ETHNIC SPECIFIC PERCEPTIONS ABOUT PREGNANCY AS RELATED TO ABUSE STATUS AND THEIR APPLICATION TO CLINICAL IDENTIFICATION OF ABUSED WOMEN

A DISSERTATION

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BY

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DENTON, TEXAS

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Date

To the Dean for Graduate Studies and Research:

I am submitting herewith a dissertation written by Edythe Madelyn Greenberg entitled "Ethnic Specific Perceptions About Pregnancy as Related to Abuse Status and Their Application to Clinical Identification of Abused Women." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

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DEDICATION

This work is dedicated to all women and their uniqueness.

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ABSTRACT

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This study was a secondary data analysis of a prospective cohort study designed to investigate abuse during pregnancy. A triangulated design was used to investigate the association between an ethnic specific topology of feelings and abuse status on a woman's first prenatal visit.

Abuse was defined as a positive response to questions on an Abuse Assessment Screen measuring physical or sexual abuse during the 12 months prior to the pregnancy or during the present pregnancy. Four perception themes--happiness, acceptance, ambivalence, and expressions of being upset--were derived from a qualitative instrument of two open-ended questions asking about the woman's perceptions and her perceptions of her male partner's feelings about the pregnancy. Approximately 454 black, hispanic, and anglo women's scores on the Conflict Tactics Scale, Index of

Spouse Abuse-physical (ISAP), and Danger Assessment were associated with the four perception themes.

Abused women who were accepting, ambivalent, or upset about the pregnancy scored higher on severe violence and ISAP than nonabused women and abused women who were happy about their pregnancy. Abused anglo women scored higher on Danger Assessment, Verbal Aggression, and ISAP than abused black and hispanic women. Abused anglo women who were upset or ambivalent about the pregnancy scored higher on verbal aggression and minor violence than abused anglo women who were happy about the pregnancy. Abused black women scored higher on minor violence than abused hispanic and anglo women. Abused black women who accepted their pregnancy scored higher on minor violence than abused black women who were happy.

Abused women who perceived their male partners as being upset about the pregnancy scored higher on minor violence and danger assessment than abused women who perceived their male partners as being happy. Abused black women who perceived their male partners as being ambivalent scored higher on severe violence than abused hispanic and anglo women. Abused anglo and hispanic women who perceived their male partner as being upset scored higher on their ISAP

scores than abused anglo and hispanic women who perceived their male partner as being happy or accepting of the pregnancy.

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CHAPTER 1

INTRODUCTION

In the 1970s, the plight of abused women entered the American consciousness as a social and health concern. The existence of abuse and its frequency had been ignored or avoided because of the nature of the problem, the threat to the integrity of the family, and the general secrecy about the family violence. Opponents indicated that what occurred in the home did not concern society as long as it remained behind closed doors. However, as the issue was being ignored, over one million women a year were victims of a crime that was three times more prevalent than rape (Mahon, 1981). It has been estimated that approximately 1.6 to 12 million women are abused each year. In addition, at least 25% to 30% of American women may be struck at least once by their spouse, and 25% to 45% of abused women are pregnant when involved in a domestic dispute (Helton, McFarlane, & Anderson, 1987a). Nurses have the capability to empower abused women by identifying them in the clinical setting and providing them with resources. The intent of this study is to identify common themes relating to a woman's perception and her spouse's perception of the current pregnancy which

can be used by the health care provider in identifying the abused woman.

Problem of the Study

Every year it is estimated that 1.8 million women will be beaten by their husbands (Straus, Gelles, & Steinmetz, 1980). Forty-two percent of women in shelters have reported being abused during pregnancy (Stacy & Shupe, 1983). Of 290 women interviewed by Helton, McFarlane, and Anderson (1987b), 8% stated they had been abused during their current pregnancy and 15% reported being abused prior to their current pregnancy. When a woman is abused during her pregnancy, what influence does the violence have on the woman's feelings about her current pregnancy? Can these feelings be related to the amount of violence? Is there an ethnic specific typology of feelings which can be used to identify abused women?

Rationale for Study

Spouse abuse is fast becoming an epidemic in this country. Safran (1986) calculated that every day at least four women will be killed by their husbands, while at least one woman every 18 seconds will be abused by a spouse. Brown, Carpio, and Martin (1982) determined that 1 in 10 women will be abused by a spouse/partner. Walker (1979)

estimated that as many as 50% of all women will be abused sometime in their lifetime, and one third of all American homes will experience spouse abuse.

Unfortunately, abuse does not stop because a woman is pregnant. In fact, many times it may increase due to the additional stress from the pregnancy. Gelles (1975) discovered that sexual frustration, stress from family transition, biochemical changes in the wife, and defenselessness of the wife may all contribute to abuse during pregnancy. Sammons (1981) concluded that abuse during pregnancy may increase as a result of an increased strain on the relationship, the father being jealous of the unborn child, the wife not being quite as sensitive to the husband's emotional and sexual needs, and if the pregnancy is unwanted or unplanned.

In her study of 742 women interviewed at a prenatal clinic, Hillard (1985) noted that 21% of the women in her study experienced increased abuse during their pregnancy, 36% reported a decrease in abuse, and 43% indicated no change (Hillard, 1985). Hilberman and Munson (1977-78) found that half (N = 60) of all women referred to a rural health clinic for psychiatric evaluation reported physical injuries as a result of marital violence. In their study, the abused women noted that during their pregnancies there

was either an increase in the abusive incidences with the focus of violence being the abdomen instead of the face, breasts, and other sites or the abuse decreased which thus encouraged some women to deliberately stay pregnant.

Stark, Flitcraft, and Frazier (1979) analyzed the medical records of 481 women who were treated for an injury in a major metropolitan emergency department. They determined from those records that abused women were three times more likely to be pregnant when the incident occurred and that they had a significantly higher miscarriage rate. Gelles' (1975) research findings also indicated that injured women who were abused were three times more likely to be pregnant when presenting to an emergency department than nonabused women.

McFarlane, Parker, Soeken, and Bullock (1992) reported abused women seek prenatal care later in their pregnancy with 29% of abused women starting their prenatal care in the third trimester versus 15% of nonabused women. Physical abuse within the past year was reported by 1 in 4 of the 293 women subjects, and physical abuse during the current pregnancy was reported by 1 in 6.

Family violence may be one way to terminate a pregnancy and decrease the additional responsibility of the father for another person. Also, because many of these women express

ambivalence over birth control, Brown et al. (1982) proposed that abuse may be one method to express the father's resentment towards the unborn child and towards the role expectations to produce children when the man is not emotionally ready for children. When abuse occurs during the pregnant period, a type of prenatal child abuse results in addition to the physical and psychological stress to the woman.

Although abuse during pregnancy has been studied, these studies have not been focused on the viewpoint of the social and psychological factors influencing the violent relationship. Therefore, it is the intent of this study to determine if there is a relationship between ethnic specific perceptions of women about their pregnancies and the amounts of family violence they are experiencing.

Conceptual Framework

Traditionally, social, legal, and religious authorities have supported family violence by promoting a patriarchal society and placing power in the hands of men. The conceptual framework of feminism is being used for this study because of its potential ability to empower women. Chinn and Wheeler (1985) and Bunting and Campbell (1990) defined feminism as a world view that values women and

confronts systematic injustices based on gender. Feminism is not intended to be anti-male but to value all individuals regardless of gender. Feminism challenges the tenets of a patriarchal society and the oppression of women. A feminist perspective tells women to embrace their rich heritage and advocates the same rights for women as society accords men (Chinn & Wheeler, 1985; Vance, Talbott, McBride, & Mason, 1985).

History of Feminism

Feminism was first identified in the late 1300s in the writings of Christine de Pisan (cited in Bunting & Campbell, 1990). De Pisan presented women as capable human beings who could learn, rule, and obtain salvation through education and intellect as well as men. She rejected the view that women were powerless and irrational (Bunting & Campbell, 1990). The feminists of the Age of Enlightenment fought for equal rights and privileges. By the 19th century, cultural feminists believed there was a basic difference between the genders, and that the psychic life values, judgments, and thinking modes of women differ inherently from those of men (Bunting & Campbell, 1990). Today, value-laden feminists address the issues of the devaluation and oppression of women.

Historically, family violence has been associated with the development of a patriarchal society. Concepts of a patriarchal society include the nuclear family, the marriage license, and patriarchy. Originally, in primitive societies, family lineage was passed along on the maternal side. Women, as mothers, were expected to parent the children, and because of this, they held positions of authority and respect in these cultures.

It was not until society moved from an extended family to pairing marriage that women began to become the property, or "slaves" of men (Martin, 1983). It is thought the transition from the extended family to the nuclear family occurred because of the increased complexity of human life. The growing complexity of life had a more specific meaning for women: "a fear of an open season on rape, and not a natural inclination toward monogamy, motherhood, and love" (Martin, 1983, p. 27). Fear for her safety was probably the "single causative factor in the original subjugation of woman by man, the most important key to her historic dependence, and her domestication by protective mating" (Martin, 1983, p. 27). By accepting a monogamous relationship and a patriarchal society, women exchanged their power for the protection of a husband.

In a patriarchal society, a man is expected to conduct all business and maintain order within his home (Ferraro, 1988). "Patriarchal law, religion, philosophy, and morality stress the superiority of males and their consequent responsibility and right to control society and the women and children in their own families" (Ferraro, 1988, p. 127). The Romans first recorded the law of marriage in 753 B.C. (Dobash & Dobash, 1977-78). This law stated that married women were to conform to their husbands, become their husbands' possession, and be under their husbands' control. Following this premise, men began to consider all people living in their homes as their property. Wives could be bought and sold. Brides were purchased from their fathers which transferred ownership of the woman from the father to the husband. Because the marriage contract was considered a business contract, women often had no say in their homelife. The husband had full authority to judge and censor his wife, could punish his wife for adultery, drinking wine, and appearing in public without his permission or unveiled (Dobash & Dobash, 1977-78). When a woman did show any signs of being strong willed, men considered it natural to beat her until she became submissive (Martin, 1983).

Christianity promoted the patriarchal family by writing in the scriptures of the subordination of wives to

husbands through obedience in order to maintain a sacred order (Dobash & Dobash, 1977-78). However, the intent was for this sacred order to be based on love, not violence.

Unfortunately, instead of love, cruelty has become an inherent component of every family culture. With establishment of English Common Law, a married woman lost all of her civil rights, had no separate legal status, and became the chattel of her husband. "The right of the husband to chastise his wife was considered a natural part of his responsibilities" (Dobash & Dobash, 1977-78, p. 429). European and American law supported the man's right to beat his wife, because men were expected to control their wives. A man could beat his wife as long as the stick was no bigger than his thumb (Martin, 1983). The California Supreme Court ruled a woman could not sue her husband for damages from the assaults because this may destroy the peace and harmony of the home which is contrary to the law (Straus, 1977).

The Arab culture forbade women to leave their homes unescorted and uncovered, and if they did so, they suffered dire consequences. These constraints against women are still in existence and practiced today in some countries in the Middle East.

In Europe during the Middle Ages, noblemen beat their wives as frequently as they beat their serfs (Martin, 1983).

Women were burned during medieval times for speaking back to their husbands and priests, for scolding and nagging, for adultery, for miscarrying, for stealing, and for witchcraft (Martin, 1983).

During the reign of Ivan the Terrible, the state church provided guidelines for when and how a man could beat his wife. A man could even kill his wife if it was for disciplinary reasons (Martin, 1983). Nearly a half century later when Russian women fought back against this injustice, they were buried with only their heads remaining above the ground as punishment (Martin, 1983). This was the sentence for breaking the law which forbid husband killing.

It was not until the 1880s that English law began to change. A women could separate from her husband if he was continually beating her, but not divorce him. Eventually laws prohibited husbands from selling their wives and daughters into prostitution and from beating their wives (Martin, 1983).

In 1864, a court in North Carolina declared that the state could not interfere in cases of domestic chastisement unless "permanent injury or excessive violence" was involved (Dobash & Dobash, 1977-78, p. 430). It was not until the late 19th century that the U.S. courts began to reject the concept of wife beating.

However, the Western world has continued to perpetuate the male-dominant structure of society. Straus (1977) has described the male-dominant structure of society as an urban-industrial society, where it is assumed that a man is superior in valued personal traits, material goods, and services. The law, society, and religious structures still consider the man the head of the household. And although laws are beginning to change and recognize women as no longer being the property of men, statutes still continue to "declare the husband the head of the household, giving him various rights over his wife" (Straus, 1977, p. 53).

Economically, women continue to earn about 40% less than men in the same occupations. "Without access to good jobs, women are dependent on their husbands" (Straus, 1977, p. 52). In addition, occupations considered "women's" occupations have a tendency to be poorly paid (Straus, 1977).

Women are further kept in a dependent position because of the value society places on the nuclear family, and its expectations that the woman is the primary caregiver responsible for the children. Should a woman elect to raise her children as a single parent, society frowns because it is felt children do better in a two-parent family. In addition, society promotes the concept that a woman cannot

be a "full woman" unless she is a wife and mother. And, should the woman divorce, she is still responsible for the economic well-being of her children. However, often when a woman becomes divorced and has children, her economic position decreases to a poverty level, while her husband's economic position improves.

Since the mid-1970s, society has begun to consider family violence as being unacceptable. In this century, woman are more likely to be involved in violence in their homes, and there continues to be a high association between marital violence and homicides and assaults (Dobash & Dobash, 1977-78).

Feminist Research

Feminism and feminist research seeks to empower women and make them more aware of themselves and others. Empowerment is achieved by teaching the woman about her personal strength, power and ability to enact one's own will and love for self in the context of love for others (Wheeler & Chinn, 1989). Power can be viewed positively and used to produce change (Vance et al., 1985). "Awareness is an active, growing knowledge of Self and others and the world in which we live" (Wheeler & Chinn, 1989, p. 2). Feminism research can help the abused woman by identifying her in

the clinical setting, teaching her about violent relationships, and providing her with resources and options.

Wheeler and Chinn (1989) compared patriarchal power and the feminist alternative. Patriarchal power emphasizes programs, goals or policies which maintain the status quo; impose change through a paternalistic authority; invest power against others; have a linear chain of command; have aggressive leaders; polarize values into "good and bad"; exploit resources; value an accumulation of material goods, resources, and dollars; rely on technology; emphasize the reward system; reward conformity; and rely on secrets, agents, and line of command. The feminist alternative emphasizes freedom from rigid programs; change growing out of consensus; value in the flow of new ideas, images, and energy from nurturing mutual networks; value in the personal power of each individual; stressing responsibility for decisions and for acting on one's decisions; leadership based on talent, interest, and skill; integration of self-love with love for others; cherishing life and its experiences; using material resources to the benefit of all individuals; considering the human experience when determining actions; long-range outcomes and ethical behavior; encouraging creativity, values, alternative views,

and flexibility; and focusing on normalizing processes and protection of the individual.

Men have controlled the research process in the scientific community, and therefore, a male bias has existed in research and publications on women. Duffy (1985) wrote the male bias in research may have profound implications for women. Because men have the political power in the research process, they have been able to reinforce the dominant social values rather than challenge them (Duffy, 1985). By more women not doing research, significant questions concerning women may never be raised, such as, what are the effects of spouse abuse on the pregnant woman?

Feminism and feminist research is intended to promote women. Bernhard's (cited in Duffy, 1985; Parker & McFarlane, 1991) eight criteria for feminist research include the following: (1) women are used as its principal investigators; (2) the researchers interact with the women involved in the study; (3) the study has potential to help the subjects as well as the researchers; (4) the focus of the research is to identify women's experiences; (5) the purpose of the research is to study women; (6) the word "feminist" or "feminism" is used in the report; (7) reference is made to feminist literature; and (8) nonsexist language is used.

This study exemplifies feminist research and applies feminism by (1) using women as its primary investigators; (2) researchers interacting with the women involved in the study to obtain their feelings about the current pregnancy, violence, and their abuse status; (3) being done to prevent abuse during pregnancy; (4) being focused on the current experiences of women presenting for their first prenatal visit; (5) having as the intent of the investigation the study of pregnant women for the purpose of improving the lives of women; and (6) having bibliographic references to feminism, nonsexist language, and the word "feminist/ feminism" being used in this study.

Feminist research sensitizes the reader to feminist consciousness "that identifies, labels, and seeks to change the societal atrocities against women" (Duffy, 1985, p. 348). Connell (1983) and Parker and McFarlane (1991) implied that feminine consciousness is concerned with intuitive knowing, receptivity, awareness of nature, and the ability to experience life as a whole, nurturing entity. Feminism values women, validates their experiences, recognizes ideology which oppresses women, and attempts to bring about social change (Hall & Stevens, 1991).

Feminist research finds victim-blaming unacceptable. In addition, feminist research is not derived from research

developed from male subjects. Feminist research includes women in the research, validates their experiences, and recognizes that multiple truths exist. The primary goal of feminist research is social change (Duffy, 1985).

Chinn (1989) stated feminist research is grounded from the woman's own personal experiences, and emphasizes the everyday life. It is committed to changing society so that people will move in the direction of peace, freedom, and choice for all. Achieving peace in the world would help alleviate violence against women in their homes.

MacPherson (1983) wrote that feminist research is concerned with values and is focused on issues related to women. Feminist researchers try to analyze the conditions under which women live and how to improve their lives. The results obtained from feminist research should be used to improve the lives of all women. Campbell and Bunting (1991) further stated the goal of feminism is to present a woman-centered patterning of human experience.

Feminists consider the researcher and participant as equal partners. Women participants are given information about their research responses in order to empower the woman (Campbell & Bunting, 1991).

Empowerment of Women

The empowerment of women is a vital concept of feminism. Sherwin (1987) wrote that women's health issues are interrelated with the social and economic status of women. Women are expected to adopt designated roles, and the health care system and society have no desire to help those women who deviate from the expected roles. Women are taught that their value lies in the ability to produce children. If she does not have children, then the woman may be told she is inadequate. Only through education can women's health be improved. Feminist ideology teaches women that they can control their reproductive capacities and what options exist. A women's acceptance of this ideology of control over her life adds to her empowerment.

In reality, an abused woman may begin to think she has no worth, and society considers her passive without any power or courage. These beliefs also foster the rescue fantasies of the health care system (King & Ryan, 1989). Original research in the realm of abused women used models based on the concept of learned helplessness developed by Seligman and Maier (1967). Seligman and Maier divided dogs into two groups--an escapable/inescapable shock group and an escape/avoidance group. Members of each group then received a series of electrical shocks to their hind paws. Even with

the correct response, the escapable/inescapable group could not avoid or stop the series of electrical shocks. However, the escape/avoidance group stopped the electrical shocks with the correct response. The end result was that the escapable/inescapable group eventually gave up and would not try to avoid the electrical shocks, even when given the opportunity. These dogs required retraining in order to avoid the electrical shocks.

Feminism, through the empowerment of women, also has the power to dispel myths about abused women. One myth pertains to family violence being a private family matter. Health care providers cannot empower an abused woman unless they are sensitive to assessing each woman for her abuse status. Health care providers must accept the attitude that violence is not acceptable. "No man has a right, because of marriage, cohabitation or dating, to beat or rape a woman" (King & Ryan, 1989, p. 48). Health care providers must identify family violence before they can effectively intervene.

A second myth pertains to a woman not wanting to leave a violent home, or she would do so. Each woman has her own individual reason for not leaving a violent home. Women may not leave violent homes because they do not have adequate resources to care for themselves and their children. To

leave one's home is to leave one's belongings, clothes, memories, and friend's (King & Ryan, 1989). Culture rewards an intact nuclear family. Religions may place the blame for the abuse on the family or discourage a woman from divorcing her husband. The legal system may award the children to the father. And, lastly, the woman may have a fear for herself, guilt, and a loss of self-esteem (King & Ryan, 1989). A women may feel guilty and think she brought about the demise of the relationship.

Summary

Feminist research is in a position to develop theories which empower the woman, not degrade her with a patriarchal theory like learned helplessness. Parker and McFarlane (1991) have applied feminism to the abused woman. Both investigators are women who were interested in empowering nurses and abused women. The nurse data collectors were empowered through a series of in-service sessions which enabled them to ask questions, and the data collection was not started until the nurses were comfortable seeking the research information. The abused women were empowered through nursing advocacy, support, and informational options (Parker & McFarlane, 1991). Their research was focused on the experiences of those abused, pregnant women. The

results of the study will be disseminated to bring about public awareness, sensitization to spouse abuse, and changes in social, health, and political policies which affect women (Parker & McFarlane, 1991).

Research in the realm of feminism has the potential to affect change in social, religious, and legal policies. This type of research can empower nurses to become advocates for all women.

Assumptions

The assumptions being used in this study include:

1. Abuse does occur during pregnancy (Dobash & Dobash, 1977-78; Martin, 1983; Straus, 1977).
2. Abuse can affect the perceptions a woman has of her pregnancy (Martin, 1983).
3. Women can become empowered to make changes (Parker & McFarlane, 1991; Wheeler & Chinn, 1989).
4. Abuse can be stopped or prevented by nursing empowerment of women (Parker & McFarlane, 1991; Wheeler & Chinn, 1989).

Research Questions

The following research questions were formulated for this study:

1. What themes occur in black, hispanic, and anglo women's perceptions of their pregnancy during the first prenatal visit and do they differ?
2. What themes occur in black, hispanic, and anglo women's perceptions about their male partner's feelings about the current pregnancy?
3. Can black, hispanic, and anglo pregnant women's feelings about their pregnancies be associated with their abuse status?
4. Can black, hispanic, and anglo pregnant women's perceptions about their male partner's feelings about the pregnancy be associated with their abuse status?

Definitions of Terms

The following terms were defined for this study:

1. Abuse status: the state or condition of a person who has incurred "acts of violence that have a high probability of causing injury to the person" (Gelles, 1988, p. 842). For the purposes of this study, the classification of abuse status was measured as follows:
   a. Abused woman: any positive response to questions 2, 3, or 4 on the Abuse Assessment Screen (see Appendix A); the degree of abuse was scored on two national tested instruments: the Index of Spouse Abuse (see

Appendix A) and the Conflict Tactics Scale (see Appendix A).

b. Non-abused woman: any negative response to questions 2, 3, or 4 on the Abuse Assessment Screen.

2. Feelings about pregnancy: subjective thoughts about the current pregnancy. For the purposes of this study, two distinctions were made in feelings about pregnancy:
   a. Woman's feelings: Woman's response to Pregnancy Questionnaire item 2 (see Appendix A).
   b. Men's feelings: Woman's response to Pregnancy Questionnaire item 1 (see Appendix A).

Limitations

The sample selected for this study was selected from all women attending a large metropolitan city health department's prenatal clinics and a large university-based prenatal clinic. These women were prospectively followed from their first prenatal visit to delivery. Each woman was provided with information on the cycle of violence as well as social, legal, and community resource agencies. Because this study used prospective data, the only limitation included the possible loss of subjects for follow-up interviews or chart review.

Delimitations

The sample for this study was delimited to all pregnant women in their first prenatal visit who had attended a large, metropolitan city health department's prenatal clinics and a large university-based prenatal clinic. All women were able to read at a sixth grade level and lived in the two cities of the study.

Summary

Feminism, used as the conceptual framework in this study, seeks to empower a woman during her pregnancy. Thus, the problem of this study was threefold: When a woman is abused during her pregnancy, what influence does the violence have on the woman's feelings about her current pregnancy? Can these feelings be related to the amount of violence? Is there an ethnic specific typology of feelings which can be used to identify abused women? If a typology of feelings can be identified, health care providers may be alerted to a woman's abuse status by her feelings and her perceptions relating to her male partner's feelings about the current pregnancy. Once identified, the woman can be empowered by health care providers with information and resources to help achieve a positive pregnancy outcome.

CHAPTER 2

REVIEW OF LITERATURE

In Healthy People 2000 (1991), violence and abuse against women was identified as one of the top 22 priority objectives for the nation's health. It has been estimated that 2 to 4 million women are abused each year by their male partners, and at least 21% to 30% of all U.S. women will have experienced violence from their male partner at least once (Healthy People 2000, 1991).

Historically, two of the leading causes of premature death in the United States have been infectious diseases and homicides. Infectious diseases have been controlled with better nutrition, better housing, better education, and antibiotics. However, violence in this country has continued to escalate, and is one of the top five leading causes of years lost prematurely (Foege, 1985).

Women who are abused are often ashamed and afraid of being identified. If the woman is pregnant, she may be more vulnerable to abuse, and less likely to seek outside assistance (Gelles, 1987a). The intent of this study was to try to identify clinical indicators which may alert the health care provider to the pregnant woman's risk of abuse

and danger. A review of pertinent literature as related to frequency and severity of abuse to women and, specifically, abuse during pregnancy is presented in this chapter.

Frequency and Severity of Abuse to Women

Aggression is an animal instinct present in all human beings, but society teaches each person acceptable ways to manage their aggression. Aggression becomes violent when it becomes "an act carried out with the intention, or perceived intention, of causing physical pain or injury to another person" (Straus & Gelles, 1988, p. 15). Violence within the family is often sanctioned because it occurs in the confines of the privacy of one's home. A man may have learned he can act aggressively or violently towards his partner to ease tensions. A women becomes abused when she "is repeatedly subjected to any forceful physical or psychological behavior by a man to coerce her to do something he wants her to do without any concern for her rights." (Walker, 1979, p. xv). Physical abuse is assault, and a crime defined by state penal codes.

Walker (1979) estimated that a minimum of 50% of all women would be abused during their life. Pagelow (1984) predicted 1.6 to 12 million women are abused each year with at least 25% to 30% of all married women being abused at

least once by their male partner. Every woman is at risk of being abused by a male partner (Chez, 1988).

Abuse of women has a tendency to increase in severity, frequency, and has a high correlation with suicide and murder (Chez, 1988). One and a half million abused women require medical care each year (Straus & Gelles, 1986). In 1989, 9 out of every 10 women killed were murdered by a male, and of these, 28% were committed by their male partner (Uniform Crime Reports, 1989). In 1990, still 9 out of every 10 women killed were murdered by a male, but the rate for the murders committed by their male partners increased to 30% (Uniform Crime Reports, 1990).

Straus, Gelles, and Steinmetz (1980), in the first national survey of violence in American homes, reported from a sample of 2,143 respondents that one in three women were abused three or more times during their marriage, with one in six couples committing at least one violent act against their significant other. Numerically, this translated into 8.7 million U.S. couples involved in interpersonal violence with 3.4 million of these disputes involving violence at a reasonably high risk for ending in an injury (Straus & Gelles, 1988). In general, 28% of all the couples were involved in at least one violent episode (Straus, 1977-78).

Straus (1977-78) reported the typical pattern for family violence was at least two serious assaults per year. One percent of the couples reported the family violence was greater than slapping or kicking in the last year; 4% had gone beyond slapping or kicking during their marriage; and 4% had used a weapon. Of 109 women interviewed by Dobash and Dobash (1977-78), 59% reported violence by the end of their first year of marriage and 92% reported violence by the end of the first 5 years of marriage.

In a study of 80 families, Gelles (1987b) noted that 21 (26%) participated in husband-wife assaults anywhere from six times a year to every day. Violence ranged from once a year for 29 (47%) of the husbands to daily for 20 (25%) of the husbands.

Abuse may be the end result of an imbalance of power between males and females. Women frequently have less power by virtue of their not always being in the labor market, and when they do work, their salaries may be lower than their husbands; they may have less education than their husbands; and do not always participate in the decision-making process (Finkelhor, 1983). Walker (1983) found that women who were more liberal in their attitudes, and less traditional in their sex role were more liable to experience abuse. Walker explained abuse as occurring when the man perceived a loss

of control, and felt a need to compensate for this loss of control.

Abuse of women is not limited to lower socioeconomic groups, but pervades all ages, races, religions, education levels, socioeconomic groups, and cultural backgrounds. Straus, Gelles, and Steinmetz (1980) regionalized abuse of women finding Southerners more prone to violent disputes, lethal violence, homicides, and negligent manslaughter; a higher incidence of abuse to women occurring in the suburbs; and no difference existing between rural and urban areas. Abuse to women was 400% more common in blacks than whites, higher in families with no religious affiliation, and the least amount of violence occurred in Jewish homes or homes where both partners were of the same religion (Straus, Gelles, & Steinmetz, 1980). Although interpersonal violence can occur in all ages, it is more common in younger couples, where the husbands had at least some high school education and were employed in a low status occupation. Interpersonal violence was inversely proportional to income; for example, the higher the family income, the less violence was identified in the family (Gelles, 1987b).

McLeer and Anwar (1989) performed a retrospective chart review on emergency department records for 412 women presenting with trauma. Abuse was documented when the woman

answered positively to the question asking if the injury had been caused by someone she was involved with intimately. The chart review revealed 5.6% of the women received their injuries from abuse. When the emergency department personnel were taught to recognize abused women, the percentage of identified abused women increased to 30%. Specifically, 42% of female trauma cases in women between the ages of 18-20 was attributed to abuse, and 35% of the cases in women between 21-30 years was attributed to abuse. Abuse ranged from 26% to 18% in women between the ages of 31 years to over 61 years of age.

Abused women are often identified when they present to a medical facility for medical/surgical complaints. Of the women presenting in a 30-day period, Rounsaville (1978) identified a total of 37 women who were abused; however, the women presented to the emergency department with surgical and psychiatric complaints, and not physical abuse. Bell, Hildreth, Jenkins, Levi, and Carter (1988) interviewed 262 male and female patients at a neighborhood outpatient medical center for abuse. Of the 141 women in the sample, 19 (14%) had been molested or raped, and 21 (15%) had been physically assaulted.

Stacey and Shupe (1983) surveyed 542 women living in a woman's shelter. These authors noted that being slapped was

reported by 8 out of 10 women, being punched was reported by 7 out of 10 women, and being kicked was reported by 6 out of 10 women.

Germain (1984) wrote that nonphysical forms of abuse are harder for a woman to deal with than physical abuse. Nonphysical forms of abuse included social isolation, home imprisonment, economic imprisonment, economic deprivation, and verbal harassment and/or disparagement.

In a study of 793 women presenting to four Planned Parenthood Clinics, Bullock, McFarlane, Bateman, and Miller (1989) reported an 8.2% incidence of abuse on self-report. The authors reported a statistical difference ($p \leq .001$) for age and marital status. Abused women were older and had a tendency to have never married or were divorced or separated. In a follow-up study to measure the prevalence of abuse on self-report versus nurse interviewed, the same investigators found 29% of the women reporting abuse on nurse interviews (McFarlane et al., 1992).

Bergman and Brismar (1991) identified 117 abused women presenting to an emergency department for treatment. The abused women's charts were reviewed beginning 10 years prior to their entry into the medical system. The women were then followed prospectively for 5 years. During this time, 90 (77%) of the abused woman had at least one hospitalization,

with a total of 420 admissions. Surgical disorders, trauma, gynecological problems, induced abortions, medical disorders, suicide attempts, and observational time accounted for the majority of admissions. Of the abused women, 69 (59%) were admitted for psychiatric complaints which included depression, psychoses, alcoholism, drug addition, and suicide attempts.

Abuse During Pregnancy

Pregnancy is a stressful event in a woman's life. The emotional events associated with pregnancy vary throughout each trimester. During the first trimester, the women may wonder whether they are pregnant or simply ill and have ambivalent feelings about being pregnant. Eventually, the woman must incorporate the changes of pregnancy into her own ego if she is to maintain a healthy concept of the pregnancy (Benson, 1984).

During the second trimester, pregnant women begin to disassociate from the fetus and start to think of the fetus as a separate individual. Women daydream about their future child and want to learn more information about the fetus. In the last trimester, women begin to tire of their new body image and hope the pregnancy will end quickly. The

women anticipate the labor and delivery process (Benson, 1984).

How a woman views her pregnancy can influence her prenatal care. Lia-Hoagberg et al. (1990) studied factors which act as barriers and motivators to prenatal care. A total of 211 low-income women were interviewed in the hospital and at home during their postpartum period. Finances were not a barrier to prenatal care. The barriers identified were child care, transportation, lack of pregnancy planning, lack of recognition of the pregnancy, and ambivalence towards the pregnancy. Of the women who were ambivalent towards their pregnancies, 75% received inadequate prenatal care. Black and American Indian women had a higher incidence of unhappiness/ambivalence toward their pregnancies. When a woman was unhappy about a possible pregnancy, she delayed her prenatal care as a way to deny the pregnancy. Women with inadequate or intermediate prenatal care were more likely to consider abortions and would delay prenatal care while considering the effects of another child in their lives. Women with inadequate prenatal care experienced more family and personal problems, such as abusive male partners, which required their energies. The greatest motivator for prenatal care was the

desire for a healthy baby or encouragement from a significant other.

A stressor which can influence a woman's perceptions of her pregnancy and impact her prenatal care is abuse. Approximately 25%-45% of women are abused during their pregnancy (Drake, 1982). When a woman is abused during her pregnancy, she should be considered a high risk maternity patient by virtue of her physical or psychological trauma, the likelihood of repeated trauma, and often inadequate economic, supportive, and emotional resources (Sammons, 1981). Often abuse increases during pregnancy because of the man's perceived changes in his relationship with his partner. The pregnancy period may be perceived by the husband as a time when his wife is vulnerable and cannot retaliate because of her pregnant condition.

Using an unstructured interview format, Gelles (1975) interviewed 80 families. Interpersonal violence was reported by 44 (55%) of the families; 10 families reported violence during a pregnancy. Three women in his study reported miscarriages immediately after the beating, while a fourth wife stated her child was born with a handicap. Gelles (1975) noted violence was considered an acceptable method of terminating an unwanted pregnancy.

Hendrix, LaGodna, and Bohen (1978) considered the concept of spouse abuse during pregnancy as an attempt on the part of the male partner to end an unwanted pregnancy and further relieve the stress of yet another child. Orr (1984) reported abused women had a higher number of abortions and miscarriages from injuries to the abdomen secondary to the violent episode.

Flynn (1977) spoke to 14 women who were abused and 19 professionals who recounted cases of abused women. Of these abused women, 50% reported being assaulted during a pregnancy.

Hilberman and Munson (1977-1978) interviewed 60 women who were attending a rural health clinic for psychiatric evaluation. Of these women, 30 were found to have experienced marital violence, and it was noted that the pattern of violence changed with pregnancy. The abuse increased with the target changing from the face and breasts to the pregnant abdomen, which often resulted in abortions and premature births. One woman in this study reported staying pregnant to avoid the violence.

In 1979, Stark, Flitcraft, and Frazier conducted a pilot study of 520 women who presented to a major urban emergency room during one month. Of the 520 women, 14 were positively identified for abuse and another 72 were

considered at risk for abuse. The areas injured most frequently were the face, chest, breast, and abdomen, with many of these injuries occurring during a pregnancy. Abused women were treated three times more frequently than non-abused women, and they had a higher number of miscarriages.

Following this study, Stark et al. (1981) studied violence against women in a sample of 2,676 women presenting to a large metropolitan hospital's emergency surgical service. The abused women used the emergency surgical service three times more frequently than nonabused women. The sites most frequently injured were the head, face, neck, throat, chest, and abdomen. Abused women had a higher incidence of abortions or miscarriages and were treated more frequently when pregnant. Of the sample, 22% of the abused women had terminated a pregnancy versus 8% in the nonabused women, and 18% of the abused women had experienced at least one miscarriage.

In a preliminary study, Drake (1982) interviewed 12 abused women. Of these women, 100% reported being abused while pregnant. Five women reported spontaneous abortions within 10 days of a physically violent episode. When a woman was abused, she would schedule additional obstetrical visits by using fictitious reasons. In most cases, the obstetrician was not aware of the abuse (Drake, 1982).

Fagan, Stewart, and Hansen (1983) interviewed 270 women receiving counseling or shelter services for domestic violence in five projects in four cities. Of these women, 40% had experienced violence weekly or more frequently; 56% reported the abuse as occurring over a minimum of three years; 33.3% received frequent injuries such as bruises, lacerations, or more serious injuries; and 44% were abused during a pregnancy (Fagan, Stewart, & Hansen, 1983).

In a study by Stacey and Shupe (1983), 42% of 542 women living in a large metropolitan shelter reported abuse during pregnancy, with the violence being aimed primarily at the abdomen and genitalia. Of these women, 8% experienced obstetrical complications. Of the women calling into this metropolitan area's crisis hotline, 42% reported they had been physically abused during pregnancy. Findings from this study implied the abuse increased during the pregnancy because of a violent tendency towards the unborn fetus as well as the woman.

Hillard (1985) screened 742 women who presented to a university-based prenatal clinic. Two groups emerged: the abused group of 81 women and the control group of 247 non-abused women (one-third of the total women screened). Of 81 women who reported abuse at home, 29 (3.9%) women reported being abused during their current pregnancy, with 15 (2.0%)

women reporting a discontinuation of abuse with the current pregnancy. When compared with the controls, abused women reported a greater consideration during the current pregnancy for an elective abortion (34%); unplanned pregnancies (73%); increased marital problems with the pregnancy (26%); and fewer reported feelings of being happy (41%). There were significant differences between abused women and controls during the current pregnancy for increased marital tension ($p \leq .001$) and happiness during the pregnancy ($p \leq .001$). Of the 81 abused women, 49% had gone to the emergency department for injuries which included bruises, lacerations, broken bones, head and dental injuries, and multiple sites of injury, such as the face, arms, abdomen, and back. Of the women who experienced current abuse, 21% reported the abuse increased during pregnancy, 36% indicated a decrease of the abuse, 43% stated there was no change (Hillard, 1985).

In 1986, Helton randomly sampled 290 pregnant women in public and private prenatal clinics in a large city. Included in the sample were black, anglo, and hispanic women from the ages of 18 to 43 years of age. A total of 68 (23.4%) women reported being abused before or during the current pregnancy and 11 (4%) felt threatened with abuse. Of the 68 women who reported being abused, 24 women (35.3%)

reported being abused during the present pregnancy and 44 (15%) reported being abused prior to their present pregnancy. Of the 24 women, 21 (87.5%) reported abuse prior to pregnancy, and 7 (10.3%) reported the abuse increased following pregnancy (Helton, 1986). Medical attention for injuries sustained was obtained by 8 (33%) of the 24 women abused during the current pregnancy (Helton, McFarlane, & Anderson, 1987b). Abuse did not vary according to race and ethnicity, however, hispanic women were more likely to be abused before pregnancy (52.3%) than white (27.3%) or black (18.2%) women (Helton et al., 1987b).

Gelles (1988) interviewed 6,002 households in a second national family violence survey. In this study, a pregnant woman had a 28.3% change of experiencing minor violence, a 60.6% greater risk of encountering abusive violence, and an overall risk of 35.6% of being involved with a violent episode. Pregnant women and men with pregnant partners reported higher rates of violence when compared to couples who were not currently experiencing a pregnancy. The pregnant women in this study reported a higher incidence of violent episodes during the second half of the pregnancy. The rate of violence for the first half of the pregnancy was 154 per 1,000, and the rate was 170 per 1,000 for the second half of the pregnancy.

Schei and Bakketeig (1989) invited 118 women to participate in a study of abuse to women. Of 111 women, 28% had experienced sexual or physical abuse or both. The most common causes of abuse were hitting, beating, kicking, biting, or threats with a knife. Of the 111 women, 17 (14%) presented with gynecological complaints consisting of irregular vaginal bleeding, vaginal discharge, pelvic pain, and nonspecific genital symptoms. Of 186 pregnancies, abuse occurred in 6 (3%) of the pregnancies and threats of violence occurred during 5 (3%) of the pregnancies.

Bullock and McFarlane (1989) interviewed 589 women in public and private hospitals. Of these women, 120 (20.4%) reported being abused, with 15 (12.5%) delivering low-birth weight infants. Of the nonabused women, 31 (6.6%) delivered low-birth weight infants. Abused women were twice as likely to deliver low-birth weight infants than nonabused women, after controlling for the obstetrical risk factors of alcohol consumption, smoking, prenatal care, abortions, maternal complications, and type of hospital. Of those women using the private hospitals, abused women had a four times higher incidence of low-birth weight infants than nonabused private patients.

Amaro, Fried, Cabral, and Zuckerman (1990) studied 1,243 English- or Spanish-speaking women attending prenatal

clinics in a large metropolitan area in the Northeast United States. Of this sample, 92 (7%) reported physical or sexual violence during their pregnancy. Incidents of violence began 3 months prior to the pregnancy and continued during the pregnancy for 11 (<1%) of the women, and 37 (3%) of the women reported violent episodes beginning 3 months prior to the pregnancy but ending with the pregnancy. One violent episode during the pregnancy occurred in at least 60% of the women, 25% had two violent episodes, and 15% had at least three violent episodes. The highest number of violent episodes was in the first trimester. Women experiencing violent episodes of marital discord were more prone to depressive periods and attempted suicides, and they expressed feelings of unhappiness about their current pregnancy. They also perceived their significant other as being unhappy about their pregnancy.

Berenson et al. (1991) interviewed 501 black, white, hispanic, and asian women attending a large university's low-risk obstetric clinic for physical abuse during their pregnancies. Of the sample, 98 women reported abuse. Of the abused women, 29 experienced violence during the current pregnancy, and the violence had increased for 6 of the women. A total of 19 of these women attempted to obtain medical treatment. Although the face and extremities were

the most commonly injured sites, 7 women reported being struck in the abdomen when pregnant. The majority of these women (92%) had been abused by their male partner. The abused women had a higher number of pregnancies and living children. White women had the highest incidence of physical abuse followed by hispanic women, then black women. Black women were divorced 15 times more frequently than white women. Abused white women used drugs 2.1 times more frequently during their pregnancy. Abused black women used drugs 3.7 times more often than nonabused black women. None of the hispanic women reported using drugs. White and black abused women used alcohol more often than hispanic, and all three ethnic groups had a higher relative risk for tobacco use. White abused women had a 4.7 higher relative risk for cocaine use than white nonabused women, and no difference in relative risk existed between abused and nonabused black women.

McFarlane, Parker, Soeken, and Bullock (1992) studied 691 black, hispanic, and anglo pregnant women for the occurrence, frequency, and severity of physical abuse during pregnancy and its impact on prenatal care. The women were followed from their initial prenatal visit to the time of their delivery. During this study, physical abuse was reported by 1 in 4 women, with 1 in 6 women reporting

physical abuse during their current pregnancy. For black women, abuse varied from 25% to 49%; for hispanic women abuse varied from 19% to 50%; and for anglo women, the abuse varied from 15% to 60%. All women reported abuse being at its highest during the second trimester. The head was the most frequent target followed by the entire body. Abused women had a tendency to delay their entry into prenatal care until the third trimester. Hispanics and anglos indicated they were abused most often by a husband or ex-husband, while black women were abused most frequently by a boyfriend. The highest number of abuse episodes during each trimester were reported by anglo women. On the Index of Spouse Abuse subscales, Physical and Non-physical, anglo women scored highest on both scales followed by hispanic women and then black women. Anglo women scored highest on all four subscales of the Conflict Tactics Scale--Verbal Reasoning, Verbal Aggression, Minor Violence, and Severe Violence. White women scored significantly higher on the Danger Assessment Scale for potential danger than black women ($F = 4.48$, $p \leq .01$). No difference was found between black and hispanic women or white and hispanic women.

Summary

Physical abuse can occur at any time in a woman's life. When abuse occurs during pregnancy, it has potential to influence the woman's perceptions of her pregnancy and to delay her entry into prenatal care. In the past, research pertaining to abuse during pregnancy has been focused on the frequency, severity, and complications of abuse during pregnancy rather than clinical indicators which could alert the health care provider to the woman's abuse status.

It is important for health care providers to be sensitive to the identification of the abused pregnant woman to provide her support and resources to improve the quality of life for both the woman and her expectant child. Health care providers can only do this if they learn to identify the abused woman. Currently, abused pregnant women may be overlooked because health care providers have not yet learned to identify abused pregnant women without specifically seeking this information. Because research has not yet been done in the realm of clinical indicators of abuse, it is the intent of this study to investigate the relationship between a woman's perceptions of her pregnancy, her perceptions of her partner's feelings about the pregnancy, and her abuse status.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This proposed research study was a secondary data analysis of a prospective cohort study designed to analyze the frequency and severity of abuse during pregnancy and associated complications of pregnancy, and effect on infant birthweight. Specifically, this study had a triangulated design to investigate the association between ethnic specific perceptions of pregnant women's feelings about their pregnancies, their perceptions of their male partner's feelings about the pregnancies, and abuse status as measured and scored on qualitative and quantitative instruments.

Setting

The data collected from this study were obtained from a large metropolitan city health department's prenatal clinics and a large university-based prenatal clinic. Every woman entering the clinics was screened using the Abuse Assessment Screen. Each woman was then accompanied to a private office where the research protocol was explained. If the woman agreed to participate in the study, she was given an informed consent form and packet of instruments.

Population and Sample

The target population for this study was all pregnant women. For this research study, all pregnant women entering the clinics for their initial prenatal visit were invited to participate until 1,200 women were entered into the study. The sample was stratified by ethnicity. Specifically, the first 400 black, 400 hispanic, and 400 anglo women were invited and entered into the study for a total sample of 1,200.

Protection of Human Subjects

The rights of the participants were protected by the following:

1. Designing a study to meet the guidelines of the Human Subjects Review Committee at Texas Woman's University, the university-based prenatal clinic, and the metropolitan city health department's prenatal clinics.
2. Explaining to the women that their participation in the study was strictly voluntary. Each woman was told that she may decline to participate in the study, and that her medical care would not be affected by nonparticipation. It was explained to the participants that they may withdraw from the study at any time and that their medical care would not be affected (see Appendix B).

Instruments

Five instruments were included in the questionnaire packet used for this study (see Appendix A). These instruments included the Abuse Assessment Screen, the Conflict Tactics Scale, an Index of Spouse Abuse, a Danger Assessment Scale, and an open-ended Pregnancy Questionnaire.

The Abuse Assessment Screen was used as an initial screening tool to determine the abuse status of the pregnant women. This 4-item instrument provided for differentiating between abused and non-abused pregnant women. The questions required yes/no answers, and a body map was included for those women who gave positive responses to being abused so that they could indicate the areas of abuse.

The Conflict Tactics Scale (CTS) was designed to measure self-report for frequency of violent tactics occurring within a relationship during the past year. The scale has four subscales: verbal reasoning--such as discussion and/or arbitration; verbal aggression--such as swearing and/or threatening to hit; minor violence--such as pushing, shoving, and/or slapping; and severe violence--such as kicking, hitting, and/or using a knife or gun. According to McFarlane, Parker, Soeken, and Bullock (1992), reliability was estimated as $\alpha = .83$ for husband to wife abuse. In the present study, internal consistency

reliability was $\alpha = .80$. CTS scores were compared to incidence rates for injury as reported by each partner to examine concurrent validity. A significant, substantial correlation between CTS scores and variables in other independent studies (Jorgensen, 1977; Straus, Gelles, & Steinmetz, 1980) supported construct validity. McFarlane et al. noted that, based on data obtained from national probability sampling as reported by Everitt (1977) and Straus and Gelles (1986), percentile normed data do exist for the CTS.

The Index of Spouse Abuse (ISA) contains 30 items. A summated-category, partition scale, the ISA was developed to measure severity or magnitude of physical (ISA-P) and nonphysical (ISA-NP) abuse inflicted upon a woman by her spouse or partner (Hudson & McIntosh, 1981; McFarlane, 1989b). Severity of physical abuse and nonphysical abuse each have separately computed scores with all items weighted according to severity of the abuse. A final score is obtained by a series of calculations that produce a score for each subscale which vary from 0 to 100 (Hudson & McIntosh, 1981; McFarlane, 1989).

Alpha coefficients of internal consistency reliability for the ISA were reported as determined by scores of 693 women from three separate samples (Hudson & McIntosh, 1981).

The coefficients for the ISA-P ranged from $\alpha = .903$ to $\alpha = .942$ and $\alpha = .912$ to $\alpha = .968$ for the ISA-NP. McFarlane et al. (1992) found internal consistency reliability of $\alpha = .95$ for the ISA as a whole, with $\alpha = .87$ for ISA-P and $\alpha = .93$ for ISA-NP. Discriminant validity (concurrent criterion validity) found by McFarlane et al. was $\alpha = .73$ for the ISA-P and $\alpha = .80$ for the ISA-NP. These coefficients indicated that the scale could accurately differentiate between abused and nonabused women (Hudson & McIntosh, 1981; McFarlane et al., 1992).

The Danger Assessment Screen (DAS) is a 15-item scale developed to assess a woman's danger of homicide. In this study, the DAS was administered to those women whose positive responses on the Abuse Assessment Screen classified them as abused women. The Danger Assessment Screen includes measurement of the presence of firearms; sexual abuse; substance abuse; indicators for potential lethal violence; issues of control; battering during pregnancy; abuse toward the children; and suicide attempts (Campbell, 1986). The alpha coefficient for reliability for the DAS with a sample of 79 was $\alpha = .71$. Content validity was established by having experts in the fields of abused women, shelter workers, and law enforcement officials review the instrument (Campbell, 1986; McFarlane, 1989). Concurrent validity

indicates a moderate to strong correlation according to the Conflict Tactics Scale (McFarlane, 1989).

The last instrument was the 3-item Pregnancy Questionnaire. The woman was asked the following: (1) Have you told your male partner you are pregnant? (2) If yes, what are his feelings about this pregnancy? (3) What are your feelings about this pregnancy? The woman was asked to write her responses on the questionnaire.

Data Collection

The data were collected on clinical days designated for prenatal care in a large metropolitan city health department's clinic and a large university-based prenatal clinic. Every woman entering the clinic was screened for spouse abuse using the Abuse Assessment Screen. All pregnant women were asked to participate in the study. Women agreeing to participate were accompanied to a private office where and explanation of the research protocol was given. At this time, the women were given and asked to sign an informed consent form. On the initial visit, the women were asked to complete a Conflict Tactics Scale, an Index of Spouse Abuse, and the Pregnancy Questionnaire. In addition, they were asked to keep a calendar monitoring the episodes of intentional injuries and follow-up visits (McFarlane,

1989). If the women reported abuse on the Abuse Assessment Screen, the Danger Assessment was administered.

Treatment of the Data

A secondary data analysis was done on data collected during the first prenatal visit for the first 150 hispanic, 150 black, and 150 anglo women at a large metropolitan city health department's prenatal clinic and a large university-based prenatal clinic who were entered into the study. For the demographic data, descriptive statistics were applied which included frequencies, percentages, and measures of central tendency and variance.

The first two research questions are: (1) What themes occur in black, hispanic, and anglo women's perceptions of their pregnancy during the first prenatal visit and do they differ? (2) What themes occur in black, hispanic, and anglo women's perceptions about their male partner's feelings about the current pregnancy? These questions were analyzed with the statistical package "Ethnography" (Seidel, Kjolseth, & Clark, 1985). Ethnography has the capabilities of categorizing common themes related to black, hispanic, and anglo women's perceptions of their current pregnancy and their male partner's feelings.

The last two research questions are: (3) Can black, hispanic, and anglo pregnant women's feelings about their pregnancy be associated with their abuse status? (4) Can black, hispanic, and anglo pregnant women's perceptions about their male partner's feelings about the pregnancy be associated with their abuse status? These questions ask if a woman's abuse status can be associated with her feelings about her pregnancy and her partner's feelings about the current pregnancy. After identifying common themes related to the women's perceptions of their pregnancies and their partner's perceptions of the current pregnancy, the women were then divided according to abuse status as determined from positive/negative responses to the Abuse Assessment Screen. The women's scores for the Conflict Tactics Scale, Index of Spouse Abuse, and Danger Assessment for each group were placed under each of the themes applicable to the women. The women's ethnicity was entered under their identified themes. Chi square analyses were computed to determine if there was a difference between abused and nonabused women in each of the perception themes for the women's perceptions and how the women perceived their male partner's felt about the pregnancy. An analysis of variance was performed on all data to determine if an association existed between the woman's feelings about her pregnancy

(her theme), her male partner's feelings about the pregnancy (his theme), ethnicity, and abuse status.

CHAPTER 4

ANALYSIS OF DATA

This study was a secondary data analysis exploring abused and nonabused women's perceptions of their current pregnancy and their perceptions of their male partner's feelings about the current pregnancy. Associations were then explored between the perceptions and the woman's abuse status. Using ethnograph software, the women's perceptions about their current pregnancy and their perceptions of their male partner's feelings about the current pregnancy were categorized into four common themes: (1) happiness, (2) acceptance, (3) ambivalence, and (4) being upset about the pregnancy. These four themes were correlated with the women's scores from the Conflict Tactics Scale, Index of Spouse Abuse, and Danger Assessment to determine if the themes could be related to the woman's abuse status.

Description of the Sample

The sample (N = 454) for this study consisted of 140 (30.8%) black women, 164 (36.1%) hispanic women, and 150 (33.0%) anglo women receiving their prenatal care at a large metropolitan area's city health department's prenatal clinics and a large university-based prenatal clinic. The

women were asked to participate in the study during their first prenatal visit, and monitored throughout their pregnancy for abuse. Only the woman's responses to the instruments on her first prenatal visit were used in this study.

The total group of 454 women participating in the study ranged from 13 to 42 years of age, with a mean age of 22.6 years. The black women ranged in age from 15 to 42 years, with a mean age of 22.7 years; the hispanic women ranged from 14 to 39 years, with a mean age of 23.3 years; and the anglo women ranged from 13 to 39 years, with a mean age of 22.1 years.

Findings

The first research question of this study was: What themes occur in black, hispanic, and anglo women's perceptions of their pregnancy during the first prenatal visit and do they differ? The second research question was: What themes occur in black, hispanic, and anglo women's perceptions about their male partner's feelings about the current pregnancy?

The themes pertaining to the woman's feelings about her pregnancy and how she perceived what her male partner felt about the pregnancy were obtained by analyzing the responses to the following questions: (1) Have you told your male

partner you are pregnant? (2) If yes, what was HIS response? (3) What were YOUR feelings when you found out you were pregnant? Each woman was asked the three questions at her first prenatal visit. The responses were entered into the Ethnograph software package and analyzed by direct analysis. Common words were identified for each woman's responses to how she felt about her pregnancy and how she perceived her male partner felt about the pregnancy The common words were then categorized into themes according to the meanings of the words (Table 1).

Examples of women's responses to the question "What were YOUR feelings when you found out you were pregnant?" were categorized into one of the four perception themes. Examples of statements for each theme are reported in Table 2.

A total of 233 (52%) women stated they were happy; 39 (8.7%) stated they accepted the pregnancy; 60 (13.4%) expressed ambivalence; and 116 (25.9%) expressed being upset about the pregnancy (Figure 1). Using the chi-square statistic, abused and nonabused women significantly differed ($p \leq .001$) by the perception themes of happiness, acceptance, and being upset, and significantly ($p \leq .05$) differed when ambivalent about the pregnancy. The women's perceptions are described in Table 3 by ethnicity and abuse.

Table 1

Examples of Common Words Categorizing Women's Feelings Towards Their Pregnancy and How Women Perceived Their Male Partner Felt About the Pregnancy and Resulting Themes as Reported by 434 Pregnant Women

Categories	Women's Feelings	Perceived Male Partner's Feelings
Happy		
	Happy	Proud
	Content	Loved It
	Pleased	Pleased
	Excited	Excited
	Delighted	Joy
	Glad	Great
Acceptance		
	Will Help	At First Didn't Want
	Understanding	Satisfied
	Accepting	Acceptive
	Calm	We'll Handle
	Agreed	Calm
	We'll Handle It	Understanding
Ambivalence		
	Happy and Scared/Afraid	Mixed
	Happy and Confused	Sad and Happy
	Excited and Scared	Happy and Worried
	Happy and Sad	Confused and Happy
	Happy and Mixed	Unsure
	Happy and Unsure	Shocked and Happy
Upset		
	Angry	Angry
	Unhappy	Argues
	Abortion	Doesn't Like
	Nervous	Abortion
	No More	Jealous
	Shock	Not Good

Table 2

Statements of Women's Perceptions of Their Pregnancy by Ethnicity

Ethnicity		
Black	Hispanic	Anglo
Happy		
I was happy.	I was happy. I love children.	I was excited about it.
I was glad.	Happy.	I was very happy.
Ambivalence		
I was undecided but then I made my mind up.	I was glad and sad at the same time. First after 9 years of trying and now being pregnant makes me happy for my baby's sake. I will try and get back later with the father.	Scared and confused on whether to keep this baby. Plus I just had a baby 13 months ago and I'm having another one. If I had an abortion, would he hate me forever or what.
I felt I wanted the baby but I wasn't too sure then I made up my mind I was going to keep my baby.	I was happy that I was going to have a baby with my husband. But I also want to finish school first. But if I try hard I can accomplish both. I feel strongly that my husband will be a very good father.	Mixed but anxious to be to be starting a new new family.
Acceptance		
I wasn't going to keep it but then I changed my mind cause I said that it will be like killing one of the ones I have.	I felt a little sad and preoccupied but after I thought about it I was happy.	At first I felt like what like what am I going to do. But I'm glad.

Table 2 (Contd.)

Ethnicity		
Black	Hispanic	Anglo
Acceptance (Contd.)		
I cried at first, then I became sad for about a week. Now I have nothing to do but accept.	Too soon after the first, but I'm happy about it.	At first I was scared and unsure but the more I thought about it the happier and more confident I became.
Upset		
I am going to get an abortion. I am not ready for this baby right now. Get this baby away from me.	Negative, the thought of abortion and adoption entered my mind because of age, financial, and marital status.	Didn't want another one just yet (Baby is 9 months).
I was unhappy.	Not too good.	Shock! Scared! Lonely! Strong!

Each's woman's response to the two questions, (1) Have you told your male partner you are pregnant? and (2) If yes, what was HIS response?, were sorted under the four perception themes: happy, ambivalence, acceptance, and upset. Examples of statements for each theme for the male partners' response are found in Table 4.

Some 284 (64.1%) women perceived their male partner as being happy; 39 (8.8%) women perceived their male partner as accepting the pregnancy; 25 (5.7%) women perceived their male partner as being ambivalent; and 95 (21.4%) women

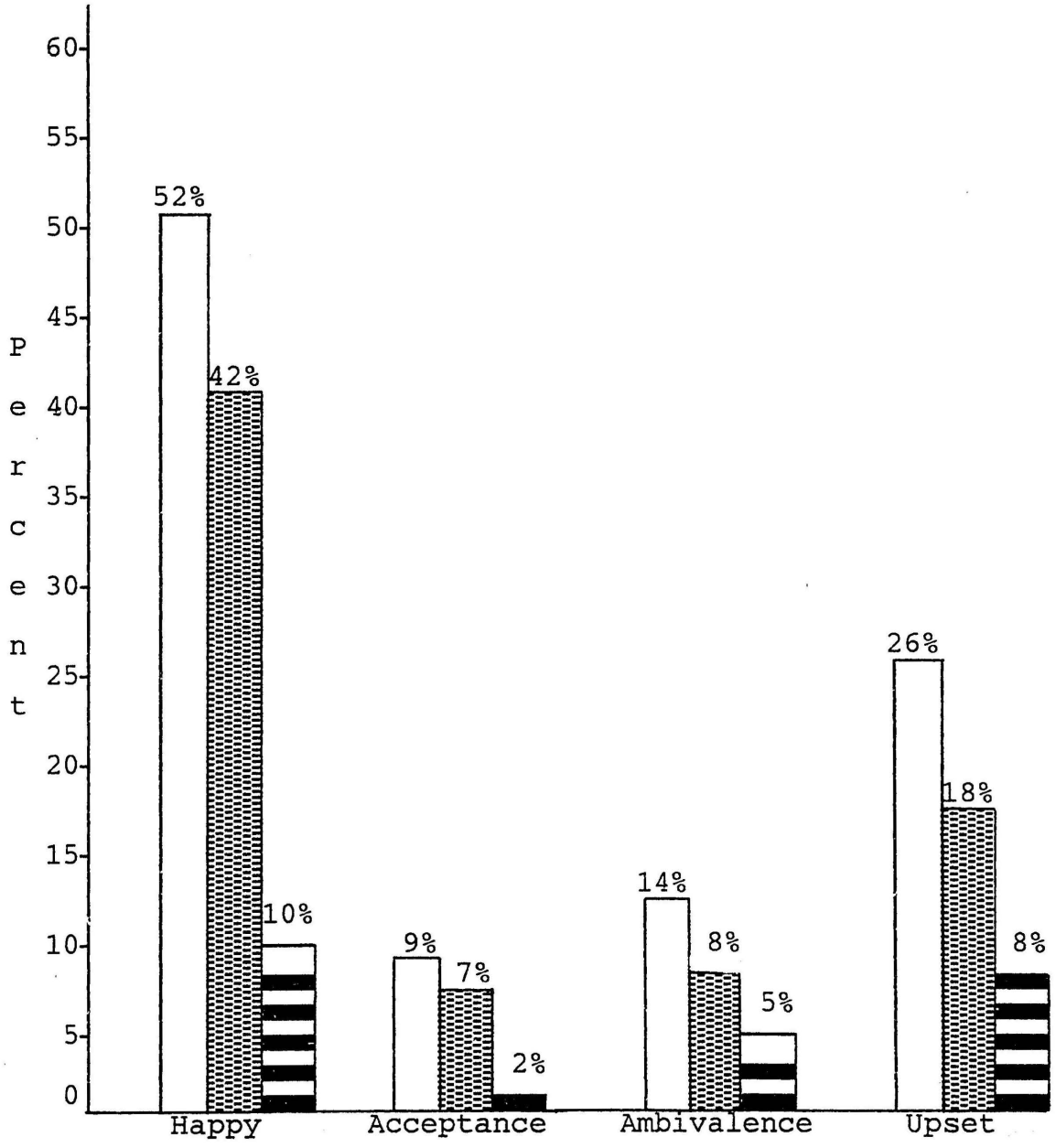

Figure 1. Perception of Pregnancy by Abuse Status Reported by All Women, Showing Nonabused and Abused Categories

= All Women
= Nonabused Women
= Abused Women

Table 3

Frequency and Percentage of Abused (A) and Nonabused (N) Black, Hispanic, and Anglo Women by Perception of Pregnancy by Ethnicity

	Black				Hispanic				Anglo				Total			
	N		A		N		A		N		A		N		A	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
H	38	8.5	15	3.3	92	20.5	16	3.6	56	12.5	16	3.6	186	41.5	47	10.5
AC	10	2.2	4	0.9	9	2.0	4	0.9	11	2.5	1	0.2	30	6.7	9	2.0
AM	19	4.2	8	1.8	5	1.1	3	0.7	14	3.1	11	2.5	38	8.4	22	5.0
U	31	6.9	13	2.9	23	5.1	9	2.0	25	5.6	15	3.4	79	17.6	37	8.3
Total Group	138	30.8%			161	35.9%			149	33.3%			448	100.0%		

Note: H = Happiness
AC = Acceptance
AM = Ambivalence
U = Upset

Table 4

Statements of How the Women Perceived Their Male Partner Felt About Their Pregnancy by Ethnicity

Ethnicity		
Black	Hispanic	Anglo
Happy		
He was excited that he was going to be a father.	Happy face. He loves children.	He was pleased about it.
He was very happy. Smile.	He wants a boy.	He was excited.
Ambivalence		
Happy and not happy.	At first he was happy but now it seems he he doesn't care at all.	He was happy but a little upset about finances.
Sad and happy at the end.	Happy and worried because we were going to be more in the family, but was glad.	Unsure.
Acceptance		
At first he did not want it but now his responses are well and he wants it. He participates in asking about it and he takes part in it.	The baby is on the way and I want this to be the last one.	He was not happy at the time, now he couldn't be happier.
He said to have the child only because I had just got rid of one.	He didn't believe me at first, now he's happy about it, and says he wants at least another child.	Happy but worry about money.

Table 4 (Contd.)

Ethnicity		
Black	Hispanic	Anglo
Upset		
A little angry because he said he can't take care of no more kids because he already has one.	He doesn't want anymore children.	Nothing.
He was mad and not too happy about it.	He didn't say anything.	No response.

perceived their male partner as being upset about the pregnancy (Figure 2). Using the chi-square statistic, abused and nonabused women significantly ($p \leq .001$) differed when they perceived their male partner as either happy or accepting of the pregnancy. The woman's perceptions of her male partner's feelings about the pregnancy by ethnicity and abuse are described in Table 5.

The third research question was: Can black, hispanic, and anglo pregnant women's feelings about their pregnancy be associated with their abuse status? Research question four was: Can black, hispanic, and anglo pregnant women's perceptions about their male partner's feelings about the pregnancy be associated with their abuse status? Research

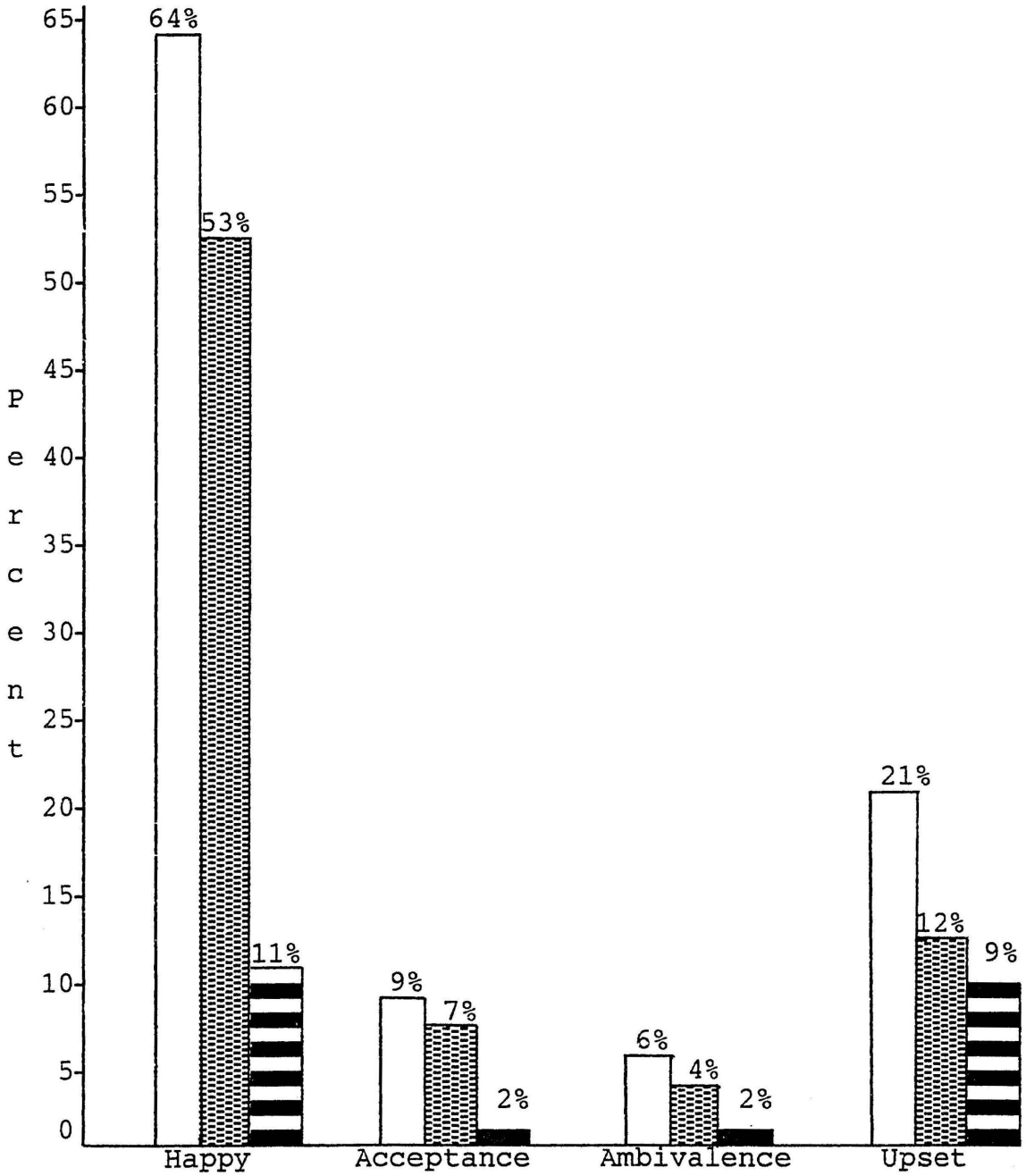

Figure 2. All Women's Perceptions of Male Partner's Feelings About Their Pregnancy, Showing Nonabused and Abused Categories

□ = All Women
▨ = Nonabused Women
▬ = Abused Women

Table 5

Frequency and Percentage of Abused (A) and Nonabused (N) Black, Hispanic, and Anglo Women's Perceptions of Male Partner's Feelings About Their Pregnancy by Ethnicity

	Black				Hispanic				Anglo				Total			
	N		A		N		A		N		A		N		A	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
H	62	14.0	15	3.4	102	23.0	18	4.1	89	15.6	18	4.1	233	52.6	51	11.5
AC	11	2.5	5	1.1	10	2.3	2	0.5	9	2.0	2	0.4	30	6.8	9	2.0
AM	7	1.6	6	1.4	1	0.2	2	0.4	7	1.6	2	0.5	15	3.4	10	2.3
U	17	3.8	12	2.7	14	3.2	10	2.3	21	4.7	21	4.7	52	11.7	43	9.7
Total Group		135	30.5%			159	35.9%			149	33.6%			443	100.0%	

Note: H = Happiness
AC = Acceptance
AM = Ambivalence
U = Upset

questions 3 and 4 were both analyzed in the same way and are discussed in tandem below.

First, abuse status was determined by the woman's response to the Abuse Assessment Screen (see Appendix A). All 454 women were asked if they had been hit, slapped, kicked or otherwise physically or sexually abused during the 12 months prior to pregnancy or during the present pregnancy. If the woman responded yes, she was classified as abused. Next, each woman had scores calculated for her responses to the Conflict Tactics Scale subscales of (1) verbal aggression (i.e., intention to inflict injury on one's partner), (2) minor violence (i.e., kicking, hitting, or slapping), and (3) severe violence (i.e., threatening to use a knife or gun) (see Appendix A). Additionally, a single score on the Index of Spouse Abuse--Physical Violence (see Appendix A) and Danger Assessment (see Appendix A) were calculated for each woman. A total of five scores were recorded for each woman.

Using ANOVA and Scheffé post-hoc analysis, the five scores of each woman were analyzed by ethnicity, woman's perceptions, woman's perceptions of her male partner's feelings, and abuse status for main effects followed by two-way interactions of ethnicity and perceptions, ethnicity and abuse, and woman's perception and abuse. Finally, a

three-way interaction was completed for ethnicity, perceptions, and abuse. Two summary tables of these findings are presented. Table 6 presents the F values for research question 3 and Table 7 presents the F values for research question 4.

Conflict Tactics Scale--Verbal Aggression and the Woman's Perceptions of Her Pregnancy

In the presence of abuse, the simple interaction effects indicated the verbal aggression response was significantly ($p \leq .05$) influenced by the interaction of ethnicity and perception of pregnancy. No significant difference was found when abuse was absent.

Abused anglo women ($M = 64.1$) who indicated upset statements about their pregnancy scored significantly ($p \leq .01$) higher on verbal aggression than abused black ($M = 29.8$) and hispanic women ($M = 27.2$). Abused anglo women who were ambivalent ($M = 67.5$) or upset ($M = 64.1$) about their pregnancy scored significantly ($p \leq .01$) higher on their verbal aggression scores than abused anglo women who were happy about their pregnancy.

Table 6

ANOVA F Values for Main Effects, Two- and Three-Way Interactions for Ethnicity, Women's Perceptions, and Abuse Status by Scores on Conflict Tactics Scale, Index of Spouse Abuse, and Danger Assessment

Source	Conflict Tactics Scale			Index of Spouse Abuse	Danger Assessment
	Verbal Aggression	Minor Violence	Severe Violence	Physical	ment
	F	F	F	F	F
Main Effects					
Ethnicity	3.719*	0.199	0.184	4.465*	3.800*
Perceptions	3.261*	6.825***	3.045*	4.808**	3.803*
Abuse Status	79.719***	93.358***	42.811***	169.934***	78.512***
Two-Way Interactions					
Ethnicity and Perceptions	0.603	0.639	0.449	1.300	1.449
Ethnicity and Abuse	0.267	1.241	0.489	2.166	0.942
Perceptions and Abuse	0.565	5.623***	4.389**	3.144*	0.793
Three-Way Interactions					
Ethnicity, Perceptions, and Abuse	3.358**	2.350*	1.521	1.602	1.644

*p≤.05
**p≤.01
***p≤.001

Table 7

ANOVA F Values for Main Effects, Two- and Three-Way Interactions for Ethnicity, Women's Perceptions of Male Partner's Feelings About the Pregnancy, and Abuse Status by Scores on Conflict Tactics Scale, Index of Spouse Abuse, and Danger Assessment

Source	Conflict Tactics Scale			Index of Spouse Abuse	Danger Assessment
	Verbal Aggression	Minor Violence	Severe Violence	Physical	ment
	F	F	F	F	F
Main Effects					
Ethnicity	4.022*	0.412	0.442	3.467*	4.014*
Perceptions	12.684***	8.813***	4.101**	11.635***	5.515**
Abuse Status	57.573***	77.096***	34.156***	137.414***	65.999***
Two-Way Interactions					
Ethnicity and Perceptions	0.922	0.671	1.931	0.880	0.865
Ethnicity and Abuse	0.948	4.462*	1.310	3.735*	2.266
Perceptions and Abuse	2.614	13.941***	7.147***	13.801***	4.022**
Three-Way Interactions					
Ethnicity, Perceptions, and Abuse	1.015	1.687	3.221**	2.152*	0.704

*p≤.05
**p≤.01
***p≤.001

Conflict Tactics Scale--Minor Violence and the Woman's Perceptions of Her Pregnancy

In the presence of abuse, the simple interaction effects indicated the minor violence scores were significantly ($p \leq .05$) influenced by the interaction of ethnicity and perception of pregnancy. No significant difference was found when abuse was absent.

Although the simple main effects indicated a significant ($p \leq .05$) difference between abused black, hispanic, and anglo women who accepted their pregnancy, the Scheffé post hoc test did not find any significant difference between ethnicities. This finding may be a result of the small number of women who were classified as accepting their pregnancy. Abused black women ($M = 22.0$) who expressed acceptance of their pregnancy scored higher on minor violence than abused hispanic ($M = 5.0$) and anglo ($M = 0.0$) women.

Abused anglo women who were ambivalent ($M = 27.4$) about their pregnancy scored significantly ($p \leq .05$) higher on their minor violence scores than abused black women ($M = 14.8$), and significantly ($p \leq .01$) higher than abused anglo women who were happy about their pregnancy. Abused anglo women who were upset ($M = 17.9$) about their pregnancy scored significantly ($p \leq .01$) higher on their minor violence scores

than abused anglo women who were happy (M = 4.8) about the pregnancy. Abused black women who were accepting (M = 22.0) of the pregnancy scored significantly ($p \leq .05$) higher on minor violence than abused black women who were happy (M = 4.5). Regardless of ethnicity, abused women who were ambivalent or upset about their pregnancy scored higher on their minor violence scores than abused women who were happy.

Conflict Tactics Scale--Severe Violence and the Woman's Perceptions of Her Pregnancy

The woman's severe violence scores were significantly ($p \leq .05$) affected by the interaction between the woman's perception of her pregnancy and her abuse status. The woman's ethnicity did not significantly effect her severe violence scores.

Abused women who were accepting, ambivalent, and expressed upset statements scored significantly ($p \leq .05$) higher on severe violence than nonabused women. No significant ($p \leq .05$) difference was found between abused and nonabused women who were happy about their pregnancy. Abused women who were ambivalent (M =15.1) or expressed upset statements (M = 11.6) scored significantly ($p \leq .01$) higher on their severe violence scores than abused women who were happy (M = 2.9). Regardless of ethnicity, abused women

who were upset or ambivalent about their pregnancy scored higher on severe violence than abused women who were happy.

Index of Spouse Abuse-Physical Violence and the Woman's Perceptions of Her Pregnancy

Although black, hispanic, and anglo women were found to significantly ($p \leq .05$) differ on their Index of Spouse Abuse-Physical Violence (ISAP) scores, the Scheffé post-hoc analysis yielded no significant difference. Anglo ($M = 8.8$) women scored higher on their ISAP scores than either black ($M = 5.6$) or hispanic ($M = 5.0$) women.

Abused women scored higher on their ISAP scores than nonabused women in all four of the perception themes. Abused women who were ambivalent ($M = 25.7$) or expressed upset statements ($M = 21.7$) about the pregnancy scored significantly ($p \leq .01$) higher on their ISAP scores than abused women who were happy ($M = 13.1$).

Regardless of their perception theme, abused women scored higher on their ISAP scores than nonabused women. In addition, abused women who were ambivalent or expressed upset statements about their pregnancy scored higher on their ISAP than happy, abused women.

Danger Assessment and the Woman's Perception of Her Pregnancy

The women significantly ($p \leq .05$) differed on their danger assessment scores by their ethnicity, perception of their pregnancy, and their abuse status. Abused ($M = 3.8$) women scored significantly ($p \leq .05$) higher on their danger assessment than nonabused ($M = 0.5$) women. Anglo ($M = 3.6$) women scored significantly ($p \leq .05$) higher on danger assessment than either black ($M = 1.6$) or hispanic ($M = 2.1$) women. Women, regardless of their abuse status, who expressed upset statements ($M = 3.2$) scored significantly higher on danger assessment than women who were happy ($M = 1.4$) about their pregnancy.

Regardless of abuse status, women reporting upset statements scored higher on their Danger Assessment scores than women who were happy. In addition, abused women scored higher than nonabused women.

Conflict Tactics Scale--Verbal Aggression and the Woman's Perceptions of Her Male Partner's Feelings About the Pregnancy

When evaluating how the woman perceived her male partner felt about the pregnancy, the women's verbal aggression scores significantly ($p \leq .05$) differed by the woman's ethnicity, how she perceived her male partner felt about the pregnancy, and her abuse status. No significant

interaction occurred between ethnicity, the woman's perceptions of her male partner's feelings about the pregnancy, and her abuse status.

Regardless of abuse status, the woman's ethnicity and perceptions of her male partner significantly affected the verbal aggression scores. Anglo ($\underline{M}$ = 26.2) women scored significantly ($\underline{p} \leq .05$) higher on their verbal aggression scores than hispanic women ($\underline{M}$ = 19.9). Women who perceived their male partner as being ambivalent ($\underline{M}$ = 47.6) about the pregnancy scored significantly ($\underline{p} \leq .01$) higher on verbal aggression than women who perceived their male partners as being happy ($\underline{M}$ = 12.2) or accepting ($\underline{M}$ = 19.0). Women who felt their male partner was upset ($\underline{M}$ = 47.6) about the pregnancy scored significantly ($\underline{p} \leq .01$) higher on verbal aggression than women who perceived their male partner as happy ($\underline{M}$ = 12.2), and significantly ($\underline{p} \leq .05$) higher on verbal aggression than women who expressed acceptance ($\underline{M}$ = 19.0) of the pregnancy. Women who perceived their male partner as being ambivalent or upset, regardless of abuse status, scored higher on their verbal aggression scores than women who perceived their male partner as being happy or accepting.

Conflict Tactics Scale--Minor Violence and the Woman's Perceptions of Her Male Partner's Feelings About the Pregnancy

When analyzing perceptions of the male partner, the women's minor violence scores were affected by an interaction between the woman's ethnicity and the woman's perceptions of her male partner. Abused women who perceived their male partner as being ambivalent (M = 29.5) about the pregnancy scored significantly ($p \leq .01$) higher on minor violence scores than abused women who perceived their male partner as being happy (M = 5.8) or accepting (M = 7.2) of the pregnancy, and significantly ($p \leq .05$) higher than those women who perceived their male partner as being upset (M = 15.9) about the pregnancy. Abused women who perceived their male partners as being upset about the pregnancy scored significantly ($p \leq .01$) higher on their minor violence scores than abused women who perceived their male partners as happy. Abused anglo women (M = 15.1) scored significantly ($p \leq .05$) higher on minor violence than abused black women (M = 5.8). Abused women who perceived their male partner as being ambivalent or upset about their pregnancy scored higher on their minor violence scores than abused women who were happy.

Conflict Tactics Scale--Severe Violence and the Woman's Perceptions of Her Male Partner's Feelings of the Pregnancy

For the abused woman, the male partner's theme significantly ($p \leq .01$) interacted with the woman's ethnicity to affect the woman's severe violence scores. No significant difference was found in the absence of abuse.

Abused black women who perceived their male partner as being ambivalent ($M = 24.3$) about the pregnancy scored significantly ($p \leq .05$) higher on severe violence than either abused hispanic ($M = 4.0$) or anglo ($M = 2.0$) women, and higher on severe violence than abused black women who perceived their male partner as being happy ($M = 2.2$), accepting ($M = 3.2$), or being upset ($M = 2.5$). Abused anglo women who perceived their male partner as being upset ($M = 19.5$) scored higher on severe violence than abused black women ($M = 2.5$) who perceived their male partner as being happy. Abused anglo women who perceived their male partner as being upset ($M = 19.5$) about the pregnancy scored significantly ($p \leq .01$) higher on severe violence than abused anglo women who perceived their male partner as being happy ($M = 3.1$) about the pregnancy.

For the abused black women, an ambivalent partner was associated with the highest severe violence scores. For the abused anglo women, an upset partner was associated with the

highest severe violence scores. Feelings of ambivalence or being upset are associated with higher severe violence scores than feelings of happiness.

Index of Spouse Abuse-Physical Violence and the Woman's Perceptions of Her Male Partner's Feelings About the Pregnancy

For the abused woman, the male partner's theme and her ethnicity interacted to effect the woman's ISAP scores. Abused hispanic (M = 29.6) and anglo (M = 33.7) women who perceived their male partner as being upset scored significantly ($p \leq .01$) higher on their ISAP scores than abused black women who perceived their male partner as being upset (M = 15.9).

Although the simple main effects indicated abused black women's ISAP scores significantly differed by the woman's perception of her male partner feelings, the Scheffé post hoc analysis did not yield any significant ($p \leq .05$) differences among the perception levels. Abused hispanic (M = 29.6) women who perceived their male partner as being upset (M = 29.6) about the pregnancy scored significantly ($p \leq .01$) higher on the ISAP than abused hispanic women who perceived their male partner as being happy (M = 2.8) or accepting (M = 1.5) of the pregnancy. Abused anglo women who perceived their male partner as being upset (M = 33.7) about the pregnancy scored significantly ($p \leq .05$) higher on

their ISAP scores than abused anglo women who perceived their male partner as being happy (M = 12.9) or accepting (M = 3.4) of the pregnancy. Abused anglo women who perceived their male partner as being ambivalent about the pregnancy scored significantly ($p \leq .05$) higher on their ISAP than abused anglo women who perceived their male partner as being accepting of the pregnancy. Regardless of ethnicity, abused women who perceived their male partner as being upset scored higher on their ISAP scores than abused women who perceived their male partner as being happy.

Danger Assessment and the Woman's Perceptions of Her Male Partner's Feelings About the Pregnancy

When analyzing the woman's perceptions of her male partner's feelings about the pregnancy, the woman's danger assessment scores significantly ($p \leq .05$) differed by ethnicity. Regardless of abuse status, anglo (M = 3.6) women scored significantly ($p \leq .05$) higher on the danger assessment than black (M = 1.6) or hispanic (M = 2.1) women.

For the abused woman, the danger assessment scores significantly differed by the male partner's theme. No significant difference occurred in the absence of abuse. Abused women who perceived their male partner as being upset (M = 5.0) scored significantly ($p \leq .01$) higher on the danger assessment than abused women who perceived their male

partner as being happy (M = 2.7) about the pregnancy, and significantly ($p \leq .05$) higher than women who perceived their male partner as accepting (M = 2.1) of the pregnancy. Regardless of abuse status, perceptions of a male partner as being upset were associated with higher Danger Assessment scores than perceptions of a male partner as being accepting or happy.

Summary of the Findings

The woman's ethnicity, how she felt about her pregnancy, how she perceived her male partner felt about the pregnancy, and her abuse status all interacted to varying degrees to influence the woman's scores on the Conflict Tactics Scale, Index of Spouse Abuse Scale, and Danger Assessment Scale. Abused and nonabused women differed significantly on all three instruments.

Abused anglo women who were upset or ambivalent about their pregnancy scored highest on their verbal aggression scores. Abused black women who accepted their pregnancy and abused anglo women who were ambivalent about their pregnancy scored highest on their minor violence scores. Regardless of ethnicity, abused women who were upset or ambivalent about their pregnancy scored highest on their severe violence and ISAP scores. In addition, regardless of their abuse status, anglo women and women who were upset about

about their pregnancy scored highest on the Danger Assessment scores.

Women, whether abused or not, who perceived their male partner as being ambivalent or upset scored higher on their verbal aggression and minor violence scores than women who perceived their male partner as happy, with anglo women scoring the highest of the three ethnicities. Abused black women who perceived their male partner as being ambivalent and abused anglo women who perceived their male partner as being upset scored highest on their severe violence scores. Abused women who perceived their male partner as being upset scored higher on their Danger Assessment scores than abused women who perceived their male partner as being accepting or happy. Abused anglo and hispanic women who perceived their male partners as being upset scored higher on their ISAP scores than abused anglo and hispanic women who perceived their male partner as being happy.

CHAPTER 5

SUMMARY OF THE STUDY

This study was a secondary data analysis which was designed to explore if a woman's perception of her pregnancy and how the woman perceived her male partner felt about the pregnancy could be associated with the woman's abuse status. Abuse was determined by the woman's responses on the Abuse Assessment Screen. If the woman had been hit, slapped, kicked, or otherwise physically or sexually abused during the 12 months prior to the pregnancy, she was classified as being abused.

Summary

An abused woman's first contact with a health care provider may occur when she becomes pregnant and seeks prenatal care (Parker & McFarlane, 1991). In this study, 454 black, hispanic and anglo women were interviewed for abuse on their first prenatal visit. During the woman's initial prenatal visit, she was asked in a private office to participate in the study. When the woman agreed to participate, five instruments were administered: the Abuse Assessment Screen, the Conflict Tactics Scale, Index of Spouse Abuse, the Danger Assessment, and an open-ended

questionnaire asking how the woman felt about her pregnancy and how she perceived her male partner felt about the pregnancy. These same instruments were administered during subsequent prenatal visits, but only the responses during the first prenatal visit were used in this study.

The woman's responses to the open-ended questionnaire were analyzed using ethnograph and direct analysis. Four themes were derived for both the woman's perceptions of the pregnancy and how she perceived her male partner felt about the pregnancy. The themes were happy, acceptance, ambivalence, and upset about the pregnancy.

Three questions appeared on the open-ended questionnaire: (1) Have you told your male partner you are pregnant? (2) If yes, what was HIS response? (3) What were YOUR feelings when you found out you were pregnant? Each response was assigned to a theme. The woman's abuse status and scores from the Conflict Tactics Scale, Index of Spouse Abuse-Physical (ISAP), and Danger Assessment were then placed under the appropriate themes. An analysis of variance (ANOVA) and Scheffé post-hoc tests were used to determine if the woman's abuse status could be associated with her perception of the pregnancy and how she perceived her male partner felt about the pregnancy.

The woman's ethnicity, perceptions of her pregnancy, how she perceived her male partner felt about the pregnancy, and her abuse status all interacted to affect her scores on the Conflict Tactics Scale, Index of Spouse Abuse, and Danger Assessment. In this study, abused women scored higher on ISAP and Danger Assessment than nonabused women. Abused women who were accepting, ambivalent, or upset about the pregnancy scored higher on severe violence and ISAP scores than nonabused women, and higher on severe violence and ISAP scores than abused women who were happy about the pregnancy.

Responses of the abused women also varied among and within the ethnic groups. Anglo women scored higher on danger assessment, verbal aggression, and ISAP than hispanic women and black women. Abused anglo women who were upset or ambivalent about the pregnancy scored higher on verbal aggression and minor violence than abused anglo women who were happy.

Abused black women scored higher on minor violence than either abused hispanic or anglo women. Abused black women who accepted their pregnancy scored higher on minor violence than abused black women who were happy.

Abused women who perceived their male partners as being upset about the pregnancy scored higher on their verbal aggression, minor violence, and danger assessment than

abused women who were happy, and higher on danger assessment than women who accepted their pregnancy. Abused women who perceived their male partner as being ambivalent scored higher on minor violence than abused women who perceived their male partner as being happy, accepting, or upset about the pregnancy. Also, abused women who perceived their male partner as being happy or upset scored higher on danger assessment than abused women who perceived their male partner as ambivalent.

Abused black women who perceived their male partner as being ambivalent about the pregnancy scored higher on their severe violence than either abused hispanic or anglo women, and higher than abused black women who perceived their male partner as happy, accepting, or upset about the pregnancy. Abused hispanic women who perceived their partner as being upset scored higher on ISAP than abused hispanic women who perceived their male partner as being happy or accepting of the pregnancy.

Abused anglo women who perceived their male partner as expressing upset statements about the pregnancy scored higher on their severe violence and ISAP scores than abused anglo women who perceived their male partner as being happy, higher on ISAP than those abused anglo women who perceived their male partner as accepting, and higher on severe

violence than abused black women who perceived their male partner as happy. Abused anglo women who perceived their male partner as being ambivalent of the pregnancy scored higher on their ISAP scores than abused anglo women who perceived their male partners as being accepting of the pregnancy.

Discussion of Findings

The results of this study have provided support for screening all women for abuse during their prenatal care. Findings from this study indicated that the woman's ethnicity, perceptions of her pregnancy, how she perceives her male partner feels about the pregnancy, and her abuse status all interact to influence her scores on the Conflict Tactics Scales, Index of Spouse Abuse, and Danger Assessment. At the current time, very little research exists in the realm of abuse during pregnancy, ethnicity, and perceptions of the pregnancy.

Abused women, especially abused anglo women, who are upset or ambivalent about their pregnancy experience more verbal and physical violence as evidenced by their scores on verbal aggression, minor violence, severe violence and ISAP than abused women who are happy. In addition, abused anglo women who were upset about their pregnancy scored higher on verbal aggression than either abused black and hispanic

women. Abused black women reported higher minor violence scores than either abused hispanic or anglo women.

Abused women, especially anglo women, who perceived their male partners as being upset or ambivalent about the pregnancy scored higher on their verbal aggression scores, minor violence, severe violence, danger assessment, and ISAP than abused women who saw their male partners as being happy or accepting of the pregnancy. Abused black women who perceived their male partner as being ambivalent scored higher on severe violence than abused hispanic and anglo women.

McFarlane, Parker, Soeken, and Bullock (1992) found physical abuse was 3.5 times greater for anglo women than black and hispanic women, and anglo women consistently scored higher on the Conflict Tactics Scale, the Index of Spouse Abuse, and the Danger Assessment Scale than black and hispanic women. The researchers also noted anglo women are more likely to experience a greater number of severe episodes of abuse.

Berensen, Stiglich, Wilkinson, and Anderson (1991) also found physical abuse occurred 1.6 times more frequently among anglo women than black women. In addition, their anglo sample had a higher incidence of physical abuse followed by hispanic women, then black women.

Straus, Gelles, and Steinmetz (1980) noted abuse was 400% more prevalent in blacks than whites. Lia-Hoagberg et al. (1990) reported black and American Indian women had a higher incidence of unhappiness and/or ambivalence towards their pregnancies.

In this study, anglo women reported higher danger assessment scores than either black or hispanic women. Other studies have found blacks make up 45.4% of all spouse homicide victims, with blacks having a rate 8.4 times greater than whites (Mercy & Saltzman, 1989).

Feminist research empowers women by emphasizing their personal strengths, validating everyday experiences, and providing information to improve their lives. This research was a triangulated study which blended qualitative and quantitative research to identify clinical indicators which can alert a clinician to the woman's abuse status. Abused women, regardless of their ethnicity, can be identified through their perceptions of the pregnancy and their male partner's perceptions of the pregnancy. Clinicians must learn to listen to these women's voices and empower them with self-worth and information. If a woman tells the clinician either she or her male partner is unhappy or ambivalent about the pregnancy, it is the clinician's

responsibility to explore the woman's abuse status and provide her with information to improve her quality of life.

Clinicians must recognize that any feelings other than happiness about the pregnancy can mean abuse. And, not only may these feelings be associated with abuse, but they may indicate an increase in severity and frequency of abuse. There is no stereotype for abuse during pregnancy. Therefore, only through recognizing the value, self-worth, and uniqueness of each pregnant woman can clinicians improve these women's lives.

Conclusions and Implications

Within the limitations of this study and based on the findings, the following conclusions were derived as significant:

1. Abused and nonabused women differed in all four perception themes.
2. Abused women who perceived their male partner as happy or accepting of the pregnancy differed from nonabused women.
3. Abused women who were accepting, ambivalent, and expressed upset statements scored higher on instruments measuring frequency and severity of physical violence than nonabused women.

4. Abused women who perceived their male partner as being ambivalent or upset scored higher on instruments measuring frequency and severity of physical violence than nonabused women.
5. Abused women who were ambivalent or upset about the pregnancy scored higher on instruments measuring frequency and severity of physical violence than abused women who are happy about their pregnancy.
6. Abused women who perceived their male partner as being ambivalent or upset about the pregnancy scored higher on instruments measuring frequency and severity of physical abuse than abused women who perceived their male partners as being happy or accepting.
7. Abused anglo women who expressed upset or ambivalent statements or whose male partners felt ambivalent have higher scores on the Conflict Tactics Scales when compared to abused black and hispanic women.
8. Abused anglo and hispanic women who perceived their male partner as upset scored higher on the Index of Spouse Abuse-Physical scale than abused anglo and hispanic women who were happy or accepting of the pregnancy.
9. Abused black women who are ambivalent about their pregnancy have higher severe violence scores than abused hispanic and anglo women or abused black women who

perceived their male partner as happy, accepting, or upset.

The results of this study indicate that a woman's perceptions of her pregnancy and how she perceives her male partner feels about the pregnancy are associated with both abuse status and for the abused woman's frequency and severity of abuse.

From the conclusions of this study, the following implications were determined:

1. All women should be screened for abuse during their prenatal visits using the Abuse Assessment Screen and asked about their feelings and their male partners' feelings regarding the pregnancy.
2. Abused women who expressed feelings other than happiness or have male partners who are perceived as being other than happy are more likely to be abused.
3. Abused women who express statements of being upset or ambivalent experience more frequent and severe abuse compared to abused women who expressed happy or accepting feelings.
4. Health care providers must learn to listen and become sensitive to women's feelings about their pregnancy in hopes of identifying the abused women.

Recommendations for Future Study

From the findings of this study, the following recommendations are made:

1. Multiple regression and discriminant analysis should be used to re-analyze instruments and data from this study to determine the probability of abuse in association with the woman's perceptions of pregnancy and how she perceives her male partner feels about the pregnancy.
2. Findings of this study should be provided to nurses, educators, and other health care providers through publications in professional journals and presentations at professional conferences.
3. All prenatal clinics should devise programs to screen their patients for abuse and the woman's associated feelings about the pregnancy.
4. Research should be done using the woman's scores on each of the instruments from each prenatal visit to determine if the perceptions of pregnancy and woman's abuse status changed throughout the pregnancy.
5. Research should be done to determine if the trimester of the woman's first prenatal visit can be associated with her abuse status, scores on the instruments, the woman's perceptions of her pregnancy, and how the woman perceives her male partner feels about the pregnancy.

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APPENDIX A

QUESTIONNAIRE PACKET

CODE NUMBER _____

The following form is to be completed by the nurse on all NEW prenatal clients. EDC_____

PRENATAL INTENTIONAL INJURY STUDY
(First Trimester)

CODE

NAME_____ SOC. SEC. NUMBER _____
(please print)

TODAY'S DATE_____ LAST MENSTRUAL PERIOD _____ _____

AGE_____ _____

ETHNICITY: Black ☐ Hispanic ☐ White ☐ Other ☐ _____

PARITY: Primagravida ☐ Multiparity ☐ _____

INCOME: Below Poverty ☐ Above Poverty ☐ _____

ABUSE ASSESSMENT SCREEN (Circle YES or No for each question.)

1. Have you ever been emotionally or physically abused by your partner or someone important to you?.....YES NO _____

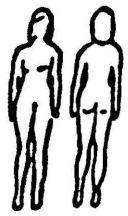
2. WITHIN THE LAST YEAR, have you been hit, slapped, kicked or otherwise physically hurt by someone?.....YES NO _____

   If YES, by whom (circle all that apply)
   Husband Ex-husband Boyfriend Stranger Other Multiple _____
   Total Number of times_____ _____

3. SINCE YOU'VE BEEN PREGNANT, Have you been hit, slapped, kicked or otherwise physically hurt by someone?.....YES NO _____

   If YES, by whom (circle all that apply)
   Husband Ex-husband Boyfriend Stranger Other Multiple _____
   Total Number of times_____ _____

Mark the area of injury on the body map _____



Score each incident according to the following scale:

1 = Threats of abuse including use of a weapon Score _____
2 = Slapping, pushing; no injuries and/or lasting pain Score _____
3 = Punching, kicking, bruises, cuts and/or continuing pain Score _____
4 = Beating up, severe contusions, burns, broken bones Score _____
5 = Head injury, internal injury, permanent injury Score _____
6 = Use of weapon; wound from weapon

(If any of the descriptions for the higher number apply, use the higher number).

4. WITHIN THE LAST YEAR, has anyone forced you to have sexual activities?.....YES NO _____

   If YES, by whom (circle all that apply)
   Husband Ex-husband Boyfriend Stranger Other Multiple _____
   Total Number of times_____ _____

5. Are you afraid of your partner or anyone you listed above?...YES NO _____

1. Invite the woman to participate in the study. (See attached consent form)
2. Administer Index of Spouse Abuse and Conflict Tactics Scale (attached)

If the woman answers YES to questions **2, 3 or 4**, administer the Danger Assessment
Give and explain use of the Abuse Calendar to All women
Give all women the March of Dimes Brochure: Are You in a Safe Relationship along with your name and clinic phone number as the contact nurse (attached)

Name of Nurse Completing Form_____

ID# _____

(First Trimester)
The Conflict Tactics Scale
(Straus, 1979)

No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or just have spats or fights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read a list of some things that your (husband/partner) might have done when you had a dispute, and would first like you to tell me for each one how often your (husband/partner) did it in the past year and second, how often it has ever happened.

	Husband/Partner - In Past Year								Ever Happened		
	Never	Once	Twice	3 - 5 Times	6 - 10 Times	11 - 20 Times	More than 20 Times	Don't Know	Yes	No	Don't Know
a. Discussed the issue calmly	0	1	2	3	4	5	6	X	1	2	X
b. Got information to back up (your/his) side of things	0	1	2	3	4	5	6	X	1	2	X
c. Brought in or tried to bring in someone to help settle things	0	1	2	3	4	5	6	X	1	2	X
d. Insulted or swore at the other one	0	1	2	3	4	5	6	X	1	2	X
e. Sulked and/or refused to talk about it	0	1	2	3	4	5	6	X	1	2	X
f. Stomped out of the room or house (or yard)	0	1	2	3	4	5	6	X	1	2	X
g. Cried	0	1	2	3	4	5	6	X	1	2	X
h. Did or said something to spite the other one	0	1	2	3	4	5	6	X	1	2	X
i. Threatened to hit or throw something at the other one	0	1	2	3	4	5	6	X	1	2	X
j. Threw or smashed or hit or kicked something	0	1	2	3	4	5	6	X	1	2	X
k. Threw something at the other one	0	1	2	3	4	5	6	X	1	2	X
l. Pushed, grabbed, or shoved the other one	0	1	2	3	4	5	6	X	1	2	X
m. Slapped the other one	0	1	2	3	4	5	6	X	1	2	X
n. Kicked, hit, or hit with a fist	0	1	2	3	4	5	6	X	1	2	X
o. Hit or tried to hit with something	0	1	2	3	4	5	6	X	1	2	X
p. Beat up the other one	0	1	2	3	4	5	6	X	1	2	X
q. Threatened with a knife or gun	0	1	2	3	4	5	6	X	1	2	X
r. Used a knife or gun	0	1	2	3	4	5	6	X	1	2	X
s. Other: _____	0	1	2	3	4	5	6	X	1	2	X

Code Number _____

INDEX OF SPOUSE ABUSE
(First Trimester)

This questionnaire is designed to measure the degree of abuse you have experienced with your partner. It is not a test, so there are no right or wrong anwers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1. Never 2. Rarely 3. Occasionally 4. Frequently 5. Very Frequently

Please begin.

1. My partner belittles me. ..... _____
2. My partner demands obedience to his whims. ..... _____
3. My partner becomes surly and angry if I tell him he is drinking too much. ..... _____
4. My partner makes me perform sex acts that I do not enjoy or like. ..... _____
5. My partner becomes very upset if dinner, housework or laundry is not done when he thinks it should be. ..... _____
6. My partner is jealous and suspicious of my friends. ..... _____
7. My partner punches me with his fists. ..... _____
8. My partner tells me I am ugly and unattractive. ..... _____
9. My partner tells me I really couldn't manage or take care of myself without him. ..... _____
10. My partner acts like I am his personal servant. ..... _____
11. My partner insults or shames me in front of others. ..... _____
12. My partner becomes very angry if I disagree with his point of view. ..... _____
13. My partner threatens me with a weapon. ..... _____
14. My partner is stingy in giving me enough money to run our home. ..... _____
15. My partner belittles me intellectually. ..... _____
16. My partner demands that I stay home to take care of the children. ..... _____
17. My partner beats me so badly that I must seek medical help. ..... _____
18. My partner feels that I should not work or go to school. ..... _____
19. My partner is not a kind person. ..... _____
20. My partner does not want me to socialize with my female friends. ..... _____
21. My partner demands sex whether I want it or not. ..... _____
22. My partner screams and yells at me. ..... _____
23. My partner slaps me around my face and head. ..... _____
24. My partner becomes abusive when he drinks. ..... _____
25. My partner orders me around. ..... _____
26. My partner has no respect for my feelings. ..... _____
27. My partner acts like a bully towards me. ..... _____
28. My partner frightens me. ..... _____
29. My partner treats me like a dunce. ..... _____
30. My partner acts like he would like to kill me. ..... _____

Code Number _____

DANGER ASSESSMENT
(First Trimester)

Several risk factors have been associated with homicides (murder) of both batterers and battered women in research which has been conducted after the killings have been taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation. (The "he" in the questions refers to your husband, partner, ex-husband, ex-partner or whoever is currently physically hurting you).

Please check YES or NO for each question below.

YES	NO		
___	___	1.	Has the physical violence increased in frequency over the past year?
___	___	2.	Has the physical violence increased in severity over the past year and/or has a weapon or threat with weapon been used?
___	___	3.	Does he ever try to choke you?
___	___	4.	Is there a gun in the house?
___	___	5.	Has he ever forced you into sex when you did not wish to do so?
___	___	6.	Does he use drugs? by drugs I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs, heroin, or mixtures.
___	___	7.	Does he threaten to kill you and/or do you believe he is capable of killing you?
___	___	8.	Is he drunk every day or almost every day? (In terms of quantity of alcohol).
___	___	9.	Does he control most of all of your daily activities? For instance, does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here ____).
___	___	10.	Have you ever been beaten by him while you were pregnant? (If never pregnant by him, check here _____).
___	___	11.	Is he violently and constantly jealous of you? (For instance, does he say, "If I can't have you, no one can").
___	___	12.	Have you ever threatened or tried to commit suicide?
___	___	13.	Has he ever threatened or tried to commit suicide?
___	___	14.	Is he violent outside of the home?

TOTAL YES ANSWERS

THANK YOU. PLEASE TALK TO YOUR NURSE, ADVOCATE OR COUNSELOR ABOUT WHAT THE DANGER ASSESSMENT MEANS IN TERMS OF YOUR SITUATION.

Code Number_____

Prenatal Intentional Injury Study
(First Trimester)

Code

Have you told your male partner you are pregnant? Yes_____ No_____ _____

If yes, what was **HIS** response?

What were **YOUR** feelings when you found out you were pregnant?

CODE NUMBER _____

The following form is to be completed by the nurse on all NEW prenatal clients.

EDC_____

PRENATAL INTENTIONAL INJURY STUDY
(First Trimester)

CODE

NAME_____ SOC. SEC. NUMBER _____
(please print)

TODAY'S DATE_____ LAST MENSTRUAL PERIOD _____ ____

AGE_____ ____

ETHNICITY: Black ☐ Hispanic ☐ White ☐ Other ☐ ____

PARITY: Primagravida ☐ Multiparity ☐ ____

INCOME: Below Poverty ☐ Above Poverty ☐ ____

ABUSE ASSESSMENT SCREEN (Circle SI or No for each question).

1. ¿Ha sido emocionalmente o físicamente abusada por su compañero o por alguien especial?.....SI NO ____

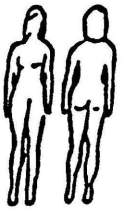
2. Durante el año pasado, ha sido golpeada, bofeteada, pateada or dañada físicamente por alguien?.....SI NO ____

Si la respuesta es SI, por quien. (Circule todos los que se apliquen).
Esposo Ex-esposo Amigo Estraño Otro ____
Número de veces_____ ____

3. Desde el embarazo, ha sido golpeada, bofeteada, pateada or dañada físicamente por alguien?.....SI NO ____

Si la respuesta es SI, por quien. (Circule todos los que se apliquen).
Esposo Ex-esposo Amigo Estraño Otro ____
Número de veces_____ ____

Marque las areas de daño en el mapa del cuerpo. ____



Score each incident according to the following scale:

1 = Threats of abuse including use of a weapon
2 = Slapping, pushing; no injuries and/or lasting pain — Score ____
3 = Punching, kicking, bruises, cuts and/or continuing pain — Score ____
4= Beating up, severe contusions, burns, broken bones — Score ____
5= Head injury, internal injury, permanent injury — Score ____
6 = Use of weapon; wound from weapon — Score ____

4. Durante el año pasado, ha sido forzada a tener actividades sexsuales?..... SI NO ____

Si la respuesta es SI, por quien. (Circule todos los que se apliquen).
Esposo Ex-esposo Amigo Estraño Otro ____
Número de veces_____ ____

5. ¿Le tiene miedo a su compañero o a alguna otra persona que ha circulado en alguna de las preguntas anteriores?.....SI NO ____

1. Invite the woman to participate in the study. (See attached consent form)
2. Administer Index of Spouse Abuse and Conflict Tactics Scale (attached)
If the woman answers YES to questions **2, 3 or 4,** administer the DangerAssessment
Give and explain use of the Abuse Calendar to All women
Give all women the March of Dimes Brochure: Are You in a Safe Relationship along with your name and clinic phone number as the contact nurse (attached)

Name of Nurse Completing Form_____

Numero de Codiga_____

(Primer Trimestre)
Escala Táctica De Conflictos
(Straus, 1979)

No importa que bien se lleve una pareja, hay momentos cuando la pareja no está de acuerdo sobre decisiones mayores, está incómoda por algo que hizo la otra persona, o nada más se disputan o pelean porque estan de mal humor cansados o por alguna otra razón. Las parejas también usan muchas maneras de arreglar sus diferencias. Yo voy a leerle una lista de cosas que puede que su esposo o compañero le haya hecho cuando tuvieron una disputa, y me gustaría primero que usted me diga en cada una de las preguntas con que frecuencia sucedió durante el año pasado y segundo si ha sucedido antes.

		Esposo/Compañero- Durante el Ano Pasado								¿Ha pasado antes?		
		Nunca	Una Vez	Dos Vezes	3-5 Vezes	6-10 Vezes	11-20 Vezes	Masde 20 Vezes	No sé	Sí	No	No sé
a.	¿Discutío calmadamente?	0	1	2	3	4	5	6	X	1	2	X
b.	¿Buscó información para afirmar el punto de vista de él o el suyo?	0	1	2	3	4	5	6	X	1	2	X
c.	¿Trajo o trató de traer a alguien para ayudar a arreglar las cosas?	0	1	2	3	4	5	6	X	1	2	X
d.	¿La insultó o la maldijo?	0	1	2	3	4	5	6	X	1	2	X
e.	¿Se enfurruñó o rehusó hablar del problema?	0	1	2	3	4	5	6	X	1	2	X
f.	¿Se salió de la habitacíon, o de la casa, o del patio?	0	1	2	3	4	5	6	X	1	2	X
g.	¿Lloró?	0	1	2	3	4	5	6	X	1	2	X
h.	¿Hizo o dijo algo para incomodarla?	0	1	2	3	4	5	6	X	1	2	X
i.	¿La amenazó con golpearla o tirarle algo?	0	1	2	3	4	5	6	X	1	2	X
j.	¿Tiró, aplastó, golpeó o pateó algo?	0	1	2	3	4	5	6	X	1	2	X
k.	¿Le tiró algo?	0	1	2	3	4	5	6	X	1	2	X
l.	¿La empujó, la agarró, o la tiró?	0	1	2	3	4	5	6	X	1	2	X
m.	¿La abofeteó?	0	1	2	3	4	5	6	X	1	2	X
n.	¿La pateó, la golpeó o le dió un piñazo?	0	1	2	3	4	5	6	X	1	2	X
o.	¿La golpeó o trato de golpearla con algo?	0	1	2	3	4	5	6	X	1	2	X
p.	¿Le dió una paliza?	0	1	2	3	4	5	6	X	1	2	X
q.	¿La amenzó con un cuchillo o una pistola?	0	1	2	3	4	5	6	X	1	2	X
r.	¿Usó un cuchillo o una pistola?	0	1	2	3	4	5	6	X	1	2	X
s.	¿Alguna otra cosa?	0	1	2	3	4	5	6	X	1	2	X

Numero de Código_____

Indice De Abuso Cónyugal
(Primer Trimestre)

Este cuestionario está diseñado para medir el grado de abuso que usted ha experimentado con su compañero. No es un examen, no hay ningunas respuestas correctas o incorrectas. Responda cada pregunta cuidadosamente y con exactitud colocando un número al lado de cada pregunta que sigue dependiendo de la frecuencia con que haya sucedido.

1. Nunca 2. Raramente 3. Ocasionalmente 4. Frecuentemente 5. Muy Frecuentemente

Empieze porfavor

1. Mi compañero me rebaja. ..... _____
2. Mi compañero me exije obediencia a sus antojos. ..... _____
3. Mi compañero se pone insolente y enojado si yo le digo que él ésta bebiendo demasiado..... _____
4. Mi compañero me hace hacer actos sexuales que no me complacen o no me gustan..... _____
5. Mi compañero se enoja si la cena, el trabajo de la casa, o el lavado de la ropa no está hecho cuando él piensa que debería estar hecho..... _____
6. Mi compañero es celoso y sospecha de mis amigos. ..... _____
7. Mi compañero me golpea con sus puños..... _____
8. Mi compañero me dice que soy inatractiva y fea..... _____
9. Mi compañero me dice que yo no me pudiera administrar o cuidar sin él..... _____
10. Mi compañero actúa como si yo fuera la sirvienta de él..... _____
11. Mi compañero me insulta o me deshonra en frente de otros..... _____
12. Mi compañero se enoja si no estoy de acuerdo con él..... _____
13. Mi compañero me amenaza con armas..... _____
14. Mi compañero es mezquino con el dinero para mantener la casa..... _____
15. Mi compañero me rebaja intelectualmente..... _____
16. Mi compañero me exije que me quede en la casa para cuidar los niños..... _____
17. Mi compañero me golpea tanto que tengo que buscar ayuda médica..... _____
18. Mi compañero piensa que no debería trabajar o ir a la escuela..... _____
19. Mi compañero no es una persona amable..... _____
20. Mi compañero no quiere que me socialice con mis amigas..... _____
21. Mi compañero me exije sexo quiera yo o no..... _____
22. Mi compañero me grita..... _____
23. Mi compañero me abofetea en la cara y en la cabeza..... _____
24. Mi compañero se pone abusivo cuando bebe..... _____
25. Mi compañero me da órdenes..... _____
26. Mi compañero no respeta mis sentimientos..... _____
27. Mi compañero actúa bruscamente conmigo..... _____
28. Mi compañero me da miedo..... _____
29. Mi compañero me trata como una tonta..... _____
30. Mi compañero actúa como si quisiera matarme..... _____

Code Number_____

EVALUACION DE DAÑOS
(Primer Trimestre)

Varios factores de riesgo han sido asociados con homicidios (asesinatos) en ambos el abusador o la mujer abusada en estudios realizados despues de haber ocurridas las muertes. No podemos predecir que sucederá en su caso, pero me gustaría advertirle del peligro de homicidio en situaciones de abuso severo y que usted se de cuenta de cuantos factores de riesgo se aplican en su situación. (En las siguientes preguntas cuando hablamos de "él" nos estamos refiriendo a su marido, compañero, ex-marido, ex compañero o quienquiera que la este actualmente dañandola físicamente).

Por favor margue SI o NO a cada una de las preguntas que siguen abajo.

SI	NO	
____	____	1. ¿Ha aumentado la violencia física durante el año pasado?
____	____	2. ¿Ha aumentado en severidad la violencia física durante el año pasado y/o ha sido amenazada con un arma o ha sido un arma usada en usted?
____	____	3. ¿Ha tratado él de asfixiarla?
____	____	4. ¿Hay alguna arma de fuego en su casa?
____	____	5. ¿La ha forzado él a tener relaciones sexuales en contra de su voluntad?
____	____	6. ¿Usa él drogas? Por drogas me refiero a "exitantes" o afetaminas, "speed," polvo de angel, cocaina, crack, drogas de la calle, heroína, o mezclas.
____	____	7. ¿La amenaza él con matarla o cree usted que él es capaz de matarla?
____	____	8. ¿Se emborracha él todos los días o casi todos los días? (En relación con el alcohol).
____	____	9. ¿Controla él la mayoria de sus actividades diarias? Por ejemplo, le dice él quienes pueden ser sus amigos, o cuanto dinero puede llevar cuando va de compras, o cuando puede usar el coche? (Si él trata, pero usted no lo deja, marque aquí_____).
____	____	10. ¿Ha sido usted golpeada cuando estaba embarazada? (Si no ha estada embarazada de él, marque aquí_____).
____	____	11. ¿Es él violento, o constantemente celoso de usted? Por ejemplo le dice él: "Si no eres mía no vas a serlo de nadie."
____	____	12. ¿Ha usted amenazado o ha usted tratado con suicidarse?
____	____	13. ¿Ha tratado o amenazado él con suicidarse?
____	____	14. ¿ Es él violento fuera de la casa?

Total de respuestas SI_____

GRACIAS. POR FAVOR HABLE CON SU ENFERMERA, BUSQUE SOPORTE O CONSEJO SOBRE LO QUE LA EVALUACION DE DAÑO SIGNIFICA EN SU CASO.

Numero de Código_____

Estudio De Daño Intencional Prenatal
(Primer Trimestre) Código

¿Le ha dicho a su compañero
que está embarazada? Si _____ No_____ _____

¿Si la respuesta es afirmativa, cual fué la respuesta de él?

¿Como usted tomo la noticia de que estaba embarazada?

APPENDIX B

EXPLANATION OF THE STUDY

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
COLLEGE OF NURSING
Houston Center, 1130 M.D. Anderson Blvd., Houston, Texas 77030 713/794-2102

Dear Participant:

You are invited to participate in a research study on violence during pregnancy and the impact on the health of the mother and the baby. The goal of this study is to provide better prenatal care for future pregnant women.

Participation will mean talking with a nurse and completing three questionnaires. The total process will take approximately 30 minutes today and at two future prenatal visits. In addition, you may be asked to keep track of any violent incidents that occur between your visits on a specially developed calendar. The calendar should be kept confidential in the home setting, since disclosure of it might precipitate violence from your partner. Talking about the violence to a partner may contribute to violent behavior by the partner.

The only possible risk of participating in this study is that talking about violence in your relationship may be upsetting. You may stop and talk about your feelings at any time. In addition, you will be provided with information about local services that are available to deal with violence.

You will not be asked any direct questions about physical violence towards your children. However, you need to know that if during the interview you choose to talk about child abuse in your home, the law states that we must report suspicion of child abuse to Protective Services. If this happens, we will talk with you further about the reporting process. Other than suspected child abuse, all information you tell us will be confidential.

The State of Texas does not have a mandatory reporting law for reporting suspected spouse abuse. This means that what you tell us regarding abuse by a partner or boyfriend will not be reported to the police.

Only the nurse in the clinic and the researcher will have access to the data you are providing. If anyone else asks about this study they will not be told about what we are studying or whether or not you are involved. Your name will not be used in anything that we discuss or write about the research. Only an ID number will be used on questionnaires. All completed questionnaires will be kept in a locked file to which only the researchers have access. Participation in this study is strictly voluntary. You can choose to participate or withdraw at any time. If you choose to withdraw, there will be no penalty, loss of benefits or services or change in prenatal care. You will be compensated for your time by receiving $10.00 for each interview.

NO MEDICAL SERVICE OR COMPENSATION IS PROVIDED TO SUBJECTS BY THE TEXAS WOMAN'S UNIVERSITY AS A RESULT OF INJURY FROM PARTICIPATION IN RESEARCH.

I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRES CONSTITUTES MY INFORM CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

Judith McFarlane, R.N., C., Dr. P.H.
Phone 713/794-2138

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
COLLEGE OF NURSING
Houston Center, 1130 M.D. Anderson Blvd., Houston, Texas 77030 713/794-2102

Querida Participante:

Usted está invitada a participar en un estudio de investigación sobre violencia durante el embarazo y el impacto a la salud de la madre y del bebé. La meta de ésta estudio es proveer un mejor cuidado prenatal para las futuras mujeres embarazadas.

La participación consistirá en hablar con una enfermera y completar tres cuestionarios. El proceso total tomará aproximadamente treinta minutos en el día de hoy y en otras dos futuras visitas prenatales. Además, puede que se le pida que mantenga un diario de cualquier incidente de violencia que ocurra entre sus visitas en un calendario preparado especialmente para ello. El calendario deberá ser mantenido confidencial en la casa, puesto que pueda que precipite una violencia al saberlo su compañero. El hablar de los actos de violencia con su compañero pueda que contribuyan a la violencia de su compañero.

El único riesgo posible que usted tiene al participar en este estudio es que el hablar de la violencia en sus relaciones puede que la altere. Usted puede parar de hablar de sus sentimientos en cualquier momento que usted lo desee. Usted también recibirá información de los servicios locales que hay disponibles para tratar los casos de violencia.

No se le harán preguntas directas acerca de la violencia con los niños. Sin embargo, usted necesita saber que si durante la entrevista usted desea hablar del abuso al niño en su casa, la ley nos exige que reportemos casos sospechosos de abuso al niño a los Servicios de Protección. Si esto sucediera, nosotros hablarí amos con usted del proceso de reporte. Cualquier otra cosa que usted nos diga, exceptuando el abuso al niño, será mantenido confidencial.

El Estado de Texas no tiene ninguna ley que exija reportar casos sospechosos de abuso a la esposa. Esto quiere decir que lo que usted nos diga concerniente al abuso de su compañero o amigo no será reportado a la policía.

Solamente la enfermera en la clínica y la persona haciendo el estudio tendrán acceso a la información que usted nos dé. Si alguien nos pregunta sobre este estudio no recibirá información sobre lo que estamos estudiando o si usted está involucrada. Su nombre no será usado en nada que nosotros discutamos o escribamos en nuestro estudio. Solo un número de identificación será usado en los cuestionarios. Todos los cuestionarios completos serán guardados en un archivo con llave al cual solamente tendrán acceso las personas haciendo el estudio. La participación en este estudio es completamente voluntario. Usted puede participar o dejar de participar en cualquier momento. Si usted deja de participar usted no tendrá ninguna penalidad, pérdida de beneficios o servicios o cambios en el cuidado prenatal. Usted recibirá una compensación de $10.00 por cada entrevista.

EL TEXAS WOMAN'S UNIVERSITY NO PROVEE SERVICIO MEDICO O DE COMPENSACION A NINGUNA PERSONA POR DAÑOS RECIBIDOS COMO RESULTADO DE PARTICIPAR EN ESTE ESTUDIO.

YO ENTIENDO QUE EL RETORNAR MIS CUESTIONARIOS CONSTITUYE MI CONSENTIMIENTO PARA ACTUAR COMO PARTICIPANTE EN ESTE ESTUDIO.

Judith McFarlane, R.N., C., Dr. P.H.
Teléfono 713/794-2138