean to the point where it makes me cry. You know, I tell them that and they just pass it off as nothing. "That's just a normal part of pregnancy." Oh, what did they tell me? That it hurts because my body's releasing a chemical for me to get ready to deliver that separates my pelvic bones, and that's why I'm in pain. That's what they told me.

> They never checked me, they never pushed on nothing, they just gave me that as an answer and checked me out and gave me a new appointment. Which is sad, because she's supposed to be the specialist…

Prenatal care.

Two women reported delayed entry to care for one of their pregnancies as a result of the abuse. For one of the women, loss of insurance inhibited her from seeking and receiving prenatal care. For the other woman, fear that her partner would find her caused her to avoid seeking prenatal care. In general, women attended prenatal care regularly, but when other conditions intervened, prenatal care was disrupted. For example, a participant who used drugs during pregnancy reported avoiding prenatal care to avoid discovery of her drug use. Another participant, frustrated by her treatment by medical providers after an abusive episode, avoided prenatal care for a period of several months. Thus, women attend, seek, and avoid prenatal care depending on her particular life circumstances. None of the women saw their partner as restricting their access to prenatal care. Although several women described not wanting their partners to attend their prenatal care appointments because they feared being embarrassed by their partner or feared that he would reveal something that she did not want her provider to know – such as her use of drugs or how they were living.

Women sought prenatal care providers with specific personal or professional characteristics that helped her maintain her public face. Several participants described choosing a female provider or a nurse midwife because they wanted to be nurtured. However, one participant who had gone to a male obstetrician for care during both of her pregnancies speculated that she might "have been more open and available to speaking to

a female than a male. And it's odd to me even now that I choose a male OB." Women sought education about pregnancy and abuse – both substance abuse and intimate partner abuse. They queried their health care providers about potential effects of drug exposure or trauma during pregnancy to their baby. Some were frustrated, disappointed, and angered by health care professions providing what they perceived as inadequate information. They felt their concerns were minimized and dismissed. Multiparous women compared symptoms between their pregnancies. Only the prospective, clinic participants were satisfied with the prenatal care they received and felt that they had received useful, appropriate information from their prenatal care providers. Several women pointed out that books about pregnancy written for the public also failed to provide the information they were seeking about abuse and or substance abuse. An excerpt from the interview with Gillian:

> They told me that they don't know enough right now to tell me. But I read my book, *What to Expect When You're Expecting* if you've done drugs, you know, then you need to be honest, so that way they can give you the best treatment possible. I got more treatment, I got better care with my first daughter whom I didn't use dope with, than I'm getting now from a specialist, so I mean they just ask me questions and they walk out the room.

When asked if she thought she was being treated differently because of her drug use, she replied:

> I don't know. I think maybe they're just too used to it because, like I said, when I go to her she just does people that have done drugs during their pregnancy, so I don't think they really get involved. I don't even feel like my doctor even knows

> me. I mean I could care less if this doctor delivers this baby or if somebody at another hospital did. Because, you know, I don't have that connection. She never sat down and talked to me, nothing. And I've been there five times now. You know, I don't think they get involved with you on a personal basis. They come in; they examine you; they leave. I mean, I told them about me bleeding, you know, and heavily, too, for two days last week, and she's like, "Well, would you like us to check your cervix?" Okay. Well I'm not a doctor, you know. Do what you all think is best. I mean, if that's what needs to be done, then yeah, something, but that's not normal, you know. And they just wrote it in my chart, and then gave me an appointment for next week.

Women followed or rejected their health care provider's advice depending on how their advice fit with her schema. Women decisions to hide or disclose their abuse were based on many factors: their own process of guarding and revealing the intersection between their public and private lives; their assessment of their health care providers motivation for inquiry; their need or desire for assistance; their assessment of the risks and benefits of disclosure; and the type of relationship or connection they had to their health care provider.

For many participants, the type of abuse screening – the content, provider manner, and timing of the screening were important variables influencing their assessment of the screening questions as well as the reason behind why the provider was asking about abuse. Hannah describes her experience with abuse screening:

> I did have a midwife, and I do believe that she asked me, you know, those pat questions [about abuse] at the beginning. But I had never – I wasn't experiencing

> any physical abuse, and I didn't identify the sexual abuse that I was experiencing, so, you know, it was like no, no, no, whatever. I didn't feel like the questions that were asked really covered what was going on. It was more emotional at that point. But it doesn't really address that.

Therefore, asking three or four routine screening questions at the initial prenatal visit failed to be seen as reflected by Hannah's experience. Nor did those questions convince her or the other participants in this investigation, that disclosing her partner's abuse to her provider would in any way be helpful to her.

Embarrassment was another key reason for not disclosing the abuse or for avoiding care after being injured by a partner. When women felt that their health care providers were genuinely concerned about them and when they thought they would not be judged harshly or negatively by them women were more likely to disclose the abuse in their private lives. As one participant explained, "I'm sure it's not any surprise to anybody –just how positively mortifying it was to have to deal with something like that. I can't say how embarrassing it is enough times."

Likewise, when pregnant, abused women abuse substances because she fears disappointing others; does not want to risk unknown consequences to herself, partner or family; or does not consider the potential affects on her child; she often will not disclose how she "deals with it". Instead, she may avoid prenatal care altogether. According to Anna:

> But then when I came back with this pregnancy, I wasn't being honest with them and they knew I was using. And, of course I didn't want to go back because I was

> using and I didn't want them to know and it was more like I could see the looks in their eyes how they just they were trying to help me, but I was just so gone.

For some participants, a prenatal care visit was a occasion when they were nurtured, focused on, and cared about in a way that was very different from what they were experiencing in their private life. For those women, prenatal care provided a respite from the other negative aspects of her life. Faith describes her feelings about the prenatal care she received:

> I never worried about going in for care, because I really looked forward to my visits. I was just so excited about the baby and I loved to go in. There really wasn't anything that we did that much...just to go in and visit ...and to have that time where I was just, you know, thinking about the baby, that was a big draw for me so, I really liked going in for my visits.

Participants voiced many opinions about the type of prenatal care they had or had wished they had received. Empathy, concern, connection, taking time at the visit, and not just focusing on the abdomen were some of the essential components of appropriate prenatal care for abused women that were offered by participants. Understanding the woman's cultural context was also considered an important component of sensitive, appropriate prenatal care for abused women. Anna offered the following advice for providers caring for abused women during pregnancy:

> I would say follow their gut feelings.... What I really think helped me this last birth was people talking to me – not at me. Not having that better than attitude. I felt people really, genuinely cared. For physicians really being more aware of what's going on – going to seminars. And like, for example, I went to one for

domestic violence for the African American woman just last week, [knowing about] certain things that apply to each culture...they're stereotypes, but also things of reality.

Consequences to self/maternal identity.

The woman who is pregnant and abused questions her ability to mother. Although this may also be common for women who are engaged in the process of becoming a mother but are not abused, the relentless negative effects of abuse on women's self-esteem further compound her doubts. The pregnant woman seeks the counsel of and connection with her own and other mothers, but often feels disconnected from them because of the abuse since she may have isolated herself because of the abuse or her partner may have isolated them as part of his abuse. She has difficulty balancing expectations and demands. She feels embarrassed, ashamed, frightened, alone, stressed, overwhelmed, guilty, and confused. Her feelings about and perceptions of her life, the pregnancy, the abuse, and her family situation fluctuate. Mental health issues are common during pregnancy. Anxiety, depression, and for some women, post-traumatic stress disorder (PTSD) were experienced. Some of the participants sought counseling services.

Process of becoming a mother.

The context of abuse alters the process of assuming a maternal identity and generally hampers a woman's ability to fulfill maternal tasks of pregnancy. Because of the ongoing stress of living in an abusive relationship, it is difficult to find the time or energy to focus on the pregnancy. She engages in playing the role of the happy, pregnant woman in order to convince herself and others that is how her life really is. She worries

about depriving her child of his or her father – often, her worries are based on her own childhood experiences.

Two of the women who left their abusive partners during pregnancy experienced negative repercussions from their communities because of their decision making them feel ostracized by those very people they most wanted support and acceptance from. According to Karima:

> There were issues of being pregnant and trying to participate in a Muslim community, pregnant and no husband in sight. And some people knew me. They knew the situation. But I had things happen; like, a phone call from one of his friends telling me that I couldn't divorce him because if I did, I would just be nothing. My life would be over. I mean, he was saying, "Think about your life as a divorced woman. You would be nothing." That was the kind of support I got from the community. So, really, what happened for me was a complete break from the community I had been with my whole life. And shortly after that we moved. My daughter was two weeks old when we moved.... And I think that was part of it. I mean, there were other reasons for moving, but part of it was, there was nothing left for me there. Our closest friends had been involved in arranging the marriage, and they weren't about to take my side because my husband was a son of their closer friend.

Self-medicating.

Women engage in various strategies to cope with the stress of being pregnant and abused – smoking, drinking alcohol, using drugs, over or under eating, sleeping, avoiding home, working, and shopping for the baby were some of the activities engaged in to deal

with the stress. However, strategies employed in the past were the same ones engaged in under stress. Thus, the women who smoked cigarettes, used drugs, or drank alcohol during their pregnancy had engaged in those habits prior to pregnancy, but because of their stress or addiction, they were often unable to stop those habits during pregnancy – even when they knew there were potential negative consequences for their unborn baby. Women self-medicated with drugs, alcohol, cigarettes, and food to numb their feelings and to blur the contradiction between internal and external demands and expectations. However, for several of the women who were using drugs during pregnancy, pregnancy was the time that they entered drug treatment programs. Gillian, who entered a drug treatment program during her pregnancy explained her prenatal drug use, "I know that I probably wouldn't have used had Craig not done what he'd done to me in the first part of my pregnancy, you know, had he not been abusive physically and mentally, I wouldn't have kept using."

Perceptual changes.

An abused, pregnant woman's embarrassment combined with fluctuating feelings and perceptions may lead to variability in her story. To someone who is unaware of the context in which she lives, the pregnant, abused woman's behaviors might appear inconsistent and confusing. They may feel that she is dishonest or not trustworthy. In actuality, she may want or need the help of others but is unable or afraid to ask for it. Or, because of her shifting perceptions, she may see the situation one way at one clinic visit and have a completely different perception of her situation by the next visit – or even sooner. Faith explains her fluctuating emotions and perceptions:

> ...My feelings went from this is a total joke. I can't believe I'm doing this. You know, it's wrong, because I'm not in a place where I should be having a child...and then I would think well, I'm a lot better off than a lot of people are that are having kids, and I've always wanted to have a kid. So from being excited and just kind of ignoring everything else, and really enjoying planning for the baby and thinking about having a baby and going through childbirth was exciting a thought for me. So I think my emotions did change on almost a daily basis, you know, because of everything that was going on. So it was anywhere from I'm a complete fool, and I'm a complete imposter, to I'm gonna be okay, to concerns about the baby, and, you know, all that stuff.

Consequences for the abusive relationship.

The pregnant, abused woman may not recognize the relationship as abusive while she is pregnant. Although she often is aware that "something is wrong" in the relationship, she hopes that things will change. Durriya explains about the role of hope in pregnancy within the context of an abusive relationship:

> ... there would be some kind of hope that if there was this pregnancy maybe something would be different and that it would be more like that real loving family unit that is sort of the stereotype of a pregnant woman and her husband. You know, like on TV where, the husband really is solicitous of the wife and takes care of her and everybody pays attention to her and all that...sometimes I think I'd hoped for that but it never happened, so I don't know why I kept hoping for it.

Because of the nature of the abusive relationship contrasted with the nature of her developing relationship to the unborn baby, the abuser's expectations and demand's take precedent over her own needs and demands as well as those of the unborn baby. As with the pregnancy, change is a feature of the abusive relationship. Because of the developing nature of the mother-child relationship and a growing maternal identity, change in the relationship also occurs over the course of the pregnancy.

Leaving not considered.

Pregnancy strengthens the ties that bind an abused woman to her partner – causing her to endure more for the sake of the family. Leaving or ending the relationship is not a consideration during pregnancy except after a crystallizing event. Women's focus during pregnancy is on constructing not disbanding their family. Women endure the abuse to meet the expectations and demands of important others. They also stay in the relationship out of commitment to the relationship and commitment to the family. An excerpt from an interview with Hannah:

> It's almost that, when I was pregnant…I knew how it should be and how I wanted it to be, and that's kind of what I was looking forward to, that this was all going to work out, but it wasn't the reality of what I was living. The hope that that would come true is kind of what keeps you going and in it, and I think it wasn't until I realized that it was never going to be, but that's when I left.

Finally, a woman may leave the relationship only to return because of the pregnancy. An excerpt from the interview with Karima:

> I think that being pregnant automatically makes you invest in the future, that you need this relationship to last or look like it's going to last, and so any moves that

> your partner makes that look like abandonment or moves toward divorce or anything like that are more problematic. Although, with my third pregnancy – well, no, I guess I wouldn't say that – I didn't know I was pregnant when we separated. My husband and I were separated for four months. And about two weeks after our separation I found out I was pregnant. And I don't know that I would have reconciled with him and gotten back together with him if I hadn't been.

Vulnerability and confusion.

Her increasing sense of need, vulnerability, and dependency during pregnancy are compounded by the dynamics of an abusive relationship. She wants her partner to live up to dreams for family. Glimpses of the good keep her invested in relationship. She engages in trade-offs to avoid the abuse. She meets his expectations or demands to use drugs and or alcohol in order to avoid his disapproval, disappointment, and emotional, physical and or sexual abuse. Sociocultural and religious values and attitudes about marriage, divorce, single parenting, and abuse are very influential to her assessment of the relationship as well as her decision-making concerning the relationship. An excerpt from the interview with Juji:

> I didn't have too much people to support me because in our culture, it's kind of like you're supposed to stay in that position when men do those things to you. It's not in our culture to leave men because of that reason.

Abuse nature and trajectory.

Emotional abuse was experienced by all of the participants during and after pregnancy. For the majority of study participants, abuse by their partner started prior to

their pregnancy and always included some form of emotional abuse. Name-calling, denigrating, taunting, and threatening were some of the emotional abuses endured by women during pregnancy. For many, however, the abusive acts were more subtle and controlling. Often, the abuse made the woman feel like she were crazy or imagining things. Attempting to understand a partner's shifting rules and to predict how the partner would react and acting accordingly in order to circumvent any abuse were common experiences among participants. Many participants reported that the emotional abuse was very harmful. According to Illyse, "It is the mind fuck that is much more damaging than physical abuse."

Accusations and evaluations about the woman's ability to mother were also commonly made by the abusive partner. Many of the abusers challenged their paternity of the child, accused the woman of being promiscuous – often without any basis for the accusation – and even blamed her for his own behaviors such as the use of drugs, sleeping with other women, or his physical abuse against her. Data from an interview with Abby: "...he has cheated on me and then he has said it was my fault and I allowed that to be one of those things that I wanted to go out and use over."

For some of the participants, pregnancy was protective of physical abuse. For other women, the physical abuse escalated during pregnancy. All of the women, however, endured some form of physical abuse during one or more pregnancies or in the postpartum period. Although slapping and pushing were the most common forms of physical abuse, women were also kicked, spit on, hit with a metal pole, strangled, punched, tied up, physically restrained, urinated on, sat on, and had things thrown at them. For some of the women, physical abuse was a constant in their life – regardless of

their pregnancy status. Many of the women responded defensively to their partner's physical attacks, but some reported retaliating with emotional and occasionally, physical abuse.

For the study participants, sexual abuse was common in their intimate relationship – whether they were pregnant or not. Many of them, however, questioned whether the sexual abuse they endured fit with the "classic" definition of forced sexual activity. With the exception of those women who experienced sexual violence with obvious physical force, most participants who experienced sexual abuse during pregnancy did not spontaneously reveal information about those experiences during study interviews when asked in general terms about the abuse they experienced during pregnancy without specific questioning about sexual abuse by this researcher. This stood in stark contrast to their spontaneous reports of emotional and physical abuse. Several of the retrospective participants said that they had not regarded it as sexual abuse at the time that it was occurring, so they would not have told their health care provider that they were being sexually abused.

Included in their descriptions of sexual abuse women told of their partner's withdrawal of affection. They also reported not wanting to have sexual intercourse but feeling unable to say "no". The perceived inability to say no to a partner's sexual advances was differentiated by the women from being physically forced into having sex. As the women pointed out, physical force was not required by their partner because they did not feel as though they were allowed to decline their partner's sexual interests. According to Illyse:

> I don't know how to explain this to you. You're not allowed to say no. It's just not in the realm of possibility in that context. And I know now from the outside that that's ridiculous. But in the way that I gave him power over me, you don't say no because you get hurt. And it comes back somewhere. It's like walking through land mines. You're going to get it somewhere. If you don't get it right now, it's going to show up later.

Another participant, Durriya, describes never feeling as though she had the right to consent to or decline her abusive partner's sexual advances:

> I think that from my perspective, my whole marriage was sexual abuse because I didn't feel like I had – I was able to tell him, "No, I don't want to have sex with you." And if I had, then I wouldn't have really had sex with him because I never wanted to have sex with him. But in terms of, like, physically forcing me, he never [did] – he didn't do that. He didn't have to.

According to Hannah:

> I never resisted.... I felt like if I did, that I might be forced, and I didn't want to know if I would be forced, so I would just go along. And part of it was – and I don't know if this was drugs [that my partner was using], or what – it's kind of confusing to me, but part of it was if I wanted to be sexually active with him, he would reject me. But then when he would want it, I didn't feel like I had that option. Or, he made me feel like I was grossly disgusting and he didn't want to touch me, you know, because I was pregnant; I mean, because my body was changing and you feel really weird anyway. It's like all these things are happening to me and I have no control over it. And it got really confusing. But I

> did feel like I didn't want to be sexual sometimes and couldn't figure out how to get out of it and didn't feel like I had connected with him, like it was a special thing. It was more like just something that was done and then it was over; kind of like our relationship.

The abuse trajectory causes confusion, conflicting emotions, induces fear, and according to participants in this investigation, eventually ends any love the woman has for her partner. For all of the participants, however, pregnancy instilled hope for the relationship and dreams for their future. Even women who no longer loved their partners or who recognized their relationship as abusive experienced a surge of hope for the future and reinvestment in the abusive relationship because of the pregnancy. Their commitment was to their developing family as well as their extended family. Thus, leaving the relationship – except under duress – is not considered. Durriya explained how she felt pregnancy and not being pregnant had differing effects on her relative to contemplating leaving an abusive relationship:

> I think I felt more – I think that the pregnancy was like a sign that – of how you are supposed to be married to that person, that you're not meant to be independent. I think that having got left so many times and then have it come back, after a while, I began to be defeated, and, like it was hopeless. And I think that those feelings are probably more, maybe more pronounced during pregnancy, but also I think that there is this almost family inclusion kind of thing that happens when you are pregnant that's sort of like something new maybe to you. Maybe the future will be different, and just this whole emphasis on family that really detracts from any thoughts of leaving.

The Postpartum Period

The postpartum period was classified as the period of time from the delivery of the baby through the following eight weeks. Consequences in the postpartum period relative to the pregnancy/unborn child, self/maternal identity, and the abusive relationship will be presented.

Consequences for the baby.

After her child was born, if she was not already aware of her love for the child, the abused mother came to the realization that she loved her baby and that the baby was, in fact, her child. While that may seem obvious, it is a natural component of becoming a mother. Accompanying this realization, the child becomes more of a priority – often taking precedence over the abusive partner. According to Libby who was interviewed after her baby was born:

> I don't think I bonded when she was inside me, not like my son. I was really into my son's pregnancy. I read everything. With her, I didn't – it wasn't like that. I bonded with her after I saw her. I started bonding, were still bonding. But it wasn't like that. Towards the end I started – when she was getting bigger and stuff, a little more bonding around it.

Worries, which may or may not be articulated by the woman, about the consequences of abuse and any alcohol or drug use in pregnancy become more prominent.

Reported neonatal outcomes.

Negative neonatal outcomes were reported for approximately 13.5% (n = 5) of the sample, but complete neonatal data was not available for three of the study participants. Neonatal illnesses included bronchitis (n= 1), meningitis (n = 2), and premature delivery

(n = 2). However, the majority of infants were reported to be full-term, average size, and without health problems.

Evolving maternal-child relationship.

Women described an evolving relationship with their infant that began in utero and continued to grow and develop after the birth. Many of the women reported being unable to focus on their pregnancy or child while they were pregnant and wanting the pregnancy to end and the baby to be out. As a consequence, maternal-infant attachment may be somewhat delayed. When asked why she thought that bonding was delayed Libby responded:

> I think maybe it's because I was – you know, all my stress and I think I had so much going on that I didn't really take the time to bond with her. It had nothing to do with the father. That had nothing to do with it. I would love her no matter what. But I think that had a lot to do with it, all the stress and everything that went on and all that. I just didn't – I put all that first, when I should have put her first, I guess. And I waited until the end until I started putting everything behind me and tried to forget about everything.

And Hannah explained how her partner's feeling negatively impacted her own feelings about the baby:

> And it wasn't until I look back at it that I see the big picture. So, at the time, I couldn't see that. And I think also part of my not connecting with the baby is that I know he didn't like the baby, he didn't want to spend time with the baby, he didn't want the baby in the room, you know, all that stuff, and so it's kind of an effort to appease him, to not be constantly caring, paying attention to the baby.

So it was – I'm not sure if it was self-protection or kind of what the thing is, but just to not cause any uproar.

Mental health issues impact relationship with baby.

Mental health issues impact the mother's relationship with her baby, as did any alcohol or drug abuse issues experienced by the mother. Several participants reported difficulty connecting with their child because of their PTSD. As stated by one participant, "I have PTSD, and part of that is this lack of feeling. And that is a handicap for parenting." Women reported seeking information regarding effects of intimate partner abuse and drug use on the baby as well as accessing parenting programs and counseling to promote and enhance their parenting skills. Women who abused drugs during pregnancy were concerned about the actual and potential effects of their drug use on their child. They sought information about drug effects, watched their child for possible signs of problems, and proactively sought out appropriate treatment and services for their child or children.

Consequences to self/maternal identity.

After the baby is born, there is no longer any question that the woman internalizes herself as a mother. She often feels overwhelmed by the demands of the newborn baby juxtaposed with the on-going demands of the abusive partner – whether they are still together or have separated. She continues to feels embarrassed, ashamed, frightened, alone, stressed, guilty, confused, and unable to cope with the stress living two lives. Because of the baby, she may feel more dependent and less able to leave the relationship. An excerpt from an interview with Hannah about her postpartum:

So here I am with this baby, and my parents, and my husband being a total shit, and I'm so embarrassed and feeling completely abandoned by him. I said, you know, I need to go to sleep. I'm really tired. So I took the baby and I went to bed. And before I got in there, I told my mom I don't want any calls. And somebody called and asked for me, and she gave me the phone. And they had called me by my first name, so she gave me the phone, and it was a dope collector, "When are you going to pay us? We're going to do this." I felt totally overwhelmed. I went to bed for, like, five days and I didn't get up. I didn't nurse very well. I didn't socialize with my parents, who were in my house. I didn't really take care of my baby, my mom did. And they were going to stay for two weeks. She was born on Tuesday; Saturday they left. They said, "You know, we think it might be better if we're not here," and so I was kind of forced to do it. At that point my husband was working. And so my parents left, and he went to work, and here I am with this baby, and I'm so, like, I don't know, I couldn't even deal with it; just laying on the couch, just crying for hours; hopeless, completely hopeless. That lasted probably two or three weeks, of being that bad. And my friend, who was pregnant at the time – her baby was born about a month after mine, so she came over, and I would just be sitting there crying. I don't know, it's supposed to be this happy thing. I felt like I was kind of cheated, like, it's supposed to be really great, you know, everybody is supposed to be happy, and have all this help. That's not what happened. So that was really weird.

Consequences for the abusive relationship.

After the baby has been born, perceptions of the intimate, partnered relationship begin to change. The abused woman becomes less willing to continue putting up with her partner's abuse. She begins to confront the disparity between her hopes and dreams of pregnancy with the reality of her life as it is. She sadly realizes that the pregnancy did not alter relationship or end the abuse. She begins to assert her will and try to regain control over her life and the situation. Use of emergency contraception after unprotected intercourse and avoiding sexual intercourse with a partner are two strategies engaged in to avoid another pregnancy by an abusive partner. Shame and embarrassment may continue to inhibit the disclosure of abuse. If she has already left her partner, she continues to fear him and may feel less able to protect her child from him because she is no longer pregnant. She starts setting rules for his behavior toward her and their baby or other children. She sets up conditions for the two of them to stay together. She may or may not share those conditions with her partner. An excerpt from an interview with Abby:

> And what I'm not allowing to be around me is, first of all, a person I can't trust. You know, you can rebuild trust and I want to rebuild it, but it's like, I'll wait and see, I'm sitting back watching. But I'm not going to have my life revolve around and also to realize that my life doesn't revolve about a man and that if things don't work out, it'll hurt, but I will survive – I am so clear on that. I'm choosing not to let him treat me any kind of way. There's things (sic) that I stand for and if he doesn't believe in that then I don't need him in my life. He needs to be responsible and not only just clean, but also have him taking care of

> responsibilities, working, doing the things he needs to be. And you know, he's being there, being there for Amber, as much as he can he comes to the hospital.... You know, I don't have my blinders on anymore. I don't have my blinders on anymore. And the more that we're apart, it seems like the stronger I get. Because last, a couple of weekends ago, I was you know, I'm in treatment and I'm fighting over the things I'm going through on a daily basis and when our past comes we don't want to talk about that stuff and then to have someone want to fuss with you about going to meeting, which is where I need to be, it really came to me. I really seen (sic) that he was being selfish about his needs and about him wanting me to be there to make him feel good and to cushion his stuff. And if I change and he doesn't change, I'm going to move on. That's just the bottom line cause I'm not going to take less than, today. And I just, my heart hurts, but at the same time, it's like, ok at least I'll know. I'll know what's going to happen.

Abuse nature and trajectory.

For all of the women, emotional abuse continued in the postpartum period. Their hope for a reprieve and a desire to be taken care of and nurtured were not met. An excerpt from the interview from Debbie describes the ongoing nature of her ex-partner's emotional abuse in the postpartum:

> I can't stand him that much because he has been – he's still verbally abusive. He's told me I'm a bad mom and stuff since I had him, and that's not cool. You know, I don't let it get to me. I'm just, like, whatever, you know. I know I'm a good mom: you're a bad dad.

Attacks on the woman's ability to parent, denial of his paternity, manipulating and other coercive behaviors initiated in pregnancy, continued in the postpartum period. Even women, like Debbie, whose intimate relationship had ended, continued to be abused by their ex-partner because of their interactions about their shared child or children. If they were together, perhaps the woman's reprieve from physical abuse during pregnancy continued in the postpartum. For other women, the physical abuse was unchanged. Likewise, sexual abuse that had been ongoing during pregnancy, if the couple were still together, for the most part continued in much the same vein. One participant reported two incidents of violent sexual assault during the postpartum period following the birth of each of her two children. While the ongoing nature of the sexual abuse had been subtle and controlling for a number of years, the nature of those two violent episodes – the first assault described as "sport fucking" and the second as "sodomy" – were much different from the usual sexual abuse. An excerpt from the data:

> Same kind of experience very shortly after he was born…Kevin sodomized me one night, shortly after. And I remember crawling to the bathroom. He fell asleep right away. I crawled to the bathroom and I laid (sic) on the bathroom floor for a few hours that night, just catatonic. You know, I had these two children, and I tore, and I was just bleeding. I thought well, you know, "What do I do? Do I go in?" I didn't go in and get any help or anything. And actually that is the first time I said to him you are never doing this to me again, never. And I didn't even speak it. But that was actually the first time I ever spoke to him about it.

Unable to talk to him directly about the abuse he perpetrated against her, this participant wrote a note to her abuser telling him that he would never do that to her again.

Beyond

Beyond was classified as the period past the postpartum. In general, it was the first two years after the birth of the child, but for some women, the time frame was much longer. After that time period, the woman generally had ended the relationship with the abusive partner or else she had become pregnant again. Consequences beyond the postpartum period relative to the pregnancy/child, self/maternal identity, and the abusive relationship will be presented. Although as initially designed, the intended focus of the investigation was on abuse during the childbearing year, due to the inclusion of retrospective participants and multiparous participants, rich data about the period beyond postpartum were obtained from the informants. For the purposes of this report, however, only brief information will be provided.

Consequences for the pregnancy and child.

In the period beyond the pregnancy, the abused woman has many regrets for her pregnancy and the loss of dreams for the relationship and family. As in the postpartum period, difficulty connecting with her child may occur because of ongoing mental health issues, stress, or feeling overloaded. Overall, the woman is grateful for and loves her child. She tries to do what is best for her child, but is not always certain what the best thing is. Data from Faith:

> I don't regret – like, you mean, like, having the baby? No, but I totally – it was one of the saddest, loneliest times in my life, I think, because I was just so freaked out and, you know, I just thought what am I doing, bringing a kid into the

> situation? We used to yell. I thought that the baby heard us. I used to just go in the bath tub every night and just cry. I just felt so sorry for the baby. And I just felt like, just like an impostor.... It was the impostor thing, you know. I just felt really, really sad. I felt really excited, but just totally terrified. But, I mean, I usually am up on my feet, so I was like well, you know, something -- it will be okay. But I think you do feel so vulnerable.... So it's sad. I mean it's sad to think about. And I don't know if I'll have another baby. I do have this desire – not like some desire that I'm going to hopefully make some bad decisions around – but I do have a desire to just have a nice pregnancy with a supportive person. And it sounds really fun. That's the way it's supposed to be, like parenting. I'm going this is not a one-person job; too much.

Consequences to self/maternal identity.

Beyond the pregnancy, many of the participants described self-doubt and distrust of their own judgment particularly it related to men. The woman wonders how she could have gone from loving her partner and her partner loving her to him abusing her. She questions her role in the abuse – what could she have done differently to change the situation – and may feel guilty about the course that she chose. She begins to see herself as a survivor instead of a victim. For many of the participants, continuing mental health issues require treatment. Depression, anxiety, and PTSD impact her life and experiences. A number of participants criticized the lack of and limited access to mental health services for abused women. An excerpt from an interview with Durriya highlights the need for integrative mental health services and community outreach for abused women

and her perceptions of the limited time and connection with patients that occurs in clinic settings:

> I think that we really need to figure out a way to integrate more mental health into abused women's lives. I think that it's a service that is too often lacking and either there's no access or there's a very limited access and I think that that's one of the few ways that people can actually make changes – because they have a person that they have a relationship, over time, and that person actually has time to listen to them. Which is not true in primary care, in clinic settings in general. And, I think that's very underutilized and that that's something… I can think of that we could be doing better, aside from doing more outreach, like community outreach into minority communities. Cause I think that it's possible that in my community…there might have been a few more dissenting voices if there had been some exposure to outside ideas or even if there had been some influence. Like let's say there was a nurse who had tried to make connections with the community and I never even talked to her, but I heard about her. You know, as one of the episodes came up, it's possible that that might be one of the persons I would call, because I had heard about her and I knew she had some kind of connection with the community – that she kind of knew who we were and she kind of thought we were ok and this was an area that she worked in. That there would've some kind of contact, because as it was there were no contacts. I just think that it's unrealistic to think that you're going to be able to have an effect on women in office settings, where you're doing all this care, that there's no time for anything else, and you probably don't know the person that well.… That doesn't

> mean that you shouldn't screen [for abuse] and that you shouldn't put up signs and you shouldn't do all that stuff – but I still think that as far as actual change, you know, real change, something, we need to go beyond that.

For women who experienced problems with their own use of alcohol or drugs or their partner's use of alcohol of drugs, without treatment, these substance abuse issues continue to be problematic. With treatment, they require on-going attention and constant work.

Participants spoke of the destructive consequences to their emotional health and well being caused by remaining in the abusive relationship for an extended period time. For some, physical injury was less of a concern than was the emotional consequences and the adverse consequences to her physical health that was a result of the ongoing stress. Illyse, who stayed with her abusive partner for thirteen years after the birth of her first child, explains:

> What happened later was – I mean, I remember where I was standing and I thought I'm going to get cancer to die to get out of this if I don't get myself out of this. I was a walking zombie by the time I left because I was living these two different lives, pretending but being just sick about being – I used to feel sick to my stomach before he would come home because things had to be perfect. And, of course, it's impossible to be perfect because it's never perfect enough. If the cookie jar is in the wrong place now, it's in the wrong place tomorrow and the next day. You know, it's that shifting of rules that is mind-fucking. It's the crazy-making part.

The abused mother wants to be a good parent – whether she continues the relationship with her abusive partner or if she has ended the relationship. An excerpt from an interview with Elle illustrates the influence of her own experience of being mothered or the lack of mothering she had on her desire to be a good mother to her own children:

> …It's time for me to give my children a mother – what my mother didn't give to me and that was a mom that was there mentally, physically, and emotionally. It's time for me to grow up. I had those kids: nobody else did. I had choices and I chose to keep them and now it's time to be a mom, their mommy. I don't want my kids to be mad at me like I was mad at my mom. I knew that she was sick when she got me smoking crack. I knew that she was in her addiction, so I forgive her for everything she did. And I pray that she's still clean and sober. You know, I want my kids to be able to, if they have an issue or something with their boyfriend or something, to be able to come talk to me about it with someone that cares.

Based on past experiences as a child growing up her family of origin, however, she often feels that she does not know what is normal or she may feel that she lacks the skills or energy to be a good parent. Elle, for example, was abused by her birth mother, did not know her birth father, and was subsequently raised by her maternal grandparents. Her grandfather was also physically abusive to her. For Elle and others, the consequences of a lifelong exposure to abuse by family members, made her feel that violence was an implicit part of family life. The mother wants to set a good example for her child or children and to structure a safe environment for child. Without any

examples, herself, this is difficult for her to do. Many of the participants described discipline as problematic for them and their child.

Co-parenting with the abusive partner or ex-partner is challenging and difficult and at many times, contentious. One-third of the participants severed all contact with their abusive ex-partner in order to maintain their safety and the safety of their child or children. For those participants, coping with questions from their child or children about their father, trying to explain her course of action and his absence in the child's life, and deciding whether and how to talk with the child or children about the abuse were considerations. An excerpt from an interview with Karima illustrates this dilemma:

> Well, and my daughter is 12 now and occasionally – not very often, but occasionally has asked about her father. And I know that she hasn't asked more just because when she does ask me, I don't sound very enthused. But it's hard to know what to tell a child when you've had that kind of relationship with the father. And so I haven't said anything really negative, which is a hard line to walk. Do you say something or do you not, do you tell the truth or not?

Many women worried about their children inheriting the behaviors of their parents. Specifically, the women worried that an abusive partner and or their own father would victimize their daughters and that the sons would exhibit anger management issues and an abusive personality. Many of the participants felt that they had been negatively influenced by growing up in an abusive home, and they felt responsible for their child or children's exposure to abuse and were concerned it having similar negative effects on their own child or children.

Consequences for the abusive relationship.

At this time, the woman actively seeks out education to learn about and understand the dynamics of abuse. Women may engage in counseling, support groups, and reading about intimate partner abuse. The abused woman also tries to understand her partner's abusive behavior. She sets standards and conditions for staying with partner or for his involvement with their child or children. She chooses to endure the abuse or leave relationship. The decision to leave is not made lightly – especially when her extended family or sociocultural or religious community is unsupportive of ending the intimate partnership. For women with such intervening conditions, deciding to end the relationship often results in the loss of other significant relationships, too – such as the relationship of family and community. Even if she ends the abusive relationship, ongoing abuse often continues in some form after leaving. The abuse may also escalate and her danger may increase. She is now able to label the relationship as abusive. She seeks out assistance for making changes in her life. She may feel frustrated with the social, legal, and or health care system and the many processes that she must go through in order to access services. At times, she feels punished by the system for her partner's actions. If she has not left, she may feel increasingly trapped in situation or may feel that she is biding her time until she is ready to leave. Data from Karima illustrates this point:

> Well, what happened was that I realized at a certain point – and this sounds like such a simple realization I don't know why it was so hard for me – but I realized that not only did I not like the way my husband was treating me, and for a long time, when that was the focus of my feelings toward him, then I could still have a lot emotionally invested in the relationship. I don't like the way he's treating me,

> so it's me. But then I started looking at the way he was treating other people, and I didn't like that, either. And then it got to the point where I just didn't like him very much. And at that point I think I was able to say well, I'm not emotionally invested in having a lot of support from you because I don't really like you. And here I have these children, so I won't leave, but no.

When asked how she dealt with the lack of connection with her partner and living with someone she did not like, she replied:

> ...I kind of deal with it in a divided way, I guess. Once in awhile I will suggest well, maybe we can go out to the movies or something, thinking maybe if we do something fun together, that might help. But he doesn't want to go. And I'm relieved because I don't want to go, either. So, I mean, it's like on the one hand, I will make moves to keep the relationship going on some level, but on the other hand, I don't really want to, you know. And I think if I had more audacity or more initiative, I would probably just leave. But again, a big issue for me is custody of children. And I don't know that I have the resources – definitely not the financial resources – to go through a custody battle, and then what kind of ex-husband would he be? It's kind of like if you have a tiger by the tail, you don't want to let go, because I don't know. And then the whole visitation thing and all that is really hard and the initial breakup is really hard on the children. I know that I would be a happier person as a single parent if I could get him to be a reasonable single father, but I don't know. So it's kind of like staying with the unpleasant known rather than dealing with the possibly more unpleasant unknown.

Summary

In conclusion, this chapter described the results of the research project "Woman Abuse During Pregnancy: Experiences and Decisions." The organizing perspective was identified as living two lives. The two contexts were the public life: pregnancy and the private life: abuse. Guarding-revealing the intersection between public and private lives and pregnancy were the two conditions. Five processes emerged from the data: pursuing the dream of the loving, peaceful family; enduring for the sake of the family; evolving perceptions of family, self, and abusive relationship; reconciling dreams of pregnancy with reality; and revealing and integrating two lives. The strategies were not linear, discrete, or time-specific but were interwoven together. Ten conditions identified by participants directly or indirectly influenced the strategies, processes, and actions of an abused, pregnant woman. They included: 1) partner ends the relationship; 2) increased danger to self or others; 3) birth; 4) commitment to the relationship; 5) abuse trajectory; 6) abuse history and exposure; 7) alcohol and drug issues; 8) social support; 9) sociocultural and religious values or influences; and 10) the woman's age or developmental stage. Three conditions were designated "crystallizing events": the partner ending the relationship, increased danger to self or others, and birth. The outcomes for the study were numerous, but can be organized in terms of legal, personal, and social domains. The following chapter will discuss the results of this investigation.

Chapter 5: Discussion, Implications, and Recommendations

The purpose of this chapter is to discuss the findings of the research investigation, "Woman Abuse During Pregnancy: Experiences and Decisions." Clinical implications will also be presented in light of the findings. Finally, recommendations for future research will also be made.

Although there has been extensive research conducted regarding intimate partner abuse of women during pregnancy, the majority of the foci have related to prevalence, risk factors, and neonatal and maternal morbidity and mortality. This information, while valuable, is incomplete without important contextual information from those women who experienced abuse during pregnancy. The current investigation sought to fill the gaps in information about woman abuse during pregnancy and the effects of such experiences on maternal decision-making and maternal identity formation.

Discussion of Findings

The convenience sample in this study was drawn from a prenatal clinic and via snowball sampling in the community. The final sample size of 12 participants was small, but the data gained through the 21 in-depth interviews was rich. Clearly, this limits the transferability of the study findings. Instead, the findings can be used as a microperspective of the lives of women who have been abused by an intimate male partner during pregnancy.

Pregnancy, abuse and the social construction of meaning.

Data revealed that the context of pregnancy strengthens the bonds of a woman to her partner and to a life together as a family. This phenomenon has been described as a normal component of women's process of maternal role acquisition (Mercer, 1986, 1995;

Rubin, 1970, 1975, 1984; Tilden, 1980). However, the influence of maternal role acquisition has not been an explicit consideration in the literature about intimate partner abuse during pregnancy. And, most likely, is something that is generally disregarded in clinical practice with this population, as well. According to participants, pregnancy imbues the woman with new hopes and dreams for the "ideal" family. This process of engaging in pregnancy hopes and dreams is a reflection of the values of the larger context in which she lives – both the immediate sociocultural and religious environment as well as the larger social context of the current western society in the United States. Discordance between her expectations and wishes for the pregnancy and the reality of her life lead the abused, pregnant woman to feel isolated, disappointed, and embarrassed. The actions and reactions of the abusive partner, extended family, friends, and others further compound and influence her perceptions and responses.

Peled and colleagues described the unexpected negative effects of public campaigns against partner abuse as presenting an image of the abused woman as a helpless victim who will only end the violence if she leaves the relationship (Peled, Eisikovits, Enosh, & Winstok, 2000). The contradiction exists between evidence regarding ongoing abuse despite leaving the relationship and public perceptions concerning staying and leaving the abusive relationship. The dominant social myth is as follows: leaving the abusive partner is the only solution to terminating violence. Another similar myth is that an abused woman can leave an abusive relationship easily, if she wishes (Sullivan & Bybee, 1999). Such public perceptions form the larger sociocultural script that serves to guide perceptions, interpretations, and actions. Only by altering the dominant sociocultural perceptions, will social expectations about women's responses to

abuse be changed (Peled et al., 2000). Professionals working with abused, pregnant women who have internalized the sociocultural script may be more likely to experience frustration in working with this population. Similarly, this discordance between myth and reality may also cause frustration and serve to further disenfranchise women who are abused and pregnant.

Women who are pregnant and abused contend with at least two different types of expectations – those expectations regarding her public life and pregnancy, and others regarding her private life and the intimate partner abuse. When her cultural or religious groups' values differ from those of the larger society, the expectations become more complex and contradictory and apparent solutions less likely. Is it any wonder that an abused, pregnant woman feels confused and ambivalent about her life and situation? The contradictory expectations further exacerbate the isolation and embarrassment that is a feature of life for an abused woman. The numerous social, personal, and legal risks and potential consequences of revealing the abuse further stigmatize and alienate the pregnant, abused woman at a time when she is particularly vulnerable, impressionable and, possibly, at significant risk for extreme, life-threatening violence.

Uncertainty about what constitutes normal conflict as compared to abuse in an intimate partnership during pregnancy may also be an after effect of a lifelong exposure to multiple forms of violence. The profound impact of multiple experiences of abuse and maltreatment that went beyond sexual violence that occurs in adulthood has been described in an investigation of the effects of sexual violence against women (Drauker & Madsen, 1999). In that investigation, violence led to women feel as though they were "living-in-exile" and resulted in varying complicated, creative response to living in a

violent context. The data provided by participants in this investigation further supported their findings. Participants in this study revealed many incidents of violence including: childhood sexual assault; childhood physical and emotional abuse and neglect; intimate partner violence and substance abuse between parents; involvement with more than one abusive, intimate male partner; adult sexual assault; community sanctioning and ignoring of violence; and community violence such as gang activity. Participants in this investigation considered each exposure to violence as influencing and flowing into the next. None of the participants considered the abuse by their intimate male partner during pregnancy as the only abusive experience in their life.

According to participants in this study, abused women, may fail to realize that the relationship has progressed from fighting to abuse. Instead of looking at the relationship as a whole, women reported focusing on an individual event or incident. At other times they are unable to distinguish normal disagreements within a relationship from abusive exchanges that control and manipulate. Study participants explain that this lack of awareness and the inability to acknowledge the abuse by an intimate male partner is further compounded by pregnancy overshadowed by the attendant hopes and dreams that accompany pregnancy. Primaparous women who have had no previous experience with pregnancy, or women for whom the abuse starts or escalates during pregnancy and do not have prior experience with abuse by their current intimate partner, found it particularly difficult to understand their partners' behavior towards them and their unborn child, because the two phenomena occur simultaneously and they have no personal basis for comparison. Consequently, the woman may attribute his abusive behavior to his feelings about the pregnancy and their unborn child. Additionally, the abusive partner may blame

his actions on her moodiness or stress from the pregnancy or he may not provide any attribution for his abuse. Popular literature and health care providers present alterations in the partnered relationship during pregnancy as a normal and common developmental process, but rarely describe what changes are normal in the transition to parenthood and what experiences might be something else entirely. Thus, women are left to draw their own conclusions as to the association between the onset of abuse and their pregnancy.

While it may seem remarkable that women have difficulty evaluating whether a relationship is abusive, especially when the details of abusive interactions with her partner are revealed; it really should not be surprising, since many people have difficulty defining what acts constitute abuse – especially within an intimate relationship between partners. For many, the lines between emotional abuse and argumentation are particularly difficult to distinguish and thus, the consequences of emotional abuse are frequently minimized by clinicians and have not evaluated in many research investigations of abuse during pregnancy. However, for many of the women in this study, it was the emotional abuse that was acutely damaging to their self-esteem. The women considered emotional abuse as significantly destructive to their self-esteem and as a result, inhibited their ability to end an abusive relationship or alter the dynamics within the relationship. Ultimately, leading them to feel incapable of making it on their own. Even when women were the primary wage earners and did the majority of household labor and childcare, they described intense feelings of self-doubt, poor self-esteem, and insecurity that profoundly impacted their perceived ability to become independent of the abusive partner.

Decision-making of Pregnant, Abused Women

Pregnant women's decisions are made within the context of relationship to significant others – in particular the contexts of family and immediate community but also within her larger sociocultural context as well. An essential dimension of maternal identity development is the connection to and relationship with father of the child and the extended family. Thus, her investment in those relationships is a normal component her process of becoming a mother (Mercer 1986; 1995). However, this fact often is missed. In this regard, current models of women's decision making process regarding leaving or staying with an abusive partner are not adequate for women who are pregnant, because they are too individualistic in focus. Such models fail to include the influence that pregnancy has on women's perceptions of the importance of the partnered relationship to herself, the unborn child, and the extended family.

In addition, due to pregnancy, abused women feel an increased vulnerability that is different from their non-pregnant state. While pregnancy may confer a level of vulnerability for non-abused women, what is specific to women who are abused and pregnant is their experience of feeling vulnerable to their partner's abuse. A woman who is not in an abusive relationship with an intimate partner during pregnancy does not fear that she, the unborn baby, or other children will be emotionally, physically, or sexually harmed by her male partner. Abused, pregnant women also feel vulnerable to the judgment and appraisal of others. The damage to the woman's self-esteem – a common and detrimental effect of ongoing intimate partner abuse – may further exacerbate the normal vulnerabilities that pregnant women feel.

Although intimate partner abuse intensely affected women's experiences of pregnancy, participants also articulated considerable disappointment and sadness for their partner's apparent lack of concern for them while they were pregnant. Women wanted their partners to nurture them: to care for and about them. They longed to have their partner's excited about and interested in the pregnancy. While several participants had partners who were interested in their pregnancy, for the most part, that interest did not translate into support or concern for them. Every participant reported feeling deserted and unsupported by her partner. This was in addition to any abuse that occurred in the relationships. Women resented their partners' expectations that his needs would always be put before the women's own needs and those of their baby. Participants described multiple occurrences of extreme demands by partners that contradicted with their own needs or desires. Many of the participants felt significant regret and loss over their pregnancy. Instead of experiencing the pregnancy they had dreamed of and desired, one that would unite their family, the women felt isolated and alone in their pregnancy. See Appendix F for a summary table of the maternal tasks within the context of an abusive relationship.

Research has focused on the lived experience of pregnancy from the women's perspective. Not unlike the findings from this investigation, results from a qualitative study of 40 Finnish women suggested three common themes to women's experience of pregnancy: the wish and striving for a perfect baby, an altered mode of being, and striving for family communion (Bondas & Eriksson, 2001). It is not unreasonable to expect that abused women will also experience joy and sorrow in their pregnancies.

However, based on the data from this investigation, it is likely that the sorrow will outweigh the joy and that the abuse will exacerbate the sorrow.

Experiences and Perceptions of the Abused, Pregnant Woman

Several factors magnify the division abused women feel between their private and public self. The increased interest in and scrutiny of her life and actions by various involved parties, that is an integral feature of pregnancy and prenatal care, exacerbates the woman's sense of vulnerability and potentiates the risk for negative interventions by health care providers and other individuals. Especially when such interventions are undertaken in the pretext of helping the family and protecting the unborn child. The woman's amplified investment in the relationship with her partner and an increased commitment to family cohesiveness and unity that is commonly experienced by women during pregnancy juxtaposes with the presence of intimate partner abuse. Her commitment to family and partner is a reflection of the larger context in which she lives. The social, cultural, and religious values that venerate the ideal of the nuclear family have become so engendered in the fabric of society that they go virtually unrecognized. Similarly, the other factors impacting this division are the cultural myths associated with each phenomenon – pregnancy and abuse. That is, pregnancy is entirely joyful and wonderful and an abusive relationship is at all times ugly, wrong, and without any redeeming value.

Sociocultural Myths

Sociocultural myths are common, often, simplistic beliefs held by a social or cultural group. One such myth is that of the nuclear, heterosexual family with a married mother, father, and one or more children being the most common family form. There are

common myths that are also pertinent to this study concerning pregnancy and abusive relationships.

Pregnancy myths.

In the United States, pregnancy is often presumed to be a happy and joyous period in a woman's life that reflects new beginnings and possibilities. The culmination of this period is the birth of the new baby and the addition of a new family and community member. The pregnancy and developing child are generally valued and welcomed by both family and community. Announcement of a pregnancy is greeted with enthusiasm and congratulations. Although doubts and ambivalence about the pregnancy are normal feelings experienced by pregnant women, they are rarely expressed to others and often are not discussed by health care providers or other women who may have experienced them while they were pregnant. While single motherhood and unplanned pregnancies are fairly common in the United States, a widespread assumption is that there is a father who is committed to the mother and invested in the pregnancy and becoming a father.

Myths about abusive relationships.

In contrast, an abusive relationship is assumed to be a horrible situation – without exception. Certainly, for some women, abuse occurs on an almost continual basis without reprieve or there may be very little that is positive or redeeming that is associated with the relationship. And, abuse is ultimately detrimental to the woman. However, for many abused, pregnant women, the experiences of abuse by their partner are tempered by other important and influential factors such as their love for their partner combined with their commitment to their marriage, relationship, and or a family consisting of a mother, father, and a child or children. These factors are further mitigated by women's sense of

their own involvement in and responsibility for the abuse; and the social, cultural and religious values and beliefs held by the couple. For some women – often those with early or lifelong exposure to violence in their childhood homes or communities, or religious or culturally prescribed gender roles and tolerance for domestic violence – there is a lack of recognition that abusive acts within an intimate, partnered relationship are not always a given (Phillips, 1998).

Women's Experiences of Abuse During Pregnancy

Studies have reported a variety of findings relative to the trajectory and nature of intimate partner abuse during pregnancy (Amaro et al., 1990; Campbell, 1989b; Campbell et al., 1992; Campbell et al., 1993; Helton et al., 1987; McFarlane et al., 1992; McFarlane et al., 1996a; O'Campo et al., 1994; Parker et al., 1994; Stewart & Cecutti, 1993). For the majority of the participants in this investigation, abuse was initiated prior to pregnancy and continued in a similar fashion throughout pregnancy and postpartum, although one-quarter of the participants described the abuse as starting in the prenatal period.

Emotional abuse.

Emotional abuse was consistent throughout the abuse trajectory and was experienced by all of the study participants. Name-calling, taunting, threatening, coercing, degrading, intimidating, and blaming were some of the forms of emotional abuse experienced by participants. Two participants described abuse during two of their pregnancies as being limited to emotional abuse, but both of them had experienced physical or sexual abuse during one or more previous pregnancies. In the remaining

pregnancies, women experienced some combination of emotional, physical, and or sexual abuse.

Physical and sexual abuse.

Participants experienced various forms of physical abuse by their partner, which ranged from slapping and pushing to strangulation and beatings with hands or other implements. For some participants, pregnancy offered a reprieve from the physical abuse while for other participants the physical abuse was initiated or escalated in severity and or frequency during pregnancy. Sexual abuse was also commonly experienced by participants throughout the childbearing year. The nature of most incidents of the sexual abuse described by participants was primarily implicit control with expectations around her being sexually available at all times, but two participants described brutal sexual assault during three pregnancy or postpartum periods. For all of the participants, the trajectory of abuse escalated over time. The time period, however, varied considerably between participants from a period of months to many years. Although some participants reported perpetrating physically abusive acts against their partner, the majority reported engaging in retaliatory emotional abuse and defensive acts, only.

A key finding from this investigation was the consistency of emotional abuse throughout the childbearing year and beyond. Since many investigations of abuse during pregnancy do not measure emotional abuse, this has not been previously described. Pregnancy did not serve as a time of reprieve from emotional abuse even if the physical abuse did lessen or cease. Further, the presence of emotional abuse in the relationship was consistently the precursor to physical and sexual abuse, which is supported by

previous research. This reinforces the importance of screening pregnant women for and educating them about emotional abuse as well as physical and sexual abuse.

The women who disclosed information about sexual abuse in their intimate relationship also did not experience a reprieve from such abuse. For some participants, the period during pregnancy and postpartum, actually increased the severity and their perception of the detrimental effects of such sexual abuse because of the concomitant bodily changes experienced by women as part of the childbearing process.

Based on the experiences shared by the women participating in this investigation, when an abused, pregnant woman reveals that she is leaving the abusive relationship, she is at high risk for severe violence and possibly, homicide. The association between homicide and pregnancy has been a recent focus of other research investigations (Horon & Cheng, 2001; Krulewitch, Pierre-Louis, de Leon-Gomez, Guy, & Green, 2001). For the participants in this investigation, 25% (n = 3) experienced severe, life-threatening abuse. Two of the participants experienced such severe violence during pregnancy. Two participants were victims of attempted homicide that occurred as a result of their attempts to end the relationship. The other participant's partner accused her unjustly of being intimately involved with another man.

Guarding and Revealing the Abuse

Women engaged in the condition of guarding and revealing the abuse in their private life. Women were embarrassed by the abuse and felt considerable shame for their partner's behavior and their acts of collusion with and resistance to the abuse. The dual-self experienced by abused women has been described extensively in prior investigations with women who have been abused by their intimate male partner (Landenburger, 1989;

1993; Smith, et al., 1995). This research on abuse during pregnancy revealed how pregnancy further exacerbates this division, ultimately causing the abused, pregnant woman to separate her life into two domains, the private: abuse and the public: pregnancy. Consequences of this division and the condition of guarding and revealing the intersection between the public and private lives were significant and varied with social, personal, and legal dimensions and implications for the pregnancy, postpartum, and beyond.

Revealing the abuse was difficult and embarrassing for many of the women. This was true in health care settings but in women's social contexts as well. Most often, women first revealed the abuse to a family member – such as a sister or mother – or a close friend. Revealing the abuse was highly stressful for most of the women, primarily due to their embarrassment and fear of negative appraisal or judgment by others. Additionally, the majority of women expressed a sense of responsibility for the abuse and considered the potential consequences for revealing the abuse – whether they were social, legal, or personal in nature – as too risky while they were pregnant.

Both Fishwick (1993) and Limandri (1987) found that abused women's actions in health care settings and health seeking behaviors occurred as a result of their perceptions of the situation, the risks and benefits of any action, as well as the responses of health care providers. The results of this investigation were similar with a pregnant sample. The majority of participants did not disclose the abuse to their prenatal care provider. Women who did reveal the abuse that was occurring in their private lives generally did not do so at the first prenatal visit, when initially screened for abuse by their prenatal care provider. Instead, their disclosure occurred only after they felt that they had established a

trusting relationship with their health care provider. Disclosure most often occurred at a time when women perceived a need for the assistance of their health care provider, when their emotional pain was too intense, after a crystallizing event, or if they feared that the abuse would be revealed through some other manner.

Only one of the community participants recalled being screened for intimate partner abuse by her prenatal care providers – even in the presence of obvious injuries. The women interpreted their providers' lack of assessment for abuse as lack of concern. This perception influenced her later decisions about whether or not to reveal the abuse. Since their medical records were not available to the PI, it is not known if the health care providers deemed that abuse assessment was unnecessary – especially when injury was evident – or if they did include such an assessment. Since some of the participants' pregnancies were more than ten years prior to the investigation, it is highly likely that routine inquiry about interpersonal abuse was uncommon for health care providers.

Emotional and psychological consequences of abuse.

Participants in this investigation reported numerous consequences from the abuse. In addition to experiencing shame and embarrassment, many of the women dealt with on-going mental health issues that included decreased self-esteem, depression, anxiety, and PTSD. Isolation, loneliness, fear, guilt, and confusion were commonly experienced emotions. Stress was also common – during pregnancy, in the postpartum, and beyond. This supported the findings of other investigations with pregnant and non-pregnant women (Campbell et al., 1997; Campbell, 1989b; Campbell et al., 1994; Cascardi et al., 1992; Curry, 1998; Curry & Harvey, 1998; Gleason, 1993; Walker, 1984).

Dealing with the abuse.

This study supplies missing contextual information about pregnant women's choices in dealing with the abuse. It contributes to the growing knowledge base about the influence of intimate partner abuse on women's choices in pregnancy. Previous research reports of increased smoking, drinking, drug use by women who are abused during pregnancy (Curry, 1998; Martin et al., 1996; McFarlane et al., 1996a, 1996b; Parker et al., 1994; Webster et al., 1996). Data from this investigation indicate that women engage in such behaviors in order to self medicate and deal with the stress of an abusive relationship, as postulated by Campbell (1992) and others, but they also do so as part of the dynamics of the abusive relationship. In other words, they may be expected or coerced by the intimate male partner to engage in those behaviors. Distancing, taunting, intimidation, and other negative reactions by the abusive partner were experienced when women attempted to quit or avoid those behaviors when they were expecting. For some women, the partner's negative reaction was enough to induce her to continue those behaviors despite her best intentions. Other women resisted the partner's pressure. Still others succumbed to using substances because of their stress. Over and under-eating and sequestering themselves away from others were also reported as strategies to deal with the abuse.

Neonatal Outcomes

The literature on neonatal outcomes has been mixed: some studies have found an association between negative neonatal outcomes and intimate partner abuse during pregnancy, others have not found such an association, and other studies have found an association, but only with certain sub-groups – such as teens, low-income women (Curry

& Harvey, 1998; Curry, Perrin et al., 1998; Dye et al., 1995; McFarlane et al., 1996a; Parker et al., 1994; Webster et al., 1996). For this investigation, participants reported neonatal outcomes that were predominantly positive. The majority of infants born to participants were full-term, healthy, and of average size. Several participants, however, reported experiencing operative deliveries, preterm birth, neonatal meningitis, and bronchitis. Without access to medical records for the women and their infants, however, complete data about the neonatal outcomes are unavailable and any associations are speculative.

Interacting with Health Care Providers and the Health Care System

During pregnancy, women routinely interface with their health care providers on a regular and often, intimate basis. Choices mothers make during their pregnancy have the potential to positively or negatively effect the immediate as well as the long-term health status of the child; this, and the fact that pregnant women have more frequent and intimate contact with their prenatal care providers and other health care in general, causes health care providers to scrutinize and evaluate the decisions women make and the context in which women live. Often, any deviation by a woman from accepted behaviors for maintaining optimum health prenatally – such as late entry to prenatal care, the use of cigarettes, alcohol or other drugs, and other "unsafe" behaviors – leads health care providers to evaluate women's mothering or her feelings about the pregnancy and her unborn child in a negative light.

Women abused by an intimate male partner live within a context that is poorly understood by outsiders. It often is frustrating for health care providers, family members and friends, and other individuals who try to assist, interface with, or understand the

decisions made by women who are abused. When a woman is pregnant and abused, the decisions that she makes are under increased scrutiny and judgment because of their potential impact on the health of her unborn child. When people – including health care professionals providing their prenatal health care – become aware that a woman is abused within her intimate, partnered relationship they wonder: Why do women stay in an abusive relationship?

Understanding why pregnant women make choices within the context of an abusive relationship is an integral step in providing appropriate, sensitive care to women. However, asking why women stay in the abusive relationship, suggests that deciding to remain in or leave the relationship is a simple choice with two options – leaving or staying. Suggesting that there are only two straight forward options or that the choice is an uncomplicated one with an obvious correct answer reflects a simplistic view of the situation does not reflect the complexity of the life context, perceptions, and emotions of a woman who is abused.

Under the best of circumstances, the ties that bind a woman to an intimate relationship with her male partner are not always apparent to outsiders. When abuse enters into the equation, it may become ever more difficult to see what bonds a woman to her partner. It is difficult to understand how or why a woman could still love or want to be with a partner who abuses her. For a woman, however, whose focus during pregnancy is on creating family, those particular ties are not easily undone.

Conversely, because the abuse between intimate partners often occurs when they are alone – unless they are told – people closest to the couple may not be aware of the abuse that is occurring in the relationship. When the relationship is emotional abusive,

obvious bruising or other injuries are absent. Even when it is physical or sexual abuse that is occurring in the relationship, the abuser may purposefully strike his partner in places where injuries and bruises will be hidden by clothing.

The Period Beyond Pregnancy and Postpartum

Although this investigation focused on the period of pregnancy and postpartum, multiparous and or retrospective participants provided rich data about the period that extended beyond the childbearing year. In brief, the women described extreme difficulty dealing with their partner relative to the co-parenting of their child or children that went far beyond pregnancy and postpartum. Even though the male partner possessed legal rights and responsibilities as a father, it was extremely difficult for a woman to get her ex-partner's parental responsibilities enforced. Lack of child support and payment for financial obligations were commonly experienced, but there was little that the mother could do to obtain the monies owed to her or others. As a consequence, in addition to the stress caused by continuing contact with their partner, use of attorneys and the associated costs were another burden the women incurred.

In addition, the ongoing contact with the abusive ex-partner that often is mandated by the judicial system after the birth of their child frequently is abusive. Intervention and support provided by the legal system was generally described as unhelpful and often, further victimizing to abused pregnant women.

Strengths and Weaknesses

One of the primary strengths of this investigation was the use of a non-shelter based sample. Since many women who experience intimate partner abuse do not seek shelter in a facility for abused women, it is more likely that the experiences described by

this sample were similar to the experiences of other abused women. Including retrospective as well as prospective participants in the investigation allowed for comparisons between the two groups and revealed important changes over time in the trajectory of the abuse as well as in women's perceptions of her life. It also exposed important contextual information about the period between pregnancy and leaving the relationship. Interviewing at different points in the childbearing year also was an important strength of the investigation. Although no participants were recruited in the first trimester, use of retrospective participants and multiparous participants revealed important information relative to early pregnancy. Use of multiparaous and primiparous informants also increased the variety of experiences. Diversity of participants was a strength of the investigation. Multiple, in-depth interviews also allowed for the establishment of a relationship between the PI and participants and promoted the accuracy of the PI's understanding of the data.

Although this investigation had many strengths, there were also several weaknesses. First of all, not all of the participants were interviewed twice. Ideally, it would have been desired to interview all participants at least two times in order to clarify meanings, engage in member checking, and achieve greater depth in theoretical sampling. Also, there were no Hispanic or Asian participants in the sample. Several of the participants, recruited through snowball sampling, were involved with in-patient treatment for substance abuse, which may disproportionately skew the findings relative to substance abuse. Finally, referrals for participants were only received from one of the clinic settings.

As described in Chapter 3, the PI engaged in four of the eight procedures recommended by Creswell (1998) as promoting validity in qualitative investigations. According to the procedures specific to grounded theory established by Strauss and Corbin (1998), the sample selection and grounds for selection were described thoroughly. Major categories were articulated. Events that lead to the emergence of the major categories were most often the participant interviews or peer debriefing. The example of women's use of violence and the selection of the organizing perspective were used to illustrate how theoretical sampling occurred and how relationships between dimensions were structured. Concepts were generated via the data with variation implicit in many of the dimensions. Multiple processes were built into the model including the ongoing processes of pregnancy and the trajectory of the abusive relationship.

Strauss and Corbin (1998) have formulated criteria for evaluating grounded theory research (see Chapter 3). Criteria related to the process included sampling, emergence of major categories, theoretical sampling, hypotheses related to conceptual relationships, and selection of the core category. The PI provided information on the convenience sample, including sample selection and the convenience, word-of-mouth, and snowball sampling techniques employed in the investigation. Several dimensions – "abuse within family of origin," "shifting perceptions," and "evolving values" – were presented as early dimensions auditioned as the organizing perspective. The rationale for their rejection was provided. Theoretical sampling around numerous dimensions occurred throughout the investigation, and examples of several dimensions – such as women's use of violence, cultural issues, and shifting perceptions were provided and the process engaged in analyzing the data gained through theoretical sampling explicated.

The selection of "Living two lives" as the organizing perspective was arrived upon after two participants mentioned the dimension, and subsequent interviews and theoretical sampling revealed the prominence of the data.

Strauss and Corbin (1998) also provided criteria for evaluating the empirical grounding of a study (see Chapter 3). Concepts were generated through the systematic and circular process of data collection and analysis. Through data analysis and member checking the relationships between dimensions were tested and refined. The conceptual linkages were explicated and data for dimensions provided. Variation among and between participants was addressed. The context and conditions of the grounded theory were posited and the processes of pregnancy and guarding and revealing discussed. The theoretical findings provide information about the context of women's decision making during pregnancy and the influence of an abusive relationship on maternal identity formation. That information had previously been missing, and speculations have been made about women's decision making.

Ethical Issues and Implications

Maintaining participant safety and scientific integrity is an important issue in research with abused women (Lutz, 1999). Several issues arose in the conduct of this investigation that grew out of ethical concerns for participants that bear discussion.

This investigation was under the ethical oversight of two institutional review boards (IRBs). Because of the sensitive topic nature and the vulnerability of participants, a Certificate of Confidentiality was obtained to protect the privacy of research participants (Lutz, Shelton, Robrecht, Hatton, & Beckett, 2000). The Confidentiality Certificate appeared to be positively viewed by the two institutions involved in the

investigation. None of the participants, however, seemed very interested or influenced by the presence of such a Certificate.

As a result of having two IRBs and a Certificate of Confidentiality the PI was required to go through several layers of approval initially and when instituting any subsequent changes to the study design. Due to an interagency conflict between the two involved IRBs regarding some of the wording on the consent form, initial IRB approval was delayed nearly five months. Although it had been anticipated that additional time and effort would be necessary because of the three institutions involved in overseeing the investigation. The actual length of time and the specific concerns had not been anticipated and significantly hindered the PI's entrance to the field of study. While subsequent expansion of the inclusion criteria to include retrospective participants, snowball sampling from the community, and a more inclusive definition of abuse did not result in such a long time in IRB review, when recruitment continued to be slow, the PI and her advisors were reluctant to submit to the scrutiny of another IRB review in order to advertise for study participants in a hospital newsletter. Concern regarding the potential negative threat to the Certificate of Confidentiality also influenced the decision not to seek participants through that mechanism. Ultimately, it was decided not to seek this form of participant recruiting. If the initial IRB review had not taken so long, it is likely that the PI and her advisors would have sought IRB approval to recruit through the advertisement in a newsletter.

As described in Chapter 3, the PI stringently adhered to the NRCVA guidelines for conducting research with battered women (Parker et al., 1990). Based on her clinical experience with battered women, one of the issues that the PI felt very strongly about was

having participants make the first contact with the PI. This was important to the PI for two reasons: first, to ensure that the abused woman's safety and confidentiality was not jeopardized in any way and second, to assure that the abused woman felt that she was not coerced or expected to participate in the investigation. In addition, concern that the abusive partner would become suspicious if a stranger contacted his partner also influenced the decision to have potential study participants initiate contact either via phone or by completing and returning a self-addressed, stamped postcard to the PI. Ultimately, having potential participant's initially contact the PI may have added unduly to the difficulty in recruiting. Many of the participants either did not have free access to a private phone or they were working and juggling parenting responsibilities while living in an abusive relationship. The PI had a voice mail number, but because she was a graduate student engaged in various activities, she was not immediately accessible by phone. Therefore, several rounds of "telephone tag" were commonly required with many of the participants before the initial interview finally took place. Surprisingly, despite this barrier, each of the potential participants who expressed interest in participating in the investigation screened positive for abuse during pregnancy and were enrolled in the investigation.

Due to the many responsibilities and stressors in their lives, however, for many of the study participants, scheduling of the interviews took a considerable amount of time. In part, as just described, making the initial contact was an issue, but other issues were also problematic for many of the participants. Among those issues were: arranging childcare, finding enough time in their busy lives to be interviewed, having the energy to think about discussing such a distressing topic, coping with various pregnancy- and or

postpartum-related issues and complications, dealing with substance abuse treatment issues, and on-going problems with their partner or ex-partner. It was readily apparent that women who were participating in this investigation – both prospective and retrospective participants – had complicated, and frequently, difficult lives that negatively impacted their ability to participate in such an investigation. The PI was often surprised, however, by the women's commitment and desire to participate in the study.

A final issue that arose was the tension between the PI's professional nursing responsibility as a mandated reporter of child and elder abuse in the state of Oregon and her responsibility as a researcher to thoroughly explore women's contextual experiences of intimate partner abuse during pregnancy. At the start of each interview and on the consent form, the PI's responsibility as a mandated reported was clearly stated and reviewed. It is unknown how that information impacted the data collected from participants in this investigation. Although none of the participants disclosed any current child abuse, it is not known whether any child abuse was actually occurring in any of the participants' homes.

There were significant ethical issues that impacted the conduct of this investigation that have not been previously discussed and were not fully anticipated at the outset of the investigation. Fortunately, to the best of the PI's knowledge, there were no problems with retaliatory violence or discovery of her participation by any of the abusive partner's due to a woman's participation in this study.

Clinical Implications

Pregnancy may in fact, present the window of opportunity for intervention with women who are abused. However, based on data from this study, intervention without a

therapeutic patient-provider relationship is likely to be unsuccessful. Throughout this investigation, women described the importance of a trusting relationship with a health care provider who knew and cared about them in their willingness to disclose the abuse, to ask for help, and to feel comfortable and respected. Therefore, perhaps one of the most important prenatal interventions for abused women would be to establish a trusting, empathetic, and caring relationship with their prenatal provider. Data from this investigation suggests that establishing such a connection during the prenatal period would provide a strong foundation promoting the woman's sense of safety and trust in revealing the abuse at another time.

Participants also reported concern about negative evaluation and appraisal by others about their situation and their choices. Many participants received conflicting explicit and implicit advice from people. Although health care professionals might be less likely than family members, friends, or community associates to explicitly voice their negative appraisal of any choices abused, pregnant women make, participants in this investigation were sensitive to the implicit evaluation that they felt they would be subjected to if the abuse were revealed.

Leaving is not considered during pregnancy.

Overwhelmingly, women participating in this investigation said that although it would be a good thing to leave an abusive relationship during pregnancy, it was not something that they had even thought about – unless she experienced a crystallizing event such as the partner ending the relationship or perceived that the dangerousness for her self, the baby, other children, or important others had increased. Birth, as another crystallizing event, precipitated a shift in the women's perspective of the situation –

including her perception of the importance of her partner to her self, child, and the family. Thus, since all pregnant women will eventually deliver their child and her perspective of the abuse changes some time after her child is born, postpartum clinical visits could be particularly important opportunities for abuse intervention and screening. Without consistency in health care providers or an established, positive relationship patient-provider relationship, it is unlikely that women will seek the assistance of the obstetrical care provider to help them with the abuse at any time.

Establishing a therapeutic patient-provider relationship.

Establishing a therapeutic relationship is considered a basic skill of clinical professionals, however, in the current health care environment, time constraints for patient visits and lack of control over busy schedules make expanded patient visits nearly impossible – especially in the course of routine prenatal care. For in-patient settings, higher patient-provider ratios also inhibit the ability of providers to spend much time with patients or to establish much of a relationship or connection with many of their patients. Organizational and systemic change among health care organizations and insurers is the rule rather than the exception in the current health care arena leading to changes in "preferred providers" for patients and loss of continuity of care. All of these circumstances are barriers to establishing a long-term, trusting relationship between patients and providers. Participants in this investigation stressed the significance of a trusting relationship with a care provider on their determination of whether they would reveal information about their private life as well as their appraisal of the risk and benefits of such a disclosure.

According to data from this investigation, the critical component of successful intervention is a trusting, therapeutic patient-provider relationship. Thus, the prenatal period can be seen as presenting an opportunity for establishing the trustful and caring relationship that is important to all patients, but is critical to those who are abused by their partners and feeling vulnerable, isolated and potentially, stigmatized. Participants in this investigation were explicit in their recommendations for health care providers: listening, being present, being non-judgmental, knowing resources for abused women, using baby steps, and providing education about abuse and normal relationship change between partners during pregnancy. Most of all, however, women want health care professionals to realize that this is not a problem that they can easily fix – that is something that the women must do. However, women did appreciate the assistance of providers who were sensitive and caring.

Participants also considered the time spent with the health care provider as very important. A provider being present and attentive to the patient during the time that the provider and patient interacted was of paramount significance. In other words, thumbing through the chart or behaving in a rushed or harried manner inhibited women from disclosing the abuse or asking for help from their health care provider. Granted, clinicians do not always know their patients, run behind or have a full schedule, but screening women for abuse in their intimate partnered relationship – asking them to reveal personal, embarrassing, and potentially, stigmatizing information – is not as routine as inquiring about one's family history of hypertension. Instead, abuse screening questions are loaded with meaning for the woman as well as laden with potential risks and implications. Therefore, a level of calm assurance, compassion, and trustworthiness

from the clinician is a reasonable expectation. An established patient-provider relationship encourages trust and comfort for abused, pregnant women and increases the likelihood that they will disclose their abuse status to their health care provider. Screening for abuse in a perfunctory or manner that may reflect the provider's own discomfort with the topic matter further inhibits women's willingness to share information about the abuse.

In contrast, women who were recruited from the prenatal clinic and thus, had screened positive for abuse during routine care or who had disclosed their abuse status to their provider at some time during their prenatal care, revealed that they had disclosed the abuse to their prenatal care provider because they felt their provider(s) were concerned about them as individuals and were not asking about abuse as a matter of rote. Importantly, based on the relationship that they had established with their provider throughout their current and or prior pregnancies, they felt that their prenatal care provider was positive and empathetic; they also believed they would not be judged harshly by their provider. Nor did they harbor fear that their actions would be questioned or punitively dealt with.

If the health care provider is not familiar with a woman's case, participants suggest reviewing the chart before going into see the patient provides the patient with a reprieve from having to re-count her story to yet another person which can be very difficult, emotional, and uncomfortable for her. In addition, allowing the patient to choose whether she would like to stay with one provider rather than seeing multiple providers also promotes the patient-provider relationship and allows trust and comfort to grow. It is important for women's health care providers to understand the contextual

barriers and facilitators for women leaving or remaining in an abusive relationship. Pregnancy is a major barrier to leaving an abusive relationship for many women.

Screening for abuse during pregnancy.

Assessing for abuse in a perfunctory, uncaring, or uncomfortable manner may actually be counterproductive to a woman's disclosure of abuse. Likewise, being unprepared for a woman's positive response and or not respecting her decision-making ability regarding the relationship is also detrimental to disclosure. If an abused woman feels that her provider does not feel empathetically about her or is uncomfortable discussing abuse, it is highly unlikely that she will share such information with her health care provider. Also, if she feels that a particular response – such as leaving her partner – is expected, she may also withhold disclosure rather than endure the negative appraisal of her health care professional.

Research suggests that clinical screening for abuse with the AAS, which consists of three or four screening questions that provide examples of specific abusive acts, is good practice (Curry, Perrin et al., 1998). However, participants in this study reported that the common abuse screening questions failed to capture the reality of their lives – especially as it related to emotional and sexual abuse. Specific to emotional abuse, women said that they were not asked about it, at all. Regarding sexual abuse, many participants suggested that questions dealing with "forced sexual activity" was not relevant to them because they did not resist their partner. They did not resist the abusive partner because they feared what would happen if they did refuse his sexual advances. Thus, were not physically "forced" per se to engage in sexual activity with their abusive partner. Instead, the tacit control, threats, and coercion that were implicit to the abusive

relationship adequately ensured a woman's cooperation with and acquiescence to her partner's sexual advances.

At other times women had not reached the point where they considered themselves involved in an abusive relationship – they fought, he did not abuse her or he had anger management or substance abuse issues that caused his abuse – the relationship or the partner were not the problem, other issues were. Whether the screening question did not capture their reality or they did not consider the relationship abusive, women in this investigation did not answer positively to their provider's screening questions when they were asked in part, because the screening question was not considered applicable to her experience.

Participants suggested that a more general inquiry about how things were going at home with the partner would allow the woman to bring up any issues that she might have – including problems with emotional abuse. The caveat that any assessment for intimate partner abuse must be done when the partner is not present was stressed by more than one participant who had been screened for abuse at a time when her partner was with her and, as a result, guarded the abuse. Since emotional abuse is frequently not screened for, educating about normal changes for couples in the transition to parenthood allows the woman to clarify information and explore relevant issues. It also sends a clear signal that emotional abuse is, in fact, abuse, that it is harmful, and not a normal part of pregnancy.

Abuse education.

While a majority of women do not experience intimate partner abuse during pregnancy, prevalence estimates that 4 – 8 women out of 100 experience physical violence during pregnancy (Petersen, et al., 1997). Thus, information specific to intimate

partner abuse and abuse during pregnancy should be included as part of the educational content routinely provided or available to pregnant women in the course of their prenatal care practice. Information and education materials on abuse in various forms such as written pamphlets and books, posters displayed on walls, and resource cards and pamphlets presented in the ladies' restrooms throughout prenatal clinics and other settings that provide health care to women provides women with ready access to information about abuse, without requiring them to reveal the abuse. Incorporating cultural, ethnic, religious, and social variables in the material sends the important message that woman abuse happens in many different contexts. Also important, it serves to inform the woman that abuse by an intimate male partner is an appropriate topic for discussion with a health care provider.

Educating women verbally, through written formats, and providing ready access to written materials on all forms of abuse supplies women with a standard of comparison for her personal experiences. To maintain her safety, integrity, and autonomy, all education must occur without the partner being present and in a manner that is empathetic and non-judgmental.

What to Expect When You're Expecting and other such books geared to pregnant women that are readily available and frequently distributed by health care providers and health care agencies adds to women's confusion about their circumstances when the adjustment to pregnancy and parenting is described as potentially stressful but there are no concrete, evidence-based examples provided of common behaviors and relationship issues experienced by couples who are expecting a baby. This is also often true of the information commonly disseminated by health care providers. In *What to Expect When*

You're Expecting, only one page addressed the changes in the relationship between partners during pregnancy. Here is an excerpt:

> All marriages, to differing degrees, undergo some alterations in dynamics and a reshuffling of priorities after baby makes three, but studies show that the shock of this upheaval is usually less stressful if the couple begins the process during pregnancy. So, though the change you're noticing in your relationship may not seem like a change for the better, it's one you're better off experiencing now, rather than after your baby is born. Couples who romanticize the notion of a cozy threesome, and who don't anticipate at least some disintegration or disruption of their romance, often find the reality of life with a demanding newborn harder to deal with (Eisenberg, Murkoff, & Hathaway, 1996, pp. 249-250).

There is a considerable knowledge base about parents' adjustment during the childbearing year. Failing to educate women about the common issues that arise between partners during this period and not differentiating between those common issues experienced in the transition from partnership to parenting and actions that are abusive, may leave abused women wondering and perplexed about their own situation. According to study participants, for women who have had significant prior exposure to violence through their family of origin or in their communities, or women who are members of community, religious, or cultural groups that sanction abuse within marriage, the lack of information about normal changes in relationship dynamic during pregnancy may be compounded by prior violence exposure and possibly, a differing barometer for violence.

Referral.

When working with abused, pregnant women, the referral system is an integral component of patient care. For the participants in this investigation who had access to a perinatal clinical social worker whose office was located in the prenatal clinic, this professional provided important social support and facilitated access to multiple services that often went beyond basic health care services. Although many perinatal care providers may not have access to a dedicated clinical social worker, a nurse case manager who was knowledgeable about myriad resources – such as housing, substance abuse programs, child protective services, child care, and others – could also provide such services that are important to such a vulnerable group. Providing a resource list for victims of domestic violence with names and numbers for shelter hotlines and services is a start, but it is not comprehensive enough for women who are pregnant and abused. Furthermore, if a woman has not reached the point of considering her partner abusive, utilizing such an intervention may serve to alienate her and compound her sense that she must guard the abuse in her life.

Research Recommendations

This investigation focused on women's experiences of intimate partner abuse during pregnancy and the influence of that experience on women's decision-making and attainment of a maternal identity. Results indicate that abuse significantly impacts women's experience of pregnancy, influencing her choices as well as her perceptions and feelings about the experience. However, considering that all of the participants in this investigation experienced multiple forms of abuse throughout their lifetime, without further examination, it would be difficult to decipher what form of abuse most impacted

women's experience of pregnancy. For example, would a woman who experienced childhood sexual abuse be at higher risk of experiencing sexual abuse by her intimate partner as an adult because of the childhood sexual abuse? Based on the data from this investigation, it would seem likely, but further exploration would be useful to more fully understand this relationship.

Data from this investigation also suggests that maternal role development is different within the context of an abusive relationship. However, further exploration of this topic would provide important information about abused women's early experiences of motherhood and the impact on her identity. Comparing between groups of women who were emotionally, physically, and sexually abused would provide further information about the influence of such abuse on women's maternal role acquisition. It would also be useful to examine the impact of experiencing different forms of violence throughout a woman's lifetime.

Additionally, it would be useful to compare other stressful contexts – such as multiple pregnancy or the influence of technology – to see how the contexts compare relative to maternal identity formation. Such an investigation would broaden the understanding of maternal role development and acquisition.

Further attention to and investigation into the influence of and interrelationships between culture, religion, ethnicity, and society will be critical to our understanding of women's experiences of abuse during pregnancy and associated maternal decision-making. Without such information, development of culturally sensitive and appropriate interventions will not ensue.

Intervention research with abused, pregnant women will also be an important next step. Although reports of two intervention studies have been published (McFarlane et al., 2000; Parker et al., 1999), further intervention research is necessary. On the basis of data from this study, a focus might be on the use of a clinical social worker and or use of a prenatal care provider support model compared with other common practice models. Such an investigation might provide important information about appropriate, effective care for this high-risk population. Another possibility might be an educational intervention on emotional, physical, and sexual abuse or normal transitional change experienced by couples during pregnancy. Still another potential intervention project could use some form of couples counseling for couples identified as positive for intimate partner abuse and compare it to standard practice. Finally, an on-going support group intervention and advocacy program might also be a useful intervention project.

Summary

The purpose of this investigation was to generate a theoretical understanding of women's experiences of intimate partner abuse during pregnancy and the influence of that experience on women's maternal identity formation and decisions made during pregnancy. Dimensional Analysis, a grounded theory method, was used to analyze the data of interviews with women who experienced intimate partner abuse during pregnancy. Results indicated that women engaged in living two lives – a public and a private life. The public life was the socially constructed experience and value of pregnancy and the private life was the socially hidden experience of intimate partner abuse. The primary process engaged in was guarding and revealing the intersection between the public and private life. The secondary process was pregnancy. Intimate

partner abuse profoundly impacted women's experiences of pregnancy and pregnancy profoundly impacted women's experiences of intimate partner abuse.

This study contributes to the knowledge about how women experience abuse during pregnancy, how the context of abuse impacts women's maternal identity development and associated decision making, and how pregnancy influences women's decisions about the abusive relationship. It supports findings of numerous quantitative investigations of the correlates and consequences of abuse during pregnancy while contributing important contextual information.

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Appendix A. Safety Protocol for Research with Abused Women

Contacting the Participant

1. Determine whether this is a safe time to talk.
2. Approach potential participants when they are alone, away from their abuser or others who may have accompanied them.
3. If the initial contact is by telephone, ensure that it is a safe time for the woman to talk.
4. Describe the study, type of participation requested, and address the issue of safety.
5. Offer participants the use of pseudonyms.
6. Inform participants that data will be kept confidential. Review certificate of confidentiality.
7. Inform participants of mandatory reporting laws for child or elder abuse.
8. Schedule an interview – help the participant to develop strategies to assure she won't be followed by her abuser and that her children will be safe in her absence.
9. Determine a safe time and location for the interview (Clinic or School of Nursing).
10. Provide financial support for transportation and or childcare ($15 for first interview; $20 for second).
11. Provide a copy of the consent form, if safe for the woman to keep.
12. Provide a business card with the PI's name and phone number for contacting.

Subsequent Interviews

1. Set up the time and place of subsequent interviews during the initial interview.
2. Consider a safe time and location (Clinic or School of Nursing).
3. Determine a safe way to contact participant by phone or mail. Determine whether a code name will be used if the abusive partner answers the phone. Determine what measures the researcher should take if the phone goes dead or she hears an altercation during their conversation (i.e., whether to immediately contact the police or to call the police if the woman doesn't call her back within a given time period).

Intervention

1. Provide each participant with information about battering, shelter phone numbers, legal information, and varying amounts of emotional support and therapeutic communication.
2. Offer participants the opportunity to explore domestic violence resources at their specific health care institution.
3. A card that can be easily hidden will be given to each participant with area and national resources for victims of domestic violence.
4. Forewarn participants that the interviews may provoke conflicting feelings of relief as well as shame, anger, hurt and confusion.

Data

1. Data will be maintained in a locked file, accessible to the PI and her faculty research advisors, Mary Ann Curry, RN, DNSc, FAAN, Linda C. Robrecht, RNC, CNM, DNSc, and Judy Kendall, RN, PMHNP, PhD.
2. Access to data stored on computer files will be limited by use of a restricted password.
3. Transcribed data will be stored separately from the audiotapes.
4. All identifying information will be removed, and each participant assigned a code number.
5. In any research reports, the utmost care will be taken to avoid any inadvertent disclosure that could identify any participant.
6. At the conclusion of the investigation audiotapes of the interviews will be destroyed.

Appendix B. Proposed Questions and Lines of Inquiry for Initial Interviews

The initial interviews are designed to establish rapport between the researcher and participant as well as to introduce the research topic to the participant. The questions are intended to be open-ended, allowing the research participant to disclose the information that she feels is most relevant to the research topic.

1. Provide information about the study, secure informed consent for participation, obtain consent to tape record the interview, answer any questions that participants may have, and fill out the demographic data form with them.

2. Tell me about your pregnancy.
   How did you feel when you found out you were pregnant?
   How did your partner feel when he found out you were pregnant?
   Has either of your feelings changed as your pregnancy progresses?
   How has your pregnancy affected your relationship with your partner?
   How do you think your pregnancy has been affected by your relationship with your partner?

3. Tell me about your relationship with your partner.
   How do you feel about your relationship with your partner? When do those feelings vary?
   How has your pregnancy impacted your relationship? How has it impacted your commitment to the relationship?
   When did the fighting start in your relationship?
   How has your pregnancy impacted the fighting in your relationship?
   Tell me about your experiences of fighting with your partner during pregnancy.
   Since you've been pregnant, how frequently do you fight with your partner?
   Tell me what it is like when you and your partner fight.
   How has the fighting in your relationship affected your pregnancy?
   Could you ever see yourself leaving this relationship?

What do you think is abuse?

4. Tell me how being pregnant has affected the way that you take care of yourself? (Ask about health behaviors such as smoking, drinking, drugs, sleep, nutrition, and exercise).
   How has the fighting in your relationship affected the way that you take care of yourself?

5. Tell me about your prenatal care.
   How has being pregnant affected the way that you get your health care?
   How has the fighting in your relationship affected your decisions about prenatal care?
   How has your fighting affected the way that you get health care?
   Are you getting the type of health care that you want and need?
   What kind of relationship do you have with your prenatal care provider?
   How can health care providers help women in similar situations?
   What would be the ideal type of health care provider or health clinic?

6. In closing, is there anything else that you would like to add?

After the interview, provide each participant with a small monitary award for participating, bus fare, a copy of the consent sheet (if desired), and a small card with local and national domestic violence resources listed.

Topical Areas:
Relationship with partner
Health issues
Health care

Appendix B. Subsequent Lines of Inquiry and Questions:

What do you think was the main reason for staying in your relationship while you were pregnant?

You mentioned not knowing what would happen if you disclosed your home situation to your midwife and not saying anything because of that. Do you think that was the most important reason for you not disclosing your abuse?

Were there any cultural or religious influences inhibiting or facilitating your leaving your former partner?

Several participants have talked about not being able to trust another man after their abusive relationship – does that mean anything to you?

Many of the women describe situations were they had to make trade-offs in what they thought was best for themselves or their child/ren to keep things safe I was wondering if anything like that ever occurred while you were pregnant?

Do you think that pregnancy is a time that women are generally unable to leave an abusive relationship? If so, why?
Follow-up questions:

Pregnancy/Birth/Motherhood

Tell me about the remainder of your pregnancy.
Tell me about your birth and postpartum.
How are you feeling about your baby?
How are you feeling about being a mom?
Did you ever consider terminating the pregnancy? Why or why not?

The Relationship with FOB

What's your relationship with the FOB like now? Do you think about getting back together with him? Does he still criticize your ability to be a good mom? If so, how do you feel about that?
Is the Restaining order in place now?
Has there been any abuse since the last time we met?
What would you like the relationship to be like?
Is he providing any support for you and the baby?
What are your hopes for the baby and his relationship with his dad?
How do your feelings about your baby's dad impact how you feel about the baby?

Healthcare

How did you feel about the prenatal care you received? Is there anything you would have liked to been different?
Any comments?

What's your relationship been like with your family?
Dad?

Self-care & Coping
What are you doing now to take care of yourself?
Are you smoking, drinking, using?

Is there anything else that you'd like to add?

One of the ideas that I keep coming back to is that of living two lives – one of the pregnant woman and the other as a woman who is abused. Does that ring true for you? If not, is there another way that you would put it?

For you, the abuse started before your first pregnancy, but it worsened over time and with each pregnancy. Is that correct? You left your former husband two times before the final incident – is that correct? What brought you back to him?

How do you think pregnancy impacts an abusive relationship or vice versa? Do you think that pregnancy is a time that women are generally unable to leave an abusive relationship? If so, why? What do you think was the main reason for staying in your relationship while you were pregnant – i.e., not considering the relationship abusive, attributing his behavior to his reaction to the pregnancy, economic considerations, wanting your family, cultural, social reasons, etc.

You mentioned not knowing what would happen if you disclosed your home situation to your midwife and not saying anything because of that. For you, do you think that was the most compelling reason for not disclosing the abuse to your hcp? Do you think it would have been helpful for your provider to let you know her legal, professional obligations?

Deciphering mixed messages: What you were feeling/thinking/knowing vs. what you were being told by your partner and others…

Were the cultural or religious influences the primary reason you stayed with your former husband?

Many of the women describe situations were they had to make trade-offs in what they thought was best for themselves or their child/ren to keep things safe, you talked about the situation while your daughter was in the hospital and you had to get your ex-husband a video game and I was wondering if anything like that ever occurred while you were pregnant?

Several participants have talked about not being able to trust another man after their abusive relationship – does that mean anything to you? They have also talked about parenting issues, is that anything that you worry about?

What do you think was the main reason for staying in your relationship while you were pregnant?

Were there any cultural or religious influences inhibiting or facilitating your leaving your former husband?

Several participants have talked about not being able to trust another man after their abusive relationship – does that mean anything to you?

Do you think that pregnancy is a time that women are generally unable to leave an abusive relationship? If so, why?

Regrets for your pregnancy? Do you think your abusive relationship affected your developing relationship with your child or impacted your attachment after s/he was born?

You said you kept hoping it would work out and you could have a normal life, do you remember when that changed? Do you think you stayed longer because you were pregnant/ had a child together? What helped you to leave?

Coping – staying away, focusing on the pregnancy – any other ways of coping?

Appendix C. Demographic Data Form

1. Code_____
2. Age_____
3. Race

   _____African American
   _____Asian/Pacific Islander
   _____Latino-Hispanic
   _____Native American
   _____White
   _____Other

4. Education

   _____No School
   _____1-6 Grade
   _____7-9 Grade
   _____10-12 Grade
   _____High School Graduate
   _____Some College or Trade School
   _____College or Trade School Graduate
   _____Other

5. Employed

   _____Yes
   _____No

6. Pregnancies

   _____0
   _____1-3
   _____3-5
   _____6 or more

7. Children

   _____0
   _____1-3
   _____3-5
   _____6 or more

8. Marital Status

   _____Married
   _____Separated
   _____Divorced
   _____Single
   _____Living together
   _____Other

IRB# 5238
Approved: 6/12/01

OREGON HEALTH & SCIENCE UNIVERSITY
Consent Form

TITLE: Woman Abuse During Pregnancy: Experiences and Decisions

PRINCIPAL INVESTIGATOR: Kristin Lutz, RN,CS, MS, Doctoral Student, (503) 494-3816

CO-INVESTIGATOR(S): Linda Robrecht,CNM, DNSc, Assoc. Professor (503) 494-3832
MaryAnnCurry,RN, DNSc,FAAN, Professor(503)494-3847
Judy Kendall, RN, PhD, Assoc. Professor (503) 494-3890

PURPOSE:
You have been invited to participate in this research study because you are pregnant and have been identified through routine prenatal screening as being in an abusive relationship or because you have experienced pregnancy while in an abusive relationship sometime in the past. The purpose of this study is to examine the effects of abuse on pregnancy and decisions.

PROCEDURES:
If you agree to participate in this study, you will be interviewed about your relationship and your pregnancy two times. If you are currently pregnant, these interviews will occur during your pregnancy or up to three months after delivery. If you are not pregnant, the interviews will occur within eight weeks of each other. Each interview will last about 1 to 2 hours and will be conducted at a place of your choice. At the first interview you will be asked to complete a questionnaire about your age, race, education, income, number of children you have, and your marital status. The interviews will include questions about your experiences and decisions. For example, "How do you feel about your relationship with your partner now that you are pregnant?" "Since you've been pregnant, how has the fighting in your relationship affected the way you take care of yourself?" "Did the fighting change when you became pregnant?" All participants will be provided with routine prenatal partner abuse screening and resource information. At your request, referrals to local health care and social service resources for women who are abused will be provided.

RISKS AND DISCOMFORTS:
Talking about your relationship problems may be difficult for you or you may experience emotional stress. You may decline to answer any questions. Your risk of abuse could be increased if your partner learns that you are participating in a study like this. It is not known how the interviews could affect an unborn child. According to Oregon Law, we must report suspected child or elder abuse to appropriate authorities.

BENEFITS:
Some people experience relief when talking about their problems. You may or may not personally benefit from participating in this study. However, by serving as a subject, you may contribute new information which may benefit patients in the future.

ALTERNATIVES:
You may choose not to participate in this study.

CONFIDENTIALITY:
Neither your name nor your identity will be used for publication or publicity purposes. You may use a "pseudonym" to protect your confidentiality. All data will be identified by a code number that is not linked to your name. The audio tapes and transcriptions will be kept in a locked drawer accessible only to the project investigators. Under the authority of Section 301(d) of the Public Health Services Act, a certificate of confidentiality has been granted to this research project. This federally issued certificate provides additional protection of your privacy by shielding your research data from a subpoena. Any information collected prior to your involvement in/or not directly related to the research project (such as your clinic or hospital record) is not protected by a certificate. In addition, if we learn about child or elder abuse we would report this to appropriate authorities.

COSTS:
There will be no costs for participating in this study. You will be paid $15 for the first interview and $20 for the second interview to help defray child care or transportation costs.

LIABILITY:
It is not the policy of the U.S. Department of Health and Human Services, or any federal agency funding the research project in which you are participating to compensate or provide medical

treatment for human subjects in the event the research results in physical injury. The Oregon Health & Science University, as a public corporation, is subject to the Oregon Tort Claims Act (ORS 30.260 through 30.300). If you suffer any injury from this research project through the fault of the University, its officers or employees, you have the right to bring legal action against the University to recover the damage done to you subject to the limitations and conditions of the Oregon Tort Claims Act. You have not waived your legal rights by signing this form. For clarification on this subject, or if you have further questions, please call the OHSU Research Support Office at (503) 494-7887. Legacy Health System is composed of non-profit hospitals that are dedicated to provide medical treatment for injury or illness. Should you suffer any injury as a result of this research project, emergency medical treatment will be available. However, compensation for emergency medical treatment will be available from the hospital only if you establish that the injury occurred through the fault of the hospital, its physicians, officers or employees. Further information regarding this policy, or questions concerning your rights as a research participant may be obtained from the Office of Research Administration at (503) 413-2474.

PARTICIPATION:
Kristin Lutz (503) 494-3900 or Linda Robrecht (503) 494-3832 have offered to answer any other questions you may have about this study. If you have any questions regarding your rights as a research subject, you may contact the Oregon Health & Science University Institutional Review Board at (503) 494-7887. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health & Science University. You will be given a copy of the of the consent form you have signed. Your signature below indicates that you have read the foregoing and agree to participate in this study.

_____ _____
Participant's Signature Date

_____ _____
Researcher Signature Date

Approved: 10/23/01

Consent Form

TITLE: Woman Abuse During Pregnancy: Experiences and Decisions

PRINCIPAL INVESTIGATOR: Kristin Lutz, RN,CS, MS, Doctoral Student, Oregon Health & Science University - School of Nursing (503) 494-3900

CO-INVESTIGATOR: Linda Robrecht, CNM, DNSc, Research Advisor and Mentor Assoc. Professor, Oregon Health & Science University - School of Nursing, (503) 494-3832

PURPOSE:
You have been invited to participate in this research study because you are pregnant and have been identified through routine prenatal screening as being in an abusive relationship or because you experienced pregnancy while in an abusive relationship sometime in the past. The purpose of this study is to examine the effects of abuse on pregnancy and decisions. This study is being conducted as part of the Principal Investigator's doctoral education. The study is being conducted at OHSU and Legacy. It is anticipated that up to 25 women will participate in the study.

PROCEDURES:
If you agree to participate in this study, you will be interviewed about your relationship and your pregnancy two times. If you are currently pregnant, these interviews will occur during your pregnancy or up to three months after delivery. If you are not pregnant, the interviews will occur within eight weeks of each other. Each interview will last about 1 to 2 hours and will be conducted at a place of your choice. At the first interview you will be asked to complete a questionnaire about your age, race, education, income, number of children you have, and your marital status. The interviews will include questions about your experiences and decisions. For example, "How do you feel about your relationship with your partner now that you are pregnant?" "Since you've been pregnant, how has the fighting in your relationship affected the way you take care of yourself?" "Did the fighting change when you became pregnant?" All participants will be provided with routine prenatal partner abuse screening and resource information. At your request, referrals to local health care and social service resources for women who are abused will be provided.

RISKS AND DISCOMFORTS:
Talking about your relationship problems may be difficult for you or you may experience emotional stress. You may decline to answer any questions. Your risk of abuse could be increased if your partner learns that you are participating in a study like this. It is not known how the interviews could affect an unborn child. According to Oregon Law, we must report suspected child or elder abuse to appropriate authorities.

BENEFITS:
Some people experience relief when talking about their problems. You may or may not personally benefit from participating in this study. However, by serving as a subject, you may contribute new information which may benefit patients in the future.

ALTERNATIVES:
You may choose not to participate in this study.

VOLUNTARY PARTICIPATION:
Participation in this research project is voluntary. If you choose to participate in this study, you may terminate your participation at any time and for any reason. If you become very upset by any questions asked during either interview you will be offered the option of terminating your interview and your participation in the research project. If there ever is an immediate risk to your safety, the interview will be promptly ended and your participation in the project may be terminated by the Principal Investigator.

CONFIDENTIALITY:
This research study will likely lead to a publication. Neither your name nor your identity will be used for publication or publicity purposes. You may use a made up name to protect your confidentiality. All data will be identified by a code number that is not linked to your name. The audio tapes and transcriptions will be kept in a locked drawer accessible only to the project investigators. Under the authority of Section 301(d) of the Public Health Services Act, a certificate of confidentiality has been granted to this research project. This federally issued certificate provides additional protection of your privacy by shielding your research data from a subpoena. Any information collected prior to your involvement in/or not directly related to the research project (such as your clinic or hospital record) is not protected by a certificate. In addition, if we learn about child or elder abuse we would report this to appropriate authorities.

COSTS:
There will be no costs for participating in this study. You will be paid $15 for the first interview and $20 for the second interview to help defray child care or transportation costs. You will be paid for the first interview even if you don't complete the second.

LIABILITY:
It is not the policy of the U.S. Department of Health and Human Services, or any federal agency funding the research project in which you are participating to compensate or provide medical treatment for human subjects in the event the research results in physical injury. Legacy Health System is composed of non-profit hospitals that are dedicated to provide medical treatment for injury or illness. Should you suffer any injury as a result of this research project, emergency medical treatment will be available. However, compensation for emergency medical treatment will be available from the hospital only if you establish that the injury occurred through the fault of the

hospital, its physicians, officers or employees. Further information regarding this policy, or questions concerning your rights as a research participant may be obtained from the Office of Research Administration at (503) 413-2474.

The Oregon Health & Science University, as a public corporation, is subject to the Oregon Tort Claims Act (ORS 30.260 through 30.300). If you suffer any injury and damage from this research project through the fault of the University, its officers or employees, you have the right to bring legal action against the University to recover the damage done to you subject to the limitations and conditions of the Oregon Tort Claims Act. You have not waived your legal rights by signing this form. For clarification on this subject, or if you have further questions, please call the OHSU Research Support Office at (503) 494-7887.

PARTICIPATION:

Kristin Lutz (503) 494-3900 or Ms. Lutz's research advisor, Linda Robrecht (503) 494-3832 have offered to answer any other questions you may have about this study. If you have any questions regarding your rights as a research subject, you may contact the Legacy Office of Research Administration at (503) 413-2474. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Legacy Health Systems. You will be given a copy of the of the consent form you have signed. Your signature below indicates that you have read the foregoing and agree to participate in this study.

_____ _____

Participant's Signature Date

_____ _____

Researcher Signature Date

Appendix E. Certificate of Confidentiality

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857

January 27, 1999

Kristin F. Lutz, RN, CS, MS
Oregon Health Sciences University
School of Nursing
Portland Campus
3181 S.W. Sam Jackson Park Road
Portland, OR 97201-3098

Dear Dr. Lutz:

Enclosed is the Confidentiality Certificate protecting the identity of research subjects in your project entitled, "Woman Abuse During Pregnancy: Experiences and Decisions." Please note that the Certificate expires on June 1, 2001.

Please be sure that the consent form given to participants accurately states the intended uses of personally identifiable information (including matters subject to reporting) and the confidentiality protections, including the protection provided by the certificate of confidentiality with its limits and exceptions.

If you determine that the research project will not be completed by the expiration date, June 1, 2001, you must submit a written request for an extension of the Certificate three months prior to the expiration date. Any such request must include the justification for the extension, documentation of the most recent IRB approval and the expected date for completion of the research project.

Please advise me of any situation in which the certificate is employed to resist disclosure of information in legal proceedings. Should attorneys for the project wish to discuss the use of the certificate, they may contact the Legal Counsel, National Institutes of Health, Mr. Robert Lanman, at (301) 496-4801.

Correspondence should be sent to:

Olga Boikess
National Institute of Mental Health
Parklawn Building, Room 17C02
5600 Fishers Lane
Rockville, Maryland 20857

Sincerely,

[redacted]

Olga Boikess

Enclosure

CONFIDENTIALITY CERTIFICATE

MH-NINR 98-02

issued to

Oregon Health Sciences University

conducting research known as

"Woman Abuse During Pregnancy: Experiences and Decisions"

In accordance with regulations at 42 CFR Part 2a, this Certificate is issued in response to the request of the Principal Investigator, Kirsten F. Lutz, RN, CS, MS, to protect the privacy of research subjects by withholding their identities from all persons not connected with this research. Ms. Kirsten F. Lutz and her faculty sponsor, Dr. Linda C. Robrecht, are primarily responsible for the conduct of this research which is funded by the National Institute of Nursing Research.

Under the authority vested in the Secretary of Health and Human Services by section 301(d) of the Public Health Service Act 42 U.S.C. 241(d), all persons who:

1. are enrolled in, employed by, or associated with the Oregon Health Sciences University and its contractors or cooperating agencies, and

2. have in the course of their employment or association access to information which would identify individuals who are the subjects of the research on mental health pertaining to the project known as "Woman Abuse During Pregnancy: Experiences and Decisions",

are hereby authorized to protect the privacy of the individuals who are the subjects of that research by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research.

This research will explore women's perspective of the meaning of abuse during pregnancy as well as the effects abuse has on maternal decision making during pregnancy. The research plan includes two interview sessions with participants lasting approximately 1-2 hours. It is anticipated that approximately 25 participants will be needed to be interviewed. Each interview will be audiotaped and the audiotapes will then be transcribed.

A Certificate of Confidentiality is needed because researchers will obtain sensitive information on sexual and other matters and may be at risk for retaliatory violence and other forms of harassment if their participation in the study becomes known The certificate will help researchers avoid involuntary disclosures, which could expose subjects, and their families, to adverse economic, legal, psychological and social consequences. However, subjects are informed that voluntary disclosures may be made to protect others from harm.

All subjects will be assigned a coded number and identifying information and records will be kept in locked files.

This research begins February 1, 1999, and will end June 1, 2001.

As provided in section 301(d) of the Public Health Service Act 42 U.S.C. 241(d):

> "Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals."

This Certificate does not govern the voluntary disclosure of identifying characteristics of research subjects but only protects subjects from compelled disclosure of identifying characteristics. Researchers are therefore not prevented from the voluntary disclosure of such matters as child abuse or a subject's threatened violence to self or others; however, the consent form should indicate clearly a researcher's intention to make any such voluntary disclosure.

This Certificate does not represent an endorsement of the research project by the Department of Health and Human Services. This Certificate is now in effect and will expire on June 1, 2001. The protection afforded by this Confidentiality Certificate is permanent with respect to subjects who participate in the research during the time the Certificate is in effect.

January 27, 1999

[redacted]
William T. Fitzsimmons
Executive Officer
National Institute of Mental Health

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
National Institutes of Health
National Institute of Mental Health
6001 Executive Boulevard, Room 8102 (MSC 9653)
Bethesda, MD 20892-9653

March 15, 2001

Linda C. Robrecht, CNM, DNSc
Oregon Health Sciences University
School of Nursing, SN-5S
3181 SW Sam Jackson Park Road
Portland, OR 97201-3098

Dear Dr. Robrecht:

RE: MH-NINR-98-02, "Woman Abuse During Pregnancy: Experiences and Decisions"

This letter amends the Confidentiality Certificate protecting the identity of research subjects in your project entitled "Woman Abuse During Pregnancy: Experiences and Decisions" to extend the expiration date until June 30, 2002. This will enable the investigators to complete this research.

Be sure to attach this amendment to your copy of the original certificate.

If you determine that the research project will not be completed by the new expiration date, June 30, 2002, you must submit a written request for an extension of the Certificate 3 months prior to the expiration date. Any such request must include the justification for the extension, documentation of the most recent IRB approval, and the expected date for completion of the research project.

Correspondence should be sent to:

Ms. Olga Boikess
Office of Resource Management
National Institute of Mental Health
6001 Executive Boulevard, Room 8102 (MSC 9653)
Bethesda, MD 20892-9653
Telephone: 301-443-3877
FAX: 301-443-2578

Sincerely,

[redacted]

William T. Fitzsimmons
Executive Officer

Appendix F. Table 3. Maternal Tasks Within the Context of an Abusive Relationship in Pregnancy, Postpartum and Beyond

Maternal Tasks	Pregnancy	Postpartum	Beyond
Seeking Safe Passage • prenatal care • formal and informal education	• Women sought and attended prenatal care except when circumstances intervened. • They sought information through other mothers, literature and health care providers. • Learning needs were not always perceived as having been met.	• Care seeking for the child continued into the postpartum.	• Women sought specialized care to meet their child or children's emotional and physical needs. • Many women sought the information of other women who had been abused during pregnancy.
Securing Acceptance of Pregnancy • partner and others	• Throughout the pregnancy most women tried to gain their partner's acceptance of their child and pregnancy. • For some women, that meant engaging in activities that they felt were potentially detrimental to the baby – such as using drugs. • Decisions were made within a context of their immediate and extended family. • Disclosure of abuse was not common.	• Women struggled to gain their abusive partner's acceptance of their child with varying success. • Acceptance of the child was frequently predicated on remaining in the abusive relationship. • Women frequently tried to please their partners, their family, and community but often, they were unsuccessful. • Decisions continued to be made within the context of their immediate and extended family.	• For many women, their partner's acceptance of the pregnancy and child was less of a concern beyond. • Leaving the relationship realigned concerns for acceptance of their child. • For most women continuing in the relationship, the partner's acceptance of the child was assured.

Maternal Tasks	Pregnancy	Postpartum	Beyond
Binding In • attachment to the theoretical child and actual child	• Binding in was not commonly engaged in until late pregnancy. • For some of the women, pregnancy and the developing maternal-child relationship offered an alternative, more positive focus from the abusive relationship. • Delayed binding in was partially dependent upon the abusive partner's responses to the pregnancy and baby. • For many of the women, there was little or no energy left with which to engage in this process.	• Binding in for some of the women was delayed to the early postpartum period.	• Continued binding in occurred in the period beyond postpartum.
Giving of Self • eating well • giving up harmful habits • emotional giving	• For many of the women, survival was the focus. • This task frequently was at odds with securing acceptance of the pregnancy • Demands of the partner made fulfilling this task difficult for many of the participants. • Attempts to engage in healthy behaviors for the child – except in the presence of addiction – were common, but not always successful. • Many abusive partners forced the women to engage in unhealthy behaviors. • For others, the stress of the abuse led them to use substances, not eat well, or sleep excessively. • For the addicted women, their baby frequently served as an additional motivation for ending the addictive behavior.	• Growing success in giving of self to the child was experienced as the women's commitment to the abusive relationship lessened. • Any ongoing addiction adversely affected giving of self.	• Significant success in giving of self as the women's commitment to the abusive relationship lessened. • Any ongoing addiction adversely affected giving of self.