Experiences of Women Who Were Battered While Pregnant

by

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Abstract

Battering of women by their male partners with the many associated injuries and deaths is prevalent in North American society. It is a reality that crosses every cultural, geographical, social, and class barrier and it is not restricted to any age group or occupation.

Pregnant women and their unborn children are especially vulnerable to this serious and potentially life threatening health problem. Pregnant women receive serious blows to the head, face, breasts, abdomen, back, arms, legs, and genitals, and they experience vaginal bleeding and miscarriages as a result of battering incidents.

There is a scarcity of published studies by nurse researchers in which women who have been battered while pregnant have been asked to share their thoughts, feelings, and experiences of battering or how they would have liked nurses and other health care providers to support them. Therefore, the purpose of this research was to use qualitative, feminist methodology informed by grounded theory method to develop supportive strategies that nurses can use as they interact with pregnant women who are battered.

The supportive strategies that I identified are **watching for signs**, **reaching out**, and **providing the options**. Equal emphasis was placed on sharing the women's experiences of living in a battering relationship. **Living in isolation** is the core variable that emerged. The co-variables are **living in fear**, **being delimited in freedom**, **lacking social support**, and **lacking self-esteem**.

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Chapter One

Experiences of Women Who Were Battered While Pregnant

Erin Pizzey's seminal book entitled Scream Quietly or the Neighbours Will Hear (1974) was a consciousness-raising endeavour in which the voices of women who were battered while pregnant were heard for the first time. In a letter to Pizzey, one woman recounted her experience: "My 'husband' beat me up constantly whilst I was pregnant . . . he kicked me, stood on me, punched me and throttled me . . . I don't know if this was the cause but our child was born blind and mentally-retarded" (Pizzey, 1977, p. 22). Pagelow (1981) believed the stories of the women in this book were "an important stimulus in arousing public awareness of previously hidden crimes of woman-battering" (p. 20).

In the final days of the twentieth century battering of pregnant women by their male partner is a serious and life-threatening health problem not only for individual women and their children but also for all of society. Indeed, death of the woman as well as her unborn child may result from injuries received in a battering incident. Dannenberg et al. (1995) found that homicide was "the largest single cause of injury-related deaths among pregnant women" (p. 1563) in a large urban area of the United States. Even more frightening is the fact that, of the 72 homicide victims, the involvement of a male partner was documented in at least 12 of these cases. The researchers noted that a perpetrator was not identified in all cases. I question the lack of information concerning the

perpetrators and the possibility of a higher number of partners being involved if further investigation had taken place.

Expanding upon the relationship between interpersonal violence and pregnant trauma victims, Poole et al. (1996) reviewed the medical records of 203 American pregnant women. It was found that 64 of these women were victims of interpersonal injury with the woman's male partner being the assailant in 23 of the 26 instances in which a perpetrator was named. Penetrating trauma consisting of gunshot wounds, shotgun blasts, and stabbing injured 13 of the women.

In relation to the effects of physical injuries, Pearlman, Tintinalli, and Lorenz (1990) studied the effects of trauma such as motor vehicle accidents, falls, and direct blows to the abdomen on 85 American pregnant women. Ruptured placentas (five cases), premature ruptured membranes (four cases), and one fetal death occurred as a result of the trauma experienced by the women. In addition, Goodwin and Breen (1990) evaluated the effects of trauma in 205 American women during the second half of their pregnancies. Eighteen of them had complications. Of the women who reported being kicked or punched in the abdomen, it was found that three women had preterm deliveries, two had ruptured placentas, and one woman who was carrying twins lost one to stillbirth and the other was born prematurely.

Furthermore, pregnant women receive serious blows to the head, face, breasts, abdomen, back, arms, legs, and genitals (Drake, 1982; Helton, 1986;

Pagelow, 1981; Pizzey, 1977; Stewart & Cecutti, 1993), and they experience vaginal bleeding (Greenberg, McFarlane, & Watson, 1997; Stewart & Cecutti, 1993) and miscarriages (Bowker, 1983; Brendtro & Bowker, 1989; Dobash & Dobash, 1979; Drake, 1982; Hilberman & Munson, 1977-78; Hillard, 1985; Pagelow, 1981; Stout & Brown, 1995) as a result of battering incidents. Needless to say, all these injuries are life threatening to the woman and her child.

Battering of women by their male partners with the many associated injuries and deaths is prevalent in North American society. In fact, as many as 120 Canadian women are killed by their partners in one year (Canadian Centre for Justice Statistics, 1993, as cited in Johnson, 1996) and "almost 450 000 are slapped, punched, choked, beaten, sexually assaulted, or threatened with a gun or knife" (Statistics Canada, 1994, as cited in Johnson, 1996, p. XV). To determine the nature and dimensions of violence against women in Canada, the nation-wide Violence Against Women Survey was conducted by Statistics Canada in 1993. Over 12,000 women were asked about their experiences. Results indicated that 51% of them had experienced at least one incident of physical or sexual abuse (Statistics Canada, 1993) and of these women, 29% were assaulted by their partner (Statistics Canada, 1994). This battering occurred before or during marriage, during pregnancy, or after separation. Of the 21% of women, who were assaulted by a marital partner during pregnancy, 40% said that the battering began during pregnancy (Statistics Canada, 1994).

Obviously, battering of Canadian women by their male partner is not an isolated entity that occurs behind closed doors of a few families living in certain geographical areas or in certain socioeconomic groups. It is a reality that crosses every cultural, geographical, social, and class barrier and it is not restricted to any age group or occupation (Bowker, 1983; Dobash & Dobash, 1979; Helton & Snodgrass, 1987; Martin, 1976; McCue, 1995; Pagelow, 1981; Sampselle, Petersen, Murtland & Oakley, 1992). It must be understood as a social problem that involves crimes against women.

Several pertinent questions arise from these data: Why is battering of women under-recognized and under-reported as discussed by Brendtro and Bowker (1989), Hillard (1985), Ozmar (1994), Quillian (1996) and others? What societal and family institutions exist that allow the horror to continue? What are the physical and emotional effects on women who are battered while pregnant? How do they live with the battering, and what is the final outcome of the situation? Lastly, how are health care providers, especially nurses, responding to this societal problem?

In order to answer some of these questions, nurse researchers in Western society began to investigate battering of pregnant women during the mid 1980s. These studies were of a quantitative nature and measured variables such as incidence rates, types of injuries to the woman and her child, relationship of battering to birth weight, and characteristics of women who were battered. These studies continue today and for the most part reflect positivist research traditions;

nevertheless, they are important in that they explore and describe different aspects of the phenomenon in order to increase nursing knowledge and to provide rationale for increased social support for women.

Although these studies will be explored more thoroughly in Chapter Two, it is significant to summarize the results at this time. Researchers discovered an incidence rate of battering during pregnancy as ranging from an alarmingly 6.6% to 21%. As expected, the physical and emotional costs of battering to women and their unborn children were enormous. They suffered bruises, cuts, and fractures and were at risk of having preterm labour and delivery of low birth weight infants, placental rupture, fetal hemorrhage, and possible death of the woman and her child. According to three studies, pregnant women who were battered used a higher rate of alcohol and illicit drugs. We must be careful not to blame the victim immediately when we read these results. The question remains whether they used the drugs to escape the reality of the battering and for comfort. One study indicated that they experienced more depressive symptoms and attempted suicide more often than women who had not been battered. More frightening is the fact that the batterer was usually the intimate partner of the woman. Bohn and Holz (1996) suggested that the lives of survivors of battering would be altered forever by these experiences. Women may have significant and long-term physical, emotional, behavioural, and interpersonal problems as a direct consequence of battering.

As I reflected upon these research studies of women who had been battered while pregnant, I realized that the most important aspect was missing. It was the women's voices; their thoughts, feelings, and experiences were rarely documented, as they lacked the opportunity both to give voice to their needs and for the support they required to meet these needs.

Purpose

There is a scarcity of published studies by nurse researchers in which women who have been battered while pregnant have been asked to share their thoughts, feelings, and experiences of battering or how they want nurses and other health care providers to support them. The purpose of this research was to use qualitative, feminist methodology informed by grounded theory method to develop a conceptual framework of supportive strategies that nurses can use as they interact with pregnant women who are battered. This framework was grounded in the data obtained from interviews with women who experienced battering while pregnant and represents their viewpoints about how nursing care should be delivered.

Battering in this study is defined as any type of physical violence that is inflicted by a male partner such as slapping, hitting, punching with a fist, repetitive beating, hair pulling, burning, or kicking. This definition of battering is narrow and it is necessary to communicate a more comprehensive and socially accepted definition so as not to understate the complexity of this phenomenon. Battering can be defined as assaultive behaviour consisting of repeated physical

or sexual attacks, or both, against an intimate partner. The partners are usually living in a cohabitating relationship, and the battering occurs within the context of coercive control (Campbell & Soeken, 1999; Tong, 1984). Other controlling behaviours by the male partner that may accompany the physical and sexual battering include verbal threats and intimidation, economic control, emotional abuse, sexual abuse, enforced isolation from family, friends, and support persons, and threats against or actual harm to the children, belongings, or pets (Campbell & Soeken; Shepard, 1991; Tong).

According to the Criminal Code of Canada, a person commits an assault when

> (a) without the consent of another person, he [sic] applies force intentionally to that other person, directly or indirectly, (b) he [sic] attempts or threatens, by an act or gesture, to apply force to another person, if he [sic] has or causes that other person to believe upon reasonable grounds that he [sic] has present ability to effect his purpose, or (c) while openly wearing or carrying a weapon or an imitation thereof, he accosts or impedes another person or begs.
>
> This section applies to all forms of assault, including sexual assault, sexual assault with a weapon, threats to a third party or causing bodily and aggravated sexual assault. (Canada Law Book, 2000, p. 486)

As can be seen by these definitions, battering of women must be understood as a multidimensional crime that attacks all parts of her being–physical, sexual and emotional. Her children are also at risk for battering by her partner. This threat heightens her fear and compounds her difficulties in coping with the situation.

Significance for Nursing

Nurses are in an ideal position to intervene with women who are battered while pregnant. They interact with pregnant women in community health settings, prenatal classes and clinics, fetal assessment units, emergency departments, and perinatal units. In spite of these contacts, research studies indicate that women are not telling nurses and other health care providers about their battering experiences and many providers are not asking (Drake, 1982; Gerbert et al., 1996; Helton, 1986; Stewart & Cecutti, 1993). Women may not disclose the battering because of embarrassment, guilt, fear of retaliation by their partner, or lack of knowledge that it is criminal behaviour (Drake, 1982; Gerbert et al., 1996; Moss & Taylor, 1991). Nurses may not ask about violence because they have been battered themselves or they have seen their mother or other relatives being battered. They may not want to reopen the wounds (King & Ryan, 1989). Nurses "often are hampered in efforts to intervene with abused women because of personal and societal myths rather than lack of skill or knowledge" (King & Ryan, 1989, p. 48). Though this is so, nurses have an ethical responsibility to promote, facilitate, and provide the best possible health care to clients (Nurses Association of New Brunswick, 1998). This care includes accommodating the biological, psychological, social, cultural, and spiritual needs of all clients (Canadian Nurses Association, 1997).

Because consciousness-raising is one of the central tenets of feminist research (Fonow & Cook, 1991), and because the purpose of this research was

to hear and document the participants' stories, I believe it has the potential to transform nurses' thinking by dispelling some of the myths that sustain battering of women. As well, nurses will have the opportunity to become more knowledgeable of supportive strategies that are recommended by women who were battered, and this knowledge will facilitate the delivery of competent and evidence-based nursing care.

Chapter Two

Discussion of the Literature

Scope of the Problem

In order to understand the pervasiveness of battering of women while pregnant, several nursing and related studies will be discussed. Most of these studies are American, but two Canadian ones will be discussed later. In a prospective study of 1,243 pregnant women, Amaro, Fried, Cabral, and Zuckerman (1990) found that 7% reported physical or sexual violence during pregnancy and 94% of these women knew their assailant. Thirty-six percent of the women saw a doctor for injuries from one of the episodes and 10% were hospitalized overnight as a result of one of the battering episodes. In this study it was found that

> victims of violence were at greater risk of having a history of depression and attempted suicide, having more current depressive symptoms, reporting less happiness about being pregnant and receiving less emotional support from others for the current pregnancy. Comparisons of victims and nonvictims showed that victims were more likely to be users of alcohol and drugs. In addition partners of victims were more likely to use marijuana and cocaine. (p. 575)

The researchers noted in their discussion of the limitations of the study that the participants "were primarily poor, Black, and Hispanic women living in the inner-city . . . and that the prevalence of violence and drug use in other populations may be different" (p. 578). They cautioned that their questioning

techniques did not fully address the relationship of battering, drug use, and depression.

In a prospective study of 1,203 pregnant women, Parker, McFarlane, and Soeken (1994) found that 20.6% of the teens and 14.2% of the adult women reported physical or sexual abuse during the current pregnancy. "Over half of the teens and adult women abused in the previous year were also abused during pregnancy, making prior abuse a major predictor of abuse during pregnancy" (p. 325); furthermore, these women tended to enter prenatal care in the third trimester of pregnancy. The perpetrator of abuse for adults was more likely to be the 'husband' and for teens, the 'boyfriend'. In addition 9.5% of the women delivered an infant weighing less than 2500 grams (6.6% of teens and 10.7% of adults).

In 1996, McFarlane, Parker, and Soeken reported more information about the women in their 1994 study. Almost thirty percent of the women smoked, and 11.9% used alcohol or illicit drugs. The findings of this study have serious consequences for women and their unborn children because illicit drug use and smoking are known causes of low birth weight (Berenson, Wiemann, Wilkinson, Jones, & Anderson, 1994; McFarlane et al., 1996). Low birth weight and prematurity predispose infants to higher rates of morbidity and mortality.

Regarding late entry into prenatal care, Taggart and Mattson (1996) found similar results. Using a convenience sample of 502 pregnant women from three ethnic groups they found a high rate of physical harm during the current

pregnancies (21%). Almost 14% of the women said they had delayed care because of injuries. They began visiting a health care provider near the end of the second trimester of their pregnancies. There were no significant differences among the ethnic groups.

In order to understand the scope of this devastating problem in Canadian society, two studies by physicians are worthy of mention. Stewart and Cecutti (1993) undertook a study with 548 pregnant women to determine the prevalence of battering, health habits, psychologic distress, and if there were demographic differences between those who experienced battering and those who did not. Women were interviewed in community-based prenatal clinics, obstetricians' offices in a large city, family physicians' offices in rural and urban areas, and in a university teaching hospital.

Thirty-six (6.6%) of the 548 women reported battering during the current pregnancy and 60 (10.9%) before it. The most common area hit during the pregnancy was the abdomen followed by the buttocks, head and neck, and extremities. The injuries included pneumothorax, stab wounds, concussions, fractures, perforated eardrums, abrasions, dental injuries, vaginal bleeding, and premature labour (Stewart & Cecutti, 1993).

Women who were battered differed in the following ways: They (a) were young (under 21 years), (b) were unmarried and failed to complete high school, (c) were unemployed, (d) were more emotionally distressed, (e) had unplanned pregnancies, (f) had unhealthy diets, and (g) smoked, drank alcohol, and used

more drugs (Stewart & Cecutti, 1993). There are inherent stereotypical difficulties with these particular profiles, and there are dangers in assuming that class plays the most significant role in battering. While economics is perhaps an important issue in battering of women, it is not the only factor to be considered.

Other important results included:

1. Rates of violence did not vary according to the five research settings. This result indicates the widespread and unpredictable occurrence of battering.

2. Past history of battering was one of the strongest predictors.

3. Only one woman who had been battered informed her prenatal care provider (Stewart & Cecutti, 1993).

In a continuation of the previous study, Stewart (1994) sought to determine whether women with a history of battering during pregnancy would be at increased risk in the three months after delivery. Her suspicions were verified as 27 (90.9%) of the 30 participants reported a total of 57 incidents in three months.

In summary, it is important to point out that battering of pregnant women is a widespread problem that extends across cultural, ethnic, and socioeconomic boundaries. The battering has extreme adverse effects on the health of the woman and her unborn child in the form of physical and psychological injuries and delayed prenatal care. The results of these studies should alert all health care providers to the seriousness of battering during pregnancy.

Health Care Response: Discussion of the Literature

How have health care providers, especially nurses, responded to the needs of women who are battered while pregnant? In order to answer this question, it is necessary to present an overview of selected research studies. As before, these are American studies. One of the earliest nursing studies was conducted by Drake (1982) whose purpose was "to initiate a nursing profile of battered women interfacing with the health care system" (p. 40). Although this study did not involve pregnant women specifically, the results provided a strong knowledge base that nurses could use when assessing and supporting any woman who is battered. Twelve participants who sought refuge in an inner city shelter were interviewed regarding their experiences of being beaten by their male partners and their experiences with the health care system as a result of their injuries. Of the 11 women who had ever been pregnant, all of them were battered during pregnancy and five of them experienced spontaneous abortions within ten days of a battering incident. Injuries included bruises, fractures, burns, lacerations, dislocated jaws, knocked out teeth, blackened eyes, and head injuries.

Eleven of the twelve women sought health care for their injuries at some time during the battering relationship (Drake, 1982). The twelfth woman was a nurse and treated herself at home. None of the women reported positive feelings about the way they were treated by health care personnel. "They felt they were treated impersonally, insensitively, and received minimal to no support from the

providers" (p. 45). One woman reported that she waited in an examining room with her small child while the hospital staff watched a football game on the television.

Drake (1982) found that only two of the women were identified as being battered and both were through self-report. None of them was specifically asked if she had been battered; furthermore, "in no case was the explanation offered by the woman to explain her injuries overtly challenged" (p. 45). When asked what reasons or feelings prevented them from identifying themselves as women who were battered, the common response was that no one had asked them. All of them expressed feelings of embarrassment, shame, and guilt at having been battered and one woman said she was too embarrassed to tell anyone.

Women were asked what the nurse or physician might have said or done that would have helped them discuss their situation. Responses included paying attention to the woman, giving her time to talk, allowing privacy, and asking her directly if she was battered (Drake, 1982). In summary, this study provided nurses with a beginning insight into the experiences and lives of women who are battered. It provided rationale for the delivery of nursing care that was directed at helping the women meet their needs, and it supported the "need for consciousness raising among nurses and other health care providers to be alert for [this] covert health problem" (p. 47) plaguing the nation.

In order to determine the prevalence rate of battering during pregnancy, Helton (1986) described how she interviewed 112 pregnant women at their

prenatal appointments. Twenty-one percent of them reported being battered and 9% said it was occurring during the current pregnancy. Helton found that the pregnant women were in various stages of coping with the violence. One woman denied battering by saying that "her 'husband' slapped her around when he was drunk or when she did something wrong" (p. 910). Other women discussed their anger and fear of the potential for retaliation against their partners. Some were preparing to leave the batterer and some had already left.

Helton (1986) also described that several men who battered came to the interview with their partners. She suggested that these men should be a part of the prenatal care of their partners. One way to involve them is for nurses to ask about their feelings regarding the pregnancy. She stressed the importance of assessing all pregnant women for battering and that nurses should be prepared to counsel and refer them to the appropriate resources. Helton encouraged nurses to provide pregnant women with the opportunity to speak in private about any concerns they may have and to provide them with written phone numbers for emergency services. As well, an exit plan for women was included.

The next year Helton, McFarlane, and Anderson (1987) published the results of their study with 290 pregnant women living in a large metropolitan area of the United States. Interviews were conducted in public and prenatal clinics and the women varied in their social and ethnic backgrounds and educational levels. Eight percent of them were currently being battered and the most common sites of assault were their faces and heads. Before the interview none of the women

had been assessed by a health care provider for battering. Helton et al. concluded that the "primary predictor of battering during pregnancy . . . was prior abuse; 87.5% of the women battered during [the] current pregnancy were physically abused prior to the pregnancy" (p. 1338). They found that the battering did not vary according to race and ethnicity.

In relation to the same study, Helton and Snodgrass (1987) reported that 63.8% of the 290 women were unaware of resources to assist them. They believed that the results of both studies give clear direction for nursing practice. Nurses must ask every pregnant woman about past and present battering, and they must be knowledgeable of how to support her immediately and of the available community resources.

Upon interviewing 488 postpartum women, Campbell, Poland, Waller, and Ager (1992) found that 7% had been battered by their partner during the current pregnancy. These women: (a) had higher levels of depression and anxiety, (b) drank more and used more drugs, (c) were less likely to receive help from families and had fewer people to go to for help, (d) had more housing problems and fewer appliances and baby equipment in their homes, and (e) were less likely to have had adequate prenatal care. As a result of their research findings, Campbell et al. suggested that questions about physical violence during pregnancy should be asked more than once during a prenatal assessment and in different ways. Women were asked if the men they were with ever hurt them and if the men ever "hit, slapped, kicked, or otherwise physically hurt them" (p. 221).

The researchers found that women responded more affirmatively to the second question than to the first. They suggested that questions about battering should be asked at every prenatal visit and in the postpartum period because battering may begin at any time. As well, Campbell et al. stressed that whenever physical violence is discovered, immediate interventions are necessary as the batterer may prevent the woman from keeping follow-up appointments. These interventions include a thorough assessment and risk of homicide, accurate documentation, sharing information about laws against battering, community resources, brainstorming with the woman about her options, and emotional support.

As part of a larger study, Campbell, Oliver, and Bullock (1993) asked 51 women why they thought they had been battered while they were pregnant. Their responses were coded by thematic analysis and the four main themes were: (a) jealousy of the unborn child, (b) pregnancy-specific violence not directed toward the unborn child, (c) anger toward the unborn child, and (d) anger against the woman.

The study included the following responses:

1. Some women believed their partners were jealous because "they were talking and thinking about the unborn child a great deal or doing things to prepare for the birth" (Campbell et al., 1993, p. 346).

2. One woman said the abuse started during the pregnancy because she was not feeling well and could not cater to her partner.

3. Another woman said the man was trying to cause a miscarriage and directed his blows at her abdomen.

4. Many women had been beaten before the pregnancy and it was "business as usual" (p. 347).

Campbell et al. (1993) urged nurses to ask women why they thought they were being battered. The researchers cautioned that if "the woman thinks the abuser's anger is directed toward the unborn child and when the abuser seems jealous of the fetus, the possibility of subsequent child abuse by the batterer is a definite consideration" (p. 348). This information should be shared with the woman and perinatal and community nurses in order that they may be alert to the danger.

As discussed previously, Campbell et al. (1993) stressed the importance of the following nursing interventions: (a) thoroughly assess the severity and frequency of battering including emotional and sexual harm, (b) accurately document the battering including the location of injuries on a body map for potential legal action, (c) inform women of the laws against battering and the services available to them and the batterers, (d) brainstorm with the women regarding their options, and (e) provide emotional support for them.

Nurses can intervene with women who are battered only when they are themselves free of preconceived attitudes. In order to determine nurses and physicians' attitudes toward women who are battered, Rose and Saunders (1986) conducted a study in which 145 nurses and 86 physicians responded to a

mailed questionnaire. The results demonstrated that: (a) nurses were less likely to believe that "beatings are justified" (p. 433), (b) nurses were less likely to believe that women are responsible for preventing beatings, (c) nurses and physicians "shared similar attitudes in their beliefs that these women should be offered help for their situation" (p. 434), and (d) those professionals "with the most intensive training on the topic held victims less responsible and were more willing to help them" (p. 427). These results confirm the need for educating all students and health care providers about battering of women.

Brendtro and Bowker (1989) interviewed 146 women who had been battered and who volunteered to be interviewed about their backgrounds, their victimization, and their use of personal strategies and outside sources to end the violence in their lives. The findings are significant for nursing practice in that it was found that organizations differed significantly in their effectiveness. The most effective formal source of help was women's groups followed in order of effectiveness by shelters for women who are battered, lawyers, social service agencies, police, clergy, and health care providers. Indeed only 31% of the women found health care providers to be effective. Nurses and physicians were rated together but anecdotal evidence suggested that physicians were much less effective than nurses.

The four major implications of Brendtro and Bowker's (1989) study are that nurses must: (a) be aware of their own attitudes and feelings with respect to the issue of battering, (b) develop an understanding of the dynamics of battering,

(c) gain the knowledge and skills necessary for appropriate assessment of women, and (d) develop effective strategies for nursing interventions. These interventions included establishing a trusting relationship with the woman and demonstrating an attitude of unconditional acceptance. Informing the woman of formal sources of community support such as women's shelters and legal options were other interventions. The researchers also believed that helping her identify her informal support systems such as friends, relatives, or neighbours was essential.

Brendtro and Bowker (1989) believed that negative attitudes could result in blaming women who are battered. Nurses must "consider whether any of the common misconceptions about 'wife' battering have influenced their attitudes" (p. 175). Two of these myths are that women "invite" (p. 175) the beating they receive from their partners and that "some women choose the role of victim by marrying men who abused them in the premarital period" (p. 175).

Sugg and Inui (1992) explored primary care physicians' experiences with 'domestic violence victims' to determine the barriers to problem recognition and intervention in the primary care setting. Ethnography was the research method and 38 physicians were interviewed. The analogy of " 'opening Pandora's box' was used by physicians to describe their reactions to exploring domestic violence with patients" (p. 3158). Too close for comfort, fear of offending, powerlessness, loss of control, and the tyranny of the time schedule were the themes identified by the researchers.

Thirty-nine percent of the physicians identified "too close for comfort" as being representative of the close identification that physicians had with their patients. If they came from white, middle-class backgrounds with no experience of 'domestic violence', they "assumed that their patients with similar characteristics would not be at risk for violence. . . . The socioeconomic status of the patient was clearly used as a marker for determining whether abuse was likely" (p. 3158). The implications of these findings are that patients from higher socioeconomic groups will not be asked and the myth that 'domestic violence' happens only in lower socioeconomic groups will be perpetuated.

Sugg and Inui (1992) also found that close identification with patients hindered those physicians who had a previous history of child abuse or physical violence by an intimate partner. Thirty-one percent of female physicians and 14% of male physicians acknowledged their experiences. "The researchers concluded that the impact of that experience is likely to influence their ability to broach the issue with patients" (p. 3160). "Fear of offending the patients was one of the strongest fears expressed by physicians" (Sugg & Inui, p. 3158). It was identified by 55% of the participants.

Physicians believed that 'domestic violence' was an area culturally defined as private. Male physicians believed that by asking patients about it, the physician-patient relationship might be endangered. Even though some patients responded affirmatively when questioned about violence, some physicians believed they needed to get unbiased information from someone other than the

patient in order to "get the truth" (p. 3159). The implications here are that physicians have to overcome their fears in addressing the issue of battering and learn to believe their patients.

Fifty percent of the physicians expressed frustration and feelings of inadequacy (powerlessness) when intervening with their patients (Sugg & Inui, 1992). They identified the complexity of the problem and lack of tools to help as barriers in their practice. In addition, they felt powerless to fix the problem and 61% revealed that they had no education on domestic violence. Regarding the theme of loss of control, 42% "expressed the frustration that although they would intervene with advice or referral to resources, ultimately the control of the outcome was in the hands of the patient" (p. 3159). They felt their attempts at intervention were useless unless the patient was motivated to change. As well "many physicians were frustrated by their inability to control the patient's behavior, and the patient's inability to control the circumstances of their lives" (p. 3159). Sugg and Inui suggested the need for extensive education of physicians regarding the battering phenomenon and specifically addressing the long-term process of leaving.

Most of the physicians (71%) "identified the time constraints of a busy primary care practice as the major deterrent for asking about violence in the home" (p. 3159). They believed there was such a low problem in their practice that asking about it was not a good investment of time. Sugg and Inui (1992) suggested that physicians should re-evaluate their time schedules. In summary,

the researchers believed that the information they found in their study was crucial in designing educational programs. These programs "must include examining and reshaping the internal barriers that may hinder" (p. 3160) practice. This belief applies to nursing education as well.

Gerbert et al. (1996) were interested in the barriers women who are battered encounter in health care settings. They interviewed 31 women and categorized their responses into client, provider, and organizational barriers. In face-to-face interviews women were asked open-ended questions about their lives, relationships, and their histories of battering. As well, women who had sought health care as a result of the injuries were asked about those experiences. They were asked about "the extent to which their physician or other health care professionals had inquired about or offered support and/or referrals regarding the violence in their lives" (p. 5).

Seven women reported positive health care experiences. They felt that the professional was helpful, sympathetic, and provided them with the information they needed. Some of them were glad they could openly discuss the battering.

Unfortunately, these positive experiences did not happen for most of the women. In relation to client barriers, some of the women chose not to disclose the battering while others made up stories to explain their injuries such as "I just walked into a door" (Gerbert et al., 1996, p. 10). Others explained that they were afraid of retaliation by their partner. They were afraid he would kill them or take

their children away. Also, the women said that they did not disclose because they felt "uncomfortable, ashamed, humiliated, or embarrassed" (p. 10).

Health care professionals imposed barriers too. Women perceived "that the professional appeared uninterested, uncaring, or uncomfortable" (Gerbert et al., 1996, p.10). Other professionals displayed intolerance for women who remain in battering relationships. "Some women reported that they felt trivialized, stigmatized, ignored, or made fun of by the health care professionals" (p. 10). One woman reported that the physician said jokingly to her "Next time try to defend yourself better" (p. 10).

Organizational barriers were perceived by several of the women. They believed that it was not part of a physician's job to discuss battering. They said that "It's not part of the system. They are there to fix the injury and that is it" (Gerbert et al., 1996, p. 11). This statement implies that there is a societal view of health care as only physical care. Other women spoke of the health care professionals as being too busy to provide optimal care. One woman recounted that she refused to press charges and the staff then proceeded to leave her alone for three hours. She got up and left.

It is difficult to believe that these atrocities are still occurring in the 1990s by so-called "health care professionals". It is obvious that the knowledgeable people who are trusted to help in time of need are unprepared or unwilling to educate themselves about battering.

In summary, it is obvious from these research studies that women who are battered receive less than adequate health care. The main reason for this lack is reluctance on the part of health care providers to pursue the topic of battering either because of lack of knowledge, a belief in the myths surrounding battering, or discomfort with the topic. As a result, the needs of many women who are battered are unidentified and thus unmet; furthermore, they leave the health care setting with the same feelings of embarrassment, guilt, and fear with which they came, now compounded by feelings of rejection from the system.

Chapter Three

Methodology

Harding (1987) defined methodology as a "theory and analysis of how research should proceed" (p. 2). The guiding methodology that I have chosen is an incorporation of the characteristics of qualitative research with the principles and assumptions of feminist theory, research, and practice.

Traditionally, nursing knowledge for the most part has been gained through the use of positivistic research methods that attempted to quantify mainly qualitative characteristics and human phenomena. This trend began in the early 1900s when the Flexner report was accepted as the standard of professionalism; it became perceived as the means to obtain scientific legitimacy (Wuest, 1993). This ideology "included an acceptance of the patriarchy in guise of the medical model and a rejection of intuitive knowledge grounded in practice as unscientific and valueless" (Wuest, 1993, p. 218). In order to achieve recognition from the medical community which was dominated by white middle-class males, nurse researchers and theorists began to establish a knowledge base that ignored gender issues and nurses' domestic heritage (Wuest, 1994). Instead research embraced logical positivistic research methods that attempted to predict and control all human experiences.

Chinn (1985), in her critique of the traditional scientific method as it is used to address nursing problems, described that it is "based on a male worldview and that the myths sustained by this partial view have perpetuated

erroneous knowledge about the world" (p. 45). She identified the following seven myths of the scientific method as being instrumental in marginalizing nursing's (and women's) knowledge:

1. Scientific knowledge represents reality and this reality is perceived as truth.

2. Traditional science is value-free and objective.

3. There is an obsession with orderliness, repetitiveness, and fixation with details in order to attain the perfect research method.

4. This religious adherence to the scientific principles is the only means for delineating truth, knowledge, and reality. It rejects any other possibility for creating knowledge.

5. Whatever is observable through sensory perception is measurable and whatever is not observable does not exist.

6. Those people engaged in the academic or scientific enterprise hold socially sanctioned authority. They believe that they can give or withhold information and coerce and manipulate people at will.

7. If the results of a research study have statistical significance, the findings have meaning. Those results that do not are irrelevant.

Chinn (1985) also concluded, "there is seldom any creativity in the conceptualizations or methods used primarily because credibility depends on doing the same thing . . . in the same way. What this does is perpetuate the status quo-a past-oriented perspective" (p. 46).

Within the past two decades nurse researchers have begun to recognize that traditional methods have limitations for addressing phenomena that are not readily measurable (Keddy, 1992; Wuest, 1995) such as the phenomenon of interest in this study, that is, the meaning of being battered while pregnant. Traditional methods fail to consider the impact of historical influences and the importance of the social context (Duelli Klein, 1983; Wuest, 1995). "Traditional scientific research does not accurately reflect the diverse possibilities for research in nursing (Wuest, 1995, p. 30). Consequently, nurse researchers are turning away from tradition and forging ahead with new and different ways of thinking about and obtaining new knowledge.

Qualitative Research Methodology

In order to address the inadequacies of the past and expand the research future, Streubert (1995) pointed out that qualitative research methods should be utilized. Qualitative research has been "described as holistic . . . concerned with humans and their environments in all of their complexities" (Polit & Hungler, 1995, p. 517). It "offers the opportunity to focus on finding answers to questions that center on social experience, how it is created, and how it gives meaning to human life" (Denzin & Lincoln as cited in Streubert, 1995, p. 12).

Qualitative researchers believe in and adhere to the following five principles:

1. Multiple realities exist and create meaning for all individuals.

2. There are multiple ways of understanding and the research question guides the research method.

3. There is a strong commitment to listening to the participants' points of view.

4. Because the researcher participates in the study, there is no need for objectivity; subjectivity is the goal.

5. It is essential that participants' experiences be reported from their perspective and using their words (Streubert, 1995).

I have chosen to use a qualitative approach because I believe the traditional scientific methods that nurses have used in the past could not adequately encompass the complexities of being battered while pregnant. They could not possibly address the multiple realities of each participant and they would either hide or reduce their voices to cold objective statistics. In addition to a qualitative method I embrace the principles of feminist methodology.

Feminist Methodology

A feminist methodology was used to guide my research process. "Feminism can be defined as a world view that values women and that confronts systematic injustices based on gender" (Chinn & Wheeler, 1985, p. 74). This perspective assumes that women are oppressed and their position in society is a result of patriarchal dominance and pervasive sexism (Chinn & Wheeler, 1985). Feminism validates women's experiences, ideas, and needs and seeks to improve oppressive societal conditions through critique and political change

(Chinn & Wheeler, 1985; Hall & Stevens, 1991). Because of the nature of my research question and the supporting data from other feminist theorists and researchers, it became obvious to me that feminist methodology was most appropriate for this study.

Cook and Fonow (1990) described the following four relevant principles of feminist research: (a) the necessity of attending to the significance of gender and gender asymmetry, (b) the importance of consciousness-raising and the emphasis on empowerment of women and transformation of patriarchal social institutions through research, (c) the need to challenge the norm of objectivity, and (d) concern for the ethical implications of feminist research.

Inherent in the principle of attending to gender and gender asymmetry is the recognition that feminist research should be for women and it should address questions they want answered with respect to their needs, interests, and experiences (Campbell & Bunting, 1991; Duelli Klein, 1983). The researcher should conduct and attempt to understand the process in a manner that respects their viewpoints and experiences rather than the male worldview (DeMarco, Campbell, & Wuest, 1993). MacPherson (1983) encouraged researchers to make a conscious effort to disseminate research findings to the participants and women in general.

Cook and Fonow (1990) argued that much of what is known about human behaviour is knowledge about male behaviour. "Taking men as the normal subjects of research is a way of ignoring gender that results in equating the

masculine with the universal" (p. 73). To add strength to this argument, Duelli Klein (1983) suggested that, although there has been "an enormous body of knowledge [produced], much of this research consists of duplicating traditional research: knowledge about women was added to the knowledge about men" (p. 90). By adding on, researchers assume that women's experiences are the same as those of men and this androcentric perspective does not allow women to investigate or be investigated in their own right (Duelli Klein, 1983). A good example of this gender asymmetry and adding on is the fact that almost all of the classic cardiovascular intervention studies included only men as research subjects (MacPherson, 1983). Medical treatments become the same for women as for men; that is, male is norm, female is other.

The gender of the researcher therefore has a crucial influence on the social relationship between the researcher and the participants (Cook & Fonow, 1990). "Understanding the common experiences of women researchers and women subjects in a society characterized by a marked degree of gender asymmetry enables the feminist researcher to bring women's realities into sharper focus" (p. 73). Fonow and Cook (1991) believed that feminist researchers use reflexivity to gain insight into the assumptions about gender relations inherent in the research process. Reflexivity refers to the "tendency of feminists to reflect upon, examine critically, and explore analytically the nature of the research process" (p. 2).

Consciousness-raising, empowerment of women, and transformation of patriarchal social institutions through research are essential principles that must be incorporated into a feminist researcher's methodology. Cook and Fonow (1990) believed that a researcher's feminist "consciousness can serve as a source of knowledge and insight into gender asymmetry and how it is managed in social life" (p. 94). Such a perspective enables researchers to view both sides of women's lives; the one in which women are oppressed and dominated by the male ideology and the other transformed view in which women see and understand this oppression and have a vision for a new ideology that incorporates women and men as equals.

The research process can become one of conscientization for the researcher and the participants. Conscientization is based on Friere's belief that

> every human being no matter how ignorant or submerged in the culture of silence he [sic] may be, is capable of looking critically at his [sic] world in a dialogical encounter with others . . . . He [sic] can gradually perceive his [sic] personal and social reality as well as the contradictions in it, become conscious of his [sic] own perspective of that reality, and deal critically with it. (Friere, 1981, p. 13)

Thus, consciousness-raising, inherent in the research act, can empower women to effect social change and transform patriarchal social institutions through politicization and action. The research study must be designed in such a way that the structural picture of the present can be transformed into an acceptable vision of the future (Cook & Fonow, 1990).

Feminist researchers object to the strongly held belief by traditional scientists that in order to be objective the researcher must separate herself from the research participants (Cook & Fonow, 1990). Conversely, feminist researchers believe that research occurs in the context of an interactive and non-hierarchical relationship between the researcher and the participants. Thus, the emphasis of the research is transformed from objectivity to subjectivity (Keddy, 1992).

The researcher plays an active role in the research process by: (a) describing her values and beliefs about the research question and process, (b) involving the participants as much as possible (Keddy, 1992), and (c) validating her interpretation of the data with the participants in order that they may benefit from the research (Campbell & Bunting, 1991). Keddy (1992) recommended that the research results should be written in easy to read language so that they can be made accessible to as many women as possible. In summary, Duelli Klein (1983) suggested that "a methodology that allows for women studying women in an interactive process without the artificial object/subject split between researcher and researched will end the exploitation of women as research objects" (p. 95).

Ethical issues are of utmost concern to feminist researchers. They avoid using language that perpetuates women's subordination and they are cognizant of the professional gatekeeper's role in the dissemination of feminist knowledge (Cook & Fonow, 1990) such as the quantitative versus qualitative debate surrounding nursing research. Feminist researchers also refuse to ignore the

emotional aspects of the research process and even negative feelings are acknowledged (Fonow & Cook, 1991). They are also committed to the well-being of the research participants and seek to do no harm (Parker & Ulrich, 1990). Finally, the research is carried out in an environment of reciprocity between the researcher and the participants (Keddy, 1992; Oakley, 1981).

Method

I chose the grounded theory method of data collection and analysis to develop a conceptual framework that nurses can utilize when supporting women who are battered while pregnant. It is hoped that the results of this research will be used to transform nursing's knowledge of this oppressive social phenomenon. Grounded theory is a research approach that is used to collect and analyze qualitative data with the purpose of inductively developing explanatory theory about social and psychological phenomena occurring in everyday life (Baker, Wuest, & Stern, 1992; Chenitz & Swanson, 1986). It is both a theory and a method.

Grounded theory was developed by two sociologists, Glaser and Strauss, in the 1960s in order to study the experiences of dying persons (Baker et al., 1992; Hutchinson, 1986). Keddy, Sims, and Stern (1996) believed that "nursing scholars have embraced their methodology in order to gain knowledge of problems specific to their patients, and the nursing work required in helping patients solve those problems" (p. 3).

Grounded theory is rooted in the symbolic interaction tradition of social psychology and sociology. Symbolic interaction is a theory about human behaviour and group life. It focuses on how people define events or realities in their everyday life and how they act in relation to these beliefs (Chenitz & Swanson, 1986). Thus "the reality or meaning of the situation is created by people and leads to action and the consequences of action" (Chenitz & Swanson, 1986, p. 4). People share their meanings through a common language of symbols and the socialization process but new meanings evolve as a result of interactive social experiences (Baker et al., 1992; Chenitz & Swanson, 1986). Reality is a dynamic process that is constructed and shared through interaction (Baker et al., 1992). The participants in this study shared their meanings of what it was like to be battered and pregnant, and they shared their understanding of how nurses could support them in meeting their needs.

Chenitz and Swanson (1986) discussed how symbolic interaction theory has implications for researchers. First, human behaviour should be analyzed from an interactive perspective in which the setting and larger social focuses are considered. Second, the researcher must try to understand the participants' behaviour as they understand it, and she must share their meanings of reality. In summary, Chenitz and Swanson believed that grounded theory is a method of studying human behaviour from this interactive perspective.

It is "useful to conceptualize behavior in complex situations, to understand unresolved or emerging social problems, and to understand the impact of new ideologies" (p. 7).

When using the grounded theory method, the researcher incorporates the tenets of symbolic interactionism in order to discover the problems that exist in the social scene and how persons handle them. In addition, the researcher generates a theory or conceptual framework which explains the person's actions (Stern, 1985). Baker et al. (1992) emphasized that grounded theory method focuses on the richness of human experiences and seeks to understand a situation from the person's viewpoint. They are two common threads noted throughout qualitative and feminist literature.

Stern (1980) delineated the following characteristics of grounded theory method: (a) the conceptual framework is inductively developed from the data rather than from previous studies, and thus the theory is grounded in the data; (b) the researcher attempts to discover the dominant or core process occurring in the social interactions. This core process "dominates the analysis because it links most of the other processes involved in an explanatory network" (Baker et al., 1992, p. 1357); (c) every piece of data is compared with every other piece of data--a process called constant comparative analysis; and (d) the researcher does not follow a series of linear steps but works within a matrix in which several processes are occurring at once.

The importance or worth of a grounded theory is determined by how useful it is to others. Stern and Pyles (1986) suggested that "to be credible, the core variable, or theory, must be well integrated, easy to understand, relevant to the empirical world, and must explain the major variation in the process or phenomenon studied" (p. 15). The worth of this study will be determined if nurses accept it and utilize the findings and recommendations in their practice, education, and research.

Participants.

Six white women who had been battered during pregnancy participated in this research study. Two of them volunteered when they heard about the research, and three were obtained through mutual acquaintances. I personally asked one woman because I knew she had experienced battering during pregnancy. I advertised this study at a housing complex for women who were building a new life after battering but I did not receive any phone calls. The following exclusion criteria were used: (a) women who were in a crisis situation such as those who had recently left a battering relationship or those who were receiving help from a health care professional in living with the battering, (b) women who were pregnant or in any physical danger from a previous partner, and (c) women who were still in the same battering relationship.

The participants lived in rural or urban areas of New Brunswick and they ranged in age from 27 to 51. Even though there were differences in ages, this

fact did not inhibit the data collection or analysis. In fact, it helped show the legal-historical trends in battering and support for women.

The participants included:

1. Dianne, 41; four children aged 24, 19, 9, and 8; separated; employed as a home health care worker; and had left her partner three years before the interview.

2. Adrianna, 45; two children aged 25 and 20; divorced; employed as a factory worker; and had left her partner approximately 16 years before the interview.

3. Mary, 51; three children aged 34, 33, and 28; remarried; employed in domestic service; and had left her partner 24 years previously.

4. Anne, 27; one child aged 11; single; unemployed; had left her partner 10 years earlier.

5. Felicia, 32; two children aged 10 and 4 months; divorced; unemployed; and had left her partner approximately 5 months previously.

6. Marie, 31; two children aged 10 and 4; divorced; unemployed; and had left her partner five years ago.

Data Collection.

In a grounded theory study, data may be collected from interviews with participants, participant observation, reading documents (Stern, 1980), reading the literature on the research question and self-reflection (Baker et al., 1992). In this study, data were collected during private interviews with each participant

either in her home or at a convenient place. The interviews were tape-recorded and I transcribed them. I noted that Adrianna and Mary expressed difficulty recalling some of the exact details of the relationship because of the time that had elapsed.

At the first meeting I discussed the purpose of my study and my personal nursing background. A loosely constructed guide was used to provide some direction to the interview (see Appendix A); however, as Anderson and Jack (1991) recommended I offered the women the possibilities of freedom and flexibility in telling their own stories using their own language. The interviews lasted approximately an hour.

Because I used grounded theory within a feminist and qualitative methodology, I understood that each woman is the expert in analyzing her experiences of battering; therefore I did not utilize some existing theory from which to deduce meaning (Anderson & Jack, 1991). I actively listened to what they were saying and I concentrated on being open to their stories as much as possible. By so doing, I attempted to discard any ideas about what I should be hearing or how I should be interpreting their stories. I encouraged each participant to go beyond the conventional responses to my questions and delve into the deeper meaning of their experiences (Anderson & Jack, 1991).

Data Analysis.

Data from the interviews were analyzed as soon as they were collected and transcribed. They were examined line by line for processes inherent in the

words and substantive codes were used to identify each process as suggested by Stern (1980). I used gerunds or "ing" words as codes because they communicate action. Some of the codes were actual words of the participants. Clusters or categories of codes were established as patterns of processes began to take shape. I wanted to determine if each participant experienced these emerging patterns or concepts. Therefore, I ensured that I asked about them in subsequent interviews.

Tentative themes of supportive strategies for nurses to use when they interact with women who are battered were developed and further refined using the techniques of reducing categories, selective sampling of the literature, and selective sampling of the data. The purpose of reducing categories was to identify connecting or linking concepts and thus I developed more general or higher-order categories (Stern, 1980; 1985).

Selective sampling of the literature was carried out "to see what has been written about the concepts under study" (Stern, 1985, p. 156). Also, the existing literature was used as data and woven into the matrix of data, categories, and conceptualizations. Selective sampling of the literature was used to help expand the supportive strategies. Selective sampling of the data involved verifying these strategies with the participants.

Through data analysis it became apparent that it would be necessary to place equal emphasis on telling the women's stories of battering, as it was to develop a conceptual framework of how nurses can support pregnant women

who are battered. Although I do not want to give away too much of the story too soon, I will reveal that the core variable of **living in isolation** emerged as the predominant theme for the participants when they were living in a battering relationship. This core variable answers the question "What guiding principle or process explains what is occurring in the scene?" (Stern, 1985, p. 156). The co-variables that emerged were **living in fear**, **being delimited in freedom**, **lacking social support**, and **lacking self-esteem**. The core variable and co-variables will be discussed more thoroughly in Chapter Four. Finally, because the purpose of this research was to develop a conceptual framework of supportive strategies that nurses can use as they interact with women who are battered, **watching for signs**, **reaching out**, and **providing the options** were the significant strategies that I identified from the participants' stories. I will discuss these themes in greater detail in Chapter Five.

I utilized the process of memoing throughout data analysis. "Memoing is a method of preserving emerging hypotheses, analytical schemes, hunches, and abstractions" (Stern, 1980, p. 23). Transcriptions of the interviews were kept in a binder and memos were kept on separate pages between each transcribed sheet. I documented all my thoughts and feelings about the research data throughout the process. Sorting and ordering the memos helped me to categorize the data.

The use of heterosexist language such as 'husband' or 'wife' was avoided as much as possible. When necessary to document this language, single quotation marks were used to indicate it was not my language.

Ethical Considerations

The research proposal was submitted for ethical review at Dalhousie University, and the Ethics Committee of Graduate Studies approved it. Every effort was made to ensure that potential participants had all the necessary information regarding this research study before they agreed to participate. I carefully explained the purpose of the study, the interview procedure, and the time that would be involved. The terminology was at a level that the women could understand.

I explained that each participant had the right to refuse to answer any questions that were too personal or uncomfortable. Also, potential participants were told that they could withdraw from the study at any time. Each woman was given a letter of introduction before she agreed to participate (see Appendix B).

Each participant was assured that confidentiality and privacy would be maintained throughout the interview, in transcription, and in any subsequent written or public presentation of my research. Code names, chosen by the participants, were used. Their real names, the corresponding code names, consents, and interview tapes were kept in a locked cabinet in my home. Each participant signed a consent acknowledging their willingness to participate in the study and to have the interview tape-recorded (see Appendix C). At the end of

the study, the women were asked if they wanted the tapes returned or destroyed and if they wanted copies of the results (Chapters Four and Five).

Throughout the interview process, I attempted to establish an empathetic and trusting relationship with the participants. If they became upset the tape was stopped until they felt they could continue. I offered emotional support throughout the interviews and I discussed available community resources as necessary.

Chapter Four

Presentation and Analysis of the Findings

In this chapter I will further discuss and analyze the findings. To further support and expand these data, I will integrate selected literature related to the phenomenon of battering. When I interviewed the participants in this study my primary focus was to ask for their advice on what guidelines to give nurses to support pregnant women who are battered. Throughout the discussions, they consistently spoke of how the battering affected every part of their being and how their lives were negatively changed as a result of it. Through telling and sharing, their stories became more fully elaborated and captured in the context of their reality (Davis & Srinivasan, 1995). The participants wanted nurses to be cognizant of this reality and to use this lens when developing supportive interventions.

One of the main tenets of qualitative and feminist methodologies is that the researcher must listen to the participants' stories and try to understand them from their perspectives. I had a responsibility not only to listen and believe but also to tell the participants' stories in order that nurses will begin to understand what it means to be living the life of a woman who is battered. Hearing, believing, and understanding are prerequisites to effectively support women; consequently, there are two important segments of this study related to their storytelling. The first segment is about the women's experiences of being battered and how it

affected them. The second one is an instructional segment that consists of their advice to nurses, and it is framed by their experiences.

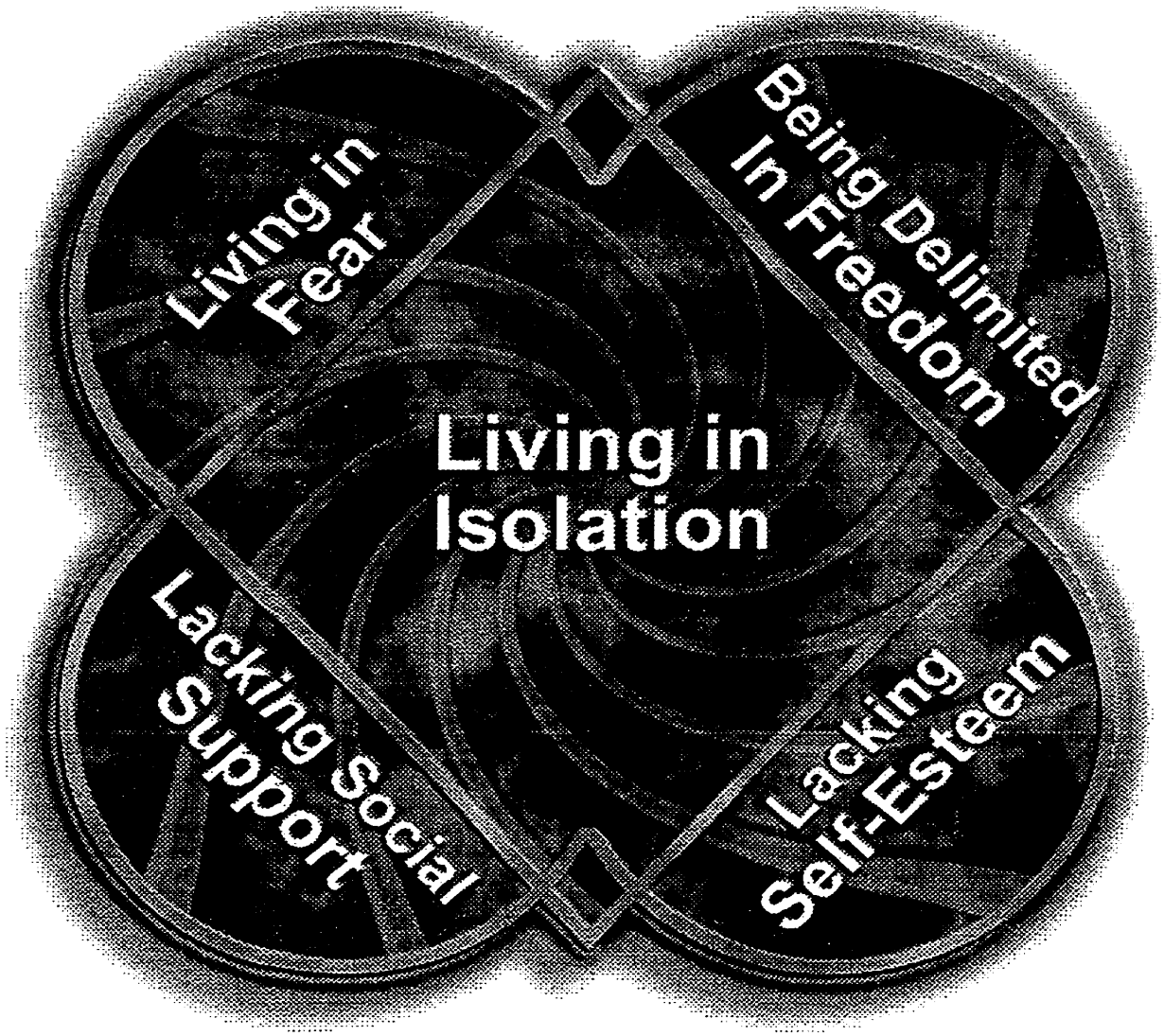

Figure 1: Living in Isolation

Living in isolation was the core variable that I identified from the women's voices and stories. The co-variables of **living in fear, being delimited in freedom, lacking social support**, and **lacking self-esteem** aid in substantiating the feelings and experiences of the women. Although the core variable and co-variables are analyzed here as single entities for editorial purposes, they must be understood as circular, interrelated, and interwoven processes that represent the true reality of the women's everyday experiences (see Figure 1). The women spoke generally of their experiences of battering, not only in relation to pregnancy; therefore, I could not analyze these data only in the context of pregnant women but I had to explore the effects as part of their overall life processes.

When I initially examined the data, I believed that living without power was the core variable which best described their lives. Upon thorough analysis, I realized that, although the women's power was minimal, they did have power in certain aspects of their lives. They demonstrated "reaching out" behaviours to others for help, they found jobs to support their families, they attempted to further their education to obtain better jobs, and they used different techniques to avoid or minimize the battering. These particular women all had the strength to plan over time and leave the relationship. Subsequently, they have made new lives for themselves; ones that are free of battering. Emphasizing their powerlessness

and lack of control would only re-victimize them; instead, they are to be recognized for their survival skills.

Living in Isolation

Living in isolation for the participants in this study was an experience in which they became physically and emotionally isolated from society. It was not by choice. It occurred as a result of their partner's actions and represented their only means of survival. **Living in isolation** encompassed living in fear of when the battering would occur and how severe it would be and wanting to discuss their fear but being unable to because of the consequences if their partner found out they had disclosed it. It involved physical and emotional isolation because the participants were not free to take part in social or educational activities or enjoy freedom of speech. Also, it meant knowing that there would be no help available from family, friends, or the legal and health care systems. The enforced isolation and battering by their partners also contributed to the women's low self-esteem; consequently, they withdrew further, kept the violence a secret, and waited fearfully for the next battering incident, thinking it might be the last one.

Throughout the interviews the participants spoke frequently of the physical battering and psychological abuse that changed their lives and forced them to live in isolation. They discussed details of when and how the battering began, their attempts to live with it, and their interactions with families and health care providers regarding these experiences.

In relation to when the battering began, four of the six participants began to experience it during the first pregnancy with their partner, though one participant received the first beating on her wedding night. "He beat the hell out of me because my father would not give me away. My father wouldn't come to the wedding. That was the beginning of my nightmare." As a result, the violence, pain, and shock marred this woman's time of joy and excitement that are common on a wedding day. The sixth participant could not remember when it started. The time that the partners had been together before the battering began ranged from a few months to two years.

It is not unusual for battering to begin during pregnancy (Bowker, 1983; Hoff, 1990; McFarlane & Parker, 1996; Pagelow, 1981; Statistics Canada, 1994; Wetzel & Ross, 1983). Bowker (1983) found disturbing results in his study. Women who married because they were pregnant suffered higher frequencies and greater severity of battering and a higher probability of violence when pregnant than other women in the study.

The battering incidents usually started with a slap when the partners were having a disagreement and Mary said they "just got progressively worse over the years." Dianne explained that they were having "financial difficulties--pressure" when he first slapped her. She was pregnant, her partner had decided not to work, and he was unhappy about the pregnancy.

Marie's first slap came when she was about six months pregnant. She was feeling sick and had not cooked her partner's supper the way he wanted it. She explained that

> the only way he would eat potatoes was if you mashed them. This one night I was really sick and I just cut them up. He freaked out. He picked up the whole table and everything went flying. Food went everywhere. I said, "I'm sorry" and then he started calling me names and gave me a big slap across the face and cut my lip. I ran into the bathroom. He came in saying, "I'm sorry, I had a bad day."

Martin (1979) believed "The triggering of violent incidents is almost always trivial (for example, she wore her hair in a pony tail, she prepared a casserole instead of fresh meat for dinner, he said he did not like the pattern of the wallpaper)" (p. 40). Langford (1996b) found that some of the women in his study were able to identify triggering events that initiated the battering. They said that "Questions about child care or finances or any gestures, behaviors, or statements that could be interpreted as challenging, such as a glance, a question or pointing a finger, would trigger violence" (p. 376). As a result of being aware of these triggers, the participants were required to avoid them in the future. They were delimited in their ability to express themselves fully; furthermore the necessity of maintaining silence to avoid the battering placed them in an isolated position.

Mary spoke of how her partner kept her isolated from family members. During the last six months of their relationship Mary had to tell her mother and

sister not to call because her partner "would get mad every time they called." He continually questioned her about her conversations. "What are they calling here for? What do they want to know? There was no such thing as you call your mother or sister just to talk. There had to be a reason." His jealousy and insecurity forced her to withdraw and isolated her from sources of support.

Anne and Felicia talked about how their partners kept them isolated from society. At age 16 Anne and her partner lived in a rural area "in the middle of nowhere in a house his father had bought for us." Her feelings of isolation were increased by the fact that they "were not allowed to have a phone and if his friends came over, I had to hide in the bathroom." During her pregnancy she was isolated from prenatal care because she was not able to keep regular appointments with a physician. Also, Anne related how she and her partner went to a Lamaze class but they only stayed five minutes. He said, "I don't want you there." His controlling behaviour reinforced the isolation and she went through her first pregnancy, labour, and delivery in a fearful state due to the lack of prenatal education. When her membranes were ruptured during labour, she remembers screaming in fear because no one explained what was happening and she had no previous knowledge of the childbirth process. When she reflected on the situation, she said, "I had no idea he would turn out the way he did. There were a lot of things that he did that did not make sense to me."

Felicia spoke of a similar experience of enforced isolation from the health care system and her family. She could not go to prenatal classes because "when you are in an abusive situation your partner does not always think you should." He would not drive her and she could not pay taxi fare. Neither would he let her see a doctor because he said, "there was nothing wrong with me" so he did not believe it was necessary. She summarized her experience by saying, "I was isolated from everyone", and she felt as if she was "kept in a trap" by her partner's controlling behaviour. It is necessary that nurses understand how women who are battered may be prevented from attending prenatal classes or keeping appointments and not blame them for their absences.

Other participants explained how they felt as a result of living with a partner who battered and kept them isolated. Dianne said, "This situation was damaging me. It got to the point where I was contemplating suicide. I'd just put my kids [outside] and I'd cry. I cried the whole time." She believed that, "he was trying to make me snap." Her strength and resilience are reflected in her reply. She said, "You're not breaking me. I'll bend and you'll cripple me but I'll not break."

Adrianna prayed that she would die to escape the situation and she "even asked him to shoot me" when he held a gun to her head. She tried to commit suicide by taking an overdose of pills because she felt that she had no place to go for support and she believed that "it was the end of the line." Both Dianne and

Adrianna said they withdrew from everyone, and Adrianna discussed how she can recognize this sign of withdrawal in other women who are in a battering relationship.

Kennedy (1993) explained the circular nature of battering and isolation. A partner may threaten to hurt not only the woman but her family and friends. At the same time he tries to convince her that these people do not like him. In order to survive, the woman begins to lessen her involvement with them and thus her sources of support are diminished. The more he criticizes her behaviour and degrades her abilities, the more she tries to improve; a multidimensional task that consumes all her time and energy and leaves none for her family and friends. As well, his "incessant monitoring and relentless questions and accusations help to fortify the isolation" (p. 395). Eventually she gives up and ceases all relationships because "the explanations required to account for her not visiting, not calling, or not writing become too much to explain and require too much [energy] to suppress the truth" (p. 395).

To understand further the lives of women who are battered, Avni (1991) conducted interviews with 35 Israeli women living in shelters. It was found that "the situation of battered women resembles that of inmates of total institutions" (p. 137). Many of the experiences of the Israeli women are similar to those of the participants in this study, that is enforced isolation. This similarity reinforces the knowledge that battering of women transcends all cultural and ethnic boundaries.

Their experiences included: (a) being prisoners in their own homes, (b) having house rules imposed on them, (c) having limited social contact with others, and (d) feeling a mortification of self.

In relation to being prisoners in their own homes, the women lost autonomy in all aspects of their lives. They were deprived of controlling their own time and space, their social connections, activities, and their bodies. Their home became their prison and the partners became their jailers. One woman said, "He used to beat me and lock the door so I wouldn't get out. . . . [Even when] I was nine months' pregnant" (Avni, 1991, p. 142).

The establishment of house rules occurred early in the marriage for the women in Avni's (1991) study. The house rules confirmed the unequal nature of the relationship, with the man being the patriarchal master and the woman his property to do with as he pleased. The partners used verbal threats and ever-present symbols such as knives to ensure that the women complied with the house rules. The rules also encompassed restricting the amount and content of the women's speech. They were "not allowed to contradict their 'husbands' by saying things which might be interpreted as dissent or disobedience" (p. 141). The partners called it "answering back" (p. 141) and the women were physically punished for such "insubordination" (p. 141). The men were free to come and go as they pleased but the women's mobility was strictly limited--a situation not unlike the one experienced by Mary, Dianne, Felicia, Marie, Anne, and Adrianna.

Social contact with others was limited and this limitation began during the courtship (Avni, 1991). It was described as being a total separation in which "The man severs her ties with even her closest family members, thus cutting her off from potential sources of aid. He deliberately comes between his 'wife' and any other person who might help her with advice or positive action" (p. 142). This control over information resulted in many women not being aware of the support systems available for women who are battered. Avni explained, "The fewer the outside contacts available to her, the greater is the 'wife's' dependence on her 'husband'. He becomes her central source of information; he is her main potential resource. . . . He defines her self for her, and it is from him that her image is reflected" (p. 143). Over time the woman becomes more dependent on her partner because she is cut off from alternative contacts and "her sense of independence wanes" (p. 143). The effects of this total separation are similar to the co-variables of **lacking social support and lacking self-esteem**.

Constantly being on guard and coping with feelings of injustice contributed to the mortification of self. Avni (1991) explained that it was "essential for them to look constantly over their shoulders and anticipate any forthcoming sanction, as those tend to be physically and psychologically abusive. The autonomy of their acts hardly exists at all as a result of their 'husband's' patriarchal beliefs" (p. 144). These beliefs were manifested in the partner's suspicion of the woman's every action. This suspicion contributed to psychological torture. "The suspect has to

be on guard all the time. Consequently, the whole thinking process is channeled into one direction only--self-preservation--while other issues have to be suppressed" (p. 144). As a result of the ever-present tension the women began to lack confidence in themselves. Their actions reflected their attempts to minimize the expectation of suspicion and thus, they narrowed their contact with others.

Coping with feelings of injustice as a result of the partner's suspicion also contributed to mortification of self. Avni (1991) described, "The mental coping with the discrepancy between the accusations and the actual situation is very difficult and undermines her sense of reality . . . in some situations she begins to doubt her position and consequently her sanity" (p. 145). Increasing self-doubt is the result. The concept of mortification of self, which was identified in Avni's study, encompasses many of the same experiences that led the participants in this study to lack self-esteem.

The experiences of the participants in Avni's study (1991) are not unlike those of the women in this study. It can be assumed that the Israeli women felt as if they were living in an enforced state of isolation brought about as a result of the partner's patriarchal beliefs. These beliefs were manifested in controlling behaviours that contributed to delimitation of freedom, lack of social support, and low self-esteem.

Johnson (1998) discussed the idea that social and physical isolation is a characteristic of many relationships where battering occurs. She believed that it is a method by which the male partner exerts dominance and control over all aspects of his partner's life. These men isolate them from family and friends and prevent them from working or going to school. At the same time they become more critical and demanding of the partners' actions at home. "Fear and shame of detection lead battered women to voluntarily withdraw from social and family interactions as their injuries become progressively worse" (p. 43).

In summary, the intense feeling of enforced isolation is reflected in the following words that Mary used to describe her battering relationship and her advice to nurses. "You feel so all alone in the world; that there isn't a soul out there to help you. If someone has their hand out and says 'I can help you' that would mean a lot."

Living in fear.

For the participants in this study **living in fear** encompassed the fear of being battered, fear of injury to themselves and their unborn children, and feelings of intense vulnerability. This fear permeated every aspect of their lives and caused them to live in isolation from family, friends, and support persons. Repeatedly, the participants voiced their experiences of living with the fear of being physically battered. The physical injuries consisted of slaps, black eyes, "fat lips", pushes, shoves, hair pulling, broken bones, burns, and beating of

various parts of the body. These injuries are consistent with the findings in the literature (Bowker, 1983; Dobash & Dobash, 1979; Drake, 1982; Follingstad, Rutledge, Berg, Hause, & Polek, 1990; Helton, 1986; Johnson, 1996; Martin, 1976; McFarlane & Gondolf, 1998; Pagelow, 1981, 1984; Pizzey, 1977; Stewart & Cecutti, 1993; Stout & Brown, 1995).

The participants experienced a circular process of fear, violence, and unpredictability of when the battering would occur. Adrianna described living with a battering partner as a "nightmare. It never stopped, never stopped. . . . You live in fear. I used to tremble in my bed when he would come home drunk. . . . He would literally drag me by the hair out of bed and beat the hell out of [me]." She feared that not only would she be beaten but also perhaps killed because often he would say, "I hate you and I am going to kill you."

Langford (1996b) found that drug and alcohol use were warning signs of potential battering. The women were especially at risk if the partner drank in secret or came home after a drinking episode. He explained, "Women were often unable to monitor their partners' drinking and subsequent agitation. . . . Monitoring their partners' increasing intoxicity gave women an opportunity to anticipate and begin engaging in interventions that could possibly de-escalate the situation" (p. 377). The responsibility becomes that of the woman to compensate for her partner's irresponsible and criminal behaviour. Herein lies another

example of a woman's efforts to survive and the partner's delegation of responsibility.

Using threats was a common ploy among the partners to instill fear. Adrianna's partner would call her before he came home from work and tell her, "When I get home, I'm going to beat the hell out of you just for something to do." Thus, she lived in fear of his arrival. Once Anne's partner fired a rifle near her head as she was hanging out clothes. He jokingly explained, "Ha, ha! I thought there was a deer behind you." Implicitly, they were using the threat of violence to ensure the women remained in an isolated psychological state of fear. Dianne was fearful because her partner had guns in the basement and she could hear him "clicking the guns" after they had a fight. "I'd ask him what he was doing and he would say 'nothing.' He scared me because he wouldn't tell me what he was up to." He used the threat of violence to maintain her fear. As well, after she left him, "he started stalking me for two or three months." She was never free to enjoy life; she was always looking over her shoulder for danger.

Like the others, Felicia's partner used psychological threats to maintain her fearfulness such as the following example. "He said, 'if you leave me, it'll be the last.' The last conversation we had was 'goodnight' . . . and it wasn't night, it was daytime. So you know what he was thinking. I'm always looking over my shoulder when I go out for a walk." Not only did she have to be on guard against

her partner but his friends, acquaintances, and strangers as well, definitely a situation of enforced isolation when she did not know whom she could trust.

Kennedy (1993) added to the understanding of the complexities of fear in battering relationships. She explained that partners who batter "do whatever it takes to make women afraid to leave. Knowing what partners are capable of doing becomes its own reinforcement. . . . Women become afraid to stay but are more afraid to leave" (p. 395). If they leave, they fear their partner will find them and kill them as well as their children, family, or friends. It is a known fact that battering escalates during separation or an attempt to separate (Bowker, 1993; Martin, 1976; Wilson & Daly, 1993). Wilson and Daly (1993) warned that threats which begin with "If you ever leave me . . . " be taken seriously by women. Therefore, it is understandable why women do not leave and if they do, they return home because of fear of death.

Many women who experience battering describe their intense fear during the relationship. In a study of the differences between women and men who kill their intimate partners, Stout and Brown (1995) found that women were more afraid of men. Of the 19 participants who reported experiencing fear, 14 were women and 5 were men. In fact, "11 of the 14 women ranked their level of fear of their partner at the most extreme point . . . on the scale" (p. 200). This fear develops from the experiences of everyday living with a partner who batters (Champion & Shain, 1998).

Mary was unable to discuss her experiences with health care providers or family because of fear. "You are too scared to say anything. . . . If it gets back to him, you know you are going to get worse." She had to keep her secret hidden for fear of subsequent and more severe beatings. As a result of her fear, she was prevented from getting the help she needed to cope with the situation.

The women feared not only for their personal safety but also for that of their children. Anne's blood type is negative and during her pregnancy her partner "was supposed to go to get his blood tested and he wouldn't. I was really worried [for her unborn child's safety] and he wasn't at all." Fortunately, the child was healthy at birth and there were no blood incompatibilities.

One of the women said how she was beaten a lot during her pregnancy. When I asked if she thought he was trying to cause a miscarriage, she replied, "I would think that but I can't prove [it]. He didn't want any kids." Her fears were rationalized because she believes that the battering caused one of their children to be "a little slow." Although the participants did not discuss the issue, it would seem that, not only were they fearfully anticipating the next battering episode, but also they were anticipating the birth with a certain amount of fear for the child's health.

Marie explained that she would never go back to her partner because she knew he almost killed her and their unborn child. Her partner had broken her jaw and nose and had kicked her in the abdomen. The injuries initiated labour. She

said that, "I could have lost the baby even at that late stage. He could have killed his child. If he could do that, what was to stop him from moving on to the kids? I would never have been able to trust him with the kids." If they remained together, she believed he might try again to severely injure her or the children. In this case her fear was the catalyst for leaving.

As part of the co-variable of **living in fear** were the women's intense feelings of vulnerability during pregnancy. They felt that their physical awkwardness put them in a dependent position and they feared their partners would take advantage of this vulnerability. Marie explained, "You have one danger zone that you have to protect." Adrianna cautioned women not to fight back because, "The more you hit back, the more they hit, and there's no way you can hit as hard as a man." The issue of increasing violence if the woman fights back is echoed in the literature (Bowker, 1983 & 1993; Straus & Gelles, 1986). As a result, the participants avoided situations or conversations that might initiate a battering incident, just another example of being emotionally isolated.

In summary, **living in fear** for the participants in this study represented an ever-present fear for their lives and those of their unborn children. The threat of battering was all encompassing and caused them to restrict their everyday activities to avoid being beaten. They knew their partners better than anyone else and they knew they were capable of carrying out their threats at any time. Wetzel and Ross (1983) called fear the most immobilizing factor in keeping a woman

trapped in a violent home. They said that fear is all permeating and motivates much of her behaviour whether she is aware of it or not.

Being delimited in freedom.

Being delimited in freedom encompassed restrictions on the participants' rights to make choices about their everyday activities especially their freedom of movement and speech. Mary explained that she only had a few minutes to get home after work or her partner would accuse her of being unfaithful to him. She described her lack of freedom by saying, "I could not sit down for a coke after work. I didn't even dare stop for bread and milk. . . . So I practically ran all the way home." Thus she missed out on the social companionship that accompanies work-life.

Anne related how she was restricted in her movement.

> I was always concerned that I have to get out of here [whenever she went anywhere]. He is going to pick me up; he is going to be out there beating the horn. "Are you finished yet?" Everything had to do with him and what would happen if I didn't do exactly what I was supposed to.

As mentioned earlier, Anne was not allowed to have a telephone in their home, and "He used to check for tire tracks going into my house if he went somewhere." He did not want her to have any visitors while he was away. If it was a relative she said, "I had to prove that it was [her]. He'd say, 'What did you talk about and why was she here?' " Both these examples represent a lack of social support and enforced isolation.

Dianne's partner controlled her freedom because he would not help her get a driver's license. She said that, "He wouldn't help me. He wouldn't teach me how to parallel park. I kept on doing something wrong. He forgot to tell me to turn my wheels." She wanted her license "so I could have my freedom . . . and get away [from him] if I had to." During battering incidents she had to take her two small children and walk to a neighbour's house. Later, Dianne's sister helped her get the license. Pagelow (1984) explained that some men leave their partners at home without transportation, and accompany them for all appointments, grocery shopping, and other activities. Society may envision this behaviour as "loving concern" (p. 309), but women know that it is an attempt by their partners to monitor and control their every move. Dianne was not able to finish some of her upgrading courses because her partner would not babysit in the evenings. She believed "He did not want me to be free." Bowker (1983) suggested that delimiting freedom not only involves lack of physical movement but limitations in decision making regarding family, monetary, career, and educational choices.

Being delimited in freedom was also characterized by hiding the battering from family, friends, and health care providers who were potential sources of social support. Mary spoke of how she hid her battering experience "because it wasn't brought out back then, it was hidden." She explained that her upbringing framed her belief system about family communication patterns. "I was brought up with the understanding that you make your bed, you lie in it. The last

thing I would ever do was to go to my mother and father." As a result, she hid the battering and remained isolated from her family and friends who might have been able to support her. After one particularly vicious incident, Mary had to stay home from work for three weeks because she "was bruised from head to toe." Not only did she hide the physical injuries but she suffered from lost income as well.

Fiene (1995) shed light on the secrecy that is often maintained in a battering relationship when she investigated the nature of "battered women's secret-keeping process" (p. 180). She found that the participants kept battering a secret because of the following three fears: (a) family members would express disapproval if they knew and the participants would feel hurt, (b) family members might believe the participants should take responsibility for the battering or that the welfare department might take the children, and (c) the partner who battered would threaten others who knew of his violent behaviour. As a result, women avoided the stigmatization that is associated with battering by keeping the violence a secret.

In this study other participants were delimited in their freedom to discuss the violence in their lives. Marie kept the secret from her father saying, "I felt like I was a failure and I didn't want my dad to know. It felt like I would be saying 'Look, I screwed up again.' " Her lack of self-esteem brought about by the battering prevented her from reaching out and getting the physical and psychological

support she needed. Thus, she remained in isolation and the battering continued.

The participants in Fiene's (1995) study reported similar stories of withholding information and covering up the signs of battering. One woman told her parents that she was sick when she had to stay home with injuries that could not be hidden. Also, Fiene found that the partners enforced the hiding by controlling how much communication the women had with other people. She believed this tactic was especially effective in rural areas where the women were left at home without a car or not knowing how to drive.

As well, Bowker (1983) recounted that some of the partners restricted their own activities in order that the battering would remain hidden. They avoided hitting their wives in the company of others, they used techniques that would not leave bruises, and they waited until the children were asleep before they began to batter. Similarly, Felicia reported that her partner "knew enough not to slap me in the face because that would be too noticeable. People would notice it." Even when the partners in Bowker's study were drunk, they were careful not to batter in public. These data indicate that alcohol cannot be used as an excuse for battering. Furthermore, it seems apparent that the partner made a conscious decision about the timing of his actions. The question remains: Why does he choose to batter?

Of particular significance to nursing is the fact that the participants hid the true cause of their injuries from health care providers. Adrianna recounted that

she told the doctor she "fell off the ladder [while I was] cleaning windows" after a battering incident. On another occasion her husband kept the secret by telling the doctor in the emergency room that "I was crazy and that I needed a psychiatrist after I took an overdose of pills. They were going to pump my stomach and I said, 'no.' Just leave me alone and I'd be better off dead. [The doctor] asked, 'What is your problem? Is your husband concerned?' He wasn't concerned." She was referring to her suicidal attempt to escape the battering. The combination of fear, isolation, lack of social support, and low self-esteem caused her to seek a permanent reprieve. By blaming her for the incident, her partner was negating his involvement and perpetuating the myth of psychological instability in women.

Dianne explained that she could not tell the nurses or doctors about her situation because it has a "lot to do with the person's upbringing; keeping things quiet. . . . In my mind, that's behind closed doors. That's quiet." The reasons that the participants gave for hiding the battering in this study are consistent with those found in Gerbert et al. (1996). As discussed previously, many of the women chose to conceal their experiences from health care providers because of fear that their partners would kill them and fear that their children would be taken away. Also, the women reported feelings of shame, embarrassment, and humiliation as the reasons why they were unable to disclose the battering.

The women in this study spoke of being delimited in their freedom even after leaving their partners because the fear continued. Adrianna explained that

after she left her partner she "hid for a week away from him so he could not find me. But I lived in terror even after that because he used to follow me around with a loaded gun." Marie said she hid from her partner after their son was born. "I stayed with her [a girlfriend] for two weeks after I got out of the hospital and he circled and called. He knew where I was. I never left the house for two weeks." These are terrifying examples of the interplay among battering, fear, lacking freedom and social support, and subsequent isolation.

In summary, **being delimited in freedom** for the participants in this study was a situation in which they were forced to keep the battering a secret from health care providers and other support persons. Thus, they had to remain in isolation. Because of their partners' controlling behaviour, they were also restricted in their pursuit of social interaction and educational opportunities.

Lacking social support.

During the battering relationship all the women lacked adequate social support systems, much of which was because of the secrecy just discussed. They lacked support from family, friends, health care providers, and the legal system. As a result, they had to remain in isolation until such time as they had the strength and resources to leave their partners.

Social support has been defined and explained in several ways. Cohen and Syme (1985) said it is "the resources provided by other persons . . . potentially useful information or things . . ." (p. 4). As well, it has been defined as

"an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (Shumaker & Brownell, 1984, p. 13). These resources may be in the form of emotional, instrumental, informational, and appraisal support (Langford, Bowsher, Maloney, & Lillis, 1997). Social support may protect people from the adverse effects of stressful life events (Cobb, 1976; Cohen & Syme, 1985; Gottlieb, 1985).

Cohen and Syme (1985) discussed the buffering hypothesis of social support and its relationship to health. The buffering hypothesis suggests that social "support exerts its beneficial effects in the presence of stress by protecting people from the pathogenic effects of such stress" (Cohen & Syme, p. 7). It is believed that social support may buffer in the following manner. It may "bolster the ability to cope" and it "may intervene between the experience of stress and the onset of the pathological outcome by reducing or eliminating the stress experience or by directly influencing responsible illness behaviors or physiological processes" (p.7). The implication from the literature is that formal and informal social support systems can help a woman who is in a battering relationship by providing needed resources such as objective information about battering and where to go for support, financial aid, and a safe place to stay for the woman and her children. Support in the form of caring and validating her worth are just as important as the tangible resources. Through the utilization of

these resources it is assumed that a woman who is battered will receive the support she needs to make important decisions about her future. Presumably, the social support will interrupt or prevent the negative effects of battering on her health.

Realistically, for the participants in this study the social support systems were negligible, even if the battering was not kept secret. Dianne, for example, described her lack of support from her mother. When she told her about the battering situation, she "would not let me come home. She said, 'You're arguing with your husband. You go home; that's your place with him.' " Because of her mother's strict beliefs surrounding female-male roles in a marriage and her refusal to help, Dianne had no choice but to go back to the battering relationship; nonetheless, she continued her "reaching out" attempts. She recounted that she "took the pastor's wife aside and showed her the bruises." She did not want her to tell anyone but she wanted her to be aware of the situation. Although she was not ready to disclose her situation completely, she was compiling a list of potential support persons.

Dianne also spoke of an experience that she had at a local women's shelter and that she did not feel emotionally supported there. She was almost due to have her baby when she went to the shelter after a battering episode. She explained, "I couldn't stay because it wasn't . . . a home atmosphere. When you go to a strange place and you have a problem, you don't feel like being there.

You want to be somewhere . . . secure." The shelter staff wanted her to press charges, but she refused. She resolved that she would avoid her partner as much as possible to prevent more battering and went back home after eight hours in the shelter. It is obvious from Dianne's experience that, although certain types of social support were available (safe shelter and information), they were not enough to meet her need for emotional support. The implications for shelter staff are that each woman must be respected as an individual. As well, staff must be willing to assist her in developing strategies that will meet her specific needs.

Adrianna spoke of the lack of safe shelters when she was living in a battering relationship. The first Canadian shelter "Oasis" opened in Calgary in 1972 (Martin, 1976) and the first shelter in New Brunswick did not open until 1981. Adrianna said there "was no place [to go] back then" to escape the battering. She explained that her friends did not help. "Your friends did not want to get involved back then. I never had one of my friends say to me, 'If you need a place to stay, you've got one.' " She told that she and her partner went for marriage counselling. "The counsellor [a male] would side with him. . . . So you look like a fool when you leave there. I used to get more beatings." As a result they stopped going. Adrianna was soliciting emotional, instrumental, and informational support, but none was available from family, friends, or social services. There was little societal awareness of battering at that time which also prevented family and friends from helping. Fear of retribution by the partner was

and still remains a genuine concern of potential support persons. As well, the belief that family matters are personal and not for public examination is still common among health care providers.

Five of the women believed that they lacked support from the health care system because no one ever asked if they were being battered during their pregnancies, at delivery, or when they sought help in emergency departments.

Adrianna explained her experience after a severe beating.

> When I told him I was pregnant, he literally beat the shit out of me. He kicked me with workboots on. I thought I was going to lose the baby. I'd gone to the doctor and he didn't say anything. I told him I had fallen down the stairs. He had seen the bruises and he looked at me kind of funny. He said, "Are you sure?" I said, "Yeah I'm sure." What are you going to say? Who are you going to say it to? That wasn't the first time. I had many beatings.

The other participants had similar experiences of not being asked.

Felicia's partner would not allow her to see a doctor or a nurse during her pregnancy. She described that she

> wasn't allowed to communicate even with my family. I was isolated from everyone . . . my friends. They would get disgusted after a while. It's like crying wolf; you say you are going to leave and you do and then you go back. I did that and I lost a lot of good friends because of it.

Felicia also related how, because of lack of informational support and low self-esteem, she had a therapeutic abortion in a previous pregnancy. She was battered by her partner and she said, "I didn't think I could do it by myself

[continue the pregnancy]. I wasn't strong enough then. . . . I didn't have the information. I didn't know who to see."

Anne discussed her lack of support from the legal system in a small community where everyone knew everyone else. She recounted that she "went through the court system and no one believed that I had been battered. The judge literally said to me, 'things like that do not go on around here.' I tried to put a peace bond on him and they wouldn't."

Radford (1989) further portrayed this denial of battering: "It is almost routine for women in refuges to complain that their experiences of victimisation have been trivialised, ordained unimportant, or turned back on themselves by 'helping' agencies" (p. 136). The legal system may view the partner's behaviour as being non-criminal, understandable, normal, or an irrelevant concern. Adrianna explained that the police told her, "there was nothing they could do" to her partner when he followed her around with a loaded gun. This situation occurred about 20 years ago before the anti-stalking laws were enacted. As a result of this lack of support from the institutions established to help such as the legal and health care systems, women may indeed feel re-victimized or that they have received a "secondary assault" (p. 136).

Sexual assault in the home may be regarded by society as the "understandable response of a man led on by a woman dressed provocatively; sexual harassment, the normal behavior of virile males" (Radford, 1989, p. 136).

If indeed these responses are true of men, I question why they usually can control their 'normal' responses in the workplace and other areas of society but believe it is permissible to unleash their violent tendencies at home.

This lack of support by social institutions forces a woman who is battered to keep the secret. If no one believes her or if society shifts the blame to her, the gradual psychological process of implicating herself begins. Society abdicates its responsibility to support her as she is encouraged to believe that she must secretly cope with the crime. She also risks punishment from her partner if she discloses the battering. Society and her partner create the need for her secrecy but she is conditioned to believe that it is of her own making.

The findings in this study that formal support systems such as the legal and health care systems are viewed as ineffective are similar to the findings of Brendtro and Bowker (1989). As discussed previously, the most effective formal sources of support were women's groups and shelters for women. Approximately 60% of the 146 women believed these resources to be helpful whereas only 31% believed the same of health care personnel. The implications of these findings are that health care providers have to learn from women themselves what is most effective in supporting them during their battering experience.

Regarding informal support systems, research studies have demonstrated that women who are battered tend to lack social support. Mitchell and Hodson

(1983) related the findings of their research with 60 women who sought assistance from shelters. They found that many of the women were socially isolated. "When asked to report the number of social contacts with friends or family [unaccompanied by their partner] in the month before their most recent separation, 28% of the women reported no such visits, while 24% reported only one visit" (p. 641). When asked to name the number of support persons with whom they could discuss their personal problems, 21% said they had no one and 40% of the women reported only one. More recently, Barnett, Martinez, and Keyson (1996) used the Multidimensional Scale of Perceived Social Support to determine sources of support from family, friends, and a special person in the women's lives. In this study of 95 women, the researchers found that women who had been battered "reported receiving significantly less social support than nonbattered women" (p. 228-229). It was found that women 30 and younger received less social support from their friends than older women did. While this is a reductionist study that attempts to quantify the qualitative characteristics of social support, nonetheless, the results are worthy of note.

In summary, Straus (as cited in Bowker, 1983) emphasized the importance of social support for women who are battered. He said, "It is important to obtain advice, assistance, and moral support from one's neighbors, relatives, and friends because these people can offer assistance in the form of

specific suggestions, aid in settling disputes, and often physical sanctuary" (p.17). If this support is unavailable, the partner has the advantage of being insulated from the negative reactions of family and community.

Lacking self-esteem.

Lacking self-esteem has been frequently reported in the literature on women who are battered (Campbell, 1986; Dutton & Painter, 1993; Follingstad et al., 1990; Frisch & MacKenzie, 1991; Holiman & Schilit, 1991; Merritt-Gray & Wuest, 1995; Mills, 1985; Trimpey, 1989; Tutty, 1993, 1996 and many others) and it was echoed in the voices of the participants in this study.

Self-esteem is a construct that is difficult to define or explain because of its complexity. Reflecting upon the seminal works of Cooley and Mead in the development of self-esteem theory, Harter (1993) explained its social origins. She said, "If others hold the self in high regard, one's own sense of self-esteem will be high. Conversely, if others have little regard for the self, one will incorporate these negative opinions in the form of self-esteem" (p. 89). The relationship of significant others and self-esteem is particularly important when analyzing this concept in women who have been battered. A comprehensive definition that is applicable is that self-esteem may be viewed as the opinions, attitudes, and feelings a woman has about herself that are generated and confirmed by others, especially her partner. The issue is related to the profound effect battering has on a woman's self-esteem.

Trimpey (1989) found that diminished self-esteem was a recurrent theme that emerged in her work with members of a support group for women who are battered. Low self-esteem was implicit in statements such as "I can't do anything right, it's my fault", and "I should have been a better wife" (p. 301). Similarly, Mary said she had "no self-esteem" and believed she deserved the beatings. She explained that she thought, "If I hadn't said this or hadn't done that, he wouldn't have touched me." Through his battering actions her partner was reinforcing her feelings of worthlessness and her isolated, fearful state prevented her from understanding that the beatings were not her fault.

Campbell (1986) found similar results of low self-esteem in her study of women attending a support group for women who are battered. The theme of damaged self-esteem was frequently discussed. The women explained how they "had been constantly disparaged by their partner, a psychological pain they often described as worse than the physical pain from beatings" (p. 17). Adrianna experienced various kinds of psychological insults from her partner; for example, he taught their two-year-old child to call her "a slut and a whore." It is difficult to imagine the terrible pain and degradation she must have felt when she heard her child say these words.

Anne's self-esteem decreased not only because of the battering but because her partner would not allow her to possess items that many women use to enhance their body image. He did not allow her to "have deodorant . . . a brush

. . . makeup. Anything that I . . . bought when I was out shopping, he would throw away." He explained his behaviour by saying, ". . . it doesn't matter now because you're ugly [she was pregnant]. Who cares?" Anne's self-esteem was so damaged by the battering relationship that she was unable to get groceries without having a friend accompany her even after she left her partner.

Anne attempted to return to night school for upgrading but she was unsuccessful. "I tried to go back to night school. I lasted two nights. He told me I was stupid because I [didn't understand]. I had no idea what I was doing in that classroom because my mind wasn't on the work." His denigration and her inability to concentrate forced her to leave the course. This situation is not unique to Anne. In a study to investigate the effects of battering on the employment status of women, Shepard and Pence (1988) found that almost half of the 42 participants "thought that their partners had discouraged them from going to school, while one-quarter stated that their partners had prohibited them from doing so" (p. 58). The women in the study were told by their partners that "they were not intelligent enough to attend school or that it was unaffordable" (p. 59).

In relation to work and self-esteem, 21% of the women in the above study said that battering had kept them from finding work by damaging their self-esteem and lowering their confidence about finding it. The partners were threatened by the women's efforts to obtain work or attend school. "Some men were jealous of the possible contact with other men, while others insisted that the

women stay home to care for the home and children while they acted as sole providers" (Shepard & Pence, 1988, p. 59). These control tactics of disallowing education and work experiences relegated women to an isolated state within the home. Because they were completely aware of what consequences would await them if they resisted their partner's demands to stay at home, the women complied as another means of survival. Not only was their self-esteem damaged but also potential sources of social support were eliminated. This support could possibly assist the woman to leave the battering relationship; a situation that the partner would do anything to avoid. It is understandable that women remain in the relationship if their partners relentlessly devalue them and their efforts to improve their lives.

Tutty (1993) explained that low-self esteem results from "the long-standing denigration of their abilities by an ex-partner" (p. 194). It may interfere with women's decision making abilities and prevent them from interviewing well with prospective employers. In her research with 18 women who had left a battering relationship, 17 of them discussed their feelings of low self-esteem during the relationship. It caused them to feel incapable of handling new situations in their life such as calling an office for needed information and appearing in court. In fact, several of them had such poor self-esteem that they considered suicide. Tutty (1993) theorized that "such low self-esteem is a pervasive problem that will affect how women deal with every aspect of their lives" (p. 195). In spite of this, in

later research, Tutty (1996) reported a positive finding in relation to self-esteem. She was investigating the effectiveness of post-shelter follow-up programs in Canadian cities and evaluating self-esteem was one of the measures. She found that there was a statistically significant improvement after three months of intervention. Obviously, this research gives health care providers a strong message to communicate in ways that raise self-esteem and encourage women to take courses that promote it. It further provides rationale for the belief that, although battering results in low self-esteem, it is not an irreversible life-long affliction.

It is not only the partner's physical battering and psychological abuse that contributes to the woman's lack of self-esteem. Society's attitude that women are responsible for the battering still prevails. Merritt-Gray and Wuest (1995) explained that rural women began to believe the poor image of themselves that their partners had created. One woman said, "when neither neighbours nor police responded to her screams, she began to believe that she deserved the abuse and questioned whether abuse was just part of life" (p.404). The participants in the study described their negative experiences with law enforcement agencies, churches, and health care services that caused them to question their sense of reality and accept responsibility for the battering.

In summary, it can be conceptualized that a woman who is battered internalizes society's belief that she is to blame for her partner's behaviour. In

order to maintain the respect of others and survive, she keeps the battering a secret. As a result, the continuation of the battering and her belief that she is to blame contributes to a downward spiraling of self-esteem. Low self-esteem interferes with a woman's ability to carry out her daily responsibilities at home and work as well as her attempts to improve her education.

Analysis of Findings

When asked why their partners hurt them, the participants said it was because they wanted to be in control and maintain power over them. To further explain these concepts, Mary related how her partner learned about battering as he was growing up at home. She explained his actions in the following manner.

> That was all he saw all his life; that was the only thing he knew. The man was the boss, and if you didn't do as he said, you paid the consequences. You didn't even have to do anything wrong, it was just the way it was.

Adrianna described the dangers of bringing up children in a household where there is battering of a female partner. "If I had stayed with the girls' father, they would have thought that men beating them is a normal way of life. It's not a normal way of life." Both these women realized the seriousness of children's growing up in a home where there are rigid gender roles and the dangerous implications for future generations. In order to understand this explanation of the battering, it is necessary to examine some of the current and prevalent assumptions of violence.

Social learning and sex role theories.

Social learning theory and sex role theory are two of several theoretical explanations that attempt to clarify why men batter their partners (Johnson, 1996; Pagelow, 1981). Social learning theory postulates that violence is a behaviour that can be used to solve problems. It is learned by observing others in social situations, especially the family and the media, and by perceiving the benefits or rewards to the behaviour (Johnson, 1996; Pagelow, 1981). Sex role theory expands upon this assumption and proposes that women and men learn appropriate gender roles through socialization within the culture of the family and wider society. Johnson (1996) explained, "Masculine toughness, power, and control are cultural messages that predominate in the rearing of boys, while girls grow up to follow submissive ladylike behaviour, to strive in maintaining relationships, and to serve others" (p.7). Walby (1990) clearly summarized these theories. "Violence and sexuality are socially shaped; men are brought up to be macho and are accustomed to using violence to settle disputes" (p.134).

There have been several research studies that suggested the possibility that battering of women is a behaviour that can be learned in the boy's home of origin (Bowker, 1983; Brendtro & Bowker, 1989; Pagelow, 1981). It must be remembered that battering of women is a complex societal issue that cannot be explained by these theories alone. It is not just an individual, hence

psychological, analysis that can easily explain away the myriad of social, economic, and political factors that perpetuate violence in any society.

Dianne, Adrianna, and Marie specifically described that they took measures to prevent their children from seeing the battering and its effects. Presumably one of the reasons for this action was to prevent them from learning that it was all right for the father to hit the mother. Mary explained that she taught her son, "You don't control women. You don't touch a woman." Dianne related that her partner rationalized his controlling and overpowering behaviour by saying he was "the man of the family" and he had "all the right" to behave as he did; furthermore, he believed that "women were below men." Adrianna's partner believed she was his property; he owned her. The statements of both partners represent their patriarchal beliefs.

Patriarchy.

Pagelow (1984) wrote that "Patriarchy is the system of family relations where men are the undisputed heads of a household and other family members are subordinate to them and must defer to their wishes and commands" (p.13). Patriarchy has to be understood within a larger social and political context.

Dobash and Dobash (1979) described a patriarchal system in the following manner.

> The patriarchy is comprised of two elements: its structure and its ideology. The structural aspect of the patriarchy is manifest in the hierarchical organization of social institutions and social relations. . . . The maintenance of such a hierarchical order and the continuation of the authority and advantage of the few are to some extent dependent upon its acceptance by the many. It is the patriarchal ideology that serves to reinforce this acceptance. (p. 43)

Yllo and Straus (1990) explained that the structural element of patriarchy continues to be reflected in "the low status women generally hold relative to men in the family and in economic, educational, political, and legal institutions" (p. 384). The ideological element is revealed in "the values, beliefs, and norms regarding the legitimacy of male dominance in all social spheres" (p. 384). As part of this legacy, men have been permitted to beat, club, and kick their partners, and this treatment was sanctioned by the state and religious institutions (Dobash & Dobash, 1979).

Because English laws directly influenced the laws of Canada and the United States, especially in the realm of domestic affairs, it is noteworthy to examine how this English common law of 1765 supported battering of women.

Dobash and Dobash (1979) explained that the law

> excluded the woman from the legal process, placed her in the same category as children and servants, demanded surrender and obedience, and elevated her 'husband' to the position of lawmaker, judge, jury, and executioner. In this capacity, the 'husband' was able to punish offenses that in any other setting would clearly not be considered offences and to use his discretion in determining the severity of punishment. Excesses were not uncommon. Even a blatantly unjust legal system would not have allowed many of the punishments meted out by 'husbands': broken nose for an unwashed dish or a black eye for a cross word. (p. 61)

Pagelow (1984) suggested that this law caused a merger of the 'wife' and the 'husband' into one legal being–the 'husband'. This law was the basis upon which 'wives' were prohibited, until recently, from testifying against their 'husband' in court and the lack of recognition of spousal rape by social and legal institutions.

Not only did the state condone battering of women as a social process but also the historical institution of the Christian Church greatly influenced thought on the hierarchical relationship between women and men (Dobash & Dobash, 1979). In order to maintain its power and authority and to eradicate heretics, the Catholic Church produced a misogynist masterpiece in 1482. This text, entitled Malleus Maleficarum, directed clerical and civil authorities, men, to persecute and prosecute witches, most often women, believed to be in league with Satan (Minkowski, 1992). In the fifteenth and sixteenth centuries, hundreds of thousands of innocent, predominately peasant women were executed by men in

England, Europe, and North America at the stake or gallows (Williams & Adelman, 1978). This illustration of femicide by church and civil leaders most emphatically placed all women in a subordinate position in society and presumably caused them to live in constant fear and restricted their everyday activities--a situation not unlike that of a woman who is battered in the twentieth century.

Although Martin Luther supported an egalitarian relationship between women and men, he often spoke of women's natural inferiority and their proper social sphere (Dobash & Dobash, 1979). In 1531, he said that the broad shoulders and narrow hips of men symbolized intelligence. God gave women narrow shoulders and broad hips so that they could keep house and bring forth and raise children. Thus, women were controlled not only by men but also through their biology. Dobash and Dobash reasoned that few people would disagree with God and his ministers: "And who can argue with God or those who speak for Him and are the only transmitters of His ideas or intentions?" (p. 53). Luther further proposed "that women were weak in character and need to be controlled" (p. 53). Later, the Calvinist, John Knox, reiterated "the natural and irrefutable inferiority of women's character, their sole place in the family, and their rightful subordination to their 'husbands' " (p. 54). As a result, the powerful combination of the mandates and teachings of the Christian Church together with the laws of the state relegated women to an inferior position in the family and

society and further sanctioned the partner's right to control and dominate using whatever measures he deemed necessary.

Although laws began to be passed in the late1800s to make battering illegal, they were slow to be accepted. Dobash and Dobash (1979) explained the resistance because "In many cases there is ignorance of the law and in others' flagrant disregard for it. This was especially true in the case of 'wife' beating" (p. 64). It is obvious that at the beginning of the twentieth century patriarchal societal structures and the inherent ideology were well established. The ideology was that the male head of the household had society's blessing to exert power over and control his partner and children. With the advent of capitalism came an emphasis on competitiveness and individualism and they continue to be perpetuated. Social structures are influenced daily by militarism, wars, economic crises, and poverty. Battering of women is one of the inherent oppressive inequities in a society built upon violence.

Summary

At the end of the twentieth century, life for a woman in a relationship where battering occurs is similar to living in a war zone. She is constantly in a state of alert because the next attack may come at any time and she has little or no warning. She never knows when the next attack of battering will occur or if it will be the last. The woman has virtually no armour to protect herself and no ammunition to fight back. She not only has to protect herself but also her children

from the onslaught of violence. All this happens behind the closed doors of her battleground--her home. Most people retreat to their homes where they can feel safe. This "haven" is dangerous for a woman in a battering relationship. The physical structures of walls and doors serve to reinforce the psychological barriers imposed by her partner to keep her isolated from her support systems. A silent war is being waged by the partner against his hostages--the woman and her children.

Why must she be alone with her secret? Powerful family traditions and images and social myths are the primary factors that keep her isolated and in bondage. Family traditions dictate that intimate relationships between partners are private affairs. They are not to be disclosed to or examined by other relatives. Because of these unwritten rules that are passed from generation to generation, a woman believes battering is a normal part of life and not something to be changed. Strong family images of the man as head of the household with all encompassing power are indoctrinated in girls and boys in the family of origin. This power overshadows the woman and dictates her everyday experiences both inside and outside her home. Her decision making powers are limited or absent and she is often dependent on her partner for all her needs because of his tactics to keep her in bondage. As a result of the constant warfare, she loses confidence in herself and her abilities as a partner, mother, and worker.

Negative myths about women who are battered are pervasive in our society. They maintain the isolation by enforcing the silence and the view of the family as sacrosanct. Dreading that she will be labeled as inept, a drug-user, a masochist, or worse, the woman continues to hide behind the veil of secrecy. Fear of losing what financial and social status she does have forces her to remain silent and remain in the battering relationship.

Just as the details of a war conducted by NATO are kept from the public, hiding the details of her violent war at home entails wearing a camouflouge bodysuit when she goes outside. She must maintain the appearance that all is well because if her partner discovers that she has disclosed the battering, the violence will escalate. Maintaining a positive image, hiding the war injuries, and caring for all family members are energy depleting tasks. After months and years of physical and emotional battering the woman begins to develop signs of ill health such as low self-esteem, depression, and suicidal tendencies.

In spite of history, steady advances are being made to support women who are battered. Increasing public awareness since the 1970s and support for the establishment of safe shelters for women and children are two major revolutionary tactics that are leading the counterattack against battering. A good example of the changes that have occurred over time exists in this research study. Thirty years ago Mary had no safe place to escape the battering. Two years ago Felicia moved into a shelter a few weeks before her baby was born.

After his birth she went back to the shelter and received the support needed to begin a new life in a second-stage housing complex.

Although safe houses are present in urban areas, rural women are still disadvantaged. There are few shelters and, if they do exist, everyone knows where they are. The fact that everyone knows everyone else compounds the problem of privacy and confidentiality. Shelter staff, police officers, social service workers, and lawyers and judges may be relatives of the batterer. Fear of further harm and lack of transportation, finances, and social support systems maintain the isolation. In conclusion, although many strides have been made to prevent battering and support women who are battered, the phenomenon continues with its life-threatening and life-damaging effects.

Chapter Five

Women Who Were Battered While Pregnant Speak to Nurses

Because the purpose of the research was to provide the means by which women who experience battering could be given voice, in this section I provide the second part of the findings, which is their advice to nurses. As a result of having their consciousness raised as to what women who are battered really want and need, hopefully nurses and other health care providers can interact and intervene in ways that are meaningful and helpful. Interwoven with the participants' stories of their experiences, thoughts, and feelings came the recommendations of how to support them. Although the intent was to develop a conceptual framework that nurses can utilize when supporting women, I believe that development of supportive strategies is a more appropriate term to describe the findings (see Figure 2). Whereas the participants were offering suggestions on how to support pregnant women, most of the suggestions can be used with all women in a variety of health care settings. **Watching for signs, reaching out**, and **providing the options** were the predominant themes that emerged from the women's voices.

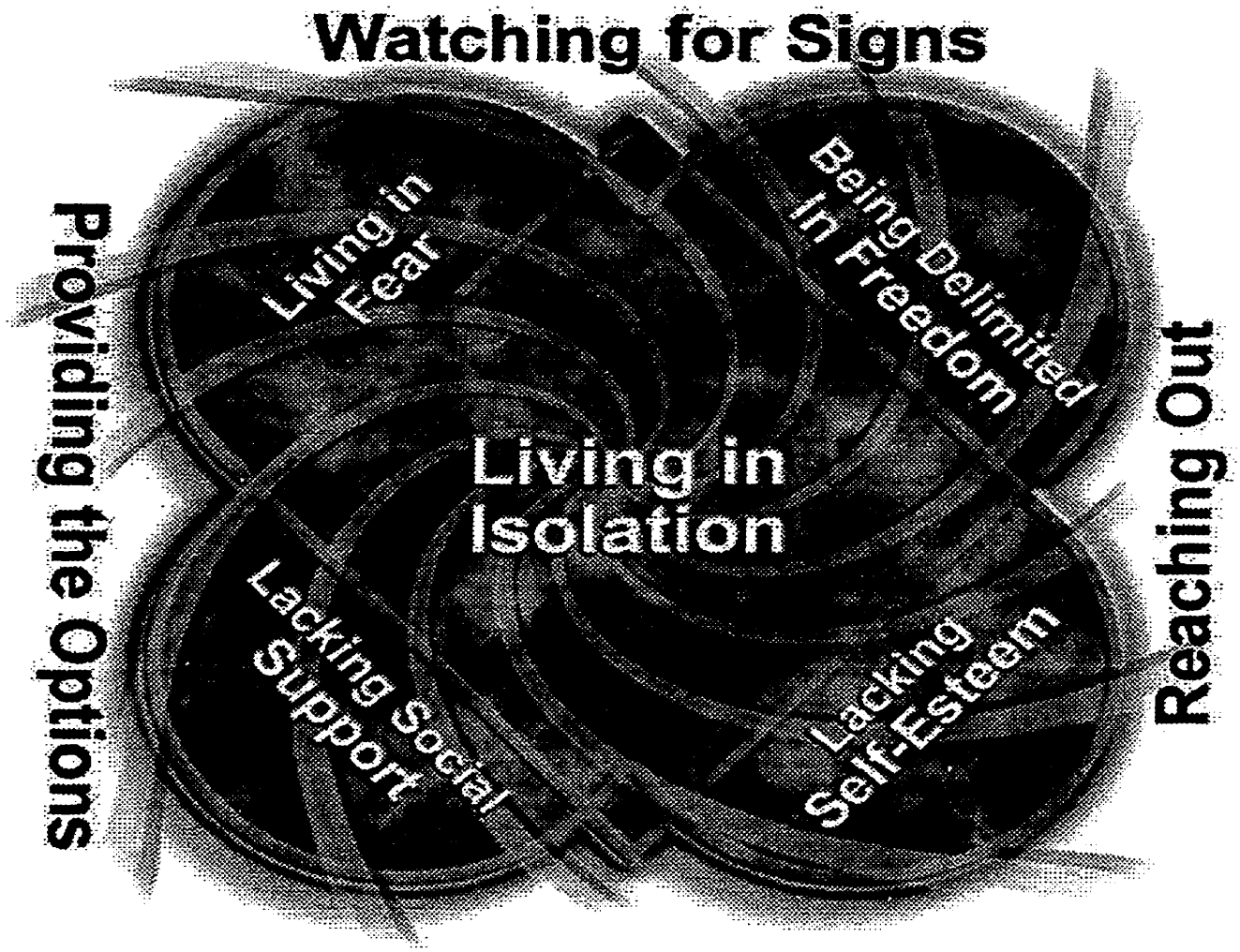

Figure 2: Woman Who Were Battered While Pregnant Speak to Nurses

Watching for Signs

The theme of **watching for signs** repeatedly came forward in the participants' voices. When asked how nurses could be of more help to women who are battered, they recommended watching for signs. Two sub-themes of **watching for signs** are **looking for the obvious** and **being alert. Looking for the obvious** involves looking for physical signs of battering; **being alert** encompasses listening and watching for verbal and nonverbal communication patterns.

Looking for the obvious.

When asked how nurses could support pregnant women who are being battered, Felicia immediately responded with, "The first thing I would say is to look for the signs of physical abuse like bruises." Dianne suggested that "Physical abuse is easy to spot because she'd have marks", and the nurse could see them "if she was breast feeding."

The participants urged nurses to watch for signs such as broken bones, cuts, burns, weight loss or weight gain, and sleep problems. In relation to weight, Dianne said, "You can't eat when you are upset. He could. We'd fight and he'd go eat a meal. I couldn't eat for days. I had a sleeping disorder too."

Marie cautioned nurses to remember that men who batter will often hit their partners in places that are easily covered by clothing and thus they are able to keep the battering a secret. Felicia described her partner's battering behaviour.

> He knew enough not to slap me in the face because that would be too noticeable. People would notice it because I was working at the time. So he would grab my arms, bang my head up against the wall, put cigarettes in my hair, burn me and all kinds of stuff.

The control tactics used by their partners may force women to conceal any physical or emotional signs and to act as if nothing is wrong. It is imperative that nurses understand that a lack of visible signs does not eliminate the possibility of battering.

Nurses and other health care providers are urged to watch for a number of other signs of battering. They include: (a) facial and bodily lacerations, cuts, bruises, welts, and burns; (b) bruised or bleeding genitalia; (c) fractures--X-rays may show various stages of healing; (d) varying stages of tissue healing of bruises and wounds; (e) repetitive bruise patterns indicating the use of a weapon; and (f) chronic problems such as back, neck, and stomach pain, headaches, fatigue, loss of appetite, insomnia, anxiety, and depression (Amaro et al., 1990; Campbell, Pliska, Taylor, & Sheridan, 1994; Campbell, Sullivan, & Davidson, 1995; Carmen, Rieker, & Mills, 1984; Ferraro & Johnson, 1983; Helton et al., 1987; Jaffe, Wolfe, Wilson, & Zak, 1986; Kerouac, Taggart, Lescop, & Fortin, 1986; Quillian, 1996).

Being alert.

Being alert for communication patterns was one of the most common suggestions made by the participants and it necessitates watching and listening to the verbal and nonverbal communication patterns of the woman as well as the patterns between the woman and her partner. The communication patterns may be better indicators of battering than watching for signs because there may be no visible manifestations.

Felicia recommended that nurses "be alert when a woman is quiet and very vague [in her responses]. You will find her head is down and she does not want to talk about certain things." Dianne reminded nurses that "mental abuse is harder to spot than physical abuse." She urged that women be observed for "sad dispositions." She used her past experiences as an example. "You're happy if he's happy. . . . My 'husband's' misery brought my misery and the same thing with my daughter." Dianne spoke of how she could "see" when her daughter was experiencing battering.

Anne suggested that nurses assess the woman's "mental state." She explained that

> my mind works a lot better now than it did because then I was always concerned that I have to get out of here. He is going to pick me up. Everything had to do with him and what would happen if I didn't do exactly what I was supposed to.

Felicia said that nurses should be alert when "the girl [sic] makes up excuses for the bruises." She described how she fractured her arm when she

was forced out of a moving vehicle. She made up some excuse about what happened when she went to the hospital. She reasoned, "When you are not ready for help, you just push everything away." Therefore, nurses must understand that disclosing the battering is a long process and their role is a supportive one to assist the woman along the way.

Adrianna expanded upon this concern of making up excuses by saying, "You kind of know by the women themselves. They are fidgety." She believes that nurses may be able to "see right through the excuse. Women that are abused don't think of what answer they give you. These are little signs that you can watch for." Adrianna recommended that nurses must be especially alert when a woman tries to commit suicide. She said, "There is a reason for it because their life is so miserable." The suggestions of the participants send a powerful message to nurses to watch for the obvious and the not so obvious.

The recommendations made by the participants coincide with those of Merritt-Gray and Wuest (1995). They reminded us that "language has been designed by men and thus does not always express women's experiences" (p. 410); therefore, they urged health care providers to be alert to the cues that women give in their language. "When women say they are 'arguing' or 'having trouble', friends and helpers need to provide opportunities for expansion and comparative feedback. The response of the person a woman first tells is critical in her continuing to tell and seek solutions" (p. 410). Thus, a supportive reaction by nurses in all settings is critical in determining how a woman will respond to the

help that is being offered. At times it seems to be a slow, circular process of offering support and then supporting the woman's decision.

Repeatedly, the participants in this study urged nurses to watch for the communication patterns between women and their partners. Anne recommended that nurses watch and listen to the interaction when the two are together after the baby is born.

> Maybe a sign would be if a woman is in having the baby and her husband didn't come to visit. . . . Or if he did come, is there a distance between them? Does she automatically do everything he says? For instance, [my] putting my son's name in his name. I didn't want to do it but he stood there and made sure I did it.

Marie advised nurses to "Look for how the person acts" when the partner arrives. She described that she "would start shaking and I know I changed colour. I would get a chill even though I knew he couldn't hurt me right there in the hospital." As well, Adrianna urged nurses to be alert if a woman is upset after her visitors leave. The nurse can ask who was in to visit and how does the woman feel about the visit. "You can tell by their answers. That's something you can pick up between the lines. They're about to give you little hints and then you can dig a little deeper." Implicit in these suggestions is the participants' assumption that nurses are experienced observers and listeners, and that they use these skills continually in their interactions with clients. The nurses' use of intuition as a source of knowledge is implied.

In addition, Adrianna believes the prenatal instructor should be alert for reactions in men when she introduces the topic of battering during pregnancy. She reasoned that a partner who batters might be embarrassed and he would definitely have to hide the fact that he is hurting his partner. If the instructor is suspicious, she should closely monitor the communication patterns between the couple and seek an opportunity to talk to the woman alone.

In summarizing the theme of **watching for signs**, the participants in the study consistently recommended that nurses have to use their observational and listening skills and their intuition to identify women who are in battering relationships. It is significant to remember that the woman may exhibit no visible signs, but her partner's controlling behaviour may be a good indicator.

Reaching Out

The theme of **reaching out** encompasses the sub-themes of **creating a therapeutic environment** and **being aware of the myths** concerning women who have been battered.

Creating a therapeutic environment.

Creating a therapeutic environment involves not only characteristics of the interactive environment but of the nurse herself. A warm, empathic environment must be established in order that pregnant women who are being battered will feel comfortable and safe in the knowledge that nurses are there to support them. This environment may be conducive to women disclosing their battering experiences.

Dianne explained the importance of environment when she described her experience at a transition house. As already described, when she was about eight months pregnant, she left her home after a battering incident and took her two children with her. She went to a local transition house but she "couldn't stay because it wasn't like a home atmosphere. You go to a strange place when you've got a problem. You don't feel like being there. You want to be somewhere where you are secure." She left after eight hours at the house and went back home.

Dianne explained how she felt "safe and secure" in the hospital environment after her son was born. She said, "I got to the point in my hospital stay [that] I didn't want to go home . . . because I knew we were going to get in a fight." As well, Marie felt safe in the hospital because "I knew he couldn't hurt me right there . . . because he would get caught." Out of these stories from the participants come the recommendations that staff of shelters, hospitals, and other institutions must have safety protocols. Advocacy must prevail to ensure that societal institutions such as the justice system continue to develop laws to protect women from men who batter and that these laws are enforced in a visible manner.

Mary emphasized the importance of a caring relationship between the nurse and her client and the positive effect it might have on a woman. When asked what characteristics of the nurse might have made her disclose her battering experience, she replied, "If it had been someone who I thought was

pretty understanding, I'm sure I would have admitted to the battering." She also instructed nurses, "Let them know that you are there to help if there is any way possible." Dianne emphasized the necessity of the nurse establishing a "good rapport" with her client at the first interaction. She also insisted that women who are battered could sense when the nurse is being "honest" with them.

Adrianna recommended that the nurse has to be trustworthy and nonjudgemental because "people have to trust you before they can tell you what's really going on." She expanded on the importance of establishing trust when a woman is in labour. "You know they're [nurses] going to help you so you might tell them a little more. Maybe not all, but they [women] are going to give you [nurses] some little signs . . . . "

Felicia elaborated on how a nurse might communicate in a therapeutic manner.

> If a woman is quiet and very vague and you find her head is down and she does not want to talk about certain things, ask her how she feels and what would make her feel more comfortable through her pregnancy. That really opens the door for her to ask you questions. Say, "I'm here to listen and what could I do to help you?" Just let her know that if she needs someone to talk to, you are there to listen. Focus on the woman's needs first. [Tell her] that there is help out there for her.

Anne stressed the importance of a nurse believing a woman when she tells her story. She had the experience of no one believing or doing anything about the battering. Anne also emphasized that speaking with a nurse who had been battered would have helped her. "I think they need to talk to someone who

has been through it. [Someone] that really does understand and not someone who is looking at you and saying, 'Well, why are you still there [in the battering relationship]? ' " Adrianna suggested that it must be difficult for nurses who have not been battered to understand the battering experience because "You have to live that role to understand exactly how people feel. They [nurses] can take all the courses they want at university but still not know what it feels like."

The nursing literature reinforces the importance of nurses demonstrating therapeutic communication skills in their interactions with women who are battered. Women must be assured that their feelings are legitimate and that they are believed, understood, and not judged (Brendtro & Bowker, 1989; Butler, 1994). As well, nurses must ensure that their words, tone, and body language demonstrate a sincere acceptance and a willingness to listen (Bohn & Holz, 1996).

Words of encouragement and support may have a positive impact. Bohn and Holz (1996) advocated telling a woman who is battered that she is a worthwhile person and that she does not deserve the battering. As well, "Helping them to understand that their behavior did not cause the abuse and that the abuser was in power and made [a] conscious decision to abuse is helpful" (p. 450).

The manner in which a nurse responds to a woman's disclosure determines that woman's response to future interactions with health care providers as well as her thoughts on the battering experience (Fishwick, 1995).

Fishwick explained, "A negative response, such as disbelief, unconcern, or seeking a reason in the woman's behavior to explain the abuse or violence, often ensures that woman will deliberately avoid use of health care services in the future" (p. 68). On the other hand, a positive response such as showing concern and offering support and information may act as a stimulus to help the woman question her relationship with her partner (Fishwick, 1995).

Historically, nurses have been taught to maintain a professional "distance" from their clients. The voices of the women in this study dispute this indoctrination and recommend that a caring relationship is a better indicator of support. Thus, therapeutic communication that demonstrates warmth and empathy and the provision of safety are essential elements in **reaching out** to women who are battered.

Being aware of the myths.

Most of the participants in this study urged nurses to become aware of the societal myths surrounding women who are or have been battered and to understand why they are untrue. Understanding these false beliefs is imperative before a nurse can begin the process of effectively reaching out to women who are battered. Before her battering relationship, Marie believed the myth that, "a woman should leave if she is being battered. I thought it would be so simple." After being in the situation herself, she realizes the difficulties. She explained the woman's dilemma by saying, "You take your kids and go where and with what? What if he tries to stop you? What do you do so you don't get hurt and they

[children] do not get hurt? [There are] just too many hows and whats." Anne too cautioned nurses to avoid telling women to leave the relationship. "If they [nurses] come in with an attitude that you have to leave this person, it's never going to happen."

Similarly, Dianne believes the myth of secrecy shrouded women who were battered in the past. When asked if she ever felt she could have told nurses or doctors about her battering relationship, she replied, "No, no . . . I think that has a lot to do with the person's upbringing; keeping things quiet like with my age group. Now, abuse is out in the open."

Adrianna explained that people believe that women who are battered cannot "mix with society, that we cannot think for ourselves, can't hold a job or make anything of ourselves." These beliefs are "wrong . . . because I have been there, done that, and I have brought up two children basically on my own." In relation to the myth that women who are battered have no education and have only low-income jobs, Adrianna believes, "You could be the richest woman and still be abused." Adrianna's belief reinforces the knowledge that battering of women is a social problem that knows no boundaries and is mediated through social structures inherent in a society.

One of the most damaging societal myths that has evolved is that women stay in a battering relationship because they like it. Adrianna gets really angry when she hears this remark. She explained, "It is not true. No one wants to be hit. People don't even have to be hit. You can be abused mentally. No one asks

for that." She explained too, "people stay with partners that do abuse them because they have no place to go. They are scared that they cannot make it on their own. That is the bottom line."

King and Ryan (1989) elaborated on five common societal myths: (a) violence among family members is a private matter, (b) the battering cannot be that terrible or the woman would leave, (c) women who live in abusive relationships tend to become helpless, (d) alcohol causes battering, and (e) battering occurs more frequently in certain racial and cultural backgrounds. In relation to the myth that violence is a family matter, nurses may have been socialized to believe that battering of a woman by her partner is acceptable (Noel & Yam, 1992). Nurses may hide behind this view because they are too embarrassed to ask a woman about violence in her home. King and Ryan reminded nurses that they have developed comfortable ways of asking about breast self-exams, painful intercourse, and other personal questions and the same can be done with questions on battering. They believed that, "uncovering violence is an essential step in providing women with effective interventions aimed at reducing the effects of abuse on their lives and their children's lives" (p. 48).

The myth that the battering cannot be that terrible or the woman would leave suggests that the woman does not want to leave and there is little value in offering support. Belief in this myth negates nurses' responsibility for intervening with women who are battered. King and Ryan (1989) provided nurses with

several reasons why women stay in battering relationships. They included the following: (a) their home life is not unbearable all of the time, (b) their home is their shelter and they have spent time and energy creating this space, (c) neighbours and friends make pleasant interludes to the battering, (d) their home is their children's home, (e) moving requires planning and energy and abandonment of all their personal belongings, friends, and years of memories, (f) they face economic insecurity and even poverty if they leave, (g) culture and religion make it difficult for women to leave, (h) the legal system may be inhospitable to women who leave, (i) the fear that they or their children will be killed by the battering partner, and (j) the fear of being seen as a failure by society or at fault for the separation. As well, there may be no place to go that is suitable. Most shelters provide only temporary help and many communities may not assist with establishing long-term living arrangements. With all these obstacles in place, women who initiate the process of leaving are to be praised and supported through every step of their journeys.

The myth that women who live in battering relationships tend to become helpless depicts women as "completely passive and without any courage or power" (King & Ryan, 1989, p. 53). This viewpoint may encourage nurses to believe that they have to 'save' women rather than provide them with the social support and information they need to make choices about their situation. It is obvious throughout the feminist and some nursing literature that the learned

helplessness theory (Walker, 1979) is detrimental to the image of women who are battered and is a stereotypical method of re-victimization (Bowker, 1993).

'Alcohol causes battering' is a viewpoint held by many people. Although there is a strong relationship between battering and the use of alcohol, an explanation may be that, as the partner becomes less sober, his violent tendencies become less inhibited (Campbell & Fishwick, 1993). As well, he may drink to excuse his behaviour. McCue (1995) explained, "Alcohol may exacerbate a situation by blowing real or imagined problems out of proportion and by lowering inhibitions, but the propensity for violence must be there in order for a man to batter" (p. 111). Belief in the myth that alcohol causes battering means that the partner's behaviour is explainable and tolerated because he is a victim of alcoholism (King & Ryan, 1989; Martin, 1979). Battering of women is not always associated with alcohol. Four of the six women in this study reported that the battering occurred whether the partner was drinking or not. The findings that alcohol is not always a factor in battering are consistent with the literature (Bowker, 1983; McCue, 1995; Pagelow, 1981).

The myth that battering occurs more frequently in certain racial and cultural backgrounds has implications that are dangerous for all women. Belief in this racist myth implies that battering is a permissible and acceptable behaviour and that women tolerate it because it is a normal part of female-male relationships. Thus, there is no concern for the health of these women (King & Ryan, 1989). Another consequence of belief in this myth is that the cries for help

of women outside these boundaries are ignored (Noel & Yam, 1992). "White women are not assessed for abuse . . . and they are not permitted the relief of having the practitioner actively inquire about the possibility of abuse" (King & Ryan, p. 54). King and Ryan reminded nurses and all of society, "Abuse is democratic; it occurs in every racial and ethnic group" (p. 54). As well as being cognizant of these societal myths, it is mandatory that nurses and other health care providers examine their own beliefs about battering. It must be understood that it is a societal problem and falls within the scope of health care as well as social and community services and the justice system.

In summary, the co-variable of **reaching out** is a composite of providing a safe, therapeutic environment and the nurse being present to the woman in a manner that demonstrates sincere concern and a willingness to support her. Furthermore, this co-variable educates nurses regarding the myths believed by so many people. It brings them to a higher level of understanding, and thus will impact their practice in a positive manner.

Providing the Options

The theme of **providing the options** encompasses the sub-themes of **asking**, **educating**, and **giving time**.

Asking.

In relation to **asking**, most of the participants recommended that nurses ask all pregnant women if they are battered; however, they urged nurses to be cautious in their approach. When I asked Anne if a doctor or nurse had ever

questioned her regarding her home life, she answered, "No". She explained, "It's hard for someone in that situation to take the first step. If someone had come to me, I would have said 'no' at first [but] I'm sure they would have been able to tell by the way I answered." Anne urged nurses to be persistent in their questioning and patient for the answers about battering.

Dianne agreed that nurses should be asking all women. She suggested that an example might be to, "Ask if there is anything personal, like to do with your home life or your relationship with your mate that you want to talk about."

Adrianna concluded that she would have disclosed the battering "if the nurse had asked and I had trusted her." She recommended that nurses

> ask in a roundabout way, because a lot of women's 'husbands' have made them believe that they deserved whatever they have inflicted on them. If they confide in you and you say something to their spouse, what do you think is going to happen to that woman? You have to be careful how you approach that.

Marie disagreed with the notion of asking all pregnant women if they are battered because "there would be some that would be very offended by it." She suggested though, "If they [nurses] thought it was happening and they were seeing the same person a lot, then they might say 'Is there anything I can do to help? Is there anyone you would like to speak to, like a counsellor? ' " It is understandable that nurses may be reluctant to ask about battering for fear of offending or upsetting women or because of their own discomfort; however, there is documentation in the literature that women do not mind being asked.

McLeer and Anwar (1989) reported in their study of the effectiveness of a standardized protocol for assessing women that, "The majority of women who had not been battered did not appear to mind being asked if they had been hit or injured by someone" (p. 65). In addition, the women appeared "relieved that someone had directly asked them how they had been hurt" (p. 65). The protocol proved effective as "The percentage of women identified positive for battering increased from 5.6 per cent to 30 per cent following staff training and institution of the protocol" (p. 66). Grunfeld et al. (1994) detected similar responses by Canadian women in their study to determine the disclosure rate for battering in an emergency department setting. "Many patients appreciated the concern showed by triage nurses in asking questions related to abuse, and many said so. There were few incidents . . . in which women expressed displeasure at being asked questions about abuse" (p. 273).

Dianne explained how a woman feels when she lives in a battering relationship and the dangers of not asking. She said, "Sometimes they need that push. They need to see a light. If nobody voices a concern, then with that person's low self-esteem, they are not going to ask for help." If she is not asked, the woman has to return home to an unhealthy and unsafe environment where her well-being and that of her children is at risk.

The nursing literature strongly recommends that all women be assessed for battering. McFarlane, Greenberg, Weltze, and Watson (1995) reported the effectiveness of a two-question screening tool that they used to detect battering

in women who sought help in an emergency department. The two questions were (a) "Have you ever been hit, slapped, kicked, or otherwise physically hurt by your male partner?" and (b) "Have you ever been forced to have sexual activities?" (p. 392). Of course, the first question implies the woman is in a heterosexual relationship. Eliminating the word 'male' would allow any woman to respond to the question whether she is male or female partnered.

Hoff and Rosenbaum (1994) "described the development of a tool to assist nurses and other primary health care providers with routine assessment . . . in diverse health . . . settings" (p. 627). They suggested that assessment tools should identify if battering or other types of abuse are occurring, for how long, the availability of social supports, and the possibility of the woman harming herself or others. McFarlane, Christoffel, Bateman, Miller, and Bullock (1991) emphasized the importance of the nurse asking as opposed to a self-report questionnaire. They found that disclosure rates increased from 8% to 29% when there was verbal interaction. Again, it is that intense desire to quantify women's experiences that leads to language such as 'assessment tools' or 'instruments'.

Asking about battering indicates to the woman that the nurse is responding to her in a holistic manner rather than attending only to her physical needs. When discussing the problem of violence in the home, the nurse could explain that battering is a serious health concern and these routine questions are asked of all women. Encouraging her to talk about her experiences validates them as real and gives her an opportunity to step back and evaluate her situation

with an unbiased support person. On the other hand, "To give analgesics and cleanse the wounds without acknowledging the circumstances that created the pain is one way to anesthetize discomfort and to avoid the abuse issue" (Kennedy, 1993, p. 397). Avoiding the battering question is another way to remind the woman of her unworthiness as a person and negate her right to supportive nursing care.

In relation to pregnant women, researchers emphasize the importance of assessing for battering throughout the pregnancy and during the perinatal period (Amaro et al., 1990; Berenson et al., 1994; Campbell et al., 1993; Greenberg, McFarlane, & Watson, 1997; Hillard, 1985; McFarlane & Parker, 1994). Gazmarian et al. (1996) believed that "violence may be a more common problem for pregnant women than some conditions for which they are routinely screened and evaluated" (p. 1915). Battering also may begin at any time during or after the pregnancy and may extend to the newborn and other children in the family (Amaro et al., 1990; Campbell, 1993; Goodwin & Breen, 1990).

Other considerations in relation to the sub-theme of **asking** include the following recommendations for nursing care of all women:

1. Nurses must ensure that conversations with a woman are conducted in a private area where no one else can overhear (Attala, 1994; Butler, 1995; Fishwick, 1995; Kennedy, 1993; McFarlane & Parker, 1994). Kennedy (1993) strongly recommended that the partner should not remain in the room or within eye contact of the woman because his presence could intimidate her. If he will

not leave, the woman can be asked to step into the bathroom for a "special" urine sample and she can be asked there. McFarlane and Parker (1994) recommended that, if the woman cannot speak English, an interpreter from the staff should translate. If a family member or friend interprets, she or he may tell the partner.

2. Each health care institution should have a standardized protocol for asking women about battering as well as the appropriate methods of documenting and photographing of injuries that can be used later in court (Attala, 1994; Bohn, 1990; Bullock, McFarlane, Bateman, & Miller, 1989; Campbell et al., 1992; Grunfeld, Ritmiller, Mackay, Cowan & Hotch, 1994; McFarlane & Gondolf, 1998; Sheridan & Taylor, 1993). It is recommended that the protocol should include a manual with: (a) definitions of battering and psychological abuse; (b) facts versus myths about battering; (c) an assessment guide, intervention strategies, and dialogue examples that are culturally sensitive; (d) cues that might alert the nurse to suspect battering such as frequent visits to the emergency department for injuries, a delay in seeking assistance with the injury, distribution or severity of injuries that is not consistent with the woman's statements of cause, a partner who does all the talking or never leaves the woman's side, and frequently missed appointments; (e) a legal overview of reporting responsibilities and pertinent criminal laws; (f) appropriate documentation procedures; (g) forensic evidence collection procedures including photographs and body map documentation; (h) review of safety issues for the

woman and staff; (I) community referrals for the woman and her partner; and (j) a bibliography (Bullock et al., 1989; Fishwick, 1995; Sheridan & Taylor, 1993). For an example of nursing guidelines, Canadian nurses can contact the National Clearinghouse on Family Violence for a copy of Family Violence: Clinical Guidelines for Nurses prepared by the Canadian Nurses Association.

3. Nurses must be prepared to intervene with the necessary information and interventions if a woman discloses that she is battered (Parker & McFarlane, 1991). This statement implies that nurses must understand that battering is a crime, be aware of their beliefs and feelings toward women who are battered, and be thoroughly familiar not only with the institution' s protocol but also the legal implications as well. Reassuring the woman that she is not alone, expressing the belief that battering is not acceptable, and explaining that the nurse will not tell the batterer that she has disclosed are important first statements to support the woman (Furniss, 1993).

4. The safety of the woman must be assessed (Kennedy, 1993; Parker & McFarlane, 1991). An appropriate tool such as the Danger Assessment Scale (Campbell, 1986) can be used to determine her safety. Campbell believed that answering the questions enhanced the women's awareness of danger and provided them with additional information upon which to plan for the future. As well, it is the nurse's responsibility to assess for the possibility of suicide (Butler, 1995; Kennedy, 1993).

5. Nurses must be prepared for the woman to deny that battering is a part of her life. "Being accepting of a negative response--even if it seems clear that the woman is abused--conveys respect for her . . . and helps to build trust" (McFarlane & Parker, 1994, p. 323). Her "negative response may represent one of the few times the woman can make a choice without fear of retribution" (McFarlane & Parker, p. 323). Being supportive of her and what she has to say may encourage the woman to disclose at a later time.

In summary, most of the participants in this study and the nursing literature recommend asking all women if they are battered. It is necessary, however, that the questions be asked in a manner that demonstrates respect for the woman and a sincere concern for her well-being.

Educating.

The sub-theme of **educating** encompasses several recommendations. The first is that nurses must educate all women, men, and children that battering is not acceptable behaviour under any circumstances. **Educating** also implies that nurses and other health care providers have the responsibility of becoming more knowledgeable of battering during pregnancy and becoming advocates for women who experience it (Amaro et al., 1990).

In relation to education about battering, Marie believes that it should be discussed during prenatal classes. She suggested that the instructor explain the "damages it could do to the child" and discuss the community resources to assist women. Also, she recommended that educational pamphlets be made available

at the prenatal class including a number to call for help. The instructor should emphasize that someone will "be there" when a woman calls. Marie believed that information on battering could be beneficial for all pregnant women. She suggested, "even if it was not necessarily happening to you, you may see the signs in someone else that you know and you can help."

Like Marie, Dianne suggested that one of the roles of a nurse is to educate women in all health care settings. She would like nurses to help women improve their self-esteem. She suggested using phrases such as, "You don't deserve battering" and "You don't have to accept someone hitting you." They can be used during initial interactions between the woman and the nurse. Such statements remove the blame from the woman and place it where it belongs, with the partner. In addition, Dianne suggested that pamphlets on battering and where to call or go for help be included in the gift packs that a woman receives after her baby is born.

Anne emphasized the importance of letting women "know there are places you can go to for help besides family and friends. Make them aware of counselling services." As part of **educating**, nurses must be aware of and supply verbal and printed information in the form of posters and pamphlets regarding: (a) local shelters, (b) emergency hotlines, (c) social service agencies and the appropriate intake procedures, (d) legal aid for women, (e) anti-stalking laws which became effective in Canada in 1993, (f) laws defining assault and police involvement in battering incidents, and (g) the necessity of having an exit plan in

the event that the woman and her children have to leave in a hurry. This plan includes keeping money, clothing, and important documents such as birth certificates, bank books, immunization records, Medicare numbers, prescription numbers, an extra set of car keys, and a favourite toy for each child in a secret place (Bohn, 1990; Brendtro & Bowker, 1989; Campbell & Sheridan, 1989; Danis et al., 1989). Nurses must be mindful that any type of printed material is a threat to the woman's safety and will have to be hidden. Institutional staff must consider the size and structure of handouts when developing protocols on battering. This information should be available in the appropriate languages of the area. As well as educating the woman regarding formal sources of social support, nurses can brainstorm with her to identify informal sources such as family and friends.

In relation to families, Mary suggested that parents have a responsibility to teach their children about battering She reasoned that boys have to be educated that they should not control women and that they do not beat women.
She said, "As long as they [individuals, families, and society] hide it, it is never going to get any better." Implicit in her statement is the necessity of partners discussing their beliefs about individual roles within the family and child-rearing practices early in their relationship. Adrianna reinforced the belief that "education begins with young people."

In conclusion, education about battering is an essential component of prenatal care in order that women and their children have healthy outcomes. Nurses have a further responsibility to educate individuals, families, groups, and

communities in order to continue the slow process of eradicating battering from society.

Giving time.

In relation to the sub-theme of **giving time**, all the participants emphasized the necessity of nurses understanding that leaving a battering relationship is a circular process that takes time. They strongly recommended that nurses be patient with women who are experiencing this unrest in their lives. Mary described her experience of leaving in the following manner.

> I started to pray "please God, let me get over him so I can leave." It took a long time to leave [3½ years]. It took a lot of thinking like "can I do this?" Finally, I just couldn't take it anymore. I had lost all feeling for him. I was 26 years old and I had my whole life ahead of me.

Felicia said how she stayed in the relationship for seven years and that she made 37 attempts before she finally left. She described that she was not ready to leave.

> You know when you are ready to leave. It takes a lot. It takes the straw that breaks the camel's back. I was eight months pregnant when I left. You get to the point when you just do not care anymore. Finally, I just looked at different resources and figured it out . . . . People are waiting now to see if I'm going to go back.

Bowker (1983) found in his study of 136 women that "many women leave home only to return again for such reasons as coercion or promises of reform from their husbands, concern for their children, or lack of resources to support

themselves independently" (p. 11). Nearly 75% of them had left at least once and many of them had left more than six times.

Marie described her process of leaving. After the first battering incident when she was six months pregnant, she knew, "this is not good, but I thought 'what am I going to do?" I have a baby on the way, no money, [I needed] trips to the doctor. I'll have to stay." After one vicious emotional attack, she explained the circular process that she "packed my bags after he went to work that day. The only person I could call was my mother but we were not talking. So I packed and unpacked my bags all that day." Eventually she decided that she had no choice but to stay until after the baby was born.

Felicia, Adrianna, and Anne cautioned nurses to avoid telling women to leave their partner. Felicia said that the woman has probably already heard that from someone else and telling her again will only "push her away." Telling her what to do is the same type of controlling behaviour that she has been living with throughout the relationship. As well, taking away her decision making ability is another form of victimization (Kennedy, 1993).

Ulrich (1991) found that, "Leaving was a process occurring over time . . . . The theme of process was described as decision making that occurs over and over 'until you are truly tired of it' " (p. 471). In order to gain a greater understanding of this process, Ulrich urged that health "care givers listen to the women's language to hear their experience of leaving from their point of view" (p. 471).

Similarly, Merritt-Gray and Wuest (1995) found that breaking free or leaving "was a gradual process whereby women who were initially unwilling to sustain the losses associated with leaving their homes began to leave in many different ways" (p. 409). The participants in their study began to stay away from home as much as possible, withdraw emotionally from their partners, separate their belongings from his, and leave the family home for periods of time. "This process of breaking free allowed the women to get a sense of what the consequences of leaving would be in terms of the family, friends, and the abuser and appeared to be a necessary step in developing a readiness for . . . not going back" (p. 409).

Bullock et al. (1989) reminded nurses that a woman who is battered does not want the relationship to end, only the battering. She frequently returns to the relationship following promises from the batterer that the violence will end. The authors admitted that it must be discouraging for nurses when they see a woman return home. Nurses have been socialized through their education and practice to be in control of crisis situations. When we interact with a woman who is battered we should not take control. Our role is to provide her with the options to meet her needs. When she fails to act on what we believe to be her best action, nurses may feel frustrated and, consequently, may blame the woman. We must recognize that the woman will decide when to leave and the role of the nurse is to provide education, advocacy, support, and resources to her. Contact with the woman must be considered success. Brown (1997) further suggested that when

a woman returns to a battering relationship, she is not necessarily inactive in attempting to change her situation or that interventions by the health care provider have been ineffective. The belief that maintaining contact and continuing support are necessary components of nursing care is essential.

Summary

The recommendations put forth by the participants in this study can be utilized by nurses and all health care providers in both institutional and community settings. The suggestions are not unusual or new concepts. Instead they are the core concepts that all nurses learned in nursing school--caring, listening, observing, creating a therapeutic environment, and the giving of physical, psychosocial, and spiritual support.

The findings suggest that women who are battered want to be recognized as unique individuals with many strengths. They want to be asked about any problems that they may be experiencing in their lives. As well, they want as much information as possible to help them deal actively with their problems. They view nurses as trustworthy advocates who should be knowledgeable of the experiences of women who are battered; furthermore, they want nurses to reach out and support them. Nurses have a responsibility to learn about this social problem and intervene with competent nursing care.

Chapter Six

Implications for Education and Research and Conclusion

Implications for Education

The results of this study clearly indicate that nurses must be aware of battering, its serious consequences for all of society, and appropriate nursing care. The implications for nursing education are two-fold; the development of continuing education programs for nurses, and integration of the phenomenon into nursing curricula.

In relation to continuing education programs, Ryan and King (1993) suggested that "well-constructed educational programs can be used to improve the identification of abused women and increase the likelihood of such women receiving effective intervention from the health care system" (p. 484). As a result of the findings of this research study and the recommendations of several writers (Langford, 1996a; Lazarro & McFarlane, 1991; Ryan & King, 1993; Young & McFarlane, 1991), it is my belief that the following concepts and content areas be included in continuing education programs. These recommendations are applicable not only for nurses but for all health care providers. They are:

1. An opportunity for health care providers to hear about and discuss the causes and manifestations of battering is essential because their understanding affects how and under what circumstances they offer support to women who are battered.

2. The incorporation of various methods of instruction is essential so that health care providers can reflect upon and articulate their personal feelings and beliefs about women who are battered.

3. It is necessary to present accurate statistical information so that health care providers will become aware of the seriousness and pervasiveness of this problem and its effects on the health of a woman and her children.

4. Delivering the educational program in the institutional setting and at various times is advantageous because larger numbers of health care providers will be able to attend. As part of ongoing learning, they can support each other as they assess and intervene with women who are battered. Onsight education is "more likely to generate an educated network and produce institutional, interdisciplinary task forces to create policies and protocols" (Ryan & King, 1993, p. 485). Also, educators, administrators, and practitioners can collaboratively develop follow-up educational and consultative mechanisms that are specific to the needs of all providers.

5. Words like "victim" should be avoided as they have connotations of powerlessness and helplessness. "Survivor" is a more appropriate one. Moreover, the terms "family" and "domestic" violence fail to address the fact that it is the woman, not the family, who is experiencing the battering.

6. Although it is usually men who batter, women living in lesbian relationships may be at risk.

7. Health care providers support women from diverse backgrounds. "Despite the variety of cultures within racial and ethnic groups, there are systematic structural forces that oppress women of color across cultural borders (Phillips, 1998, p. 679). Racism manifests itself in the unequal access that women of colour experience in relation to health services, education, justice, and economic security. Stereotyping and stigma also impact a woman's experience of battering. "Fearful of casting a shadow on their communities, women of color must weigh their need for help against the possible reinforcement of negative stereotyping about members [including their partners] of their racial or ethnic groups" (Phillips, p. 689). Exploration of racism and oppression is therefore an integral part of an educational program.

8. Because battering of women is a social problem that knows no boundaries, because statistics indicate that many Canadian women have experienced it, and because many nurses are women, educators must remember that some of the nurses or other health care providers participating in the educational program may have experienced or are experiencing battering and their experiences will affect their interactions with women who are battered (Attala, Oetker, & McSweeney, 1995). It is recommended that educators acknowledge their awareness at the beginning of the presentation. It is necessary that they communicate that counsellors are available for private and confidential debriefing sessions throughout the educational session and at any time that a woman may need support in coping with her experiences.

9. A thorough explanation of the institution's protocol on assessing and intervening with women who are battered is a necessary element. The findings of this study indicate that nurses and other health care providers should be aware of the possible signs of battering or lack of and of the necessity of providing an environment in which women feel safe to disclose. It is also recommended that all women be asked about battering in their lives and provided with the necessary information to make choices about their individual circumstances. Opportunities to role-play situations where providers assess and intervene are integral components of any educational program.

10. The program must include the legal implications of battering and the role of law enforcement agencies. As well, a concise description of all community resources for both women and men and the methods used to access them is essential.

11. An emphasis on interdisciplinary collaboration among all health care providers in developing and delivering the continuing education programs is imperative. A survivor of a battering relationship who is willing to share her experiences will send the most powerful message.

12. Ongoing education programs and opportunities for nurses and other health care providers to share their concerns and suggestions for improvement are necessary.

In relation to integration of violence against women content into a nursing curriculum, Ross and Hoff (1994) described the development of a curriculum guide for the University of Ottawa School of Nursing.

> [The guide] describes the analytical framework; outlines the knowledge, attitudes and skills needed by nurses and other health care providers on behalf of victims and survivors of violence; suggests the relevance of this content to each type of service provider across the several categories of abuse; deals with the additional risk factors of ethnicity, disability, sexual orientation and citizenship/immigrant status; and shows how personal and professional abuse histories may be linked to caretaking. (p. 36)

Key features of the guide include an emphasis on experiential learning in diverse clinical settings and integration of theoretical content from a variety of disciplines. The guide includes concepts, methodologies, and resources that are applicable in diploma, baccalaureate, and master's programs as well as continuing education programs. In summarizing, the authors said, "The curriculum guide provides concrete suggestions for moving from incidental to systematic coverage of victimization and abuse" (Ross & Hoff, 1994, p. 36).

In a more specific manner, Kerr (1992) described how the nursing faculty of an Ohio university integrates theory and practice issues related to violence against women. A growth and development course and a psychosocial nursing course address the theoretical issues. Students learn about the nature of violence, its effects on all family members, the nurse's role in primary, secondary, and tertiary prevention of violence, and the legal and ethical issues. Clinical placements include experiences in acute psychiatric settings, a safe house for

women and their children, a crisis intervention centre for teens, and a family-centered inpatient and outpatient chemical abuse treatment program. Teaching/learning methods include lecture, interactive discussion periods, journal entries, and use of various audio-visual aids.

In summary, the participants in this study believe in the value of educating nurses and other health care providers about battering of women. This education must be an integral part of all nursing programs and all continuing education programs that occur in practice settings. With knowledge comes understanding and change and thus over time the progression of violence against women will cease.

Implications for Research

The implications for research are distinct--women who experience battering during pregnancy want their voices to be heard. They do not want to remain in isolation any longer. They must be given the opportunity to describe their experiences, voice their needs, and provide direction to health care providers as to how they might help women meet their needs; however, more research studies are needed to address these issues.

Because there was a small number of participants in this research study and they were from only two areas in New Brunswick, similar studies with the same purpose are needed to hear the voices of women of different racial and ethnic backgrounds and from different geographical areas throughout Canada.

Further retrospective and prospective qualitative studies are needed to investigate the following important issues that were raised in this study:

1. How can health care providers make prenatal care more accessible to women who are battered?

2. What are the specific needs of pregnant women who are battered and living in rural areas and how can health care providers reach out to them?

3. What are the physical and psychological effects of battering on the child before and after birth?

4. What are the effects of an institutional protocol incorporating the supportive strategies from this study in relation to improving rate of disclosure?

Conclusion

No accurate statistics inform health care providers of the number of pregnant women who are battered or how often. The media, individual women, and nurses however inform me that an untold number of women live silently with the secret.

The findings of this research study and the literature indicate that women who are in a battering relationship live in a state of physical and psychological isolation brought about by their partner's controlling personality. Their daily experiences encompass fear, and lack of freedom, social support, and self-esteem. They live in fear of the next battering incident, what will trigger it, if anything, and if they will survive. They live in fear for their children's lives too.

The battering relationship delimits women's freedom. Their entire day is planned according to their partner's wishes. Are they allowed to have visitors? Can they go to work or are there too many bruises to conceal? Their freedom of speech is delimited for they dare not tell anyone about the horrible secret they keep. Disclosure, if discovered by the partner, is equated with subsequent and severe beatings including possible death.

The partners' suspicion of external influences and societal myths sustain the isolation, and sever women from needed social support systems. Their partners may not permit them to have any contact with family, friends, or the health care system. The societal myth that domestic affairs are best kept behind closed doors abdicates society's responsibility to intervene.

Many women who are battered develop feelings of low self-esteem. Often partners blame women for the beatings because they do not comply with their unrealistic demands or they suspect that they have not. Continual blame and suspicion of their every action cause women to doubt their own abilities and their self-esteem diminishes. Furthermore, society forces women to keep the secret. As a result, women's productivity at home, work, and in the educational setting suffers.

As bleak as this picture seems, the suggestions to nurses made by the participants in this study can make a difference in women's lives. Women who are battered expect nurses to be knowledgeable of this crime and how to support them. They want nurses to be alert for the physical and psychological signs of

battering, keeping in mind that there may be none. Women anticipate that nurses "will be there for them." They want a safe, quiet environment where they can speak confidentially to a nurse who listens, believes, cares, and does not judge them. They want to have the opportunity to tell nurses about their experiences when they have made the decision to disclose. Therefore, nurses have to make "asking" a routine part of every assessment. Lastly, women expect that nurses will provide them with the information they need to take the next step in their lives. Regardless of whether a woman stays in or leaves a battering relationship, she wants to be assured that there always be someone "with a hand out" to offer support.

Appendix A

Interview Guide

1. Demographic data - age, marital status, occupation, number of children, highest level of education you had the opportunity to complete, and type of community in which you live.
2. I understand that your partner physically hurt you when you were pregnant.
3. What was that like and how did you feel about the battering?
4. Why do you think he did it?
5. Had it happened before - when, how often?
6. What injuries did you have?
7. What were your experiences like when you came in contact with health care professionals such as nurses and doctors?
8. Did they ask you about violence in your relationship with your partner?
9. Did you feel you could talk openly to them about it?
10. If they did not ask you or you did not feel comfortable discussing it, what could they have said or done that would have encouraged you to disclose the violence?
11. What do you think nurses and doctors should do to help other women who are having experiences like yours?
12. Who helped you the most during this experience?
13. What did they do that helped you?
14. What was the outcome of the pregnancy?

15. How did you cope with all of this?
16. Did you receive counselling from a therapist during or after this time?
17. How did the battering affect your relationship with your partner?
18. Did you leave the person who hurt you?
19. Who helped you leave?
21. How do you feel about yourself now?

Appendix B

Letter of Introduction

My name is Denise Isaacs and I am a nurse enrolled in the Master of Nursing Program at Dalhousie University in Halifax, Nova Scotia. As part of the requirements for my degree, I must conduct a research study. I have chosen to investigate the experiences of women who have been physically hurt by their male partner while they were pregnant.

Battering of pregnant women occurs in all areas of our society but it is often not recognized or understood by nurses. I am conducting my study in order to help all women, including nurses, understand this experience. You may have a copy of the results if you wish.

If you agree to participate in my study, I would like to interview you at a time and place that is convenient to you. This private interview may take one or two hours. I will be asking about your life when you were growing up, your experiences of being hurt, how you coped, and who helped you. If possible, I would like to interview you a second time. With your consent, I will tape record the interviews so that I will not omit any of your important information. You have the right to refuse to answer any questions that you feel are too personal or uncomfortable. If you wish, the tape will be returned to you after I transcribe it (write it down) or I will destroy it. This tape will be locked in a cabinet in my home. You may choose to withdraw or not participate in this study at any time.

I want to assure you that our conversations will be kept confidential and your name will not be mentioned in any of my written work or public presentations of this study. If you agree, I would like to give you a code name. Your real name and the corresponding code name will be kept in a locked cabinet in my home.

There is no financial cost to you for participating in this study nor will there be any financial compensation from me.

Please call me at 506-847-7258 after six p.m. or leave a message during the day if you have any further questions. Thank you for considering to be a participant in my study.

Appendix C

Participant Consent Form

In signing this document I am agreeing to take part in a research study conducted by Denise Isaacs, a student in the Master of Nursing Programme at Dalhousie University, Halifax, Nova Scotia. I understand that I will be interviewed by her regarding my experience of being physically hurt while I was pregnant. I agree to the conversation being tape recorded and I understand that the tape will be returned to me, if desired, or destroyed following transcription.

I understand that confidentiality will be maintained throughout the study and that no participant description will be directly accounted to me. I understand that I may refuse to answer specific questions and that I may withdraw from the study at any time. I understand that the results of this study will be used to help nurses understand my experience and to be more helpful to pregnant women.

_____

Signature of Participant

_____

Signature of Investigator

_____

Date

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