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THE WAVERING LINE IN THE SAND: THE EFFECTS OF DOMESTIC VIOLENCE AND SEXUAL COERCION

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Control and power regarding sexuality and fertility challenges many women, especially those involved in abusive relationships. This preliminary study was done to explore the relationship between domestic violence, sexual coercion, and pregnancy. The sample was comprised of community-dwelling women attending support groups for survivors of abuse, and women attending group therapy sessions while housed at a battered woman's shelter. Both questionnaires and focus groups addressed the women's experiences with contraception, sexuality, pregnancy, and domestic violence. Only the qualitative phase of the study, plus demographics from the questionnaires, are presented in this article. The responses suggest that many of the women felt they could not avoid intercourse with their abusers, despite fears of pregnancy. Focus group transcript analysis revealed recurrent themes of problems regarding pregnancy, tactics of abuse, inability to access birth control, and denial and mistrust. This article explores the reality these women face and the thought processes they employ to survive and remain in their relationship. Health care providers can use this information to better understand their clients, to assist them in obtaining and using effective contraception, and to support clients as they make their decisions.

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The nature of sexual relationships has not been fully explored and, in our ignorance, many assumptions are made by health care providers. Among those assumptions is the idea that each act of intercourse is made with complete consent of both parties and may therefore be easily preceded by discussions of safe sex, condom application, and other contraceptive use. In reality, many sexual acts between partners are forced, unwanted, and sometimes violent. Just as the true scope of abuse experienced by women is not known, it is not known how pervasive forced or coercive sex is in the general population. Some estimates suggest that half of all women will experience some abuse in their lives, with possibly 3% to 25% living as battered women. Women in established abusive relationships are known to be at risk for sexual abuse (Campbell, 1989, 2002; Campbell & Alford, 1989; Campbell & Soeken, 1999). Until this problem is fully understood, health care providers cannot provide appropriate teaching, counselling, and contraception prescriptions to many of their clients.

REVIEW OF LITERATURE

Rape, sexual coercion, denial of access to contraception, put-downs, and forced sex acts all constitute sexual abuse (American Medical Association [AMA], 1992). Sexual abuse can exist in isolation, one bleak aspect of a coupling, or can be part of a larger pattern of abuse which includes physical and emotional aspects. Teens report more physical and/or sexual abuse than adults during pregnancy (Martin, Mackie, Kupper, Buescher, & Moracco, 2001; Parker, McFarlane, Soeken, Torres, & Campbell, 1993). Focusing on the lifetime history of abuse in girls who become pregnant as teens increases that percentage dramatically. Studies have shown up to 62% of pregnant adolescents had a history of sexual abuse (Berenson, San Miguel, & Wilkinson, 1992; Boyer & Fine, 1992; Gershenson et al., 1989; Gessner & Perham-Hester, 1998; Jacoby, Gorenflo, Black, Wunderlich, & Eyler, 1999; Kenny, Reinholtz, & Angelini, 1997; Roosa, Tein, Reinholtz, & Angelini, 1997). These studies suggest that sexual abuse may be associated with altered attitudes and practices towards sex by its victims (Heise, Ellsberg, & Gottemoeller, 1999). Girls who have been exploited in this way are more likely to find themselves again exploited, for example, as prostitutes (Widom & Kuhns, 1996) or with unintended pregnancies (Deitz et al., 1999; Jacoby et al., 1999). Being abused when younger could inhibit the development of a sense of self and personal power (Chandy, Blum, & Resnick, 1996; Lanz, 1995), creating instead the belief that any future abuse is inevitable,

or it could be an effort to gain control over the childhood experience where they felt violated (Heise, Ellsberg, & Gottlemoeller, 1999). Other studies have reported a connection between lowered self-esteem and increased psychological pathology with all forms of childhood sexual abuse (Gise & Paddison, 1988; Lungerg-Love, Marmion, Ford, Geffner, & Peacock, 1992), which may affect decisions women make in the future.

Being able to access and use contraceptives effectively is intimately connected to a woman's experience of battering. Wingood and DiClemente (1997) found that African American women in abusive relationships are less likely to use condoms or ask their partners to use condoms than women in nonviolent relationships, because the women experience more verbal and emotional abuse when they do. Studies have shown battered women are significantly at a higher risk for sexually transmitted diseases (STDs) and other infectious diseases such as AIDS (Augenbraun, Wilson, & Allister, 2001; Bohn, 2002; Campbell, 2002; Campbell & Soeken, 1999; Eby, Campbell, Sullivan, & Davidson, 1995; Martin, Kilgallen et al., 1999; Martin, Matza et al., 1999), which could be prevented by using condoms. The inability for battered women to negotiate safe sex is part of the coercive control of abusers.

Coercive control over a woman's sexuality and fertility can also be seen in unintended pregnancies. Seventy percent of women who reported violence in the four-state Pregnancy Risk Assessment Monitoring System (PRAMS) study had unwanted or mistimed pregnancies (Gazmarian et al., 1995). The risk of physical violence may increase towards women in pregnancy (Gelles, 1988), but in Gazmarian et al.'s study, the risk was four times greater for women with unwanted or mistimed pregnancies. This study could not separate what came first, the abuse or the pregnancy, because in the questionnaire subjects were asked about violence in the 12 months before the pregnancy.

One potential solution to the inability to use birth control may be for women to seek tubal ligations, IUDs, or Depo-Provera, all forms of birth control which do not involve partners. The study by Martin, Kilgallen et al. (1999) cited a study that suggested that female sterilization rates may be higher in couples in which the male is abusive. Glander, Moore, Michielutte, and Parsons (1998) found that many women seeking abortions have abuse histories and are significantly less likely than nonbattered women to inform their partner of the pregnancy and the termination.

Once pregnant, battered women may face obstacles to prenatal care. One multicentered study showed that battered women seek care an average of 6.5 weeks later than nonbattered women (Taggart & Mattson,

1996), which mirrored the findings of McFarlane, Parker, Soeken, and Bullock (1992), who found that battered women were twice as likely to start prenatal care in the last trimester of pregnancy. In addition to the loss of control over pre-pregnancy events, battered women may lose control over pregnancy outcome. Abuse can cause miscarriages as well as stillbirths (Campbell, 2001; Jacoby et al., 1999; Ribe, Teggatz, & Harvey, 1993; Wood, Maforah, & Jewkes, 1998). Once the pregnancy progresses past 20 weeks, risks still plague those who are battered. Of 559 pregnant girls between the ages of 13 and 19 given questionnaires, more than 37% reported some form of abuse (Curry, Doyle, & Gilhooley, 1998). These battered teens were significantly more likely to have second trimester bleeding.

In summary, the experience of abuse forms the hub of a wheel of potential pathology. The spokes leading from that hub include loss of control over sexuality (including unintended pregnancy, sexual precocity, and risk-taking behaviors), sexually transmitted infections, and future abuse (especially sexual). Not all survivors are destined to follow one or more of those spokes, but the risk for doing so seems to be increased, particularly if the abuse occurs in adolescence or is ongoing. Women may respond to the abuse by exerting control when they can, for example, by avoiding attention by not presenting to prenatal clinics with obvious injuries or by seeking abortions or tubal ligations. The occurrence frequency and the thought processes behind these decisions have not been studied.

This study aims to examine the reality battered women face in their sexual and reproductive lives by asking the question: "What is the effect of being in a battering relationship on a woman's reproductive choices and control?" Women were asked intimate questions about their hopes and dreams for their pregnancies, the things they were forced to do sexually to avoid or minimize battering, and how they dealt with birth control and infection fears. Their answers and information from the literature review led us to theorize that a common mental pathway is forged from their experiences of abuse. These thought patterns may be unique to battered women and serve both to help the woman survive and to keep her locked in the abusive relationship.

METHODS

To begin to understand the impediments battered women face to controlling their own fertility, a preliminary study was conducted. The study was both quantitative and qualitative in its design and had approval of

the university's Institutional Review Board. Only the analysis of the qualitative phase, with demographic information from the quantitative phase, are presented here.

Sample

This study used a convenience sample of battered women who were participating in an outreach support group for survivors living in the community and women living in a women's shelter in a large, Midwestern city. Participation in the study was voluntary, anonymous, and conferred no remuneration. Informed consent was obtained from the participants, including consent to audiotape the discussions. Three focus groups were conducted. Two focus groups were conducted with women residing in the shelter and one was offered to battered women living in the community who were participating in a shelter outreach program. Nine resident women attended the shelter sessions, four in the first group and eight in the second. Three women attended both shelter sessions, although they may not have participated in both. One participant and the investigator attended the session for women in the outreach program. Taped conversations were transcribed and when possible, transcriptions were given to participants for their review and comment.

Data Analysis

The investigators examined focus group transcripts on two occasions, three months apart. The first examinations sought elements pertinent to health care providers. The second focused on what the women were saying. Data were analyzed for themes using the template technique described in Crabtree and Miller (1992). The template provides a guide to identify meaningful units, or themes, in the text. Each investigator examined the transcripts separately and compared their identification of themes. The themes were then clustered and dominant themes were quantified (Polit & Hungler, 1999). Both investigators again examined this final template of themes.

RESULTS

Focus groups were directed at addressing issues regarding sexuality, pregnancy, birth control, breastfeeding, and dealings with health care

providers. The most common themes throughout the three groups were negative attitudes toward pregnancy; contraception issues; dishonesty, denial and mistrust; and tactics of abuse. These are discussed after a presentation of the participants' demographics.

Demographics

These women were poor, with half of the shelter residents making less than $10,000 a year. Half of the shelter residents attended college, although no one graduated. The one college graduate in the outreach group also had the highest income. The women in the shelter were younger than the outreach group, with ages ranging from 20–48 years. The outreach group ranged from 27–69 years. Eight of the 12 shelter inhabitants identified themselves as black, the other four were white. The situation was reversed for the outreach group—four were white and one was black. The other difference between the two groups was onset of intercourse. The shelter group reported sexarche ranging from 11–17 years of age (average 14.87 years), whereas the outreach group ranged from 16–23 years with 19 years being the average. The shelter respondent who reported first intercourse at age 11 also noted that this was rape.

Pregnancy

The meaning of pregnancy was varied and bittersweet for these women. It was something men both wanted to avoid and sought, even with the same pregnancy. The women believed men wanted pregnancy to "keep them down." Two women spoke of loving being pregnant, even with the restrictions placed on them by their abusers or families. They loved the curves pregnancy brought, or the feeling of life inside of them. A third wistfully wanted a normal pregnancy, one with attention to her and the growing baby, in a climate of understanding her needs and limitations. Out of the ten women total, two had spontaneous abortions they attributed to attacks. Three others reported attacks aimed at causing miscarriage. One delivered a baby prematurely and attributed it to stress. Another delivered a large baby and believed the macrosomia was caused by her partner force-feeding her. The number of negative comments regarding pregnancy far outweighed the positive for this group of women. One woman did report that her abuser stopped hitting her once she began to "show."

Contraception

Men used contraception as a method of control over women. Their refusal to use it did not necessarily mean they wanted their partners to become pregnant, but reflected the deeper implications birth control seems to hold for them. Two women reported the men viewed use of contraception by their mates as license for infidelity. One woman reported her family was opposed to her tubal ligation: "If God had wanted your tubes tied they would have come that way." Over half of the women had or were planning tubal ligations. For most of them, this represented a supreme act of power in the relationship. They could choose to stop having children, regardless of the man's wishes. The control was not always in the woman's hands, however, as one woman was forced into sterilization. The quantitative phase of the study revealed that most of the women had experience with various contraceptive methods, and only 15 of the 64 pregnancies of the group were attributed to birth control failures.

> S: My abuser, he wanted the first one, then he wanted another one, and another one and I was like, no way.
>
> I: After I had two kids and two miscarriages, he decided that it was time for me to use birth control. . . . when he said birth control I figured he was just talking the pills or maybe the shot. He decided to force me into having my tubes tied. And that's always been a heartbreak to me.
>
> N: I wasn't allowed to use birth control even though I know I could get pregnant. But I wind up pregnant anyway, and he didn't have to change, he still wants to fight, you know. And I just decided, I'm going to do something, this is it, I'm getting them tied, burnt, whatever goes with it, I'm not having any more kids. And that's about it. And I think I'm healthy.
>
> M: I was on birth control until I met my baby's father. And then he didn't want me on birth control, not because he wanted me to have a baby, but he thought that would give me the right to sleep with other people. Even though I'm not like that. When I got pregnant, he didn't want me to have the baby. But I did. He tried to kick the baby out of me when I was like five months along. But it didn't work.

When asked about what methods of birth control may have worked for them, the women had some suggestions. All methods would have to be extremely low cost or free, due to the inability to access money. Since transportation is often a problem, a service that comes to the house would help. All materials found would be destroyed by the abuser, and

could precipitate more abuse, eliminating condoms, diaphragms, and possibly pills and IUDs as well. This leaves Depo-Provera, sterilization, and possibly cervical caps. Despite potential difficulties involved with finding childcare and financing, sterilization remained the best choice for these women. The ability to act without the partner, timing the surgery for immediately postpartum when child care is already arranged, and relying on Medicaid for funding probably explains the popularity of this method.

Dishonesty and Denial

One theme that frequently arose was how the women would deny the truth of the situation, or not question the inconsistencies presented to them. Their stories themselves were often inconsistent, a reflection perhaps of the chaotic lives they have led. One woman moved several times in her pregnancy and had stories from each location. She said she had basically no prenatal care for the last months of the pregnancy, yet had stories of health care providers during that time. She also believed she would not conceive because her partner smoked marijuana. The relationships described seemed to be characterized by a profound lack of honesty and trust on both sides. One woman described having to steal money from her partner to pay for prenatal vitamins. Many of the men accused their partners of being unfaithful; the women expressed doubt of their partners' fidelity.

> A: My abuser . . . said because of some operation when he was younger . . . he couldn't have kids. I believed him, really . . . So I didn't get on any birth control. And he didn't want me to get on it anyway. He was upset about losing his son to his wife, and he wanted to have another kid, I think, trying to make up for it somehow.

> T: Before I had my last baby, I had a miscarriage, by him, from him fighting, jumping on me . . . And I knew I had a black eye because he done jumped on me and I fell in the mud trying to run from him. Went to the hospital when I started hurting real bad, went to the hospital. They did an ultrasound from the inside of my body. They couldn't find no heartbeat. It was dead. And he never once came to see me in the hospital. He said he couldn't see me like that, that's what his excuse was, he couldn't see me like that . . . He didn't care. Now that I think about it. Cause when he told me he couldn't see me like that I was like, Oooh, he couldn't see me hurt like that, you know. But now that I think about it, he just didn't want to come, he didn't care.

A: There's all this stuff about him I don't know from his past. Things he said, then he goes back on it, and he tells something different cause he lied about it and didn't remember. He didn't want kids, and then he did . . . He was happy about it, but he was trying to deny that it was his. But then he said, "When the baby comes, I want paternity testing." I said I'm not that kind of a person, you know, that sleeps around. And I said that's fine, you can have that. He didn't believe me, I don't think he does still.

Tactics of Abuse and Methods of Sexual Coercion

Several common elements of life with an abuser emerged from the conversations. The main goal of the men seemed to be to remove all control and decision-making from the women. The second goal seemed to be to placate their insecure egos. This was achieved in a variety of methods. One abuser denied food for his pregnant mate, wanting her to remain slim, while another forced his mate to eat to make a big baby. Virtually all the women had stories of isolation. The abusers accomplished this by denying access to phones, cars, friends, and health care providers, and by moving frequently. Money was often lacking or was a source of tension. And finally, sexual abuse was ubiquitous. From forcing intercourse to demanding abortions, these women were allowed very little control over their sexual lives.

I: I was raped several times by him.

A: He wanted me to get an abortion, and all, when I was pregnant . . . He was never around. When he was, he was hitting me and being abusive when I was pregnant. And after she got here, he was never around, either. He was always gone. That's when we moved to Colorado. All his family is out there. I didn't have anybody so I was always alone.

A: He wanted to have intercourse all the time, all the time, and do all these different, disgusting, degrading things I had never even thought about doing.

Y: Sometimes you never even heard about the things he wants you to do. . . . Sometimes it's a forced thing. . . . A lot of times he got off work or whatever, and I'll be asleep, and he doesn't like me to wear clothes in bed, and so that's just easy access to him. . . . When me and my sister go into the bathroom and talk, he's like, are you screwing your sister?

Although not examined specifically, there were indications that many of these women experienced abuse long before the relationship that brought them to shelter. Two women said their menarche was delayed

because of abuse by their fathers, a situation the therapist present considered common. Many of the women reported families that were abusive. The family and abuser often had the same agenda of control of the woman and seemed to be cut of the same cloth. Pregnancy and contraception were particularly problematic for the families. The women reported their families were opposed to them becoming pregnant, opposed to birth control use, and demanded adherence to superstitious pregnancy behaviors. This assault from all sides disturbed the women and added to their anxiety.

Denial of Abuse

Many of the women in the focus groups hinted at some behavior that would cause them to leave the relationship, some line they would not allow him to cross. For those experiencing emotional or psychological abuse, it might have been being hit. For others, it might have been watching their children being physically abused. For "I," "being forced into a tubal ligation" seemed to be the last straw which spurred her into leaving her husband. When the investigators presented the hypothesis of the "line in the sand" to the staff of the shelter where the study was conducted, they concurred and volunteered additional information. Most of their clients maintained this line in their minds, and they used semantic arguments to convince themselves it had not been crossed. For the woman who believes she will leave if he hits her, she may discount the strangulation, shoving, and tripping he regularly employs; he never, after all, balled up his fist and struck her. The line may appear to move, allowing for escalating violence, by using this strategy. She may need to add provisions and exceptions to allow her to continue living with her situation.

The realization of the line and its crossing may be retrospective. "I" described not attempting to have any sort of control in her life. She accepted that she would be beaten, despite following his orders precisely. She related not wanting to be sterilized and hoping something would make the surgeon not proceed, yet she could not stop that line-crossing. Perhaps the deep sense of betrayal she felt afterward shook her enough to motivate her to leave.

We hypothesize here that women learn this "line in the sand" mentality to provide an illusion of control over their powerless situation. The development of it warrants further study. Do abused children also develop this, or do they learn they have no power at all? How does this line come into play in regards to sexual abuse? Virtually all of the women in the focus groups had some story of impaired personal power in their

sexuality. Perhaps the women never thought of this as a loss of power, simply the reality of dealing with men.

DISCUSSION

The present study allowed a glimpse into the thought processes battered women employ. The most striking and pervasive of these was the persistent denial to themselves of what was happening. The women believed their partners when they said they were infertile, they believed the men cared for them deeply despite beating them, and they ignored lies. This behavior is known to exist in most battered women. Denial and minimization of reality is probably a survival tactic (Rene Renick, personal communication, August 1999). The woman desperately wants to believe she has a happy family (Campbell, Pugh, Campbell, & Visscher, 1995) and information counter to that is ignored. In addition, the abuser wants her to think she is crazy and gives mixed messages. If her external reality is incongruous, eventually her internal reality will follow suit. Inconsistent behavior and thoughts probably are not questioned as they become more frequent and routine. The isolation the batterer creates eliminates the "reality check" to remind the woman what is tolerable behavior.

Despite being fairly well educated, these women were unable to avoid abuse and sought care from shelters, defying stereotypes of education rescuing women. Their literacy level seemed low, however, for the amount of education received. The group was poor, mainly because their source of income was now estranged. Virtually all of the women felt they had mental or psychological problems because of the abuse and requested help in this area. Some of the women in the outreach groups told the investigator informally that they wanted expanded psychological services offered at the shelter and that desire may have influenced answers on the questionnaires. Some of the statements the women gave suggested that their problems may have predated the abuse, or were worsened with it. For example, one woman wrote that she was manic-depressive because of the abuse. From the responses, there is little doubt that life with an abuser may have serious psychological consequences.

The qualitative phase of the study was very similar in design to that of Campbell, Pugh, Campbell, and Visscher (1995). Both studies used focus group methodology and asked women in shelters about the circumstances surrounding their pregnancies. In the present study, numbers of pregnancies the women had were not assessed, nor were the

outcomes of each pregnancy; in contrast with Campbell et al. The women in the present study all lived in the Midwest and not in two diverse locations as in the Campbell study. Many of the themes elicited in Campbell's study were also seen here, although from a different perspective. For example, the theme of "Lack of Consistency" was noted, but subsumed into the "Dishonesty and Denial" theme in the present study. Elements of the "Definition of Manhood" theme were seen in how men regarded birth control. Overall, the results from the present study supported the work of Campbell et al. In both studies, women acknowledged having little control over contraception, pregnancy outcomes, or many other aspects of their lives. Both groups of women were attacked by abusers in attempts to cause spontaneous abortions. Abusers were characterized as insecure, jealous, inconsistent, and self-absorbed. The tactics they use were similar in both studies.

A major limitation of the present study is the small sample size and the inability to generalize the findings beyond the population of women in shelters or attending support services provided by the shelter. Due to the retrospective nature of the study, there may also be a recall bias, but most studies with battered women have found an underestimation of the abuse they have experienced. The strength of the study is that this study hears the voices of battered women about how their sexuality and fertility was controlled by an abuser. Understanding the nature of control exerted in abusive relationships can be vital information for health care providers.

IMPLICATIONS FOR NURSES

If this "line in the sand" is a common theme in the lives of battered women, perhaps nurses could use it as an intervention. Helping a woman recognize what her own limits are, and how she may have already crossed them could help reorient the woman to her own needs and thoughts. When assessing for abuse, it might be useful to ask what her limits are. Asking in a nonjudgmental way, and offering to be a resource when that limit is reached, could establish the nurse as an ally when she is ready to leave, while reinforcing the idea that the woman can make decisions for herself.

Not being able to plan sexual activity equals not being able to avoid infection or pregnancy. Health care providers need to recognize limitations these women face when prescribing birth control. We need to do more than prescribe methods. We need to investigate a woman's understanding and her ability to use the method effectively. Furthermore, more

research is needed on methods that do not require male participation or acceptance.

When women present with spontaneous abortion (SAB), we usually dismiss concerns of "I fell, could that have caused it?" This question, however, may be an attempt to disclose the abuse. This study and others suggest that SABs after an episode of domestic violence may be more common than previously assumed. To learn the true picture and to provide complete care, each presentation of SAB should be assessed for abuse. We should not accuse the woman, certainly, but provide a safe environment for her to discuss the possibility. When assessing for abuse in the first prenatal visit, it may be best to preface the questioning with an explanation of the risks domestic violence poses to her pregnancy. Women need to be informed of these risks and be given permission to discuss their fears.

This study suggests that female sterilization may be associated with abuse, either in a woman's attempt to exert control over her own life, or an attempt to control her. The accepted procedure of discussing consent with the couple together is still valid but is not sufficient. All providers must ask the woman alone about her consent to the procedure and provide alternatives that would be accepted by the abuser. The nurse is in a unique position of strength here. If the woman discloses abuse and does not want to have the procedure, the nurse could find a medical excuse to defer it. The nurse could then openly suggest other contraceptive methods that would be "safer" for the couple. Birth control is then open for discussion, perhaps for the first time, for the couple. In addition, the woman's secret is safe, and she may build on that foundation of trust by returning for help.

The women in the focus groups had other practical suggestions for providers. Most of the women wanted the hotline number in some safe form. This could be incorporated into the letterhead, billing statements, and prescription pads. They wanted something ubiquitous, so the men would not suspect them of disclosing. Pamphlets on the "red flags" of an abusive relationship could be given, provided they were part of a larger packet of information given to everyone. The woman, if alone, should be alerted to the contents of the packet, however, so she can remove any materials that may initiate a battering episode.

CONCLUSION

This group of battered women had difficulty understanding, obtaining, and using contraception. The women understood public health messages

about condom use for the prevention of sexually transmitted infections, but they often lacked permission to use condoms. Batterers used contraception as one of many methods to control the women. The most common end result was to deny them access and to force them to become pregnant, but one also forced the woman to end her childbearing. The men did not always deny contraceptive use because they wanted children; some men believed contraception gives the woman the right to be unfaithful. For others, denying contraception was just another tool to control the woman. Health care providers must recognize and openly discuss the challenges women may face in controlling their fertility. Women need to have the opportunity to discuss abuse, contraception, sterilization, and pregnancy alone with the provider, without other persons present. Family members may be as abusive as the partners. Health care providers need to learn the stages of an abusive relationship and the appropriate interventions for each one.

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