Published in final edited form as:

J Interpers Violence. 2015 July ; 30(12): 2087–2108. doi:10.1177/0886260514552274.

Comparison of Abuse Experiences of Rural and Urban African American Women During Perinatal Period

Shreya Bhandari, PhD, MSW¹, Linda F. C. Bullock, PhD, RN, FAAN², Jeanita W. Richardson, PhD², Pamela Kimeto, PhD (c), RN², Jacquelyn C. Campbell, PhD, RN, FAAN³, and Phyllis W. Sharps, PhD, RN, FAAN³

¹Wright State University, Dayton, OH, USA

²University of Virginia, Charlottesville, USA

³Johns Hopkins University, Baltimore, MD, USA

Abstract

A subsample of 12 African American women (6 urban and 6 rural) were selected from a larger longitudinal, randomized control trial, Domestic Violence Enhanced Home Visitation (DOVE-R01 900903 National Institute of Nursing Research [NINR]/National Institutes of Health [NIH]). All African American women were chosen to control for any racial- and/or race-related cultural differences that may exist among women across geographical areas. The experiences of abuse during the perinatal period are drawn from in-depth interviews conducted at five points in time during pregnancy and the post-partum period. The analysis describes three major themes that highlight the similarities and differences among rural and urban women. The main themes found were (1) types of abuse, (2) location of abuse, and (3) response to abuse. In addition, two sub-themes (a) defiance and compliance and (b) role of children were also identified. Implications for universal screening for women of reproductive age, safer gun laws, and the need for further research are discussed.

Keywords

domestic violence; anything related to domestic violence; battered women

Intimate partner violence (IPV) is a serious public health problem with the Centers for Disease Control and Prevention (CDC) reporting 35.6% of U.S. women experiencing lifetime rape, physical violence, or stalking from an intimate partner (former or current husband, boyfriend, or partner; Black et al., 2011). Perinatal IPV is defined as violence that occurs before, during, and up to 1 year after pregnancy and is perpetrated by an intimate partner (Sharps, Laughon, & Giangrande, 2007). Prevalence rates of IPV during pregnancy in the United States ranges from 0.9% to 20% (Gazmararian, Lazorick, Spitz, & Ballard,

Reprints and permissions: sagepub.com/journalsPermissions.nav

Corresponding Author: Shreya Bhandari, Assistant Professor, Department of Social Work, 271 Millett Hall, Wright State University, 3640 Colonel Glenn Hwy, Dayton, OH 45435-0001, USA., shreya.bhandari@wright.edu.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

1996) with most studies reporting 4% to 8% (Saltzman, Johnson, Gilbert, & Goodwin, 2003). These rates mask the disproportionate prevalence of IPV in different racial groups. For example, African American women are 3 times more likely to experience abuse during pregnancy than Caucasian women (McFarlane, Campbell, Sharps, & Watson, 2002).

Although IPV affects women across racial, economic, and educational divide, women who identify themselves as African American, mixed race, and/or indigenous experience the highest rates of intimate partner homicide and IPV in the United States (Bent-Goodley, 2004; Black et al., 2011). In 2009, the CDC established that homicide was the second leading cause of premature death in African American women between ages 15 and 24 and that near fatal homicides contributed to long-term injury and disability (CDC, 2009). Cheng and Horon (2010) showed that younger and unmarried African American women are at greater risk of dying due to homicide by a current or former intimate partner in the first 3 months of pregnancy than their Caucasian counterparts. The abuse inflicted on African American women is severe and they are more likely to be re-victimized by their abuser when compared with Caucasian and Latina women (El-Khoury et al., 2004).

Social isolation in low-income, racially segregated urban neighborhoods with limited levels of residential mobility has been associated with higher prevalence of IPV. Literature identifies these urban areas as “islands of distress,” where high levels of neighborhood disorder and poverty intertwine with a sense of being trapped and perception of powerlessness to escape (Mitchell & LaGory, 2002; Ross, Reynolds, & Geis, 2000). Similarly, inadequate access to services, low levels of education, high rates of poverty, and social isolation are all factors that may impact a rural woman’s IPV victimization experiences (Kershner, Long, & Anderson, 1998; Logan, Walker, Cole, Ratliff, & Leukefeld, 2003).

Geographical Differences in IPV Victimization Among Non-Pregnant Women

One study has examined geographical differences in IPV victimization among non-pregnant Caucasian women (Logan et al., 2003). Among rural women, the violence began earlier, usually during the first month of dating and the abuse was more frequent and severe than that experienced by women living in urban settings. Both groups, however, reported similar rates of emotional and sexual abuse. This study was one of the first to show that intimate partner victimization differs depending on the geographical location.

IPV and Pregnancy

Abuse during pregnancy, compared with before and after pregnancy (Bacchus, Mezey, & Bewley, 2004; Charles & Perreira, 2007; Yost, Bloom, McIntire, & Leveno, 2005), is usually lower and has been characterized by three different patterns: (a) physical abuse occurring before and starting again immediately after pregnancy while emotional and sexual abuse often continuing during pregnancy (Martin et al., 2004), (b) abuse occurring before, during, and immediately after pregnancy, and (c) abuse that starts during pregnancy, which is the least common of the three (Campbell, Garcia-Moreno, & Sharps, 2004).

These patterns show that for some women pregnancy is a protective period and for others it is business as usual (Campbell, 1998). Power and control are the goal of the violence (Campbell, Oliver, & Bullock, 1993). For many women, this control is the same as it was before becoming pregnant (Decker, Martin, & Moracco, 2004). For others, the violence occurs as the man tries to re-assert control as the woman focuses more attention on her changing body and the developing fetus (Bacchus, Mezey, & Bewley, 2006). Pregnancy being viewed as protection from abuse, however, should be regarded critically, as 20% of the women who stayed with their abusers, experienced an increase in the number of homicide risk factors (Decker et al., 2004).

The current study seeks to elucidate whether perinatal IPV differs between African American women who are living in rural and urban environments. This study capitalizes on a large multi-site trial implementing a home visit intervention aimed at reducing IPV against pregnant women and followed women for 2 years post-birth. This provided an opportunity to tease apart some of the differences that may exist in two distinct geographical regions of the United States. Because recruitment at the urban site was predominantly African American women, it was decided to compare the experiences of perinatal IPV among African American women by geographical location to control for possible racial/ethnic differences between abuse experiences. While there are several factors that may influence the IPV experiences of pregnant/post-natal women in urban and rural environments, there is a dearth of research focused on the differences in experiences between these women presented from their own perspectives (Bergen, 1995; Cavanagh, 2003). Furthermore, if one considers the increased IPV prevalence rates of African American women compared with Caucasian women, their experiences of abuse during pregnancy and the post-natal period in the context of living in rural and urban areas are glaringly absent from the literature.

Method

The current study reflects data collected from in-depth interviews as part of an embedded mixed-method Domestic Violence Enhanced Home Visitation (DOVE) study conducted between 2006 and 2011. DOVE was a multi-site randomized controlled trial that tested a research-based structured empowerment intervention aimed at reducing IPV during pregnancy using prenatal home visitation (see Bhandari et al., 2012; Rose et al., 2010, for a full description of the study methods). The embedded mixed methods approach consisted of independent concurrent collection of quantitative and qualitative data. The 5-year DOVE study began in 2006 and enrolled 239 women from an Eastern metropolitan area and a Midwestern rural area in the United States. The larger study was designed to test the DOVE intervention (National Institute of Health, National Institute of Nursing Research, 2006–2011) and to explore the longitudinal patterns of perinatal abuse and variations across geographical settings. Therefore, a comparable group of 6 urban African American women was included in this analysis, making the total sample size 12 ($n = 12$). Institutional Review Board approval for this study was obtained from all participating universities and health departments.

Participants

Given the dearth of empirical data comparing African American women experiencing IPV in rural versus urban environments, and pregnant and post-partum African American women in particular, authors extracted this population from the larger DOVE qualitative data. Consistent with the larger randomized control trial, qualitative participants included women who met the following criteria: (a) 31 weeks pregnant, (b) reported IPV within the last 12 months as disclosed to a research nurse or home visitor on the Abuse Assessment Scale (AAS; Parker & McFarlane, 1991) and/or the Women's Experience in Battering (WEB) scale (Coker, Smith, McKeown, & King, 2000), (c) English speaking, (d) enrolled in a prenatal home visiting program of a participating health department, and (e) completed all of the requisite interviews.

Embedded in this participant group were African American women from both rural and urban settings. While 52 women agreed to participate in the qualitative portion of the study at the rural site, only 6 rural women were African American and completed all five interviews. While the qualitative sample is small, the selection of 6 rural respondents represent the total number of African American women who had qualified for the qualitative study by completing interviews at baseline, 3-, 6-, 12-, and 24 months after the delivery). Hence, an equal number of urban African American women were purposively selected.

Procedure

Referrals for the study were received from the respective rural and urban health departments. Interviews were conducted at participants' homes at a time convenient to them unless the women preferred an alternate location. Women were asked if it was safe to do a home visit; if not, the research nurse ascertained the safety issue, made appropriate referrals for the women and re-scheduled the interview at a mutually convenient and safe time and place. During the home visit, the women were again asked about current safety and all study personnel were trained in safety procedures. All 12 women had been interviewed by trained research staff at five points in time: baseline, 3-, 6-, 12-, and 24 months after the delivery. The interviews lasted 60 to 90 min and the participants received a monetary gratuity for the time spent to complete each interview. Interviews were transcribed and audio files, as well as transcripts were stored in a locked cabinet.

Topical areas in the interview were descriptions of family and current living situation; experiences of pregnancy in the context of IPV; family context of abuse, including children; response to abuse and sources of support; resources and barriers in the setting; and strategies for coping with the abuse. Women were encouraged to talk about the experience of abuse over time, and to discern any perceptions of experiences (e.g., events occurring before and after an abusive episode; timing of the abuse related to pregnancy and childbirth landmarks). Interview questions were open-ended and broad (e.g., "Other women have reported abuse by their partner while pregnant. Is this something that has ever happened to you? What was that like for you?"). All interviews asked similar questions, but the follow-up interviews emphasized the changes in the women's experiences and perceptions from their baseline interview. Follow-up probes were used to elicit descriptions of contextual factors (i.e., what was happening at the time). Questions were not necessarily asked in the same order with

each woman, because the goal was to ensure that the women told their individual stories according to what was important to them. However, all topical areas outlined in the interview guide were covered with each woman.

Data Collection

From those who expressed interest, a subset of women was selected, using a theoretical sampling procedure (Glaser & Strauss, 1967), to gain a better understanding of the differences and similarities between African American urban and rural dwelling women experiencing IPV during and following pregnancy. The general process of open-coding qualitative data requires researchers independently and then as a group to read, interpret, label (code), reduce to themes, and then discuss the meanings elucidated in the data (Ulin, Robinson, & Tolley 2005). Three members of the analytical team applied an open-coding strategy as defined by Saldana (2012) to identify similarities and differences between the urban versus rural women. In practice, this meant that each researcher independently generated a label/code that summarized an attribute in the transcripts. These codes were used to make comparisons and to identify patterns in the transcribed interviews of the participants. During subsequent meetings, codes were reconciled to create the 15 codes noted below. The resulting 15 codes were derived using iterative individual open coding followed by consensus. The 15 codes were as follows:

1. Severity of IPV
2. Increase or decrease of abuse throughout pregnancy and 2 years post-partum
3. Intrusion (woman having to move, change jobs, etc., because of the abuser)
4. Type of violence (sexual, physical, or emotional) including use of a weapon
5. Behaviors of abuser (jealous, steals her money, demands she not see her family or friends)
6. Location of violence (inside the home, in a public place, in isolation, in front of other people)
7. Frequency of violence
8. Her use of violence
9. The use of children by the abuser to perpetrate abuse or intrusion; the woman's facilitation of relationship between abuser and child
10. Substance abuse by abuser
11. Compliance or defiance as a trigger to violence used by the woman in response to dictates of the abuser
12. Woman's response to IPV (she makes a pile of his clothing and sets it on fire, drives around in her car, returns to her apartment, goes to a shelter, takes out a Protective Order ...)
13. Woman's self-reported mental state ("I'm happy," "I've been depressed," "I'm lonely," etc.)

14. Communication experiences between perpetrator and woman (mostly in follow-up interviews, relevant when the relationship has ended or the perpetrator is incarcerated)
15. Relationships perception (perpetrator vs. woman)

Next, magnitude coding (Saldana, 2012) was used to assess the frequency of the 15 codes and which codes could be consolidated under larger themes (see table 1).

Findings

Studying a span of more than 2 years sheds light on the differences and similarities in experiences of abuse throughout this period providing a glimpse into the lives of these participants. As would be predicted by the power and control wheel applied to IPV studies (Pence & Paymar, 1993), control asserted by the abusers and active resistance seemed to be the central themes driving the experiences of abuse in the lives of these women. The similarities and differences in experiences of abuse in both settings are explained through the following three main themes and two sub-themes: (1) types of abuse, (2) location of abuse, and (3) response to abuse: (a) defiance and compliance and (b) role of children. Examples drawn from the transcripts describe and explain the themes. All the names associated with the comments are pseudonyms.

Types of Abuse

All 12 women, regardless of location, experienced at least one type of violence, but often a combination of physical, emotional, and sexual violence. The type of abuse or severity of the abuse alone fails to independently distinguish the unique experiences of the women in each setting. All women sensed that emotional abuse was more damaging to their lives than physical or sexual abuse. Responses about types of abuse could discriminate between rural and urban experiences. They include the items used in the physical abuse or threats of abuse, the severity of the abuse, the type of violence during and post-pregnancy, and the changes in partners. The following quotes highlight the gravity and severity of abuse without trying to prove if one was worse than the other. The following is an example of physical violence experienced by a rural woman during pregnancy:

... He just come up the steps and he jumped on the bed and threw the ex-parte papers on my face ..., he started choking me, and I told him that if I can't breathe, the baby can't breathe, ... And then he told me he didn't care and he told me that he'll kill the baby if I didn't give (him money) that's when he pushed me and dragged me from the bathroom to the bedroom ... (Kwanza)

An urban woman described an equally severe episode of physical violence:

And he just was grabbing me and I kept snatching away from him and putting my finger in his face and he grabbed me and he put me up against the wall and he just was squeezing me and when I pushed him he smacked me ... usually it would just be him hitting me—like he would twist my arm or grab my hand and squeeze my hand or something like that. (Shanice)

The experiences of the two women highlight the gravity of physical violence in the lives of the participants. Participants discussed the nature of different forms of abuse that they experienced. They perceived that emotional violence took the greatest toll on their lives. One rural participant said, “The emotional abuse was really bad ... Physical abuse (pause) also was bad but not as bad as the emotional ... Everyday I was being called out a name” (Kwanza).

Abusers in both settings controlled the lives of women by expressing jealousy, accusing her of cheating, and contesting being the father of the baby (a form of emotional violence). The following comment from a rural woman highlights the kind of accusatory control:

It was the fact that every time I’m around him he would still bring up things I did and didn’t do, constantly accused me of cheating, this, that and the other, like, you know, ask me what I’m, ask me am I with anybody else, and stuff like that ... I’m ... trying to move on with my life, you know. (Ramona)

The choice of weapons used during abusive episodes differed between the two settings. Some rural women talked about their abusers using objects such as kitchen knives or pieces of furniture, whereas some urban women talked about the abusers using guns. Although no urban woman reported being shot, guns were used as a means of threatening. The following quote by an urban woman is an example: “But I tried to get away from him and I was actually talking to somebody else and he had came to the house and pulled a gun out on me and my mother” (Celeste). Another urban woman said, “Oh, he, he put a gun at my head once” (Diamond). On the other hand, a rural woman said, “A coffee table ... yes, picked it up and threw it” (Kwanza).

Pregnancy was a time that the abuse changed in form and severity. Urban African American women reported more severe violence during pregnancy than rural women (see tables 2 and 3). Similarly, once the baby was born, most women in rural settings reported that the violence decreased considerably or took a very different form. For example, in rural areas, behaviors of abusive partners targeted the new intimate partner, stealing, or creating inconveniences for the woman. An example of an excerpt from a rural woman who left her abusive partner and had a new non-abusive partner at the 24-month interview noted, “He’ll (abusive ex-partner) cuss at him (new non-abusive partner) and throw stuff at him, and bottles and stuff, and oh, God, it’s bad ... He just automatically just switched all his anger over to X (new non-abusive partner)” (Lakisha). Other abusive behavior was seen in the form of irresponsibility or neglect toward the woman and the new-born baby. A rural woman shared what happened when she went to the hospital to deliver the baby:

Uh, with my boyfriend ... when I came home, I was upset with him for using my car and getting into that accident, so I was really angry. And stealing my money, ... asking him what did he buy with that money for my baby, cause he didn’t buy anything for my daughter out of all the money that he stole out of my savings account, and all of his things were brand new. Brand new shoes and clothes and hats and jewelry. You know, I was upset ... I was about ... to have a yard sale and sell all of (his) stuff in the yard and get my money back. (Kiera)

Most urban women reported continuing violence at 24 months. An urban woman reports the following at 24-month interview:

And then he started screaming and hollering in my face, and baby [XX] started crying, and I'm like, "that's why I don't want you around them and stuff like that," ... he just choked me. He like grabbed my neck. He like scooped up and grabbed my neck, squeezed it, and kind of lifted me up a little bit, but my feet didn't come off the ground or anything. (Shanice)

If rural women left their abusive partners and started a new relationship, they were more likely to ensure that the new relationships were non-abusive. If they saw red flags of abusers controlling their lives, they left before the abuse actually began. The following quote by a rural woman explains that:

... he (new partner) constantly wanted to know where I was at all the time ... he rung my phone off the hook ... And then he, kind of like disrespected me, ... put me down and stuff ... I was just beginning to feel miserable; and ... I didn't want to feel that way, so, that's why I had to break up with him, because I didn't want to go back to those feelings of worthlessness or, ... having one suspicion after another ... and I couldn't take another person lying to me or playing mind games, accuse me of things I'm not even doing, so. I mean I just couldn't take it anymore so. (Kiera)

For both groups, violence during pregnancy was prevalent, but urban women reported more forms of severe violence at this time. Physical abuse changed in subsequent interviews to include more irresponsible and insensitive behavior by the abusers, especially in the rural setting. Rural women who engaged in a new relationship were quicker to recognize red flags of abuse and withdrew from the relationship before the situation became unmanageable.

Location of Abuse

A major difference in two sites was the location where the abuse occurred. Urban women reported abuse occurring in public places, such as malls or gas stations. In rural areas, the abuse occurred inside their houses or apartments. An urban woman offers one example:

He came up there and pulled me to the back of the store, and he kept pushing on my stomach, ... and asked was I pregnant. I said, "No, I'm not pregnant." He kept saying, "Yes, you is pregnant," and make a real big scene. "I'm gonna hurt you, I'm gonna hurt you." ... The next store I went in he came in there, kept saying the same thing. So I was leaving out the Mall, and he was coming behind me ... So he pulled my shirt up, and he said, "Why it so hard?" (Nakisha)

As the violence in the urban areas occurred in the public setting, it was no longer a private affair. The following quote from an urban woman states that the entire community knew about her abusive situation:

Because ... like their whole block knows. Everybody knows now, so it's like, it became a big mess. So, that's another reason why I wouldn't talk to him, just kind of let things die down a little bit. Because I'm like, everybody's making such a big deal. (Bressika)

In urban settings, even when violence occurred in public places, nobody came to help. One urban woman mentions,

... First he threatened to kill me outside going at home, and then all of a sudden he just choked me and beat me into a wall ... So, and it was like a lot of people at the gas station, but nobody wouldn't help. (Tyler)

For most rural women, the violence occurred in private settings, in different rooms of their houses. One rural woman explained, "So I tried to get to one [cell phone] ... in the bathroom, that's when he pushed me and dragged me from the bathroom to the bedroom and then, I don't remember what happened after that" (Janiqua).

Responses to Abuse

There were also similarities in the women's responses to abuse: (a) concern by participants about the safety and well-being of their children, with a high value placed on the two-parent home; (b) efforts by participants to foster a relationship between the child and the perpetrator/father of the baby, which included traveling for prison visits; (c) continued efforts by perpetrators to control and emotionally abuse participants while incarcerated and/or after termination of the relationship, through expressions of jealousy, intimidation, and manipulation of the children. Differences in responses to abuse reported by urban and rural participants included urban perpetrators' control through demands about women's physical appearance and pregnancy termination versus rural perpetrators' control through requirements for cooking and cleaning. These topics are explained below as the sub-themes of (a) defiance and compliance and (b) role of children.

Defiance and compliance—Regardless whether they complied with or defied the controlling behaviors of the abuser, women in both settings experienced violence. A rural woman who refused to comply with the demands of her abusive partner states,

He was using my car, I wouldn't give him money. He has his own job, so you know, why should I give him money, if I wouldn't do things that he told me to do, or just, itty bitty things that you shouldn't even argue over. (Janiqua)

However, the way the abusers controlled the lives of women in the two settings did differ. Urban women reported insistence on abortion by their intimate partners. This was only heard by women from the urban setting. The following is a statement from an urban woman:

No. My, we, we can be talking and if it's something that he don't like that I said ... That's when he, ... (would), start having an attitude towards me. So I lied and told him that I had a abortion. When he found out that I didn't have abortion, that's when he really started hitting me in my stomach and stuff like that. (Bressika)

Abusers in urban settings also controlled the way women looked by telling them how to wear their hair and/or how to dress. The following quote provides an example from an urban woman:

... and we was fussing about what I had on—I had on a tank and some shorts and the shorts they were real short and he didn't like it and I kept walking from him and just was ignoring everything he was saying and he don't like for nobody to ignore

him. And he just was grabbing me and I kept snatching away from him and putting my finger in his face and he grabbed me and he put me up against the wall and he just was squeezing me and when I pushed him he smacked me. (Shanice)

Rural women did not speak about their dress or appearance being controlled except in the case of a 16-year-old rural participant who said,

And then so he wanted me to stop dressing how the way I dressed, even though I just dressed the same when he met me but, and I never dressed like nasty or nothing, but he wanted me to change the way I dressed. I couldn't wear shorts, and nothing tight or nothing like that. All I had to wear pants and capris and stuff. (Sabrina)

Whether women agreed or disagreed with how their partners expected them to behave, they still experienced violence. Fights around cooking and cleaning were more common in the rural area. One rural woman described this type of interaction,

Well, well, every time, ... I ... was with him, I mean I'd cook dinner when he was hungry cause everybody else was like (stuttering) you know how you go out and cook your own food and buy your own food and things like that, you know, and then there were times he didn't appreciate, I'm like, I was like, "No, I don't want it" ... Then it'd turn into an argument. It, it's just that the fact that, you know, if it, I mean, every time he started an argument he'd expect me to be in my place, why? (Ramona)

Although women talked about being controlled in both settings, there was a difference in the nature of demands depending on location.

Role of children—Control of women's lives through children was a hallmark of abusers in both settings. This control was exerted in various ways, refusing to return the baby or child after visitation, pointing out faults in parenting, and/or using the baby as a tool to re-establish intimate relationship with the woman. One of the rural women mentioned how her partner harassed her by making a false complaint to children's division:

Well, because I wouldn't let him see her, ... he just made a false hotline call on me saying I was trying to kill my kids when I, when I knew that was not true cause I, cause I love my kids, and everyone in my family knew that was a lie. (Ramona)

Women from both urban and rural settings were often faced with the important decision to leave or stay in the abusive relationship for the protection of the new-born baby and other children. A rural woman said, "I just don't want nothing to happen to my son, that's about all" (Janiqua). Women in both settings were entirely responsible for child rearing. Partners who contributed did so sporadically and were undependable. An urban woman shares her story,

... I had them (twins) for him and it's like I wasn't really ready for no more kids at the time, but he really wanted them and stuff and I wasn't thinking about how I would feel or like me having to be the one with them every day and stuff like that. And it had me mad, like "Well, you the one that wanted them. I didn't really want them. You wanted them and you're not even here to help me with them. I can't

even call you and tell you like, well, [partner xx] I need a break ... they need some Pampers and wipes or anything.” I have to do it all by myself. (Shanice)

In spite of irresponsible behavior from their partners, women in both settings wanted the father of the baby to play a role in their baby’s life even if they chose to leave the abusive partner. Another common phenomenon in both settings was women traveling to prison with the new-born baby, and in several cases, with other children, to spend time with their abusive partners. Two reasons for traveling to the prison for contact with the father of the baby appeared to be the control asserted by the abuser and/or the woman wanting the connection of her child with the father of the baby. One rural participant said,

I don’t, when I go to the prison ... the visits ... should be for him and baby [xx], not for me ... Because I, I know who my dad is. I want my son to know who his dad is. My dad was, you know, in my life, and it’s not my son’s fault what happened with me and him, with me and his dad. My son has nothing to do with that. (Janiqua)

Abusers in both settings seemed not to be interested in the babies’ well-being per se but used the babies strategically to control the lives of the woman or to re-establish the relationship.

I just got tired of it, just got fed up, just like when I had the baby, telling him, you know, that, “I don’t want you to call me. I don’t want you to talk to me about nothing, just, unless it’s about ... your daughter.” I was like, I just really don’t even want to really have a friendship with him at this point right now because it’s kind of hard, but I don’t know, I just decided, you know, just strictly the baby. (Lakisha)

Instances of refusing to return the baby and pointing out faults in parenting were replete in the data providing evidence of how the abusers controlled the lives of these women.

I was like, “Are you still bringing her, or do you want me to come get her?” And he was like “Oh, I’ll bring her.” So I’m just sitting there waiting, and about 9 o’clock rolls around and he doesn’t answer the phone. So now I’m worried ... and so I called the police. I called the Sheriff’s Department and talked to them and had them to go out there and see if everything was okay. He told the sheriff that was his baby, and he didn’t want to bring her home. So I, I kept talking to the sheriff. I’m like, “Well, no, that’s not the deal that we had.” ... He’s (Sheriff) like “No, you know that’s not right. She’s been living with her mom this whole time. Just take her to court if you want the child.” So he finally had to give her back to me. (Lakisha)

There were however differences in the way women took control of their lives. Rural women seemed to be much more in control when it came to their babies. For example, a rural woman said that she did not allow her abusive partner to come and visit the baby if he was drunk:

He’s not allowed to come over here if he’s been drinking ... If I smell beer on him I tell him he has to leave ... Yes, one time, and I told him that he couldn’t be over here. He’s not allowed to come over here if he’s been drinking ... He didn’t like it at first, but he said, “I understand, and I respect your wishes,” so he left and came back the next day when he was sober. (Janiqua)

As women in the urban setting were more likely to stay with their partners, this level of control over what happened with their babies was not spoken about as often as among the rural women. However, in spite of being in control of the situation, both rural and urban women were vulnerable and non-immune to experiencing violence.

The role of children emerged as a significant force in the interactions between abusers and victims. The child became like a pawn in the hands of the abuser, and for the mother, they were the incentive to either discontinue or perpetuate their relationship with the abuser.

Discussion

The present study provides a unique contribution to the literature in describing the experiences of perinatal abuse of women residing in rural and urban settings during pregnancy and 2 years post-natal. The study sample is unique in focusing on African American women, and in following, abused women closely from pregnancy till 2 years post-partum. Our findings differ from other reports that found the rural women reporting severe violence and they were the ones being threatened with guns. According to other research with non-pregnant Caucasian counterparts, the women living in rural areas reported experiencing more severe violence that included threats with weapons and the violence occurred more frequently than that reported by the urban women (Logan et al., 2003; Shannon, Logan, Cole, & Medley, 2006).

The increase of abuse in the urban settings may be due to a variety of reasons. First, reduced competition for resources such as public housing may have made it more feasible for women in rural areas to leave their abusive partners and get help that they needed to rebuild their lives. This was not possible for most urban women due to long waiting lists for resources, which may prolong the dependency on abusive partners making them more vulnerable to violence. These differences are important to understand to guide service and health care interventions and providers.

Urban women experienced more severe physical abuse that included being threatened with weapons and other acts of violence, such as choking. Strangulation of a pregnant woman also depletes oxygen to the placenta that clearly put the developing fetus at risk, thus possibly explaining some of the high rates of poor pregnancy outcomes for urban African American women (Healy et al., 2006).

It has been shown in numerous studies that health care providers fail to screen for abuse and they most likely never ask if the woman has been choked or had a loss of consciousness during the pregnancy. Likewise, for rural women, the violence may not be as severe but because the violence occurs behind closed doors, providers need to ask questions about how anger is managed in the home. Screening, regardless of setting, is important and needs to be done universally and systematically whenever women enter into health care settings.

Another unique finding was the use of different objects (like knives and tables) in rural areas versus weapons like guns in urban areas by the abusers to threaten the women. This sheds some light on how guns may be viewed in the two geographical areas and how much guns have become everyday business in urban United States. Another difference was the location

of the abuse. It is not clear why the public versus private space abuse patterns differed in rural versus urban settings, but its prominence in the data suggest a need for further study.

Another important finding in our study was abusers controlling the lives of women through children. Although this practice was not observed in Logan et al. (2003), this pattern emerged in our study perhaps because the study covered the perinatal period of the lives of these abused women. The differences between urban and rural women's experiences may also be related to the cultural nuances associated with rural and urban environments. The literature suggests that rural areas are more isolated and may have more traditional gender role stereotypes. This may contribute to controlling behaviors by abusive partners in rural areas where women were expected to perform the traditional gender roles of cooking and cleaning (Logan, Shannon, & Walker, 2005; Websdale, 1995).

Implications for Practice

This study raises novel considerations for IPV interventions. First, interventions supporting the health and safety of women should take into consideration geographic differences. The victimization experiences have implications for health and mental health practitioners, as well as policy makers. It is likely that victims in urban areas may require far more extensive protective and treatment services than their rural counterparts. The victimization issues in urban areas must be considered within the context of multiple victimization experiences. Educational and support materials, for example, could be tailored to the specific challenges faced by women in certain locales. Second, interventions should include strategies that seek to decrease the use of children as pawns in the continued cycle of abuse. IPV during pregnancy may be more common than many conditions for which women receive care during pregnancy including preeclampsia, placenta previa, and gestational diabetes (McFarlane, Parker, & Soeken, 1996). Yet, many women are not screened for IPV during pregnancy (Shaw, 2003). It is imperative that girls of all age are screened for IPV especially during the perinatal period. Universal screening of IPV has been recommended for all health care providers (American Medical Association, 2007) and our findings indicate that this is particularly true for pregnant women.

Limitations

A limitation of this study is small sample size. As a qualitative study, the purpose was to describe the differences between urban and rural experiences of abuse in the perinatal period for African American women. Therefore, generalizability of the findings to other women is limited. However, the purpose of this qualitative study was to provide an in-depth examination of the lived experiences of African American women experiencing IPV. Although a relatively small sample, the 2-year study period interactions provided evidence that African American women experience abuse in different ways based on their geographic location.

Acknowledgments

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported by Grant R01NR009093-01A2 from the National Institute of Nursing Research (NINR).

References

- American Medical Association. Health and Ethics Policy Number 515.965. Chicago, IL: Author; 2007. Family and intimate partner violence. Available from <http://www.ama-assn.org>
- Bacchus L, Mezey G, Bewley S. Domestic violence: Prevalence in pregnant women and associations with physical and psychological health. *European Journal of Obstetrics & Gynecology and Reproductive Biology*. 2004; 113:6–11. [PubMed: 15036702]
- Bacchus L, Mezey G, Bewley S. A qualitative exploration of the nature of domestic violence in pregnancy. *Violence Against Women*. 2006; 12:588–604. [PubMed: 16707813]
- Bent-Goodley TB. Perceptions of domestic violence: A dialogue with African American women. *Health & Social Work*. 2004; 29:307–316. [PubMed: 15575458]
- Bergen R. Surviving with rape: How women define and cope with violence. *Violence Against Women*. 1995; 1:117–138. [PubMed: 12295407]
- Bhandari S, Bullock L, Bair-Merritt M, Rose L, Marcantonio K, Campbell J, Sharps P. Pregnant women experiencing IPV: Impact of supportive and non-supportive relationships with their mothers and other supportive adults on perinatal depression: A mixed methods analysis. *Issues in Mental Health Nursing*. 2012; 33:827–837. [PubMed: 23215984]
- Black, MC.; Basile, KC.; Breiding, MJ.; Smith, SG.; Walters, ML.; Merrick, MT.; Stevens, MR. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011.
- Campbell JC. Abuse during pregnancy: Progress, policy, and potential. *American Journal of Public Health*. 1998; 88:185–187. [PubMed: 9491004]
- Campbell JC, Garcia-Moreno C, Sharps P. Abuse during pregnancy in industrialized and developing countries. *Violence Against Women*. 2004; 10:770–789.
- Campbell JC, Oliver C, Bullock L. Why battering during pregnancy? AWHONN's Clinical Issues in Perinatal and Women's Health Nursing. 1993; 4(3):343–349.
- Cavanagh K. Understanding women's response to domestic violence. *Qualitative Social Work*. 2003; 2:229–249.
- Centers for Disease Control and Prevention. Leading causes of death in females. 2009. Retrieved from <http://www.cdc.gov/women/lcod/>
- Charles P, Perreira KM. Intimate partner violence during pregnancy and 1-year post-partum. *Journal of Family Violence*. 2007; 22:609–619.
- Cheng D, Horon IL. Intimate partner homicide among pregnant post-partum women. *Obstetrics & Gynecology*. 2010; 115:1181–1186. [PubMed: 20502288]
- Coker AL, Smith PH, McKeown RE, King MR. Frequency and correlates of intimate partner violence by type: Physical, sexual and psychological battering. *American Journal of Public Health*. 2000; 90:553–559. [PubMed: 10754969]
- Decker M, Martin S, Moracco KE. Homicide risk factors among pregnant women abused by their partners who leaves the perpetrator and who stays? *Violence Against Women*. 2004; 10:498–513.
- El-Khoury MY, Dutton MA, Goodman LA, Engel L, Belamaric RJ, Murphy M. Ethnic differences in battered women's formal help-seeking strategies: A focus on health, mental health, and spirituality. *Cultural Diversity & Ethnic Minority Psychology*. 2004; 10:383–393. [PubMed: 15554800]
- Gazmararian LS, Spitz AM, Ballard TJ. Prevalence of violence against pregnant women. *Journal of the American Medical Association*. 1996; 275:1915–1920. [PubMed: 8648873]
- Glaser, BG.; Strauss, AM. The discovery of grounded theory: Strategies for qualitative research. Chicago, IL: Aldine; 1967.

- Healy AJ, Malone FD, Sullivan LM, Porter TF, Luthy DA, Comstock CH, D'Alton ME. Early access to prenatal care: Implications for racial disparity in perinatal mortality. *Obstetrics Gynecology*. 2006; 107:625–631. [PubMed: 16507934]
- Kershner M, Long D, Anderson J. Abuse against women in rural Minnesota. *Public Health Nursing*. 1998; 15:422–431. [PubMed: 9874924]
- Logan TK, Walker R, Cole J, Ratliff S, Leukefeld C. Qualitative differences among rural and urban intimate violence victimization experiences and consequences: A pilot study. *Journal of Family Violence*. 2003; 18:83–92.
- Logan TK, Shannon L, Walker R. Protective Orders in Rural and Urban Areas: A Multiple Perspective Study. *Violence Against Women*. 2005; 11(7):876–911. [PubMed: 16043576]
- Martin SL, Harris-Britt A, Li Y, Moracco KE, Kupper LL, Campbell JC. Changes in intimate partner violence during pregnancy. *Journal of Family Violence*. 2004; 19:201–210.
- McFarlane J, Campbell JC, Sharps P, Watson K. Abuse during pregnancy and femicide: Urgent implications for women's health. *Obstetrics & Gynecology*. 2002; 100:27–36. [PubMed: 12100800]
- McFarlane J, Parker B, Soeken K. Physical abuse, smoking, and substance use during pregnancy: Prevalence, interrelationships, and effects on birth weight. *Journal of Obstetrics, Gynecologic & Neonatal Nursing*. 1996; 25:313–320.
- Mitchell C, LaGory M. Social capital and mental distress in an impoverished community. *City Community*. 2002; 1:195–216.
- National Institute of Health, National Institute of Nursing Research. Domestic Violence Enhanced Home Visitation Program-DOVE (NR009093-01A2). Baltimore, MD: Johns Hopkins University; 2006–2011.
- Parker B, McFarlane J. Identifying and helping battered pregnant women. *Maternal and Child Nursing*. 1991; 16:161–164.
- Pence, E.; Paymar, M. Education groups for men who batter: The Duluth model. New York, NY: Springer; 1993.
- Rose L, Alhusen J, Bhandari S, Soeken K, Marcantonio K, Bullock L, Sharps P. Impact of intimate partner violence on pregnant women's mental health: Mental distress and mental strength. *Issues in Mental Health Nursing*. 2010; 31:103–111. [PubMed: 20070224]
- Ross CE, Reynolds JR, Geis KJ. The contingent meaning of neighborhood stability for residents' psychological well-being. *American Sociological Review*. 2000; 65:581–597.
- Saldana, J. The coding manual for qualitative researcher. 2. Thousand Oaks, CA: SAGE; 2012.
- Saltzman LE, Johnson CH, Gilbert BC, Goodwin MM. Physical abuse around the time of pregnancy: An examination of prevalence and risk factors in 16 states. *Maternal and Child Health Journal*. 2003; 7:31–43. [PubMed: 12710798]
- Shannon L, Logan TK, Cole J, Medley K. Help-seeking and coping strategies for intimate partner violence in rural and urban women. *Violence and Victims*. 2006; 21:167–181. [PubMed: 16642737]
- Sharps P, Laughon K, Giangrande S. Intimate partner violence and the childbearing year. *Trauma, Violence & Abuse*. 2007; 8:105–116.
- Shaw D. "Screening" for domestic violence [commentary]. *Journal of Obstetrics & Gynecology Canada*. 2003; 25:918–921.
- Ulin, PR.; Robinson, ET.; Tolley, EE. Qualitative methods in public health: A field guide for applied research. San Francisco, CA: Jossey-Bass; 2005.
- Websdale N. Rural woman abuse: The voices of Kentucky women. *Violence Against Women*. 1995; 1:309–338. [PubMed: 12295676]
- Yost NP, Bloom SL, McIntire DD, Leveno KJ. A prospective observational study of domestic violence during pregnancy. *Obstetrics & Gynecology*. 2005; 106:61–65. [PubMed: 15994618]

Biographies

Shreya Bhandari is an Assistant Professor in Wright State University, Department of Social Work. Her scholarship highlights coping strategies and help seeking behaviors of rural women experiencing domestic violence during pregnancy and domestic violence among South Asian women.

Linda F. C. Bullock is the Associate Dean for Research and Director of the PhD program at the University of Virginia School of Nursing. She was the PI for the rural site where the study being reported was conducted, and currently she is Co-PI on another grant testing the DOVE protocol using mHealth technology.

Jeanita W. Richardson is an Associate Professor in the University of Virginia School of Medicine, Department of Public Health Sciences and Assistant Director of Community Health Programs & Research. Her scholarship highlights the nexus between the health and learning readiness of children domestically and internationally and her academic responsibilities involve teaching and consulting research teams on the role of culturally respectful approaches to research in general and qualitative research in particular.

Pamela Kimeto is a PhD candidate in University of Virginia, School of Nursing and Fulbright Scholar from Kenya. Her research interests are intimate partner violence and its effect on growth of children less than two years of age.

Jacquelyn C. Campbell is Anna D. Wolf Chair and Professor in the Johns Hopkins University School of Nursing and National Program Director of the Robert Wood Johnson Foundation Nurse Faculty Scholars Program. Dr. Campbell has been conducting policy work and research on violence against women since 1980 with continuous federal research funding since 1984 including being PI of an NIH funded Pre and Postdoctoral Training Grant since 1990. She has published more than 225 articles and seven books and is an elected member of the Institute of Medicine.

Phyllis W. Sharps, Professor, and Associate Dean for Community and Global Programs, at the Johns Hopkins University School of Nursing. Dr. Sharps is the director for the Center of Global Initiatives, and also the East Baltimore Community Centers (EBCNC), three community based nurse managed centers for the School of Nursing. She has been the principal investigator for \$3.5 M 5 year research grant funded by NINR, Domestic Violence Enhanced Home Visitation – DOVE, and also for a second 5-year NIH/NCID \$4.2 M grant “Perinatal Nurse Home Visitation Enhanced with mHealth”, which tests the use of computer tablets for screening and intervening for IPV in the home. She is Fellow of the American Academy of Nursing and a 2013 inductee into the International Nurse Researcher Hall of Fame, Sigma Theta Tau International Nursing Honor Society.

Table 1**Coding Categories.**

Category
Types of abuse
1-Severity of IPV
2-Increase or decrease of abuse throughout pregnancy and 2 years after
3-Type of violence (sexual, physical, or emotional) including the use of weapon
7-Frequency of violence
14-Communication experiences between perpetrator and woman (mostly in follow-up interviews, relevant when the relationship has ended or the perpetrator is incarcerated)
15-Relationships perception (perpetrator vs. woman)
Location of abuse
6-Location of violence (inside the home, in a public place, in isolation, in front of other people ...)
Response to abuse
(a) Defiance and compliance
3-Intrusion (woman having to move, change jobs, etc., because of the abuser)
5-Behaviors of abuser (jealous, steals her money, demands she not see her family or friends ...)
8-Her use of violence
11-Compliance or defiance as a trigger to violence used by the woman in response to dictates of the abuser
12-Woman's response to IPV (she makes a pile of his clothing and sets it on fire, drives around in her car, returns to her apartment, goes to a shelter, takes out a Protective Order ...)
13-Woman's self-reported mental state ("I'm happy," "I've been depressed," "I'm lonely," etc.).
14-Communication experiences between perpetrator and woman (mostly in follow-up interviews, relevant when the relationship has ended or the perpetrator is incarcerated)
15-Relationships perception (perpetrator vs. woman)
(b) Role of children
9-The use of children by the abuser to perpetrate abuse or intrusion; the woman's facilitation of relationship between abuser and child
14-Communication experiences between perpetrator and woman (mostly in follow-up interviews, relevant when the relationship has ended or the perpetrator is incarcerated)
15-Relationships perception (perpetrator vs. woman)

Table 2

Descriptive Statistics of Conflict Tactics Scale and Severity of Violence Against Women Scale Scores by Location.

IPV Scores	Location		<i>t</i> Value
	Missouri (<i>M</i>)	Baltimore (<i>M</i>)	
CTS total scores (24 months)	5.4	8.7	1.08
SVAWS total score (24 months)	47.94	48.28	−0.12

Table 3

Descriptive Statistics of CTS and SVAWS Scores by Location.

	Location		
IPV Scores	Missouri (<i>M</i>)	Baltimore (<i>M</i>)	<i>t</i> Value
CTS injury			
Baseline	3.64	7.00	-3.28***
Delivery	0.21	0.91	-2.93***
3 months	0.41	1.15	-2.2**
CTS psychological abuse			
24 months	3.50	7.07	-2.04*
CTS sexual abuse			
Delivery	0.68	1.45	-1.73*
SVAWS total score			
18 months	47.11	52.17	-2.46**

*
 $p < .10$.**
 $p < .05$.***
 $p < .001$.