Published in final edited form as:

Health Care Women Int. 2011 September ; 32(9): 833–854. doi:10.1080/07399332.2011.585532.

Pregnancy and Intimate Partner Violence: How do Rural, Low-Income Women Cope?

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Abstract

The authors conducted thirty-two in-depth interviews with 20 rural, low-income, women residing in the United States, who were pregnant ($n = 12$) or three months postpartum ($n = 8$) and had experienced intimate partner violence (IPV). Using purposive sampling and the grounded theory method, the authors generated a conceptual model of coping. The urge to protect the unborn baby was the primary influence for participants' decisions about separating from or permanently leaving an abusive relationship. Implications include universal screening for IPV in child-bearing women, inquiry into maternal identity development during pregnancy, and improved resource access for rural, low-income women.

The authors set out to explore and identify the protective processes pregnant, rural American women employ within the context of physical and social isolation, lack of accessibility to resources, poverty, and patriarchy. These contextual factors are also relevant to the lives of battered women globally. Although such risk factors and their consequences are well-documented through international prevalence studies, what is lacking is research on how pregnant women cope under such circumstances (Farid, Saleem, Karim, & Hatcher, 2008; Gazmararian, Lazorick, Spitz, Ballard, Saltzman, & Marks, 1996; Perales, Cripe, Lam, Sanchez, Sanchez, & Williams, 2009). Thus, the authors' conceptual model of coping with IPV during pregnancy has potential practice and policy implications for battered women on an international level as well as the United States.

IPV Prevalence

Intimate Partner Violence (IPV) during a woman's pregnancy is not unique to the United States. Prevalence rates of IPV in developing countries range from 1.2% to 31.7% while industrialized nations have a somewhat smaller range of 3.4% to 11% (Campbell, Garcia-Moreno, & Sharps, 2004; Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005). Egypt has the highest known prevalence (31.5%) (El-Zanaty, Hussein, Shawky, Way, & Kishor, 1996), followed by India (21–28%) (International Center for Research on Women, 1999; Puwar, Jeyaseeian, Varhapande, Motghare, & Pimplakute, 1999) and Saudi Arabia (21%) (Rachana, Suraiya, Hisham, Abdulaziz, & Hai, 2002). Poor women both in developing countries and the United States have the highest rates of abuse during pregnancy (Campbell et al., 2004). Prevalence rates for American women range from 0.9% to 20.1% (Campbell et al., 2004; Tjaden & Thoennes, 2000). Among rural women living in Appalachia, Bailey and Daugherty (2007) found rates between 14.6 to 28% for physical and/or sexual abuse during a current pregnancy and rates of psychological abuse as high as 80%. The risk factors for IPV during pregnancy, in developing nations and industrialized ones, include geographical isolation, lack of necessary resources (e.g., employment, education), poverty, gender inequality, unplanned/unwanted pregnancy, and substance abuse by the male partner (Nasir & Hyden, 2003; Yost, Bloom, McIntire & Leveno, 2005). Abuse during pregnancy presents a serious global public health issue, leading to poor obstetric outcomes such as preterm labor, vaginal bleeding, miscarriage, fetal injury, rupture of the uterus, ante partum hemorrhage, low birth weight, and maternal death (Campbell, Poland, Waller, & Ager, 1992; Martin, Mackie, Kupper, Buescher, & Moracco, 2001; Saltzman, Johnson, Gilbert, & Goodwin, 2003).

In the United States, enduring IPV prior to pregnancy increases the woman's risk of additional abuse pre- and post-natal by 10.4% to 24.4% (Amaro, Fried, Cabral, & Zuckerman, 1990; Parker, McFarlane, & Soeken, 1994). Additionally, pregnant women who leave an abusive relationship are at a higher risk for attempted or completed homicide than nonpregnant women (Decker, Martin, & Moracco, 2004). Intimate partner violence accounts for 13%–20% of homicides during pregnancy in the United States (Horon & Cheng, 2001; Parsons & Harper, 1999). Additional health concerns include women turning to smoking or other substances during pregnancy to cope with the stress of abuse (Martin et al., 2001). Researchers are inconclusive about whether pregnancy increases the risk of intimate partner violence. Although some researchers find that pregnancy is a time for increased risk for women (Berenson, Wienmann, Wilkinson, Jones, Anderson, 1994; Webster Chandler, Battistutta, 1996), others indicate no difference in risk (Jasinski & Kaufman, 2001) or they highlight how, for some women, pregnancy is a time of respite from abuse (Campbell, 1998).

Clinicians, advocates, and researchers note pivotal moments or turning points that help women reject violence in their intimate relationships, including threats to their children's safety, changes in the frequency and severity of the violence, and improved access to necessary resources (Eisikovits, Buchbinder, & Mor, 1998; Koepsell, Kernic, & Holt, 2006). Yet, information is lacking in regard to *how* rural, low-income, battered women (residing in the United States) cope and make decisions during pregnancy. Thus far, researchers have

addressed low-income, rural and urban populations, as well as pregnant women facing IPV, but they have not combined these factors as we have in done in our study (Campbell, 1998; Campbell, Oliver, & Bullock, 1998; Krishnan, Hilbert, & VanLeeuwen, 2001; Logan, Walker, Cole, Ratliff, & Leukefeld, 2003). Another feature of our inquiry includes a community sample of low-income women receiving public health care who, due to a dearth of formal services and/or rural cultural norms (e.g., male dominance), often do not access domestic violence services or the criminal justice system. Thus, our inquiry draws from a population understudied in the United States and is in common with the situations of battered women globally: women who do not stay at domestic violence shelters, call the police, and/or seek a legal protection order.

Pregnancy and IPV in the United States: ‘The Double Bind’

Pregnant women make significant decisions regarding prenatal care, their intimate relationships, and the unborn child, yet little is known regarding the effect of IPV on these decisions. Lutz (2005a) found that pregnant battered women live in two disconnected worlds, the public façade of the nonviolent intact family and the private one with abuse. Lutz’s (2005a) ‘double binding’ theory, developed from study with urban low-income women, highlights the concurrent and often contradictory process of binding with both the unborn child and the abusive partner.

The double-bind theory identifies five interwoven processes for women coping with the incongruence of pregnancy and IPV (Lutz, 2005a). Initially, women pursue dreams of maintaining family harmony and a positive image of their intimate partners, reinforcing a separation between public and private worlds. Although they experience abuse in their private lives, they do not want to publically admit its existence. During this period, women minimize IPV warning signs in an attempt to connect with their abusive partner as they hope to improve the situation for the unborn child.

The second process is enduring IPV for the sake of the family. Pregnant women suppress their own individual needs and tolerate abuse for the purpose of maintaining family harmony. These women undergo tremendous emotional pain and confusion as they become more conscious of IPV in the relationship. Their hope of the relationship changing lessens, which often results in ambivalent feelings toward their partner and a sense of helplessness in their situation; they remain focused on meeting the family’s needs. Survival for themselves and the unborn, however, becomes heightened.

The third process is a balance between increasing despair and a desire for a positive outcome. Fears of living on one’s own also prevail. The increasing disparity between the real and the “ideal” (i.e., nonviolence) world exacerbates the pregnant woman’s stress. She begins to critically examine the abusive relationship and her partner’s needs become less important to her than protecting the unborn child and her other children. She may privately label her partner ‘an abuser’.

The fourth process is reconciling dreams with reality as women realize that there is something significantly wrong in the relationship. At this point, women become either resigned to the abuse or start thinking about ending the relationship. Although they realize

the costs of enduring abuse until the end of pregnancy, to survive they feel it is necessary to postpone this decision until after the baby is born.

The fifth process occurs once the baby is born and the mother focuses on protecting the newborn from the abuse. The woman's focus shifts from hopes and dreams of an intact family to the negative effects of the abusive relationship. A decision about the relationship is reached: to end it, make plans to end it, or continue it but with conditions for the abuser. In the case of seven women in Lutz's sample, the escalation of violence after birth (approximately 18–24 months) helped them make the decision to leave the abusive relationship (Lutz, 2005a).

The nuances of intimate partner violence and the double bind women face clearly demonstrate that the decision to stay or leave the abusive relationship is not simple. Intimate relationships are interactive entities and responses to abuse are dynamic in nature. These processes need to be placed in the broader social and structural environment to give them meaning (Bergen, 1995; Cavanagh, 2003). For instance, in our study coping cannot be extracted from the contextual factors that exist in rural areas, including physical and social isolation, lack of accessibility to resources, and a socio-cultural milieu supporting male dominance (Adler, 1996; Few, 2005; Websdale, 1998).

Coping with IPV in Rural America

Rural life is not free of the violence, drugs and other problems that inflict metropolitan areas in the United States. In fact, intimate partner violence occurs in rural locales as often or at higher rates than in urban areas (Johnson & Elliott, 1997; Websdale, 1995). Additionally, many rural women also live in poverty which further increases their stress. The rates of lifetime IPV among low-income women range from 40% to 80% compared with the national average of 25% (Raphael, 1996; Tjaden & Thoennes 2000). Researchers underscore the strong correlation between battering in low-income women and adverse physical health symptoms (Campbell & Lewandowski, 1997; Campbell & Soeken, 1999). With limited access to health care and costly drugs, low-income rural women do not get medical treatment early enough, leading to chronic health conditions. Not only is there a dearth of medical resources in rural areas, there are also fewer opportunities for employment, child care and housing (Dietz, 1991; Struthers & Bokemeier, 2000).

Rigid gender norms in many rural areas of the United States leads to the attitude there is nothing wrong with women facing violence from their intimate partners, as it is part and parcel to maintaining the subordinate status of women. Gender inequality has a tremendous impact on the rates of violence against women, including those who are pregnant (Archer, 2006). Patriarchy is a recurring theme found in the United States as well many countries around the world (Moghadam, 2004). The "belt of classic patriarchy" found in North Africa, the Middle East, and South and East Asia (Kandiyoti, 1988) encourages males to be dominant and limits the opportunities for females to be fully integrated into activities outside the home. However, variations of patriarchy, not necessarily termed "classic", are found in many societies, including rural America.

In comparing rural and urban (non-pregnant) women in the United States, researchers highlight their differences in coping with an abusive relationship and in accessing resources. In rural areas, access to safety through shelters or hospitals is limited due to physical and geographic isolation as well as lack of public transportation. These services may be located a few hundred miles away and thus not easily accessible (Adler 1996; Logan et al., 2003; Few 2005). Thus, battering can go on without anyone intervening and injuries might heal before anyone notices them. Researchers also underscore how rural women have less social support, lower levels of education and income, more physical abuse, more childhood physical and sexual abuse, and worse overall health than urban women (Logan, Stevenson, Evans, & Leukefeld, 2004).

Shannon and colleagues (2006) also studied differences in coping skills between rural and urban women ($N=757$) facing intimate partner violence. Urban women used more emotional support, positive self-talk, and exercise/meditation to manage the abuse whereas rural women relied more on denial. Emotion-focused coping strategies are highly associated with harmful effects on physical as well as mental health (Logan, Cole, & Walker, 2005; Shannon, Logan, Cole, & Medley, 2006). Women in rural areas may use more emotion-focused coping strategies (e.g., denial, minimization) because of a lack of available resources.

A commonplace phenomenon in rural areas includes maintaining reticence about family matters out of fear and shame that the whole community will find out about private issues. There is also a lack of trust in service providers keeping sensitive information private (Websdale, 1995, 1998). Families meet on a regular basis in churches, grocery stores, schools, beauty parlors, and elsewhere, such as government offices and social service agencies (Johnson, 1994). Websdale (1998) identified the nexus between local police and some abusers in rural areas. Friendship and sharing of common interests between police and abusers makes it more difficult for women in rural areas to depend on the local police. Women stated that if the police officer knew the abuser they received little or no help (Websdale, 1998). Yet rural women, like their urban counterparts, are not “helpless individuals” but actively seek safety for themselves and their children (Gondolf, Fisher, & McFerron, 1990; Hutchinson & Hirschel, 1998).

How battered women employ strategies to withstand or oppose the violence is well documented on a global level (Campbell, Rose, Kub, & Nedd, 1998; Cavanagh, 2003; Geiger, 2002). Researchers indicate that women typically are resistant to violence and use a variety of mental and behavioral strategies to prevent, withstand, stop, or oppose their subjugation (Gillum, Sullivan, & Bybee, 2006; Kocot & Goodman, 2003). In fact, in the face of escalating violence, women often demonstrate increased activity in protecting themselves and their children. Merritt-Grey and Wuest (1995) interviewed thirteen survivors of IPV living in rural Canada. These women were resistant to the violence and made plans to leave the abuser. The process of breaking free involved slowly moving their belongings from their homes to shelters, their own living place, or the homes of friends/family. These women sought safety by physically and emotionally distancing themselves from the abusive situation, gaining employment, and, for some, through a caring relationship with another male.

Pregnant women who are abused clearly face significant obstacles in keeping themselves and the unborn baby safe. Living in rural areas and in poverty further complicates this situation. Thus, we examined *how* low-income women living in rural areas cope with violence in their lives during pregnancy. We also explored how pregnancy and the unborn child impacted battered women's decisions about staying or leaving the abusive relationship.

Present Study

We employed a grounded theory method to better identify complex and hidden psychosocial processes with the goal of developing theory (Glaser, 2001). We were "immersed" in the world viewpoints of the participants. Our two research questions were: 1) how do pregnant, low-income, rural women perceive the impact of intimate partner violence on their lives? and, 2) how does pregnancy and the unborn child impact the ways in which these women cope and make decisions regarding the abusive relationship?

Method

Data Collection

Participants ($N=20$) for this exploratory study were recruited from the Domestic Violence Enhanced Home Visitation (DOVE) project, an intervention study of 360 urban and rural women from the East Coast (urban) and the Midwest (rural) of the United States (Sharps, 2005). The larger study was designed to evaluate the DOVE intervention rather than to explore participants' coping experiences with IPV. Thus, we sought to further examine this facet of participants' lives and were guided by the assumption that not all concepts related to coping for low-income, rural, pregnant battered women had been identified by prior researchers.

The larger randomized control trial, and this qualitative study also, included participants who: 1) were less than 31-weeks pregnant, 2) had a history of IPV (within the last year) or IPV during the current pregnancy, 3) were English speaking, and, 4) were enrolled in a perinatal home visitation program. For the present study, participants had to be low-income women residing in rural areas. In this study "low-income" was defined as those individuals living at or below 185% of the poverty level (i.e., \$21,200 for a family of four living in the continental United States) (Federal Register, 2008). Subsequent theoretical sampling for our qualitative study was based on the grounded theory criteria of "saturation" of conceptual information and code categories related to coping (Denzin & Lincoln 1998; Oktay, 2004). Based on purposive and theoretical sampling criteria, and upon approval of the University's IRB, twenty individuals became research participants for this exploratory study.

Qualitative interviews were conducted at participants' homes (abuser not present) or at a safe location of their convenience. The first author conducted the qualitative interviews and was accompanied by a DOVE nurse. Being South Asian by origin, the first author was hesitant about rural participants from the Midwest being comfortable with her. Thus, the American nurse introduced the researcher to the participants and mentioned that she had experience working with abused women in India and was there to learn more about the

women in the United States. This helped to build rapport, although a few women preferred to maintain eye contact with the nurse rather than the researcher.

Twelve women were interviewed twice (once during pregnancy and again at three months post-delivery) and the remaining eight women were interviewed when the baby was three months old. Thus, thirty-two interviews were conducted in all. Interview duration ranged from 45 to 90 minutes. Remuneration of fifteen dollars was provided to participants for each completed qualitative interview. Transcribed texts and audiotapes were stored in a locked file. Identifying data were removed and pseudonyms were used.

Measures

Interview guide—The in-depth interviews were guided by a set of open-ended questions guided by the content areas (safety planning, resistance, pacifying, accessing formal and informal social supports) of the Intimate Partner Violence Strategies Index. This index is a 39-item scale of strategies validated on a sample of primarily African American women in an urban area of the United States (Goodman, Dutton, Weinfurt, & Cook, 2003; see Appendix A for scale items). Instead of following the IPV index itself, the qualitative interviews were unstructured, the researcher asked broad questions, followed by probes to gain additional information and clarification. Participants were encouraged to disclose as much of the background and context surrounding their experiences as possible. For instance, the interviews began by asking participants “What are some of the ways you keep yourself safe? What are some of the ways you keep your children—particularly your unborn baby—safe?” Probes, if needed, were often drawn from the IPV Strategies Index, such as safety tactics of changing house locks or hiding car keys. Additionally, participants were asked, “How does pregnancy influence the coping skills you used?”, and, “How does the unborn child influence the coping skills you used?” Finally, participants were asked about their advice for other pregnant battered women and service providers.

Data Analysis

Our qualitative data analysis was conducted using a constant comparative method and was based on transcriptions of the semi-structured in-depth interviews (Glaser, 2001; Denzin & Lincoln, 1998). Our coding allowed the data to be broken down, conceptualized, and reconstructed in new ways. Our process included repeated sortings, codings, and comparisons that yielded increasingly complex and inclusive categories and continued until all of the data were accounted for in the core categories of the grounded theory paradigm (Glaser, 2001). Initially, content areas of the IPV Strategies Index (Goodman et al., 2003) provided a context to understand the strategies women used to keep themselves safe, resist the violence, pacify the abuser and access formal and informal networks. However, as we collected and analyzed data further, a theory on coping was developed that went beyond an accounting of protective strategies to encompass the constructs of “protection of the unborn (fetus) baby”, “decisions about intimate relationships”, and “the role of sole provider”. Interrelationships were established between these three major constructs.

Trustworthiness

To ensure methodological rigor, our trustworthiness (Oktay, 2004) of the data involved member (i.e., participant) checking to establish that the reconstructions were credible and that the findings were faithful to participants' experiences. Participants were provided written and oral summaries of their responses and given opportunities for correction, verification, and clarification through follow-up interviews and/or telephone contacts. In addition, peer debriefing (i.e., ongoing consultation between the first author and her dissertation committee) was used to review the first researcher's audit trail which included a reflexive journal that documented procedures, insights, and analytical decision-making regarding the research process.

Results

Demographic and Abuse Information

The mean age of participants for this study was 23 years, with a range of 16 to 32 years. Thirteen women were Caucasian, five were African American and two were Native American. Ten women were single, one was married, five were separated and four were divorced. Four women did not complete high school/GED, while eight women did finish, and eight had some college or trade school education.

All 20 women experienced at least one type of violence or a combination of physical, emotional and sexual violence. Eleven women in this study experienced all three types of violence, while seven women experienced physical and emotional violence. One woman experienced emotional violence only and one woman experienced emotional and sexual violence. The following participant quote highlights the gravity of abuse during one's pregnancy:

I actually got pregnant from him and everything. We were actually going to have three, and that's so sad, you know, we were going to have triplets....Everything was great, then he started acting funny, he was trying to get temper with me, one day he wanted money, and I didn't have any and he choked me, and we split up. He came back, he was much better, [he said] "I want our babies, I want our family." I didn't know what was going on. One night [at her place of employment] he was like waiting for me there. And he threw me against the wall, hit me in my stomach really hard, was choking me, and then he got a knife out, my friend [co-worker] came And he actually stopped him, he was wanting more money, it turned out that he was on crack....I started bleeding, I had to go to the hospital, and I had a miscarriage. (Jane, age 24)

Conceptual Model of Coping with IPV during Pregnancy

Figure 1 shows a conceptual model of coping; (its pillars represent psycho-social strategies such as resisting violence, pacifying the abuser, safety planning, and accessing formal and informal support networks (Goodman et al., 2003). Within the model are key constructs including "protection of the unborn fetus", "decisions about intimate relationships", and "sole provider" that emerged from the data. Concern for the unborn fetus, as well as

providing for any existing children, were the main factors influencing the decision to leave or to stay in the abusive relationships. Regardless of their relationship status, women in this study felt they needed to be the sole providers for their unborn baby as they realized the danger of abuse to the unborn fetus and hence the need to protect it. In order to be the sole providers for their children, they knew they would need to enhance their emotional and physical self-care. Taking on the role of sole provider (and subsequently taking better care of themselves), making decisions about their intimate relationships, and enlisting a variety of psycho-social coping strategies, ultimately enabled them to protect the unborn fetus. Each of the aforementioned constructs along with their interrelationships is explained more fully in the following paragraphs.

Protection of the unborn baby—The impetus for these women to reject violence in their lives included the urge to protect the unborn baby (see Figure 1 “Model on Coping with IPV”). Participants had mixed feelings between leaving the abuser and improving the relationship. They began to see how even with the unborn baby in their lives there was still no change in their abusive partner. The urge to protect the fetus also heightened safety issues for their other children. Protection influenced all decisions in the women’s lives and was the crystallizing event for them to break free from the abusive relationship during their pregnancy:

I’d probably be with him if I didn’t have kids, ‘cause I mean, in my first abusive situation that was 14 years ago, the only reason I left the relationship, he put me in the hospital twice, and the only reason I left is when he hit my son the first time, and I took off that day. So I mean it was the kids that kept me going. If it weren’t for the kids I’d probably still be there, in a situation like that. I wasn’t strong enough to leave for myself. And this one [abuser], I mean, this guy would choke me until I passed out. I mean, I could have died at any one of those times, so I’m just fortunate that I didn’t. So, when I found out I was pregnant I left because I knew that if he’d strangle me, he’d cut off her [unborn baby] air. And I do things for my children that I wouldn’t do for myself. It’s sad ‘cause I should have just as much love for myself as I do for my kids. I know that, but it’s just not there yet.
(Lisa, age 32)

Participants gained a strong desire to protect the unborn fetus and that motivation was the starting point of making life decisions in favor of the unborn baby rather than waiting to make a life change (i.e., leaving the abuser) until the child was born. The unborn baby was key in deciding to end the abusive relationship and enter into a new (less- or non-abusive) one.

Seventeen of the women in this study left their abusive partners permanently. Of these seventeen, at the follow-up interview (i.e., when their baby was three months old), eleven were not in an intimate relationship and six of them were dating somebody other than the abuser. All participants left or were separated from their abusers at some point during their pregnancy:

I just think that pregnancy made me make a decision that it’s beyond what I want and what I feel is best. I have to make a decision for what’s best for the baby, not

for me, and not for my family, and not for my marriage. What's best for my baby.
(Susan, age 27)

Decisions about leaving/staying or starting a new intimate relationship—The decision about staying or leaving the abuser or beginning a new intimate relationship was made with the safety of the unborn fetus in mind. The majority of participants ($n=17$) did not continue being trapped in an abusive relationship as they eventually left the abuser. However, some of them still yearned for the abuser (in most cases he was the father of the baby) to be a father figure in their child's life, even though they did not look at him as their intimate partner. The three women who did not permanently leave their abusers stated the need for a father figure as an important reason for staying. For women who dated an ex-partner or a new partner, he became the father figure for their children even if he was not the biological parent. Those women without a partner expressed loneliness and frustration in dealing with their children single handedly and expressed the need for a companion. Some women in this study ended up with a new partner as protection from the previous, abusive partner. Thus, decisions regarding their partner status were influenced by consideration of the need for a father figure, for a companion and/or protector, along with an overriding concern for the safety of the unborn baby.

That's when I had my boyfriend move in. At the time he wasn't my boyfriend; he was just C's (her older son) dad. He moved in to protect us cause I was pregnant and I had our son there and he didn't want nothing to happen to us, and I didn't want nothing to happen to us, so if B (her former abusive partner) came and see this big Black dude, he wasn't gonna do nothing. He'd you know, start cussing and walk away. (Gail, age 25)

Sole provider—These women reconstructed a sense of self and regained a sense of identity by taking on the role of "provider" for their children. For the three women who did not leave their abusers, they also perceived themselves as sole providers for their children as they continued to have mixed feelings regarding staying with or leaving the abuser. They feared abuse possibly occurring again and wanted to have the necessary resources in place, if needed, to leave permanently. All women in this study desired a better future for their children and focused on enhancing their situation (for example, gaining employment or securing public assistance) in order to provide for their children and be the best mother possible. They looked at their unborn baby as a ray of hope for improving their own lives:

He is a surprise. He's everything positive that was negative in our relationship. He's a gift, basically. B (father of the baby and the abuser) treated me like crap when he was drunk, but he gave me a gift at the end. This little boy is my everything and my other little boy is my everything. Without them, I'm nothing. These kids are my whole life. His dad and the way he is apparently for a reason, but I don't regret J (the baby) at all. At the beginning I did. I didn't know if I wanted him because of his dad. I look at him every day, knowing he looks like his dad, but it's not his fault. He didn't do nothing. He loves me. He's just everything. (Gail, age 25)

In taking on the role of sole provider, these women decided to take better care of their physical and mental health so they could be there (literally and figuratively) for their children. They paid more attention to their diet and exercised during pregnancy, which they had previously neglected. Additionally, they consciously addressed mental health issues, such as managing their anger (and thus avoiding legal trouble as in the case of getting arrested for physically assaulting someone) and stopping self-destructive behaviors:

There's been a couple of times I would have gotten into an argument with people, and I don't like to argue. I'd rather just fight, and now I have to think about him [unborn baby]. If I go to jail, who's gonna take care of him, you know? (Shanice, age 24) If I wasn't pregnant, I probably would have ended up killing myself because I was so overwhelmed with grief over losing my son (lost custody of older son) and having people telling me I'm crazy, and there were times where C (her abuser) would mentally toy with me, and I'd fall for it because I wanted my marriage to work. (Janice, age 22)

IPV coping strategies—Participants used different strategies including resisting violence, pacifying the abuser, safety planning and accessing formal and informal supports to attain safety of the fetus (see pillars in Figure 1). Once women connected with needed resources (e.g., employment, public assistance, housing) and were provided opportunities to deal with their situations, they were able to separate from or leave their abusers. As Lisa, age 32, stated, “I have kids to take care of, so you just have to get up and cope with it and move on.” Participants also mentioned activities that kept them occupied and were distractions from the abuse, including fishing, cleaning their homes, cooking, reading, watching movies, exercising, smoking and chatting on the internet:

I would cook, I would clean, I would pretty much walk on egg shells, I really would not say nothing. Now it got so bad to the point where I was like how is your day and he would just blow up, if he had a bad day or something. I just started speaking to him very little....Try not to say much.... I just try to stay away from him basically. I try to stay out of his life. (Nakisha, age 22)

Discussion

Our study revealed how leaving the abuser was the predominant coping method during pregnancy for rural, low-income women. The urge to protect the unborn fetus became the impetus for separating from the abuser and for some participants ($n=17$) to permanently end the abusive relationship. Our results differ from Lutz's (2005a) study where respondents ($n=5$) remained in the relationship or left the abusive situation *after* the birth of the baby ($n=7$). Lutz's (2005a) “double binding” theory highlights the parallel and often conflicting process of binding with both the unborn child and the abusive partner. Similar to Lutz's (2005a) findings, our participants did bind with the abuser and endure the violence for the sake of maintaining an intact family. However, at some point during their pregnancy the “double bind” resolved in favor of connecting with and protecting their unborn over the needs of the abuser. The severity of violence, which was significant in our study but not clarified in Lutz's study, could be a reason for differing results.

Lutz (2005b; Lutz, Curry, Robrecht, Libbus, & Bullock, 2006) underscores how the inconsistency between the experience of abuse and the accepted socio-cultural norms of a two-parent household further alienate battered women from themselves and thus their mothering role. Zeitlin and colleagues (1999) found that abused women ($n=11$) in the United States do not bond with their fetus and later their newborn as well as their non-abused counterparts ($n=27$). In contrast, women in this study viewed leaving the abuser during pregnancy as protecting the unborn fetus and thus proving to be a “good mother”. Although the domestic violence they endured did have negative consequences on their self-image (feelings of shame and worthlessness), it did not severely impact their maternal identity. Important life decisions, whether about intimate relationship status or taking care of themselves, were dependent on the bond with their unborn/newborn baby and their other children. Our findings lend support to Gilligan’s (1982) conclusion that American women define themselves within the context of relationships and their ability to care.

Whether the pregnancy was planned or unplanned, all participants in the present study were strongly motivated to protect the unborn fetus and their other children; they did not want their children to go through what they had experienced with the abuser. In fact, with the father of their baby being abusive, they were more aware that they had to be the healthy parent for their child. Participants used their strength and courage to be the sole provider. Accessing employment, public welfare and housing helped several women in this study to be independent providers for their children. Hence, financial dependence (as highlighted by prior domestic violence researchers in the United States) was not viewed as a reason to stay with the abuser, as many of the participants’ partners did not have stable employment.

In rural populations, women use more placating and safety planning strategies rather than separating from or leaving their abusive partners (Riddell, Ford-Gilboe & Leipert, 2009). Yet, researchers have not addressed women who concurrently experience pregnancy and IPV. In our study, for the seventeen women who permanently left the abusive relationship, six dated a new partner or went back to an ex-partner. Thus, finding another partner upon leaving a former relationship may be in line with rural culture that stigmatizes single women and pressurizes them to be in a relationship (Kershner, Long, & Anderson, 1999). The three women who remained in the abusive relationship perceived a lessening of or an ability to control the violence. These women expressed also wanting a father figure for their children. These reasons for staying are similar to ones well documented in the domestic violence literature in the United States (Herbert, Silver, & Ellard, 1991).

Another possible reason for differences in this study compared with others in the United States may relate to how most of the participants reported that they had seen their mothers being abused by intimate partners and thus may not have wanted to perpetuate the cycle of violence for their children. Anderson and Danis (2006), in their study of adult daughters of battered women ($N=12$), found that participants vowed that their children would not be exposed to domestic violence. Yet, seven women in their study admitted being abused by their intimate partners. However, these women highlighted how they ended their relationship when they saw that it was affecting their children.

Implications

Pregnancy offers a time-limited opportunity for service providers to be influential in expectations, assumptions, and responses regarding safety for mothers and their unborn babies. The findings of this study provide additional support for universal screening of IPV among the population of pregnant women. Women's denial of the abuse and the dream of maintaining family harmony may wax and wane, particularly as their maternal identity strengthens and the urge to protect the fetus becomes paramount. Thus, it is important to consider, both in the United States and internationally, screening women for IPV over the course of their pregnancy. Yet, the screening process may not warrant disclosure if handled in a manner that does not take into account IPV power and control dynamics, particularly male dominance. For instance, some participants in our study did not disclose IPV because their abusive male partners were present at the interview. It is essential for health care providers to screen women for abuse in a private and confidential manner while attending to the patriarchal context found in American rural areas as well as in many countries.

Although there is a growing body of international research focused on pregnancy-related violence, there are still areas where empirical evidence is limited. A focus on understanding the different contexts and influences within the community would help in assessing resources available for pregnant women. With barriers to necessary services and the impact of abuse on physical and mental health, it is important to understand globally how low-income, pregnant women in rural areas cope when they are also experiencing abuse. Additionally, further international inquiry into women's identity as mother and protector of her unborn is important. In our study, participants during their pregnancy separated from or permanently left the abuser as their identity as a mother became stronger and they consequently focused their energies on protecting the unborn baby rather than staying in the abusive relationship. Further exploration into the phenomenon of women going back to ex-partners for protection from their current abusive partners and the use of social networking through the internet (mentioned by 4 women in this study) may be particular to the United States, but also may warrant additional international studies.

Researchers highlight how pregnant women who face IPV experience more life stressors than non-abused women (Bhandari et al., 2008). The women in this study viewed themselves as the sole provider for their children (regardless of partner status) and, thus, they realized the need to take care of their physical and mental health, including becoming economically self-sufficient. With pregnancy restricting women from acquiring employment, and the interwoven relationship between poverty and violence, it is essential that countries adopt policies to provide essential financial and health resources for low-income abused pregnant women and, consequently, opportunities to break from violence for themselves and their children. The US could learn from countries such as Sweden and Denmark which have adopted policies that provide support to economically disadvantaged families and, as a result, have lower poverty rates than countries that lack such initiatives (Kury, Obergfell-Fuchs, Woessner, 2004).

Strengths and Limitations of the Study

This study appears to be the first that addresses coping among rural, pregnant, low-income women who have experienced intimate partner violence. In doing so, it provides fruitful insights for health care and social service providers along with researchers interested in enhancing individual and environmental resources for this population. A limitation of the study is the small sample size. As a qualitative study using a grounded theory method, the focus was on theoretically explaining the phenomenon; thus generalizing to other women without similar contextual factors (e.g., rural, low-income, pregnant) is limited. Additionally, twelve women were interviewed during pregnancy, while eight were interviewed when the baby was three months old; and hence some recall bias might have existed.

Conclusion

The participants in our study (rural, pregnant American women) used various coping strategies, including resisting violence, pacifying the abuser, safety planning, and accessing formal and informal supports. These coping strategies revolved around protection of their unborn babies, making decisions about leaving or staying in the abusive relationship, starting new non-abusive relationships, and becoming a sole provider. Despite the challenges they endured, these women saw their babies as a ray of hope for a new beginning for themselves. Rather than waiting to see if the birth of their babies would transform their abusive partners into becoming the fathers the women wished them to be, they decided to separate from or permanently leave the abuser during the pregnancy.

Acknowledgments

The authors wish to thank David Bullock for editing this manuscript. This Research was supported by grant R01NR009093-01A2/NINR from the National Institute of Nursing Research.

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APPENDIX A

Items and Categories for the Intimate Partner Violence Strategies Index

Formal Network

- 1 Tried to get help from clergy
- 2 Tried to get help from her employer or coworker
- 3 Talked to a doctor or nurse about abuse
- 4 Called a mental health counselor for yourself
- 5 Tried to get him counseling for violence
- 6 Stayed in shelter
- 7 Talked to someone at a domestic violence program, shelter, or hotline
- 8 Tried to get help for *yourself* for alcohol or substance abuse
- 9 Tried to get *him* help for alcohol or substance abuse (added at T3)

Legal

- 10 Filed petition for CPO
- 11 Filed or tried to file criminal charges
- 12 Sought help from legal aid
- 13 Called police

Safety Planning

- 14 Hid car or house keys
- 15 Kept money and other valuables hidden
- 16 Developed code so others would know I was in danger
- 17 Worked out escape plan
- 18 Removed or hid weapons
- 19 Kept important phone numbers I could use to get help
- 20 Kept extra supply of basic necessities for myself/children
- 21 Hid important papers from him
- 22 Put a knife, gun, or other weapon where I could get it
- 23 Changed locks or somehow improved security (added at T3)

Informal Network

- 24 Talked to family or friends about what to do to protect myself/children
- 25 Stayed with family or friends
- 26 Sent kids to stay with friend or relatives

- 27 Made sure there were other people around (added at T3)

Resistance

- 28 Fought back physically
29 Slept separately
30 Refused to do what he said
31 Used/threatened to use weapon against him
32 Left home to get away from him
33 Ended (or tried to end) relationship
34 Fought back verbally (added at T5)

Placating

- 35 Tried to keep things quiet for him
36 Did whatever he wanted to stop the violence
37 Tried not to cry during the violence
38 Tried to avoid him (added at T3)
39 Tried to avoid an argument with him (added at T3)

Source: (Goodman et al., 2003)

Figure 1. Model on Coping from IPV from Pregnancy to Three Months Post-Natal by Rural, Low-income Women.