THE UNIVERSITY OF CALGARY

DOMESTIC VIOLENCE AGAINST WOMEN AND UNPLANNED PREGNANCY: A NEW LINK?

by

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The undersigned certify that they have read and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled ''Domestic Violence Against Women and Unplanned Pregnancy: A New Link?'' submitted by Tanis M. Newsham in partial fulfilment of the requirement for the degree of Master of Social Work.

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ABSTRACT

Domestic violence against women has been studied from a variety of standpoints. However the literature lacks investigation of the effects domestic violence has on women's reproductive health. The purpose of the following study was to identify if violence in a relationship is a contributing factor in the occurrence of crisis pregnancies, multiple pregnancies, or ineffectual contraceptive use. All participants in the study fell into two categories, the **crisis** pregnancy group, or the **non-crisis** pregnancy group. Participants were given a survey which assessed for both physical and psychological abuse. Independent t-tests and chi square analysis were used to analyze the results. The results show that women involved in abusive relationships were more likely to experience crisis pregnancies. Further it was shown that women in abusive relationships were more likely to choose abortion and have a higher percentage of abortions when compared to women in non-abusive relationships. Women in abusive relationships were not more likely to have more pregnancies than women in non-abusive relationships, and although women in abusive relationships reported using reliable methods of birth control they were more likely to appear in the crisis pregnancy group than the non-crisis pregnancy group. Discussion and recommendations follow.

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INTRODUCTION:
DOMESTIC VIOLENCE
AND
REPRODUCTIVE HEALTH

Domestic violence against women has become increasingly visible in the past several years. In Canada task forces have been established at all levels of government to study the issue of domestic violence against women. The legal system has reacted to public outrage and has reviewed and revised police policy with regard to violence against women in the home. Academic journals have developed to deal specifically with research on violence against women. Researchers have studied the phenomenon of domestic violence against women from a variety of conceptual frameworks. However, with all the attention given to this issue, the literature seems to consistently overlook the effects domestic violence has on reproductive health and sexuality.

Conservative estimates suggest that one out of every ten women in Canada live in an abusive relationship (Lupri, 1989; Nutall, Greaves & Lent, 1985). The psychological and physical implications of such relationships have been investigated by a number of researchers. What researchers have concluded is that domestic violence against women can result in decreased self-esteem, increased depression and use of tranquilizers, chronic psychosomatic complaints, sexual disorders, and self-mutilation (Douglas & Strom, 1988; Edleson *et al,* 1991; Kuhl, 1984; Long & McNamara, 1989; Mitchell & Hudson, 1983; Russell, 1982; Walker, 1984). Similarities have been noted

between strategies used on prisoners of war and those used on women in violent relationships (Romero, 1985). Further, it has been found that women in violent relationships exhibit similar, often identical responses to their victimization as do victims of rape, childhood sexual/physical abuse, disasters, crime, as well as Vietnam combat veterans (McCann *et al* 1988). What these and similar studies conclude is that domestic violence against women invariably affects, in some way, the psychological wellbeing of women.

The purpose of the following study is to investigate if the psychological and physical experience of being abused by a male partner affects in some way a woman's reproductive health. Specifically I am interested in finding out if domestic violence influences the occurrence of crisis or unintended pregnancy, the number of pregnancies and the use of contraception.

It has been established in the research that contraceptive behaviour is influenced by self-esteem (Chaudry, 1987; Condelli, 1986; Herold *et al,* 1979; Hunt & Annandale, 1990; Kar & Talbot, 1980; MacCorquodal, 1984). Domestic violence against women researchers also have noted that self-esteem is affected by violent relationships (Russell 1982, Romero 1985).

It is my contention therefore, that domestic violence against women indeed affects the reproductive health of women. The research questions specifically investigated are as follows:

1) **Are women who are experiencing crisis pregnancies more likely to be in abusive relationships than women experiencing non-crisis pregnancies?**
2) **Are women in abusive relationships more likely to have a higher number of total pregnancies than women in non-abusive relationships?**
3) **Are women in abusive relationships more likely to abstain from contraceptive use or use the least effective methods than women in non- abusive relationships?**

As the data collected allowed for further investigation an additional question was asked, which was as follows:

4) **Do women in abusive relationships differ in pregnancy outcomes when compared to women in non-abusive relationships?**

The following chapter will explore domestic violence against women. In addition I will investigate the current body of knowledge on contraceptive behaviour and efficacy rates of currently available contraceptive methods.

Chapter Two will explain the methodology used in this study. In the following two chapters results will be presented and discussion and implications for further research will follow.

CHAPTER ONE

I: DOMESTIC VIOLENCE AGAINST WOMEN

A: **Definitions:**

Domestic violence against women is just one form of abuse in a wide continuum of violence against women. Women are subject to both subtle and often garishly overt forms of discrimination and violence. These may take the form of unsolicited or demeaning comments about their physical appearance or more serious forms of female directed violence such as pornography and rape. For many women the home is considered a sanctuary, a refuge in which to hide from a society which tolerates such discrimination. Yet, in fact, in both Canada and the United States a women is more likely to be assaulted and injured, more likely to be raped, and more likely to be killed by a male partner than by any other type of assailant (Brown & Dutton, 1990:70). I use the term 'domestic violence against women' because it defines a very specific form of violence. 'Domestic violence', a commonly used phrase, is somewhat meaningless, for it does not convey the gender-specific reality of who is doing what to whom within the family context. It is for this reason I choose to identify and label a phenomenon which occurs in nearly every part of the world as 'domestic violence *against women*'.

I use the term domestic violence against women as a label which includes physical abuse, sexual abuse and/or emotional abuse. This abuse may be mild or it

may be lethal. How one defines 'abuse' varies from person to person, and author to author depending on one's world view and level of tolerance.

i) **EMOTIONAL ABUSE:**

Emotional abuse or verbal aggression may be hard to detect in women due to the lack of physical evidence, such as bruises or broken bones which may occur in other types of abuse. This however does not negate the seriousness of this form of domestic violence against women. In fact similarities have been noted between the psychological abuse of wives and female partners and techniques used in brain washing prisoners of war (NiCarthy, 1982; Russell, 1982).

Researchers use different labels to characterize behaviours which are considered by most to be negative and abusive while not being either physically violent or sexually violent in nature. For example Hudson and McIntosh (1981) use the term 'nonphysical abuse' whereas Gondolf (1987) prefers the term 'indirect abuse'. NiCarthy (1982) uses 'emotional abuse' to describe this set of nonphysical behaviours and Patrick-Hoffman (1982) uses 'psychological abuse'. Whichever label one chooses to use the meaning remains the same, as does the impact on the victim.

Behaviours which are considered emotionally abusive also vary depending on the type of behaviour, its intent and its frequency. Some behaviours which have been defined as emotionally abusive are as follows:

- ☼ Explicit threats of violence.
- ☼ Implicit threats of violence.
- ☼ Extreme controlling behaviour.

- ☼ Pathological jealousy.
- ☼ Mental degradation.
- ☼ Isolating behaviour.
- ☼ Monopolization of perception.
- ☼ Enforcement of trivial demands.
- ☼ Ignoring her feelings.
- ☼ Ignoring or insulting women as a group.
- ☼ Ignoring or insulting her beliefs, religion, heritage or class.
- ☼ Withholding approval, appreciation or affection as punishment.
- ☼ Humiliating her in public or private.
- ☼ Not allowing her to work or control money.
- ☼ Punishing or depriving the children when he is angry at her.
- ☼ Threatening to kidnap the children if she leaves him.
- ☼ Abusing pets to hurt her.
- ☼ Manipulating her with lies and contradictions.

(NiCarthy, 1982; Russell, 1982; Sonkin, Martin, & Walker, 1985).

This is not an exhaustive list of emotionally abusive behaviours, nor is any particular behaviour necessarily more abusive than another. When one considers the range or frequencies with which such behaviours could occur a male partner may be considered mildly rude or highly abusive.

Therefore for the purpose of the study emotional abuse will be defined as follows: *any behaviour, by one individual, which is neither physically violent or sexually violent in nature and whose explicit or implicit intention is to control, manipulate, intimidate, isolate, humiliate, degrade or otherwise cause emotional pain to another individual.*

ii) **PHYSICAL ABUSE:**

Studies suggest that 20% of all women reporting to hospital emergency rooms have been previously abused or are currently being abused; almost half of the presenting injuries resulting from this abuse (Stark, Flitcraft, Zuckerman *et al*, 1981). Physical abuse seems easier to define due to the physical signs which may appear on the victim. Physical abuse can not be underestimated in its severity and significance. One need only read the papers to see the number of women maimed, tortured and killed by their male partners. In fact more than 40% of all Canadian female homicide victims are killed within the family context (Statistics Canada, 1989). Physical abuse can range from shoving to murder. The following list includes, but is not limited to, behaviours which have been defined as physically abusive:

- Pushing or shoving.
- Holding or restraining her against her will.
- Slapping.
- Biting.
- Kicking.
- Choking.
- Hitting or punching.
- Throwing objects.
- Subjecting her to reckless driving.
- Refusing to help her when she's sick, injured or pregnant.
- Abandoning her in dangerous places.
- Locking her out of the house.
- Threats of murder with a weapon in hand.
- Mock, pretended, and playful violence.
- Burning with a cigarette.

☼ Cutting with a knife.

☼ Pointing or firing a fire arm.

(Danzin, 1984; Hotaling & Sugarman, 1986; McGreggor, 1990; NiCarthy, 1982).

I will define physical abuse in the following way: *any behaviour, by one individual, which is physically violent in nature and whose explicit or implicit intention it is to kill, harm, control, manipulate, intimidate or isolate another individual.*

iii) **SEXUAL ABUSE**

The sexual abuse of wives and female partners is often overlooked or excluded when one discusses domestic violence against women. This certainly does not mean that women in 'romantic' relationships are somehow exempt from sexual violence. It may be due to dated notions about proprietary rights and 'conjugal duties'. The laws in Canada protecting women from sexual assault did not afford married women this protection from their husbands until 1983. In many countries and cultures a woman is still expected to defer to the sexual whims of her husband or male partner, often being denied any ownership of her own body and sexuality. Many women still feel obligated to satisfy the needs of their male partners as well as endure sexual comments, advances and aggression.

Some behaviours which have been defined as sexually abusive are:

☼ Telling anti-woman jokes or making demeaning remarks about women.

☼ Treating women as sex objects.

☼ Being jealous, angry, and assuming she's having sex with every available man.

☼ Insisting she dress in a more sexually suggestive way than she wants to.

- ☼ Minimizing the importance about her feelings about sex.
- ☼ Criticizing her sexually.
- ☼ Insisting on unwanted or uncomfortable touching.
- ☼ Withholding sex and affection.
- ☼ Calling her sexual names like "slut, whore, or frigid".
- ☼ Forcing her to strip when she doesn't want to.
- ☼ Publicly showing sexual interest in other women.
- ☼ Having affairs with other women after agreeing to a monogamous relationship.
- ☼ Forcing sex with him or with others, or forcing her to watch others have sex (including pornography).
- ☼ Forcing particular unwanted sexual acts.
- ☼ Forcing sex after a beating.
- ☼ Forcing sex when she is sick or it is a danger to her health.
- ☼ Forcing sex for the purpose of hurting her with weapons or objects.
- ☼ Committing sadistic sexual acts.

(NiCarthy, 1982).

These behaviours like those which are physically and emotionally abusive are intended to humiliate, degrade, control, intimidate, manipulate and isolate.

For the purpose of this thesis domestic violence against women will include emotional, physical and sexual abuse, and will be defined as follows:

> ***Any behaviour, by a male partner, whether physically or sexually violent in nature or nonphysically or non-sexually violent in nature and whose explicit or implicit intention is to control, manipulate, intimidate, isolate, harm, kill, humiliate or degrade his female partner. This includes relationships between married, co-habitating, and dating***

partners.

B: **ETIOLOGY:**

> We need to stop thinking of male violence as some kind of freak of nature, like a tornado. Because the thing about tornadoes is, you can't do anything about them (Pollitt, 1989:20).

Since the earliest times of Judeo-Christian worship women have been held in a subservient position to men. This subservience was, and in some religions and cultures continues to be, legitimized and celebrated in theological tracts and religious institutions. There appears to be no identifiable period in the history of human kind which was free from domestic violence against women. The following quotations reveal the attitudes which were present centuries ago:

> Unto the woman [God] said, "I will greatly multiply thy sorrow and thy conception, in sorrow thou shalt bring forth children, and thy desire shall be to thy husband, and he shall rule over thee".
> Old Testament, Genesis 3:16 (ca. 900 BC).

> A woman, an ass, and a walnut tree, bring thee more fruit the more beaten they be. English Proverb (16th Century).

History has not been kind to women, to be sure, but neither has recent history. With the advent of public mass communication and education one would expect such attitudes to have changed, particularly in light of the women's movement. Unfortunately this is not the case, as is noted in the following facts and quotes.

> A little bit of rape is good for a man's soul.
> (Norman Mailer, speech at Berkeley CA., 1972)
>
> I adore women. I am their slave, up to a certain point. I pamper them, cater to them, but when necessary you have to bop'em. (Telly Savalas, 1975)
>
> What they want isn't to be treated with respect and care. They want to be treated like shit. They seem to like it.(John Steed, British rapist/murderer, 1986)
>
> Rules are like women. They are meant to be violated. (Denys Dionne, Quebec Court Justice, 1990).
>
> *The above quotations compiled by Starr (1991).*
>
> In the time from January 1, 1991 - March 1, 1991 the Winnipeg Police Department received 2,284 domestic calls. Of these 11.5% of the calls resulted in reports being written, 83.6% no reports were written, and therefore no charges laid (Social Planning Council of Winnipeg, 1991).

It is clear that the attitudes which existed in biblical times, to some degree, continue to flourish. Certainly changes have occurred in recent history. Shelters for women fleeing abusive relationships exist in cities and some rural communities all across Canada. Programs for abusive men have sprung up in many communities, and the law is beginning to change. In 1983 the Solicitor General of Canada handed down a charging directive which obligates the RCMP and municipal police to lay charges of assault when an assault has occurred, or is suspected of having occurred, regardless of whether the victim wants this action taken. This alleviated the burden on the victim to charge her assailant who, in many cases the victim feared retaliation from. In addition to this policy change Canada has seen a number of women successfully use Battered Woman Syndrome as a defense, the first being *Lavalee Vs. The Queen* (Rurka, 1991). Legal institutions have become increasingly sensitive to the issue of domestic violence

against women as have law enforcement agencies. Public service announcements are common, and many schools offer classes in family violence as part of their curriculum.

We know domestic violence is an age old problem. But why is it so prevalent and intractable? Many authors have written entire books trying to answer this very question. And, depending on the political and theoretical viewpoint of these authors, the answer to this question varies. For the purpose of this thesis I will briefly explore several of these theories.

i) **Sociobiological View:**

One theory about the occurrence of domestic violence against women is the idea that violence towards women is an extension of man's innate nature to be aggressive (Wilson, 1975). In 1869 John Stuart Mill referred to men's "mean and savage natures" as the probable cause of domestic violence against women. This sociobiological view, discounted by many, has had the support of several researchers (Daly, Wilson, & Weghorst, 1982; Freud, 1955; Lorenz, 1978; Wilson, 1985). One tenant of the sociobiological view of male aggression towards women is Darwinian in its logic. Aggression was an advantageous behaviour in the days of hunting and gathering. The more aggressive groups fared better and survived, whereas the less aggressive groups tended not to fare as well. In these groups it was more likely that the aggressive individuals out on the hunt were men, as the women stayed back to care for children. It is therefore believed that aggression is a trait which through evolution and natural selection has been bred into men. Other sociobiological theories about domestic

violence against women involve the psychophysiological aspect of male sexual arousal and response (Tannenbaum & Zillman, 1975; Zillman, 1986); evolutionary biology, paternal certainty and pathological jealousy (Burgess & Draper, 1989); the effects of androgen/testosterone on fetal development (Money & Erhardt, 1972); and the observations of aggression and intimidation in non-human primates (Nadler, 1988; Turkington, 1987).

The sociobiological view accounts for the tendency for males to be aggressive and domineering towards women by attributing it to inborn characteristics, which are acquired through genetic inheritance and evolution. This perspective, in my view, tends to put the responsibility for violence somewhere other than on the violent individual. A man can not help but be violent and aggressive, because it is his nature. This is somewhat demeaning to men, and certainly does not account for the majority of men who are in fact gentle and non-aggressive.

ii) **Psychoanalytic View:**

Psychoanalytic theories of domestic violence against women also focus on aspects which are internal to each individual man, or woman. Some psychoanalysts view domestic violence as a result of stress, anxiety and poor childbearing (Gondolf, 1985). Abused women are masochistic, or exhibit 'learned helplessness' (Kleckner, 1978; Walker, 1979). Women ask for, solicit, or actively seek abuse by their frigidity, aggressiveness, masculinity, manipulative behaviour, or feelings of guilt and unworthiness (Garbarino & Gillam, 1980; Lion, 1977; Shainess, 1979; Snell, Rosenbaum

& Robey, 1964). Researchers have studied the issue of the masochistic female personality, and as one researcher concluded, it is a myth (Kuhl, 1984). Although this perspective has not been supported in the research the idea of the masochistic female continues to be supported by societal norms (Schecter, 1982; Wardell *et al*, 1983).

Some psychoanalysts view the abusive male as exhibiting displaced anger and resentment. By abusing their female partners, men are re-channelling their resentment of being over mothered. In fact psychoanalyst researcher Leroy Shultz (1960) suggested that men who attempted to murder their wives were actually transferring their dependency needs from their mothers to their wives and then lashing out when their wives did not meet these needs. Psychoanalysts also attribute pervasive violence against women and misogyny to men's early development in a world where most of the faces are those of women (school teachers, mothers etc.)(Chodorow, 1978; Dinnerstein, 1976; Lesse, 1979; Sexton, 1973). Men are forced to exaggerate their masculinity to confirm their maleness. It is an act of identity-preservation which causes men to demean and violate women.

In the psychoanalytic approach to the understanding of violence against women in the home, it seems an underlying assumption that women are responsible for their own victimization. They either actively seek abuse, by nagging or through their masochistic tendencies, or they rear their sons in such a way that men see no other recourse but to become abusive in order to retain their masculinity. Victim-blaming approaches do little to further the understanding of domestic violence against women, nor give credence to the societal context in which it occurs. The psychoanalytic

approach seems to take the focus off the abusive behaviour, and therefore off the personal responsibility for it, and directs it in an intangible, illusory way in which mixed messages are conveyed. Men may be given the false impression that abusive behaviour is not their fault, but their partner's, and it she who should change so he no longer needs to abuse her.

iii) **Social Learning Theory:**

Another theory about the etiology of domestic violence is social learning theory. Albert Bandura (1973), a pioneer in the field, analyzed aggression from this perspective. Bandura viewed aggression as a behaviour which is learned by observation, modelling, and reinforcement. Domestic violence, which of course is not limited to aggressive behaviour but often includes it, can be attributed to a learning process. Men learn as boys, by observing their fathers abuse their mothers, or by experiencing abuse themselves, to act in abusive ways in order to attain a desired response, such as compliance, sexual gratification, or the feeling of superiority. This idea, that abusive behaviour is transmitted through generations by witnessing and experiencing abuse is well supported in the research (Carroll, 1977; Coleman, 1980; Forsstrom-Cohen & Rosenbaum, 1985; Owen & Straus, 1975; Pagelow, 1981; Rosenbaum & O'Leary, 1981; Sonkin *et al*, 1985; Star, 1983; Ulbrich & Huber, 1981; Weitzman & Dreen, 1982).

Some social learning theorists also recognize that learning occurs in the context of culture. Men can learn violent and abusive behaviour and the rewards which can be achieved with it through mass media portrayals of violent, macho heroes, and

stereotypical uses of violence and intimidation as a response to conflict. One need think no further than Sylvester Stallone's success as an 'actor' to realize the incredible draw audiences have to violent men. In our culture, violence is celebrated both in our media and in our streets, it is unrealistic to think that it would simply stop at the front door. Violence is also eroticized in our culture, as is the case with pornography. This too may teach men who consume pornography, that violence is "erotic, sexually desirable and desired by women as a necessary proof of virility" (Roy, 1982:96). It is pointed out by learning theorists that domestic violence is intentionally or unintentionally reinforced by women victims, family members, friends, and society in general (MacLeod, 1987). The reduction in tension which usually precedes a physically violent episode, compliance by the victim, sexual gratification, respect or fear from family and friends, feelings of control and power, and the general lack of recognition of domestic violence as a truly 'criminal' offence may all serve to condone, perpetuate, and reinforce men's domestic violence against their female partners (Ganley & Harris, 1978).

iv) **Feminist View:**

Feminists have long regarded domestic violence against women as a feminist issue. Feminists argue that other theories about domestic violence against women negate the intense political and social climate of patriarchy in which male prerogative is assumed, expected, and legitimized (Lystad, 1975). Feminists feel other theories blame the victim or annul the responsibilities of the man for his violence.

Although not incompatible with social learning theory, feminist theorists place

added emphasis on the impact of patriarchy. Domestic violence against women is viewed as a legitimized tool used to oppress and subjugate women (Strordeur & Still, 1989). It is sanctioned and maintained by political, social, and economic factors within our society (Gondolf, 1987; Bograd, 1988). From this perspective individual men are not trained or parented to be abusive, instead men as a class are brought up in a society in which men are rewarded politically, economically, and socially for the continuing oppression of women as a class (Bograd, 1988; Chapman & Gates, 1978; Dobash & Dobash, 1979; Russell, 1982; Walker, 1979, 1984). As an extension of this reward system, sexually, emotionally, and physically abusive behaviours perpetuate a male dominated world by instilling fear in women and restricting their full participation in society. Feminists place full responsibility for abuse on the abusive individual. Basic assumptions of feminist ideology are that no person, woman or man, deserves to be abused, and that each person is responsible for their own behaviour (Bograd, 1988). It is therefore felt by feminists, that regardless of the etiology of domestic violence against women, men must take responsibility for their own actions, and it is they who must change their behaviour.

The above theoretical perspectives have not, by any means been a comprehensive investigation of the theories. It was my intention to give the reader an overview of the variety of theoretical perspectives which exist surrounding the etiology of domestic violence against women. It is not the purpose of this thesis to ascertain the cause (if indeed a single cause exists) of domestic violence against women. It is

assumed that domestic violence against women exists, and has existed for centuries, why it exists is not the issue for this researcher, how it affects women's sexual and reproductive wellbeing is.

C: PROFILE OF THE ABUSED WOMAN:

As was noted in the previous section, domestic violence against women has a long history. Today domestic violence against women continues. How many women can expect to become involved in an abusive relationship? Is there any one 'type' of woman who is more likely to be abused than another? The following discussion on the profile of the abused women will explore these questions. Much of the information used is taken from Linda MacLeod's *Battered But Not Beaten* (1987) in which she interviewed women in transition houses and second stage shelters across Canada.

i) **Incidence:**

In 1985 Linda MacLeod found that almost 33,000 women sought shelter from abusive male partners (MacLeod, 1987:6). Further investigation revealed that when the numbers of women who sought shelter but were turned away due to lack of space, the numbers of women who did not require emergency accommodation but sought referrals, information or counselling, and the numbers of women who did not disclose abuse are all taken into account, it is conservatively estimated that one million Canadian women are battered each year (MacLeod, 1987:7).

In the United States, Walker (1979) estimated that one in two women will be

abused during the course of their marriage. In a national study it was found that one out of six couples experience at least one violent act, one in eight couples inflict abuse which causes serious injury, and in one in twenty-five marriages continuous violence exists (Straus, Gelles & Steinmetz, 1980). Researchers conservatively estimate that one in ten women in North America are involved in an abusive relationship at any given time (Lupri, 1989; Nutall & Lent, 1985). Whichever statistic one chooses to use to describe the incidence of domestic violence, the conclusion is inescapable, thousands of women are the victims of domestic violence.

ii) **Socioeconomic Status:**

It is often assumed that domestic violence against women occurs only in poor families. MacLeod (1987) found, of women seeking shelter in transition houses, the majority were indeed poor, 68% of whom earned less than $10,000 per year. The majority of these women had two or more children and therefore fit the Statistics Canada's definition of living in poverty should they support their families solely on their own incomes. Further, 75% of the women in transition houses had a combined family income which constituted poverty.

It is not true however that only women from poor households are victims of abuse. Women from higher income households likely have the financial resources to find alternative accommodations, rather than seek shelter in transition houses and therefore are not as easily identified. In fact, it has been found that women from higher income brackets are more likely to access information, advice and counselling rather than

shelter, and more likely to experience more severe forms of abuse than women from lower income households (London Battered Women's Advocacy Clinic Inc., 1985; William & Shupe, 1983:120). Domestic violence against women seems to cross socioeconomic divisions, however how women from different income levels respond to their victimization may vary.

iii) **Education:**

As is the case with economic status, education level also restricts women's options in dealing with, or escaping from an abusive male partner. MacLeod (1987) found in her survey of transition houses that 70% of the women had not completed high school, only 2% had a university degree (MacLeod, 1987:21). Once again, as is the case with socioeconomic status, the disproportionate amount of women with lower education levels in transition homes are likely due to their limited options. Women with higher education levels have access to better paying jobs, and therefore greater economic independence, this increases the choices and options they may have when the decision is made to flee an abusive relationship.

iv) **Race:**

Coley and Beckett (1988) reviewed the literature from 1967-1987 which pertained to domestic violence against African-American women. These researchers found that black women were no more likely to be abused than women from any other racial category, and that no particular race is more at risk for domestic violence against women

than any other. This finding disputed the stereotype of African-American women being abused in greater numbers.

MacLeod (1987) identified two groups of women which may have difficulties accessing services for abused women or reporting or identifying abuse. These are aboriginal and immigrant or refugee women. MacLeod found that 15% of women in the Canadian transition houses were aboriginal (MacLeod, 1987:24). Further 18% of women were legal or illegal immigrants. However, the barriers which exist for aboriginal and immigrant women preclude any assumptions about these women experiencing less abuse.

For instance, many aboriginal women live on reserves or in other rural communities. This leads to isolation and therefore difficulty in seeking shelter. In addition, many aboriginal women are reluctant to trust the police, legal system or social service agencies for fear of their children being apprehended (MacLeod, 1987:24). They may be more likely to keep abuse a secret due to the high value which is placed on family privacy. Aboriginal women may experience abuse to the same extent as non-aboriginal women, however due to cultural and societal barriers may be less likely to acknowledge, report or flee abusive relationships.

Immigrant women, like aboriginal women face a number of barriers in accessing services for abused women, and therefore the incidence of domestic violence against women in this group may appear lower. In some cultures the patriarchal rule of the husband or male partner is never questioned. In certain communities women are expected to obey not only their male partners, but their uncles, male cousins and male

sons as well. Dissention from this cultural norm is often viewed as shameful, and women may therefore not disclose abuse for fear of being ostracised from their communities.

Many immigrant women are not sufficiently adept in either English or French to report abuse. Some women come from countries in which the police force was greatly feared and distrusted, and therefore will not call the police for assistance. In addition, many immigrant women fear deportation and chose to remain in abusive relationships as opposed to taking the chance of being deported (MacLeod, 1987:27).

It is therefore unrealistic to assume that one particular racial group is more or less likely to experience domestic violence against women than another. Reported cases of domestic violence are by those women who can report it, whereas women who are linguistically, culturally, or geographically restricted from reporting domestic violence against women may go unrecognized by the legal and social service systems.

v) **Personality Characteristics**:

As was discussed in the previous section on etiology, some theorists attribute domestic violence against women to personality traits of the women, who solicit provoke or pick abusive men as partners (Hilberman & Munson, 1977-78; Snell, Rosenwald & Robey, 1964). The personality characteristics which predispose women to abusive relationships are masochism, aggression, masculinity, frigidity, hostility, and controlling or castrating behaviour. However little empirical data supports this claim (Kuhl, 1984).

Other researchers have ascribed attributes such as docility, submissiveness, low

self-esteem, dependence, and ingratiating behaviour to abused women (Hilberman & Munson, 1977-78; Ball & Wyman 1977-78). However, the distinction is not made between characteristics which exist previous to an abusive relationship and those that result from one.

Research on the personality profile of the abused women is somewhat scarce (Kuhl, 1984). Those studies which do exist are based on myths and stereotypes about women or fail to distinguish pre-disposing or existing personality traits from those learned or acquired due to being abused.

It therefore seems that no particular 'type' of woman is more likely to be abused than any other. It does seem however that the types of services accessed by women in abusive relationships may vary depending on their socioeconomic status, education, and or cultural or religious background.

D: **PROFILE OF AN ABUSIVE MAN:**

Much more literature exists on the profile of abusive men than on abused women. Entire books have been written on this subject (Gondolf, 1985; Strodeur & Stille, 1989). The following will be a discussion on the abusive male partner. As the focus of this thesis is on women and their experience of abuse the discussion on abusive men will be brief.

i) **Socioeconomic Status and Education**:

Domestic violence against women has been associated with a male partner's

unemployment and lower education level (Fitch & Papantonio, 1983; Roberts, 1987; Straus & Hotaling, 1980; Stuart & Campbell, 1989). The greater representation of abusive men from lower socioeconomic stratum may occur for a number of reasons. First, a lack of employment may increase an abusive man's stress, causing a high level of anxiety. He may therefore be quick to anger and subsequently abuse. Secondly a lack of employment may increase the time an abusive man spends at home, and may therefore increase the opportunity for the abusive behaviour to occur. Finally, a man's lack of employment may be viewed by a man as a failure to live up to his expectations of being the breadwinner (Hornung, McMullough & Sugimoto, 1981).

ii) **Childhood Violence**:

A factor which appears to influence the likelihood of abusive behaviour is witnessing or experiencing abuse as a child. Many researchers have found a connection between abusive family history and abusive adult interactions (Coleman, 1980; Fagan, Stewart, & Hansen, 1983; Straus & Hotaling, 1980; Hambeger & Hastings, 1986; Hotaling & Sugarman, 1986). Sonkin *et al* (1985) reported that the proportion of abusive men who witnessed or experienced abuse in their childhoods was 50%. Other researchers have found highs of 75 - 85% of abusive men who have witnessed or experienced abuse in their childhoods (Fitch & Papantonio, 1983; Roy, 1982; Waldo, 1987).

Men who have been victimized themselves, or have witnessed the victimization of their mothers may, as social learning theorists assert, learn through observation and

modelling to use abuse as a means of dealing with conflict. Feminists theorize, men use abuse as a means of ensuring their continued domination of their female partners in a socially sanctioned manner, which through socialization they have learned both in the culture and in the home.

iii) **Alcohol and Drug Abuse:**

The association between domestic violence against women and alcohol\drug use has been well researched, the conclusions however vary. For instance, Hotaling and Sugarman (1986) reviewed 52 case comparison studies regarding risk markers associated with violent men. They found, of the nine studies which dealt specifically with alcohol, drug use, and violence, seven concluded this to be a consistent risk marker (Caesar, 1983; Coleman, Weinman & Hsi, 1980; Coleman & Straus, 1983; Hofeller, 1980; Lopez, 1981; Rosenbaum & O'Leary, 1980; Van Hasselt *et al* 1985). To be classified as a 'consistent risk marker' alcohol and drug usage had to occur in at least three independent investigations and found to be significantly related to husband to wife violence in the predicted direction in at least 70% of these investigations (Hotaling & Sugarman, 1986:104). Sonkin et al (1985) found that 62% of violent male partners had used alcohol during their last physical assault. Fitch and Papantonio (1983) also found an association with more than half of the male batterers interviewed abusing alcohol, more than one third abused drugs.

However researchers have found that many violent and abusive men do not abuse alcohol (Gangley & Harris, 1978; Gondolf, 1985; Roy, 1977). It appears that some

violent men use alcohol frequently, while other equally violent men do not use it at all (Sonkin *et al*, 1985).

What these studies suggest is that many men become abusive under the influence of alcohol or drugs, however many of these men are equally abusive without alcohol or drug consumption. Men who are predisposed to violence are more likely to use alcohol (Sonkin *et al*, 1985). These men likely use alcohol as an excuse to become violent, and therefore feel that it is the alcohol and not themselves who is responsible for abusive behaviour (Frank & Houghton, 1982).

iv) **Psychiatric Problems:**

Other researchers have not focused on the social context in which violence against women occurs, but have investigated personality disorders of individual men. Faulk (1974) found that approximately 61% of male abusers had a psychiatric disorder, the most common being depression and delusional jealousy. Hamburger & Hastings (1985) identified three major personality factors involved in male violence towards female partners: schizoid/borderline, narcissistic/antisocial, and passive dependent/compulsive personality. However control groups were not used in either the Faulk (1974) or Hamberger and Hastings (1985) studies so it is unclear if these men exhibited characteristics which were significantly different than non-abusers. Hamberger and Hastings (1986) replicated their previous studies and concluded that no single "abuser profile" was found.

It therefore appears that, as with victims of domestic violence against women, abusive men do not come from one identifiable group. An abuser may abuse alcohol and drugs, or he may not. He may have an identifiable personality disorder, or he may not. It does seem that having a history of violence in childhood influences abusive adult behaviour. However it must be noted that the vast majority of research done with abusive men is limited to those men who have been charged with assault, or have been ordered by the courts to attend counselling. Therefore little is known about abusive men who may be involved in the judicial or social service systems.

E: **PHYSICAL IMPLICATIONS OF DOMESTIC VIOLENCE AGAINST WOMEN:**

The physical implications of domestic violence against women are far reaching and often fatal. As was noted earlier in this thesis 40% of female homicides occur within the family context (Statistics Canada, 1989). However most women who are victims of domestic violence do not meet this tragic end, but their injuries are nonetheless serious. Straus (1986) noted that nonlethal violence inevitably preceded domestic homicide. The following list includes, but is by no means limited to, the physical consequences domestic violence:

- ☼ Single or multiple bruising to any or all parts of the body.
- ☼ Burns from electric appliances, cigarettes or acids.
- ☼ Dental problems with soft tissue injuries to mouth area, fractured teeth or facial fractures.
- ☼ Perforated ear drums.

- ☼ Serious bleeding injuries, especially to the face and head and internal organs.
- ☼ Breasts, chest and abdomen are often specific target areas, especially if the woman is pregnant.
- ☼ Injuries may appear untended, such as old untreated fractures.
- ☼ Chronic psychosomatic complaints.
- ☼ Sexual disorders.
- ☼ Substance abuse.
- ☼ Ulcers.
- ☼ Miscarriages.
- ☼ Chronic back pain.
- ☼ Suicidal behaviour.
- ☼ Hospitalization for extended periods.
- ☼ Concussions
- ☼ Death.

(Campbell, 1986; Fagen *et al* 1983; Goetting, 1989; MacLeod, 1987; Ontario Medical Association, 1991; Rodriguez, 1989; Romero, 1985).

As seen above the experience of being physically abused has serious and potentially fatal consequences. Research has shown that physical abuse commonly escalates in both severity and frequency over the duration of an abusive relationship (MacLeod, 1987; Stark, Flitcraft, & Zukerman *et al*, 1981). Therefore the significance and seriousness of physical abuse can not be underestimated. In fact, Romero (1985) compared strategies used on prisoners of war and battered wives and concluded that "physical abuse, torture, and death appear to be used more by American wife batterers than the Chinese captors in Korea" (Romero, 1985:543).

F: **PSYCHOLOGICAL IMPLICATIONS OF DOMESTIC VIOLENCE AGAINST WOMEN:**

The psychological impact of domestic violence against women may be somewhat harder to detect. However the experience of being degraded, humiliated, beaten or raped repeatedly by a male partner unquestionably affects the emotional wellbeing of the victim. Women may complain of a variety of ailments without relating it to or disclosing abuse. Therefore certain psychological complaints may not be correctly attributed to the experience of being abused (Ontario Medical Association, 1991).

Of those studies which investigated the psychological impact of domestic violence against women the following outcomes have been noted:

- Acute anxiety attacks.
- Feelings of helplessness or inability to cope.
- Depression.
- Suicidal thoughts or attempts.
- Drug/alcohol abuse.
- Noncompliance with prescription drugs, under use or over use.
- Feelings of powerlessness or loss of control.
- Lowered self-esteem.
- Sexual disorders.
- Chronic psychosomatic complaints.
- Post traumatic stress disorder (or Battered Woman's Syndrome).
- Avoidant responses.
- Feelings of detachment.
- Chronic fear and feelings of apprehension.
- Isolation and loneliness.

Campbell, 1986; Dutton, 1988; Douglas and Strom, 1988; Kuhl, 1984; MacLeod, 1987: Ontario Medical Association, 1991; McCann *et al* 1988; Mitchell and Hodson, 1983; Romero, 1985; Russell,1982; Stark and Flitcraft, 1985; Wolfe, 1985).

The implications are serious. Of particular interest to this researcher is how feelings of helplessness, loss of control, lowered self-esteem and non-compliance with prescription medication may impact on contraceptive behaviour. The following section will review literature regarding contraceptive behaviour.

II: CONTRACEPTION

A: **What Is Available:**

Table I (p. 36) lists currently available contraceptives, how they work, their advantages, disadvantages, suitability, convenience, availability, cost and efficacy rates. The contraceptives are listed from the most effective to the least effective.

B: **Factors Affecting Contraceptive Choices:**

Table I lists methods which are all currently available to Canadian women and men. The following discussion investigates factors which may influence contraceptive choices.

i) Socioeconomic Status:

Socioeconomic status has been researched in regards to its influence on fertility and subsequent contraceptive use. Benidict (1972) found that in nineteenth and twentieth century urban industrial societies, prestige and wealth tended to be associated with low fertility. It is felt that the pursuit of prestige and wealth, a higher socioeconomic

stratum, is best achieved through small families. Children cost time and money, and may put a strain on the achievement of wealth, and therefore the smaller the family the less time and money spent on children.

The pursuit of higher education, and greater participation in the workforce by women also tends to affect fertility and contraceptive use. The U.S. Bureau of Census (1987) found that on average, each 1,000 working wives aged 30 - 34 had about 350 fewer children than each 1,000 non-working wives of the same age. In fact, fertility among the poorer, non working women was 80% higher than the high-income workers. Zelnick and Kanter (1973) also noted that a woman was more likely to use contraception if she was college educated, the family income was above $15,000 and she was considered "non-poor" in status. Similarly Kane and Lachenbruch (1973) found sexually active non-pregnant women tended to be better educated and from "white collar" households than women seeking abortions. Women may delay childbearing and marriage in order to finish university degrees or to advance in careers. In order to prevent pregnancies, it is imperative that contraception be used, unless of course the woman chooses to abstain from intercourse.

ii) **Religion:**

Most people are born into some sort of religious context. Religion may affect many aspects of a person's life, how they view their world and how they conduct themselves in it. Most religions have some sort of rules or guidelines regarding sexuality. And, it therefore seems likely that one's religious affiliation may affect one's

use, or lack of use, of contraception. The research shows that this appears to be the case, with qualifications. For instance Hunt and Annandale (1990) found that the Catholic religion is an important factor in the choice of contraception. These researchers found that more than 60% of the Catholics in the study chose natural methods of contraception. Similarly Yusuf (1980) found that after controlling for variables such as age, parity, education, workforce participation and birth place, Catholic women, particularly those from southern European countries, accounted for the lowest proportion of contraceptive users. These women, however, made up the largest proportion of users of the "rhythm method", the only method sanctioned by the Catholic Church. Diamond, Steinfoff *et al*, (1973) found that over 70% of women who anticipated intercourse and did not want to become pregnant, yet chose not to use contraception were Catholics. However this same study found that of those women using birth control, more Catholic women than Buddhist or Protestant women had used the pill (Diamond, Steinhoff, *et al*, 1973).

Although researchers seem to have singled out Catholics to be less likely to use barrier or chemical forms of contraception, it is presumptuous to state that Catholics do not use birth control, for certainly the researchers show that Catholics use natural methods of birth control which, if used properly, can be a highly effective way to prevent unwanted pregnancies. Religions which prohibit contraception and encourage large families, such as the Hutterites and the Mormons have high fertility rates. In fact Provo, Utah has the highest fertility rate of any city in the United States (Janssen & Hauser, 1981). These religious groups are quite insular, as compared to other religious groups,

in terms of education, sanctions against inter-marriage and community cohesion. The influence from other communities is minimized through restrictions on travel and association with outsiders, and the impact of church run schools (Janssen & Hauser, 1981). Yet in most cases, it seems that it is not necessarily the religious affiliation that affects contraceptive decision making, but religiosity. For instance, in Canada and the United States Catholics and Protestants tend to have similar fertility rates, however women who consider themselves 'very religious' from both affiliations have higher fertility rates than those women who are less religious (Mosher and Hendershot, 1984). Similarly, Blake (1984) found that "practising Catholics" as compared to "non-practising Catholics, "expect larger families... are more traditional in defining the maternal role and know less about birth control" (Blake, 1984:338). So it is inadequate to only consider religion as a factor in contraceptive choices, but important to consider religiosity as well.

iii) **Contraceptive Knowledge:**

It seems logical that individuals who understand the physiological aspects of human reproduction would be better able to prevent unwanted pregnancies than those individuals who lack this knowledge. Further it seems likely that individuals who are knowledgable about contraception would be more likely to use it than those individuals who lack contraceptive awareness. Zelnik and Kantner (1979) found that close to half of the sexually active teenage women interviewed did not think they were able to become pregnant, and therefore did not see any reason to use contraception. The reasons these young women gave for their beliefs that pregnancy could not occur were:

they were having intercourse at a time of the month when conception could not occur; they felt they were too young to become pregnant, or they had intercourse too infrequently to become pregnant (Zelnick and Kantner, 1979:292). Presser (1977) found that only 33% of urban women over the age of 21 and only 10% of women under the age of 21 could correctly identify the fertile period of the menstrual cycle, it is therefore unlikely that young women could rely on this knowledge to prevent pregnancies. Age does not in any way prevent pregnancies in fecund women and the frequency of intercourse has no bearing on fertility. Therefore a lack of information regarding fertility and human reproduction could certainly affect the perceived need for contraception. Although sexuality education has improved greatly since these studies were done, many adolescent women and men still lack accurate reproductive knowledge and continue to rely on myths (Masters, Johnson, and Kolodny, 1988:157).

Knowledge of contraception should logically be causally connected to contraceptive use. However researchers have found that this connection is tenuous at best. For example Hansson, Jones and Chernovertz (1979) found that contraceptive knowledge did affect contraceptive use in the predicted fashion, however concluded that it represented only "modest practical significance" (Hansson, Jones, and Chernovertz, 1979:33). Other studies have also concluded that contraceptive knowledge is not in itself an accurate predictor of subsequent contraceptive use (Fischman, Collier, Stewart and Schwarz, 1974; Fischman *et al*, 1974). In fact Nadelson, Motman and Gillian (1980) found that of women who were either pregnant, aborting, or nonpregnant and had taken sex education, all scored high on factual knowledge regarding contraception. However

this knowledge did not necessarily relate to contraceptive use or fewer unwanted pregnancies.

It therefore seems that although contraceptive knowledge is important for contraceptive use, it is not the only factor involved in contraceptive use. As the above studies show women may be aware, and understand contraception and human reproduction, yet choose not to use it.

iv) **Accessability:**

It seems obvious that accessibility is an important factor in choosing a method of birth control. For women who choose to use the pill they must first obtain a prescription from a physician. Likewise if a women chooses an IUD she must have access to a physician in order to have it inserted, cervical caps and diaphragms also must be fitted by a qualified physician in order to ensure a proper fit. Individuals who choose condoms, contraceptive sponges or foam must have access to these products. Canadians are fortunate in having a socialized medical system, where universal access is ensured. However rural women may be somewhat disadvantaged due to the comparative lack of physicians as do urban women. Kar and Talbot (1980) confirmed the importance of accessibility, and concluded that accessibility is significantly related to both contraceptive intentions and contraceptive use.

TABLE I: CONTRACEPTIVE METHODS

METHOD	HOW IT WORKS	ADVANTAGES	MAIN DRAWBACKS AND PRECAUTIONS	SUITABILITY AND BEST PEOPLE TO USE IT	CONVENIENCE, AVAILABILITY AND COST	FAILURE RATE AMONG AVERAGE USERS	FAILURE RATE AMONG RELIABLE & CONSIS-TENT USERS
FEMALE STERILIZATION (Tubal Ligation)	Fallopian tubes occluded (clipped) cauterized (burned) or cut to prevent egg from reaching uterus.	▸ Highly effective ▸ One time relatively simple procedure with few complications. ▸ Done as "day" surgery (out patient or in hospital) ▸ Covered by medical insurance.	▸ Usual risks of surgery and anaesthetic. ▸ Irreversible in most cases.	▸ Good candidates women who have completed child bearing; not suitable for those with doubts about future desire for children or fear of infertility.	▸ Minor operation done by physician in hospital, often as "day" surgery. ▸ Women usually back to work (fully active) in a few days. ▸ Cost: $150, covered by medical insurance.	Very Low 0.015 - 0.04%	Very Low 0.015 - 0.04%
MALE STERILIZATION (Vasectomy)	Sperm conducting tubes (vas deferens) cut, clipped or tied to prevent sperm getting through penis into vagina.	▸ Highly effective ▸ One time, simple outpatient office procedure, done in 20 minutes. ▸ Done under local anaesthetic, less risky than female sterilization. ▸ Covered by medical insurance.	▸ Some post op pain. ▸ Occasionally infection. ▸ Sometimes (unwarranted) fears of post vasectomy impotence.	▸ Good candidates men who have fulfilled desire for paternity; not suitable if anxious about sex life, potency or virility.	▸ Minor operation done by physician on request, usually in doctor's office or as hospital "out patient". ▸ Cost: $100, covered by medical insurance.	Very Low 0.15%	Very Low 0.15%
THE BIRTH CONTROL PILL	Estrogen prevents egg maturation and progestin stops lining of uterus from preparing to receive egg: cervical plug may impede sperm penetration.	▸ Most effective reversible method for preventing pregnancy if direction followed. ▸ Low risk of PID (pelvic inflammatory disease) and ovarian cysts; ▸ Protects against cancer of the ovaries and uterine lining; ▸ May lessen benign lumpy breast disease. ▸ Does not impair fertility; ▸ May reduce risk of ectopic pregnancy.	▸ Nuisance side effects; nausea, headaches, weight gain, reaction with other drugs eg. antibiotics; and breakthrough bleeding which may call for brand change. Missed pill requires back-up contraceptive for rest of month. ▸ Slight risk of blood pressure elevation; ▸ Possibly raises blood lipid levels ▸ possible raise in cardio and cerebrovascular risks **(far greater with smoking)** ▸ May aggravate diabetes and epilepsy; ▸ May increase risk of cervical cancer and non-malignant liver tumours.	▸ Good for women under 35 (some say under 40). Not for smokers, especially if over 30, nor women with high blood pressure, heart problems, diabetes, high cholesterol/blood fats, liver, kidney or gall-bladder disease, epilepsy or jaundice.	Easy to use for women with regular lifestyle; requires daily pill swallowing, whether or not having regular intercourse. Periodic medical checkups advised while on it. Available by prescription. Discuss benefits vs. drawbacks and drug interaction with physician. ▸ Cost: $150 - 175 per year.	4%	1.5%

INTRAUTERINE DEVICE (IUD)	Mechanisms unclear, but foreign body in uterus triggers collection of white blood cells (which kill sperm) and hostile uterine environment impedes implantation of fertilized eg. May prevent fertilization by harming sperm.	▸ Highly effective. ▸ Inexpensive; ▸ Once fitted, usually unfelt/unnoticed; ▸ Needs replacing only once every 2-2 1/2 years; ▸ Convenient, effective, long lasting; ▸ Easily removed and reinserted if necessary; ▸ Doesn't generally disturb intercourse; ▸ No daily equipment needed; ▸ No effect on breast feeding.	▸ Chance of unnoticed slippage or expulsion; ▸ Must regularly feel for string to check placement; ▸ Increased risk of PID, possibly with resultant infertility (especially in women with many partners); ▸ May increase menstrual bleeding and cramping; ▸ Rare chance of uterine perforation during insertion; ▸ Possible higher risk of ectopic pregnancy, miscarriage, septic abortion if conception accidentally occurs with IUD in place.	Good candidates: monogamous women not exposed to STD's; not suitable for women at risk of STD's; poor candidates; teenagers, women with multiple sex partners; often best suits women who have had all desired children or not allowed for some reason to take the Pill.	Inserted by physician. Once i place can remain for 2 - 2 1/2 years, often without trouble. Must feel for string to ensure it is in place. Available from physician or family planning clinic. ▸ Cost: $25 - 50 per insertion, may average $10 - 20 per year.	4%	1.5%
DIAPHRAM/cERVICAL CAP	Round, flexible rubber cap, inserted into vagina before intercourse, smeared with spermicidal foam or jelly, blocks entry of sperm into cervix.	▸ No health risks; ▸ May help protect against sexually transmitted diseases; ▸ May protect against cervical cancer; ▸ No hormonal additives to body; ▸ Needn't disturb intercourse (if put in ahead); ▸ No effect of breast feeding.	▸ Occasional allergic reactions (to spermicide of latex in diaphram); ▸ Somewhat messy and annoying to insert and remove. ▸ Can be dislodged during intercourse; ▸ Very rare risk of toxic shock syndrome (less than 3 per million).	Suitable for women comfortable with touching own genitals; requires expert fitting and instructions for use; not fully reliable for those (e.g. teens) who don't know how, or are likely to use incorrectly. Regular checkups advised; re-fitting/re-sizing necessary following pregnancy.	Requires forethought; prescribed and sized by physician or family planning expert; user must learn correct placement; most reliable for organized, monogamous steady couples; must be left in place six hours after intercourse. Available at pharmacies, family planning clinics. Cost: $25 each; averaging $8-10 per year plus spermicide.	10% with spermicide	2% with spermicide.
CONDOM WITH SPERMICIDAL FOAM OR SPONGE	Thin sheath over erect penis traps sperm, prevents entry into cervix so ovum can't be fertilized. Best used with spermicide; newer spermicide-impregnated brands still need water-based foam or jelly (Not vaseline or petroleum jelly).	▸ Easy availability in many stores and pharmacies without prescription; ▸ Latex brands help protect against sexually transmitted diseases (eg. AIDS, gonorrhoea); ▸ Gives men an active role in birth control; ▸ Offers good protection if used consistently and carefully; ▸ Lambskin types not recommended.	▸ Inhibits spontaneous lovemaking; ▸ Unaesthetic; may reduce pleasurable (erotic) sensation; ▸ Possible allergy to latex or other condom material and/or spermicide; ▸ Can break (1-3 tears per 100 untested brands); ▸ May slip off; ▸ Requires care o removal to avoid spills.	Good to protect against STDs. Often first method tried by teenagers; good if can incorporate as regular part of lovemaking; not fully reliable for people who are likely to use incorrectly or inconsistently.	Readily obtained in many stores and any pharmacy; must be put on before any genital contact; shop around for best brand; must use with lubricant and spermicide. Advice available from family planning centres, family doctor. Cost: around $5 for 3 (including spermicide); might average $250 yearly for thrice weekly sex.	14%+	2-8%

Table I continued

CONTRACEPTIVE SPONGE	Physically traps and absorbs sperm, blocks entry of sperm into cervix and chemically kills sperm. Can be worn for up to 30 hours and must be left in for six hours after intercourse. An attached loop facilitates removal.	▸ One size fits all- no special fitting or prescription needed, available over the counter in most pharmacies; ▸ No hormonal additives to body; ▸ May help prevent sexually transmitted diseases, when used alone, with condoms or oral contraceptives; ▸ Inserted hours before intercourse; permits spontaneous, repeated intercourse up to 24 hours after insertion.	▸ Occasional itching, irritation or allergic reactions (to spermicide or polyurethane): ▸ Chance of being dislodged during intercourse; ▸ Very rare risk of toxic shock syndrome; ▸ Possibly annoying to insert and/or remove; ▸ May contribute to risk of yeast infections; ▸ Must have availability of water in order to wet the sponge prior to insertion; ▸ A bowel movement or other internal straining may cause the sponge to move down or fall out; ▸ Occasional tearing on removal.	Suitable for women comfortable with touching own genitals; good for nursing mothers; not fully reliable for women who don't use it consistently and correctly. NOT suitable for anyone who's had toxic shock syndrome; possibly less effective in women who have had children.	Must learn to use correctly; condoms should be used as well as sponge for first few months; must be left in place for at least six hours after intercourse. Cost: about $6 for 3; might average about $300 a year for three sponges weekly.	14%	10%
CONDOM	See condom and spermicide	See condom and spermicide	See condom and spermicide	See condom and spermicide	See condom and spermicide	10%	3%
RHYTHM METHOD (Natural Family Planning, Thermo-symptom Method, Billings Method)	Requires abstinence from sexual intercourse during female's fertile time. Chart by symptothermal method, recording temperature readings and changes in vaginal mucus to pinpoint day of egg release.	▸ Condoned by various religions; ▸ No use of chemicals or devices if used as a sole birth control method; ▸ Educates couples about fertility; ▸ Can be useful in achieving pregnancy when desired; ▸ Enhances body awareness.	▸ Uncertain methods if periods irregular or menstrual cycles upset; ▸ Requires motivated dedication; ▸ Disturbs natural sex life; ▸ May cause tension, stress, worry; ▸ Requires abstinence from sex for more than a week each month; ▸ High rate of failure if improperly used; ▸ Effectiveness highly dependent on body awareness and knowledgeable use.	Suitable for stable women, willing to monitor cycles, keep accurate records, and abstain from intercourse several days each month; instruction course advised; unsuitable for uncommitted women, those with irregular cycles or those who are often ill, do 'shift work' or are unable to keep records.	Reliable only in well instructed, motivated women, requires cooperation and commitment; advice available from family planning centres. Cost: computerized cervical thermometers; about $150 each; regular ovulation thermometer $15; charting materials; 20$ yearly.	20-40%	2-8%
WITHDRAWAL OR CHANCE	Withdrawing the penis just prior to ejaculation in order to prevent semen from entering the vagina, or relying on chance to prevent pregnancy.	▸ Condoned by various religious groups. ▸ No use of chemicals or devices; ▸ Requires little or no forethought or preparation.	▸ Highly ineffective in preventing pregnancy. ▸ Withdrawal may impede sexual gratification.	Best used by those couples who are not actively trying to prevent pregnancy.	Convenient in that it requires little or no preparation. Cost: free.	20 - 40%	20 - 40%

Taken from: *Comparison Chart of Birth Control Methods.* Berlex Canada Inc. and Masters, Johnson & Kolodny (1988). *Human Sexuality: Third Edition.* Glenview Illinois, Scott, Foreseman and Company, pg. 193.

Table I continued

v) **Convenience:**

As seen in Table I, some methods of birth control are clearly more convenient than others. Some require maintenance such as the cervical cap and diaphragm, and others require some sort of daily action such as the pill and natural family planning. Other methods impede sexual spontaneity such as barrier methods, while some require initial intervention and not much thought or up-keep following, such as an IUD, Norplant, injectable hormones, or sterilization. Condelli (1986) found that along with 'concern about side effects', and 'protection from pregnancy', convenience was the most important variable related to contraceptive choice.

vi) **Gender Roles:**

Those individuals who are traditional in their attitudes towards sexuality tend to have higher fertility rates than those individuals who adhere to more liberal values. This has been shown with regard to religion. That is, those that consider themselves highly religious tend to have more traditional attitudes towards sexuality (Herold *et al*, 1979). This also appears to be the case with gender roles. Women and men who adhere to more traditional attitudes towards gender roles tend to have higher fertility rates than individuals who have more liberal or modern attitudes. Gender roles also influence other factors associated with contraceptive choices which have been discussed previously. For instance women's aspirations for career advancement may be considered a somewhat modern phenomenon, with the traditional role of women being primarily that of wife and mother. Indeed Goldsmith *et al* (1971) found that women who successfully

used contraception were more likely to have higher education goals and postpone marriage when compared to women seeking abortion or term carriers. Reiss *et al* (1975) found successful female contraceptors to have a more liberal attitude towards premarital intercourse, and were more likely to seek contraception than women who had traditional attitudes. Similarly Joe *et al* (1979) found conservative attitudes to be associated with lower contraceptive usage. Conservative attitudes towards sexuality include traditional gender roles, such as the stay - at - home wife and mother, and the breadwinning father. MacCorquodale (1984) and Scanzoni (1976 a & b) both found individuals with more egalitarian gender roles to be more apt to use contraception, more likely to use it effectively and consistently, and more likely to desire smaller families than couples with more traditional gender attitudes. Kar and Talbot (1980) also found that women who had greater autonomy in decision making, actions, and had the freedom to discuss contraception were more likely to use contraception than those who did not.

vii) **Social Support:**

Perceived social support has also been found to influence contraceptive choices. Kar and Talbot (1980) found that not only was spousal approval highly correlated with contraceptive use, but support from friends was also significantly correlated. Condelli (1986) also found social support to be an important factor in choosing a contraceptive and concluded that "subjective-norm support for using the contraceptive was a powerful correlate of choice" (Condelli, 1986:487). He found support was the most powerful single discriminator for choosing the pill for contraception (Condelli, 1986).

viii) **Self Esteem:**

How individuals feels about themselves and their bodies has been shown to influence a variety of health related behaviours. Self esteem has been shown to influence contraceptive behaviour as well. Herold *et al* (1979) found self esteem to be significantly correlated with a positive attitude towards birth control pills, consistent use of birth control, lack of embarrassment about going to a clinic for contraception, and lack of embarrassment over internal examinations. Freeman (1977) found positive self image, mastery-achievement attributes and emotional expressiveness to be positively correlated to consistent birth control use. How a woman feels about herself and her body certainly would affect the type of contraception used. For instance if a woman disliked herself, or felt her genitals were 'dirty'she would certainly be a poor candidate for insertive barrier methods of contraception such as the diaphragm, cervical cap, or contraceptive sponge. Women who feel good about themselves and their bodies, who have high self esteem, should be more likely to take an active interest in how their bodies function and when they will choose to become parents. This appears to be the case. Campbell and Barnlund, 1977; Garris, Steckler, and McIntyre, 1976; Hornick, Doran, and Hofferman, 1979 and Miller, 1976 all found self esteem to be positively correlated to contraceptive use.

It appears that no single factor can be used to predict the likelihood of contraceptive use by an individual. Many factors combined influence contraceptive decision making, one's goals and aspirations, religious and gender attitudes, and basic

issues such as availability, accessibility and convenience. It is important that a woman feel positive about herself and that her decisions regarding contraception be supported by her male partner, as well as her friends and family.

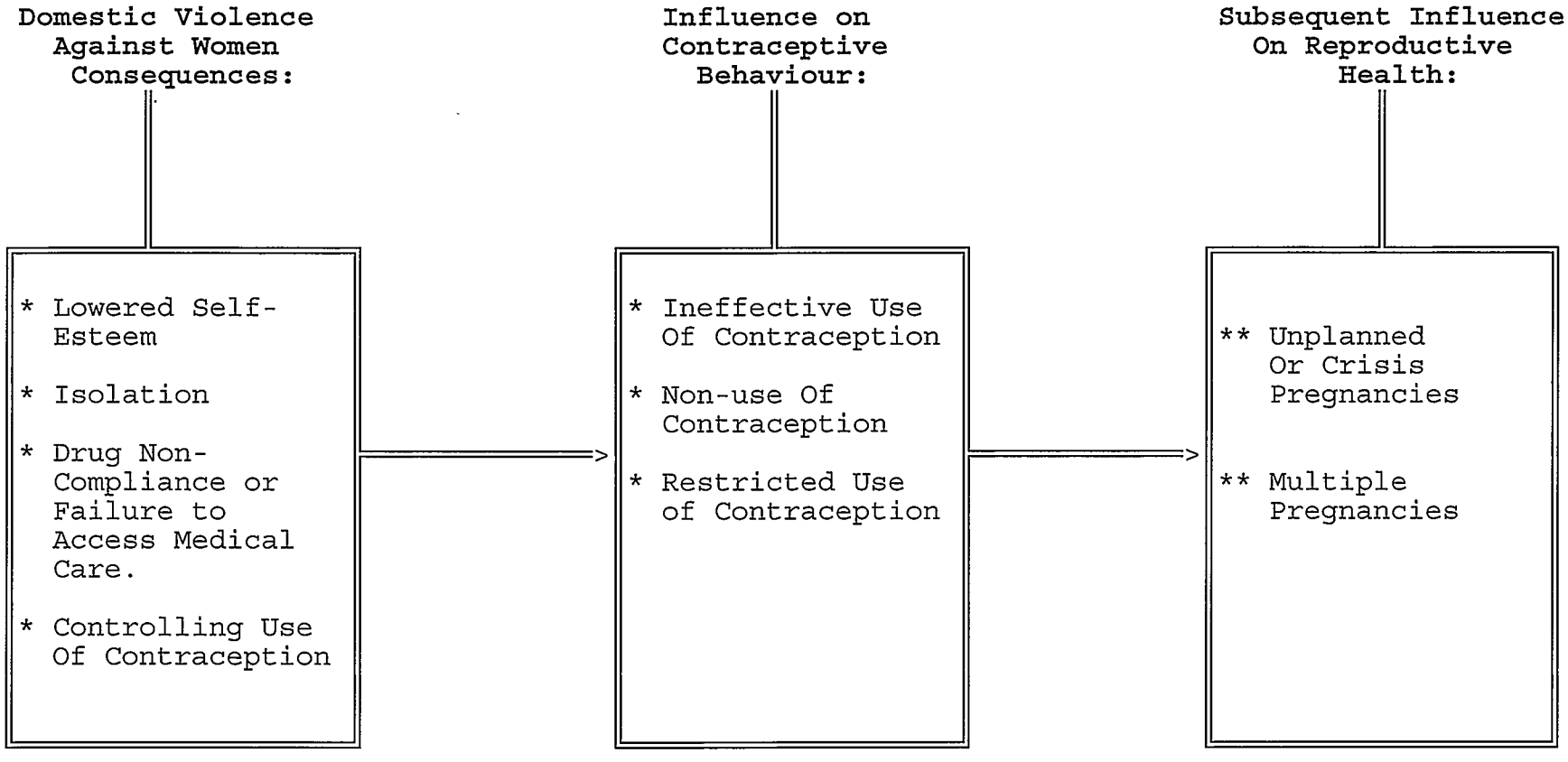
The following section will set out a theoretical framework which links domestic violence against women to poor contraceptive behaviour and usage. This framework creates the foundation for my hypotheses.

III: MAKING THE LINK: DOMESTIC VIOLENCE AGAINST WOMEN AND REPRODUCTIVE HEALTH

It is theorized by this researcher that domestic violence against women affects reproductive health by interfering with or impeding effective use of contraception. This is illustrated in Diagram I.

As can be seen, the outcomes of domestic violence against women seem to have the effect of interfering with the use, or effective use, of contraception by influencing behaviours or mechanisms which are important to contraceptive behaviour. For instance, low self esteem is an established outcome of domestic violence against women (Dutton, 1988; MacLeod, 1987; Russell, 1982). Similarly, low self esteem is associated with poor contraceptive use (Herold, et al, 1979; Freeman, 1977; McIntyre, 1986; Miller, 1976). Similarly, drug non-compliance has been found in women victims of domestic violence (Ontario Medical Association, 1991), drug compliance is essential for efficient use of oral contraceptives. Substance abuse has also been a behaviour noted in victims of domestic violence against women (Ontario Medical Association, 1991; MacLeod, 1987). Intoxication due to alcohol or drugs may impede the proper use, or total use, of contraception. Similarly, isolation is a common outcome of domestic violence against women (Campbell, 1986; Douglas & Strom, 1988; Russell, 1982). If a women is isolated from her friends and family, she will lack social support, which has been shown to be an important factor in the choice and use of contraceptives (Kar & Talbot, 1980). In addition

DIAGRAM I: MAKING THE LINK:
DOMESTIC VIOLENCE AGAINST WOMEN AND UNPLANNED PREGNANCIES



to social support, isolation may also restrict a woman's mobility and participation in the community in which she lives. This may adversely affect her accessibility to contraception in that she may not visit her physician or she may be prohibited from leaving home unless accompanied by her male partner.

In addition to the above influences on reproductive health the outcomes of domestic violence against women are theorized as exerting, less subtle influences associated with domestic violence against women may also impact on a woman's reproductive health. For instance, an abusive male partner may overtly sabotage a woman's efforts to use contraception, such as throwing out birth control pills, piercing holes in condoms or diaphrams, or strictly prohibiting the use of any contraception. In addition, women who are sexually assaulted by their partners would unlikely have the foreknowledge or opportunity needed to use barrier methods of contraception.

If the use of any contraception, or the effective use of contraception is compromised in some way due to the experience of domestic violence against women, as is hypothesized in this study, then it is likely that unintended pregnancies would result. It is this line of thinking that lead to the research questions investigated in this thesis. If domestic violence against women does exert a negative influence on the reproductive health of women it is hypothesized that women experiencing crisis pregnancies would more likely be involved in abusive relationships than women experiencing non-crisis pregnancies. Similarly, it is hypothesized that women involved in abusive relationships would likely have a higher number of total pregnancies than women in non-abusive relationships. And, it is also thought that women in abusive

relationships are more likely to abstain from contraceptive use or use the least effective methods.

The next chapter outlines the methods used to study these questions.

CHAPTER TWO

METHODOLOGY

The purpose of this study was to: 1) explore if women experiencing crisis pregnancies are more likely to be in abusive relationships than women experiencing non-crisis pregnancies, 2) to explore if women in abusive relationships are likely to have a higher number of total pregnancies than women in non-abusive relationships, 3) to explore if women in abusive relationships are more likely to abstain from contraceptive use or use the least effective methods than women in non abusive relationships. 4) To see if women in abusive relationships differed in regards to pregnancy outcomes when compared to women in non-abusive relationships. The purpose of exploring these questions is to investigate if domestic violence against women negatively impacts on the reproductive health of its victims.

I: DESIGN:

The design used to investigate the research questions was **exploratory research design**. This type of design attempts to generate "insights and explanations which can then be studied more rigorously at other levels of research" (Grinnell, 1988:328). As noted early on in this thesis the research lacks investigation of the effects of domestic violence against women on reproductive health. Therefore an exploratory design was

used as it seemed most appropriate.

In order to collect the information needed survey research was used. Two standardized instruments (to be discussed shortly) were used to identify women involved in abusive relationships in addition to supplemented questions regarding reproductive health. This collective survey was self-administered by those women who consented to participate.

When using inferential statistics with survey data, it is assumed that all members of the sample complete the survey (Rabin & Babbie, 1989). When this fails to occur, which it often does, the possibility of response bias exists. It is likely that such a bias exists in this study, as the response rate in this thesis was rather low. This is discussed further in the section on limitations.

II: SAMPLE SELECTION:

In order to obtain the data required it was imperative to collect information from women who were currently pregnant, either experiencing an unintended or crisis pregnancy, or an intended or non-crisis pregnancy. It was assumed by this researcher that women seeking abortions or 'options' counselling for a pregnancy would be experiencing a crisis pregnancy. Therefore, in order to derive information about women experiencing crisis pregnancies, Kensington Clinic and Calgary Birth Control Association were used as survey sites. Kensington Clinic is a private abortion clinic located in Calgary, and Calgary Birth Control Association in an agency who, among their functions, offers 'options' counselling to women seeking information, counselling or referral for

unintended pregnancies. In order to compare women experiencing crisis pregnancies to women experiencing non-crisis pregnancies a Calgary obstetrician/gynaecologist offered his office as a survey site. Women seeking prenatal care, for non-crisis pregnancies at the doctor's office were asked to participate in the study.

All women visiting the locations listed above were asked to participate providing the following conditions could be met:

1) The woman was 18 years or older.
2) The woman could both read and understand English.
3) The woman read and signed the consent form.
4) The woman agreed to fill out the survey unaccompanied by her male partner or support person.
5) For women at the obstetrician's office only: women were 21 weeks pregnant or more.

The conditions pertaining to age and comprehension of English were met, understandably, in order to ensure the women was clearly in control, both legally and intellectually, of her decision to participate. I felt that women's comfort level and honesty in answering may be compromised if a male partner or support person were present, and therefore felt it appropriate to ask that participants fill out the survey in private. In order to ensure a woman was experiencing a non-crisis pregnancy, women were required to be at least 21 weeks pregnant. As pregnancies can be terminated in Alberta up to the nineteenth week, I felt that women who were carrying pregnancies to term and seeking

prenatal care would be considered to be in the non-crisis group.

Subjects were approached individually during their counselling or doctor's visit. At the discretion of the counsellor or nurse women were asked either prior to the counselling/doctor visit or following it. They were informed about the nature of the research and if they expressed interest were asked to read and sign the consent form (which appears as Appendix I). In order to ensure confidentiality signed consent forms and completed survey forms were separated. Women, upon completion of the survey forms were requested to put the survey form in an unmarked envelope which was provided, and seal it before returning it to the nurse\counsellor. Consent forms were kept in a separate envelope and both surveys and consent forms were stored in locked cabinets at the survey sites. When the data was collected by this researcher it was also kept in a locked cabinet, and will be destroyed following the defense of this thesis.

Due to the sensitive nature of the questions asked in the survey women were encouraged to debrief with a counsellor/nurse following completion of the survey. In addition a list of community resources was attached to the survey which women could detach and keep if they so wished (Appendix III).

The study ran for a period of two months (from July 1, 1993 to August 31, 1993). During this time 41 women experiencing non-crisis pregnancies agreed to participate, and 60 women experiencing crisis pregnancies agreed to participate. Counsellors from both the Kensington Clinic and Calgary Birth Control Association commented on the general resistance of women to participate. Although resistance was anticipated, the magnitude of the resistance was unfortunate. In retrospect, it may have been helpful to

allow for more time in order to collect more data from the crisis pregnancy group. Although the study was intended to run for the entire two months, the obstetrician was delayed in beginning. He however managed to obtain 41 subjects and mentioned that women in this group were generally quite interested in filling out the survey.

III: Measuring Domestic Violence Against Women:

In order to establish if women were currently involved in abusive relationships, two instruments were used, the Abuse Risk Inventory for Women (Yegidis, 1989) and the Index of Spouse Abuse (Hudson & McIntosh, 1981). The Abuse Risk Inventory is also known as the Interpersonal Relationship Survey (the reason for the dual naming is unknown by this researcher) and appears as Appendix II, the Hudson Index of Wife Abuse appears as Appendix III.

A: Abuse Risk Inventory:

The Abuse Risk Inventory for women (ARI) was developed by Bonnie Yegidis in 1982 in order to identify psychosocial correlates of abuse and build these into test items (Yegidis, 1989:7). Yegidis defined abuse as "the physical assault of a woman by her husband or other male intimate partner such that physical injury is likely to result" (Yegidis, 1989:2). Although this instrument identifies women who are victims of physical abuse, rather than identifying other aspects of domestic violence against women, such as emotional abuse I felt this to be an appropriate tool for the purpose of my study. The instrument contained items which I felt were unnecessary or inappropriate for my study

and were subsequently removed. These items related to demographic information such as race, annual income, education in addition to history of child abuse or parental domestic violence.

Data pertaining to reliability suggest the ARI is unidimensional. The high alpha coefficient (.88) derived in initial reliability studies suggest the items are relatively homogeneous (Yegidis, 1989:3). As a means to establish validity there are four items on the questionnaire that pertain to whether or not respondents have ever been assaulted (physically, emotionally, or sexually) by their male partner. It was noted that women who identified themselves as abused did not necessarily score 50 or more which indicated abuse according to the score key. This is discussed further in the Results section. Validity and reliability studies on the ARI have been done by a number of researchers (Bagwell, 1986; Choate, 1986; King and Cervera, 1987). These studies suggest the ARI is both valid and reliable. However it is noted by Yegidis that caution be used in using the scale as it is still experimental. Yegidis suggests that the ARI be used only in conjunction with other assessment data. I therefore used the Hudson's Index of Spouse Abuse to supplement the ARI (see Appendix III).

B: Index of Spouse Abuse:

The Index of Spouse Abuse was designed to measure the severity and magnitude of both physical and nonphysical domestic violence against women. The instrument is comprised of Likert-type questions relating to actions or behaviours which are considered to be abusive. Some behaviours are considered highly abusive (such as, "my partner

beats me so badly I must seek medical help", while others are considered less seriously abusive (such as, "my partner orders me around"). The Index of Spouse Abuse is comprised of two subscales, physical and nonphysical abuse, and the two subscales are scored independently of one another.

The ISA has been found to be very reliable, with alphas that range from .90 to .94 for the physical subscale and .91 to .97 for the nonphysical subscale. Validity has also been shown, with the scale having accurately differentiated between women known to be abused and women known not to be abused. It has also shown good construct validity with predicted correlations being low for personal and social problems believed to have little or no connection to domestic violence against women, and high with personal and social problems believed to have a connection with domestic violence against women. I felt the ISA was an appropriate tool for the purpose of my study and included all items contained in the instrument.

IV: Defining Domestic Violence Against Women:

Deciding on a criterion for choosing which women were abused and which were not was no easy task. Yegidis (1989) specified scores of 50 or more for fitting the criterion of 'abused'. Using this criterion, 21 women in the study were identified as being abused according to the Abuse Risk Inventory. Yegidis included three questions in order to validate abuse. The questions were basic and direct, and asked specifically "in the past

year have you been abused physically, sexually or emotionally?" The number of women who answered 'yes' to one of these questions was 28. This means that 7 women who identified themselves as being abused were not identified by the ARI as being abused. As the ARI is designed to identify women at risk of 'physical' abuse it is possible that the 7 women self-identified as abused answered yes to being emotionally abused.

Hudson's Index of Wife Abuse has two subscales, one for physical abuse and one for non-physical abuse. Physical abuse is identified by scores of 10 or more, and subsequently 18 women were defined as abused (2 less than the ARI). Non-physical abuse is determined by scores of 25 or more, and 11 women fit this criterion (although 25 women answered "yes" to being emotionally abused on the ARI).

After grappling with the ill-at-ease feeling of labelling women non-abused when they themselves identified themselves as abused I settled on the following indicator of domestic violence against women. Women are identified as being involved or at risk of abuse if (a) they had an ARI score of 50 or more, and (b) they had either a Hudson's physical score of 10 or more **or** a Hudson's non-physical score of 25 or more. This criterion was known as **Abuse1**. Using this as an identifier of abusive relationships 18 of the 101 women in the study were identified as being abused.

V: <u>Measuring Reproductive Health</u>:

A: Contraceptive Behaviour:

In order to investigate contraceptive behaviour, three questions pertaining to

contraceptive use were asked (see Appendix II). The questions asked about contraceptive usage in the past year, the most recent contraceptives used, and the expected method of contraception to be used in the future. These questions were followed by a list of currently available methods, and participants could choose more than one answer.

The contraceptive choices were then categorized into three groups: 1) ineffective, 2) moderately effective, 3) highly effective. Contraceptives which were considered to be ineffective were: nothing/chance, withdrawal, and/or rhythm method. Contraceptives considered moderately effective were: the condom, condom with spermicide, the sponge, the cervical cap, or the diaphram. Highly effective contraceptives included the I.U.D., the birth control pill, tubal ligation, vasectomy, or the morning after pill. These categories were defined using Table I (page 37). The ineffective methods had actual failure rates of 20 - 40%, the moderately effective 10 - 14% and the highly effective .015 - 4%.

In order to identify true contraceptive behaviour women in the non-crisis group were not used in the results. It is presumed that women planning pregnancies would not be using contraceptives.

B: Reproductive History:

Reproductive history or obstetric history was investigated by asking direct questions about pregnancies and pregnancy outcomes. Participants were asked how many times they had ever been pregnant and what the outcomes of the pregnancies were (live birth,

adoption, abortion, or miscarriage).

VI Demographic Information:

In terms of demographic information, age and partner's age were investigated. Who the woman lived with, how long she and her partner had been together, and her marital status were also considered.

VII Limitations:

A: Location:

The women selected to form the crisis pregnancy group came from one of two locations: the Calgary Birth Control Association or the Kensington Clinic. Both are pro-choice in their philosophies and consider abortion to be one acceptable option in terms of options in dealing with an unintended pregnancy. Women who present themselves at either locations are made aware of this pro-choice philosophy. Further, it is assumed that women who, upon knowing the clinic or agency's philosophical standpoint on abortion, choose to receive services must also be somewhat comfortable with the pro-choice philosophy. Therefore women who strongly oppose abortion would be unlikely to show up in this crisis pregnancy group. Women experiencing crisis pregnancies, who do not view abortion as an acceptable alternative, would likely choose to continue their pregnancies and either parent the child or make an adoption plan.

It is possible therefore, that some of the women in the non-crisis pregnancy group

were in fact experiencing crisis pregnancies, as women in the non crisis group were defined as such only by the gestational age of the pregnancy.

The Kensington Clinic charges a fee for abortion services, as the cost is currently not completely covered by Alberta Health. Women may pay from $375.00 to over $1000.00 depending on their place of residence and the gestational age of their pregnancies. Aboriginal treaty status women have their abortions covered by the Department of Indian Affairs, women receiving social assistance may or may not receive funds to pay for their procedure depending on their worker and their tenacity. Therefore the vast majority of women who go to the Kensington Clinic must have some access to money. It therefore may limit the extrapolation of results to all women seeking abortion, as the women in this study who were having abortions had to have the financial resources to do so. It may be that women experiencing crisis pregnancies who choose to have abortions at the hospital may be different.

It is for this reason that Calgary Birth Control Association's participation in this study was important. Women who attend Calgary Birth Control Association for options counselling do not have to pay for this service. In addition they have the option of choosing one of the two hospitals in Calgary to have an abortion. They do not have to pay out of hand for their procedure provided they have AHCIP coverage.

The non-crisis pregnancy group came from a Calgary obstetrician's office. His office is located in North East Calgary. It may be that women visiting his office are indicative of women from this geographical area only.

B: Length of Study:

It was anticipated by this researcher that many women, particularly in the crisis group, would refuse to participate. However the magnitude of this refusal was grossly miscalculated. Calgary Birth Control Association found it very difficult to find women to participate for two reasons: 1) The counsellors felt uncomfortable asking and, 2) the women were too emotionally drained from their counselling sessions to consent. Kensington Clinic cited similar reactions to the study.

The counsellors at both Calgary Birth Control Association and Kensington Clinic were briefed about the study before it began. Discussion arose as to when the best time would be to ask women if they would like to participate. Women could be asked before the session was to begin, or after the counselling session had concluded. Neither time was ideal as women are usually anxious preceding the session and often emotionally drained following. Therefore when the women was to be asked was left to the discretion of the individual counsellor. However it was reported that many counsellors felt uncomfortable asking at either time and subsequently did not ask at all. Additionally, many women asked chose not to participate for the same reasons the counsellors felt uncomfortable asking them to (ie. they were too anxious before the session and too drained following). In the two months that the study ran 60 women agreed to participate, in that time approximately 600-700 women visited either the Kensington Clinic or Calgary Birth Control Association, so it is clear that only a very few women felt comfortable with this study. By comparison the obstetrician, who was late in beginning the study and only had three weeks, was able to solicit 41 participants, and commented on their general

willingness to participate.

Therefore the data collected from the crisis pregnancy group and the conclusions made are only reflective of the women who agreed to participate. An argument could be made that these women posses a quality unique to only this group of women.

C: Non-Random Sample:

Due the sensitive nature of both crisis pregnancies and the subject matter availability sampling was used. Those women who felt comfortable completing the survey did so, those who felt uncomfortable did not. As random sampling in this survey was impossible to obtain, an argument could be made that the data collected reflects only those women who participated, and can not and should not be generalized to other women.

VIII: Ethical Considerations:

A: Confidentiality:

Due to the extremely contentious nature of abortion, it was imperative that women's anonymity be assured. As was described earlier this was accomplished in a number of ways. First of all women were asked to complete the survey in private. Secondly, upon completion of the survey they were asked to put the survey in an unmarked manilla envelope and seal it. They were instructed not to put their names or any identifying information on the survey. Thirdly, all signed consent forms were kept in a locked filing

cabinet, separate from the completed survey forms. Consent required any signature the women felt comfortable giving (ie. a first initial and last name, or first name and last initial). Finally, all surveys and consent forms , once collected by the writer, were kept in a locked cabinet, and no attempts were made to identify or contact participants.

The same process was used for women in the non-crisis pregnancy group Although these women were not seeking abortions or options counselling, the sensitivity of the subject matter warranted precautions be taken to protect the anonymity of these participants as well.

B: Subject Matter:

Domestic violence against women is an experience that has touched the lives of many women, either directly or indirectly. The questions asked in the survey were direct, and likely to evoke strong emotions. Therefore women were given the opportunity to debrief following completion of the survey. In addition, as time constraints existed at all three survey sites, a tear away list of community resources was attached to the survey (Appendix V). Once the surveys were collected it was noted that many women had taken the resource list with them.

CHAPTER THREE

RESULTS

I Demographic Information:

A: Age:

Of the 101 women who agreed to participate the mean, age was 27.47 years of age. The crisis and non-crisis groups differed in terms of age. 63.8% of the women in the crisis group were 25 years of age or younger (the mean age was 24.97), whereas only 17.6% of the women in the non-crisis group were this age. The majority of women, 57.5%, in the non-crisis group were, in fact, 31 years of age or older, the mean age for this group was 31.10 years.

Although statistically significant (to .0004 level of significance) this finding is not remarkable. The women in the non-crisis group are expected to be experiencing planned pregnancies. As women appear to be delaying childbirth until their late 20's or early 30's it is no surprise that the women in this group are also this age (Goldsmith *et al*, 1978).

Similarly, the same is true for the crisis pregnancy group. These women are expected to be younger than the non-crisis group. Women in their teens or early twenties may wish to pursue academic or career goals. And in the event of an unplanned pregnancy may choose to terminate their pregnancies in favour of completion

of these goals, choosing to delay childbirth until their late 20's or early 30's.

Women who were identified as being in abusive relationships with their male partners tended to be younger than women in non-abusive relationships. Women identified as abused had a mean age of 25.71, whereas women in the non-abused group had a mean age of 27.84.

B: Partner's Age:

The majority (56.7%) of the male partners in the population of respondents were 30 years of age or younger, the mean age was 29.16. See Table II for summary of comparisons between partners of abused and non-abused women, and partners of women experiencing crisis and non-crisis pregnancies.

C: Place of Residence:

Most of respondents (27.7%) lived with their husbands. As expected women experiencing planned or non-crisis pregnancies tended to live more with their husbands than any other type of living arrangement, whereas only 5% of women in the crisis group lived with husbands. Women in the crisis group tended to live alone or with their parents.

Of women in abusive relationships 9% lived with their parents or alone, 5.9% lived with a male partner. Women in non abusive relationships tended to live with their husbands (26.7%) or with their husbands and children (14.9%).

D: Length of relationship:

The average length of relationship for the study was 4.62 years. The crisis and non-crisis groups differed substantially with regard to length of relationship. The crisis group averaged 3.26 years in their present relationship, whereas the non-crisis group averaged 6.33 years in their present relationship. This difference was also noted between the abused and non-abused groups. Those women identified as abused were involved in their present relationship an average of 3.73 years, whereas those women identified as non-abused averaged 4.80 years.

E: Marital Status:

Of the total population of respondents, 47% were single, 44% married and 9% divorced. Women in the crisis group tended to be single (43%), with 10% being married and 6% divorced. Comparatively, more women in the non-crisis group tended to be married (34%), with 4% single and 3% divorced. Abused and non-abused groups also differed with regard to marital status, with the majority of abused women (14%) being single, 3% were divorced and only 1% were married. Of those women in the non-abused group the majority (43%) were married, 33% were single and 6% were divorced.

For a complete compilation of demographic information please see Table II.

TABLE II: SUMMARY OF DEMOGRAPHIC INFORMATION					
	Total Population	Crisis	Non-Crisis	Abused	Not Abused
Respondent's Age	27.47	24.97	31.10	25.71	27.84
Partner's Age	29.16	27.38	32.05	26.67	29.73
Length of Relationship	4.62	3.26	6.33	3.73	4.80
RESIDENCE - Percent of Respondents					
Husband	27.7	5.0	22.8	1.0	26.7
Husband & kids	14.9	3.0	3.0	0.0	14.9
Male Partner	13.9	11.9	2.0	5.9	7.9
Male Partner & kids	6.9	5.0	2.0	1.0	5.9
Alone	14.9	13.9	1.0	4.0	10.9
Parents	13.9	13.9	0.0	5.0	8.9
Other	7.9	6.9	1.0	1.0	6.9
MARITAL STATUS - Percent of Respondents					
Single	47.0	43.0	4.0	14.0	33.0
Married	44.0	10.0	34.0	1.0	43.0
Divorced	9.0	6.0	3.0	3.0	6.0
Widowed	0.0	0.0	0.0	0.0	0.0

II: Answering the Research Questions:

A: Are women in the crisis pregnancy group more likely to be in an abusive relationship than women in the non-crisis group?

The answer to this question was formulated from two different standpoints. Initial investigation compared the crisis pregnancy group to the non-crisis pregnancy group with regard to identified numbers of women in abusive relationships. Following this I then compared women in abusive relationships with women in non-abusive relationships and identified the number of women experiencing crisis and non-crisis pregnancies. Although this is essentially the same thing, it was nonetheless interesting, and revealing. These comparisons yield similar results, namely that in this study women experiencing crisis pregnancies are indeed more likely to be experiencing domestic violence than women in the non-crisis pregnancy group. Or in other words, women in abusive relationships are likely to experience unplanned or crisis pregnancies, as was speculated in this thesis. This is shown in Table III using Chi Square analysis.

Table III: Chi Square Analysis: Abuse by Crisis

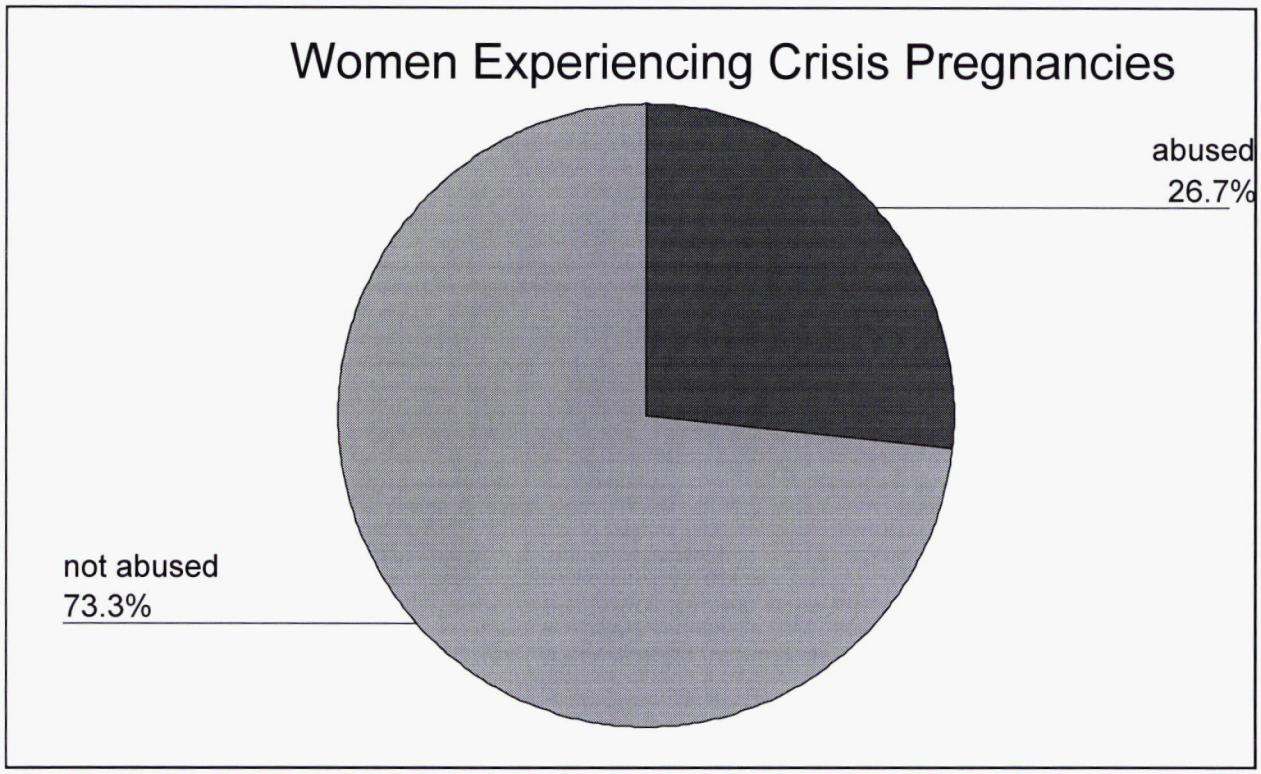
ABUSE1	Count / Exp Val / Row Pct / Residual	CRISIS yes (1)	CRISIS no (2)	Row Total
abused (1)		16	2	18
		10.7	7.3	17.8%
		88.9%	11.1%	
		5.3	-5.3	
not abused (2)		44	39	83
		49.3	33.7	82.2%
		53.0%	47.0%	
		-5.3	5.3	
	Column Total	60 59.4%	41 40.6%	101 100.0%

Chi-Square	Value	DF	Significance
Pearson	7.89524	1	.00496
Continuity Correction	6.47760	1	.01092
Likelihood Ratio	9.10109	1	.00255
Phi value	.280		
Minimum Expected Frequency -	7.307		

As was identified early in this thesis, it is estimated that 10% of Canadian women experience domestic violence (Lupri, 1989; MacLeod, 1980; Nutall & Lent, 1985). Therefore, if this were a random sample, it would be expected that 10% of the participants in this study would be experiencing some form of domestic violence against women. However, as indicated previously, this was not a random sample of women, and therefore it can not be assumed that 10% of the women would be experiencing abuse. Using Abuse1 as a predictor of existing or potential abuse, 18 of the 101 women (17.82%) are in abusive relationships, which is higher than expected in an random sample. When the comparison is made between women in the crisis group and women in the non-crisis group a startling difference emerges. Sixteen of the 60 women (26.67%) in the crisis group are identified as being involved in an abusive relationship, whereas 2 of the 41 women (4.88%) in the non-crisis group are involved in abusive relationships. Therefore more than one quarter of the women experiencing crisis pregnancies are also experiencing abuse. Chi square analysis shows this to be a significant difference (X^2 =7.90, DF=1, p<.005). The Phi value of .280 indicates a moderate strength of relationship.

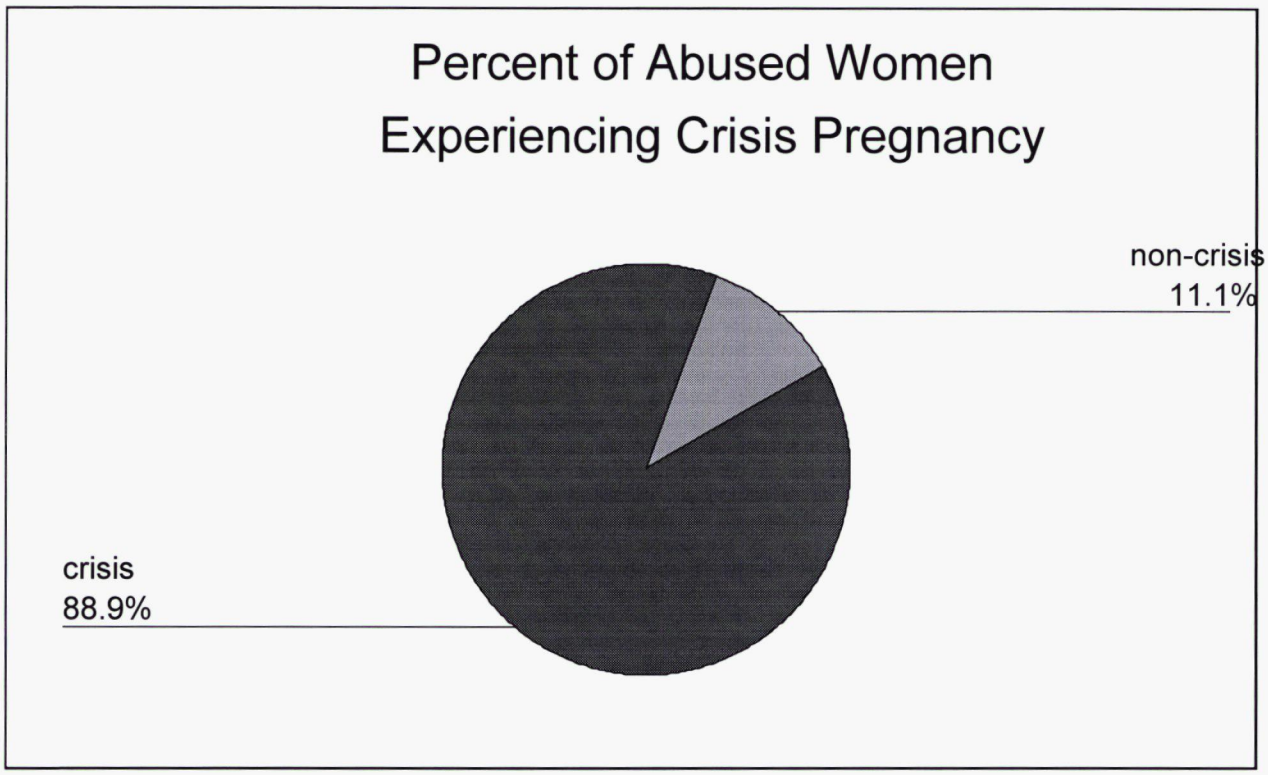
This is shown in Chart 1a.

Chart Ia


Women Experiencing Crisis Pregnancies
abused
26.7%
not abused
73.3%

The difference between the crisis and non-crisis group becomes markedly pronounced when abuse is used as the independent variable and crisis/non-crisis as the dependent variable, a subtle but helpful difference in perception. Again, 18 women are identified as being abused according to Abuse1. Of these women 88.9% of them are experiencing a crisis pregnancy, 11.1% are experiencing a non-crisis pregnancy. This is illustrated in Chart 1. As can be seen, the vast majority of women in abusive relationships (all but two women) were found in the crisis pregnancy group. Again this is a statistically significant finding ($p<.005$) and as noted above the phi value of .280 indicates a moderate strength of relationship.

Chart Ib


Percent of Abused Women
Experiencing Crisis Pregnancy
non-crisis
11.1%
crisis
88.9%

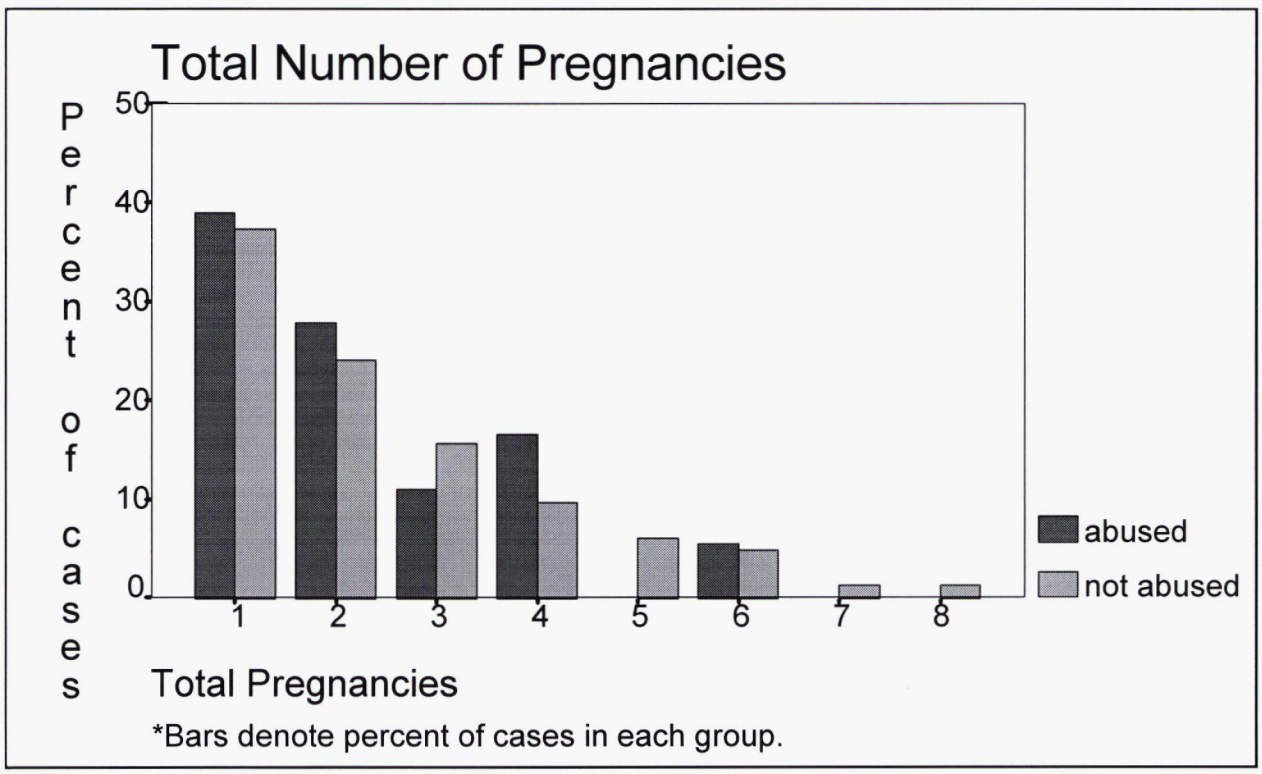
B: Are women in abusive relationships more likely to have a higher number of total pregnancies than women in non-abusive relationships?

The answer to this question was investigated using both a T-test and regression analysis. In order to use the t-test it is assumed that observations are randomly sampled from a normal distribution (Weinbach & Grinnell, 1987). Although a lack of a random sample exists in this study, the t-test is considered robust and precedent exists for its use (Ramsey, 1980; Tiku & Sing, 1981). Neither of these two tests yielded the expected results, namely that women in abusive relationships have a higher number of total pregnancies than women in non-abusive relationships. The T-test revealed the mean number of pregnancies to be 2.28 for abused women and 2.48 for non-abused women. This very slight difference was not statistically significant. Likewise, when regression analysis was conducted controlling for age, as the women in the abused group tended to be younger and age would certainly affect the number of pregnancies a woman had, no significant difference was found between the two groups.

It is interesting to note that, although no significant difference was found between abused and non-abused women, that the two women with the highest number of pregnancies (7 and 8) were abused based on their ARI scores, but did not meet the criterion for Abuse1 and therefore were included in the non-abused group.

For a summary of pregnancy totals please see Chart II.

Chart II


Total Number of Pregnancies
Percent of cases
50
40
30
20
10
0
1
2
3
4
5
6
7
8
abused
not abused
Total Pregnancies
*Bars denote percent of cases in each group.

C: Are women in abusive relationships more likely to abstain from contraceptive use or use the least effective methods than women in non-abusive relationships?

This question was investigated using Chi square analysis. Birth control methods were categorized as effective, moderately effective, or ineffective. As respondents could answer multiple responses to the question regarding contraceptive behaviour, the results were examined in two ways. The first Chi square was done using the most effective method used in the previous year, and the second Chi square used the least effective method used in the previous year. Both perspectives yielded the same result, namely that no significant difference was found between abused and non-abused women with regard to reproductive behaviour. The reason there was no difference found between these two groups, as was hypothesized, may be due to the way in which this particular question was investigated. This is discussed in the following section. It is also interesting to note that although no statistical difference was found between the abused and non-abused group, the abused group actually reported using a higher percentage of effective birth control methods than the non-abused group. This is surprising as the vast majority of women in the abused group (close to 90%) were experiencing crisis pregnancies. This leads one to speculate why, if they were using the most effective forms of contraception, were they experiencing crisis pregnancies? For interests sake I have included the contraceptives used by both abused and non-abused women.

Chart IIIa

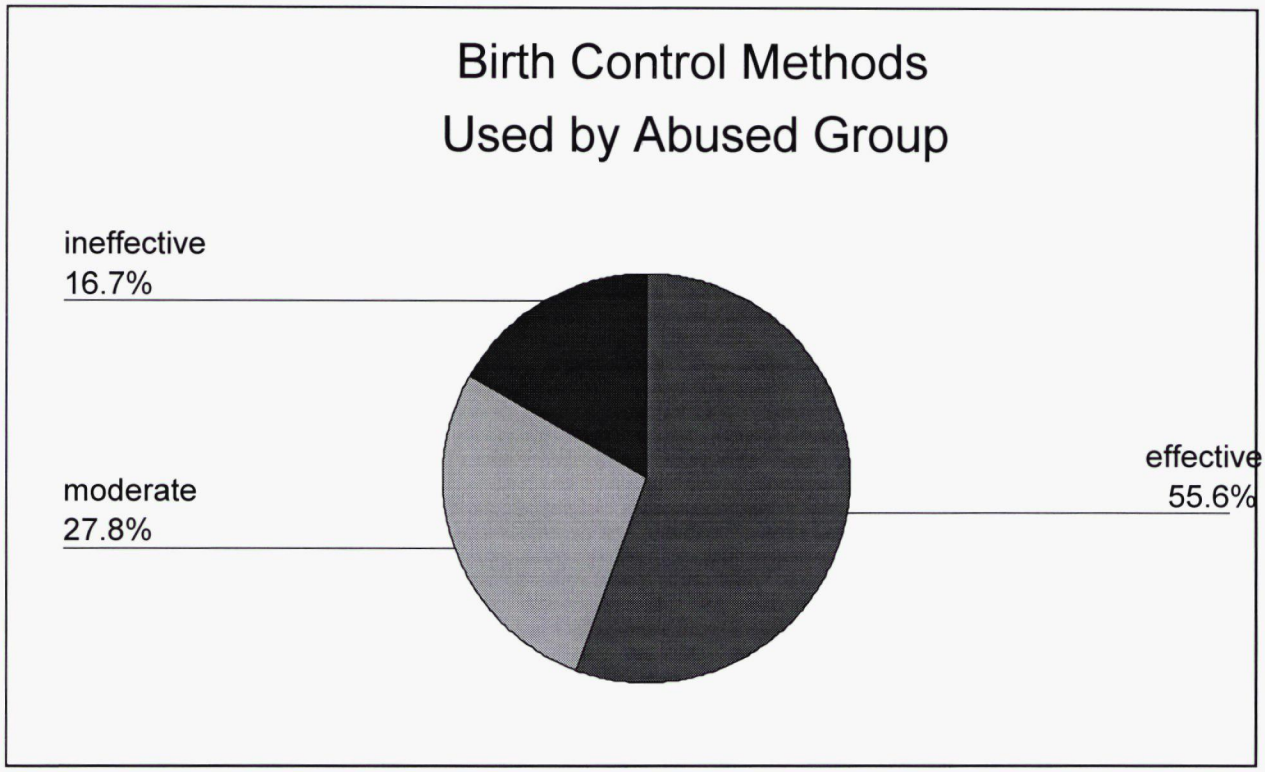
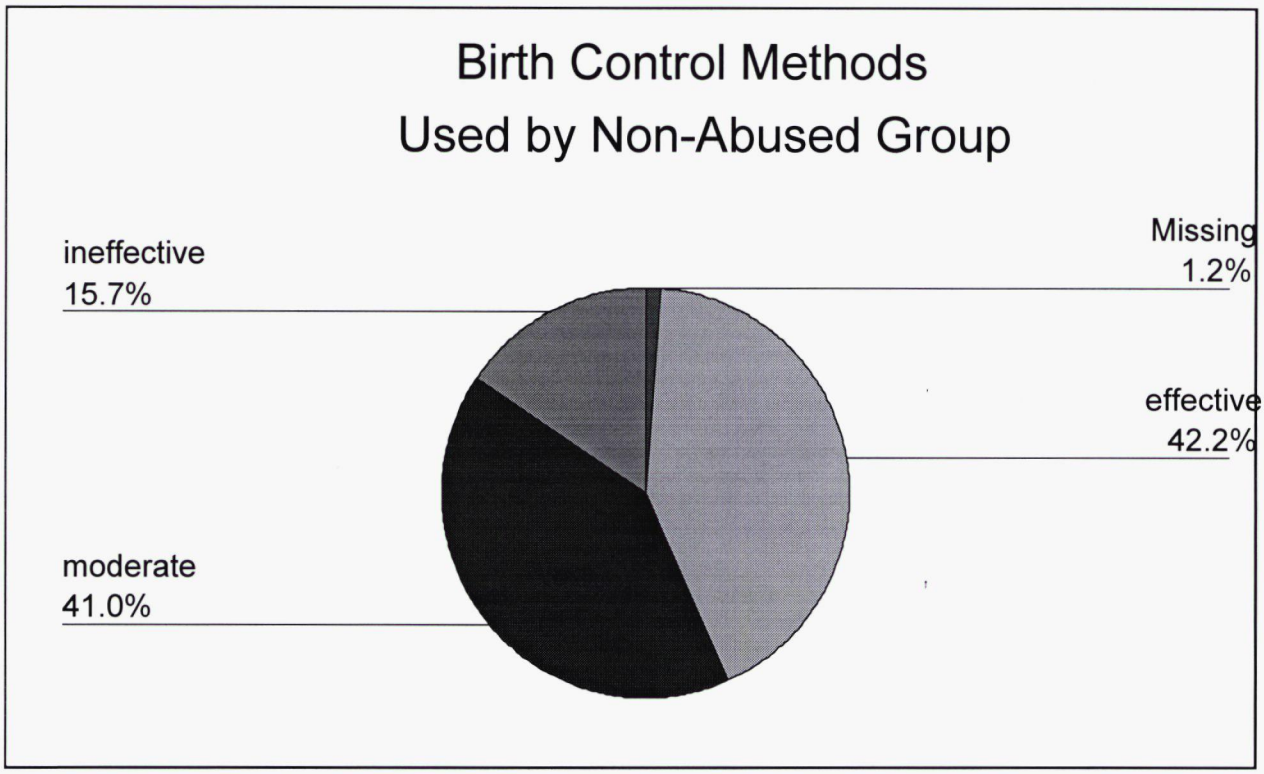

Birth Control Methods
Used by Abused Group
ineffective
16.7%
moderate
27.8%
effective
55.6%

Chart IIIb


Birth Control Methods
Used by Non-Abused Group
ineffective
15.7%
Missing
1.2%
effective
42.2%
moderate
41.0%

As the data collected allowed for further investigation an additional question was investigated.

D: Do women in abusive relationships differ in pregnancy outcomes when compared to women in non-abusive relationships?

As was identified earlier in this study, women in abusive relationships do not differ significantly from women in non-abusive relationships in terms of total pregnancies. I was curious to see if the outcomes of these pregnancies were different for abused and non-abused women. Therefore T-tests were performed with respect to pregnancy outcomes, ie. live births, abortion, or miscarriages. As no one in this study had ever placed a child for adoption this outcome was logically excluded. In addition T-tests were performed using the percentage outcome per total pregnancies (ie. of the total number of pregnancies what percentage ended in live birth, abortion or miscarriage).

i) LIVE BIRTHS:

The T-test for the pregnancy outcome 'live birth' revealed a significant difference between abused and non-abused women. Of the 18 women in the abused group the mean number of live births was 0.5 (SD= .707), whereas of the 83 non-abused women the mean number of live births was 1.17 (SD= 1.05), $T = -0.53$, $P < 0.002$. When the percentage of live births is calculated the results are similar. Abused women have a mean percentage of live births per total pregnancies of 0.1481 (SD = 0.219), whereas

non-abused women have a mean percentage of live births per total pregnancies of 0.456 (SD = 0.397), T =-4.56, P< 0.000.

It was shown that women in abusive relationships are significantly less likely to give birth when pregnant than women in non-abusive relationships.

ii) ABORTIONS:

The T-tests performed with regard to abortions revealed that women in abusive relationships have significantly more abortions than women in non-abusive relationships, and have a higher percentage of abortions per total pregnancies. Women in the abused group had an average of 1.389 abortions (SD = 0.850) whereas women in the non-abused group averaged 0.9036 abortions (SD = 0.826), T =2.21, two tailed significance = 0.037. Similarly when the percentage of pregnancies terminated was calculated women in abusive relationships terminated an average of 0.7500 of their pregnancies (SD = 0.368) whereas women in non-abusive relationships terminated an average of 0.4528 of their pregnancies (SD = 0.410), T = 3.04, P < 0.005.

iii) MISCARRIAGES:

In terms of miscarriages, in this study women in abusive relationships did not differ significantly from women in non-abusive relationships. This was an unexpected finding as other research has found that miscarriage is often an outcome of domestic violence against women (Ontario Medical Association, 1991).

Table IV: Pregnancy Outcomes T-test Summary

	# of Cases	Mean	SD	T-value	2-tail sig.
Live Births					
Abused	18	.5000	.707	-3.30	.002
Nonabused	83	1.1687	1.046		
% Births					
Abused	18	.1481	.219	-4.56	.000
Nonabused	83	.4560	.397		
Abortions					
Abused	18	1.3889	.850	2.21	.037
Nonabused	83	.9036	.821		
%Abortions					
Abused	18	.7500	.368	3.04	.005
Nonabused	83	.4528	.410		
Miscarriage					
Abused	18	.3889	.778	.13	.897
Nonabused	83	.3641	.932		
%Miscarry					
Abused	18	.1019	.199	.42	.681
Nonabused	83	.0807	.181		

CHAPTER FOUR

DISCUSSION AND CONCLUSIONS

I: What It All Means:

It appears that domestic violence against women does, as predicted, negatively influence reproductive health. The following discussion will examine the results of each of the research questions in greater detail and explore the implications for professionals and discuss areas for further research.

A: Demographic Information:

The data showed that both women in the crisis group and women in the abused group tended to be younger than women in the non-crisis group and women in the non-abused group. That the crisis and non-crisis groups differed was not surprising. Women tend to delay childbearing until their late 20's or early 30's (Goldsmith *et al*, 1971). and therefore women in the non-crisis group are understandably in this age group. Younger women may wish to terminate pregnancies in order to finish school, start careers or wait until they are married (the majority of women in the crisis group were single). As age is related to the other demographic information sought, such as place of residence and marital status, it was not surprising that the crisis and non-crisis groups differed in these other areas as well. What is not clear however is why the abused and non-abused

group differed in these same areas. It is possible that younger women in abusive relationships tend to terminate their pregnancies, and are therefore showing up in this particular survey, whereas older women in abusive relationships may not terminate their pregnancies and are showing up in the non-crisis group or not at all. However only two of the women identified as being abused were in the non-crisis group, so it is unlikely the former. Rather it is likely that older women in abusive relationships are not showing up in this particular study, however the reason is unclear.

B: Domestic Violence and Crisis Pregnancy:

The answer to research question number one was yes, in this particular study women in abusive relationships are more likely to experience crisis pregnancies than women in non-abusive relationships. The results indicate that the experience of being involved in an abusive relationship does somehow influence the occurrence of unplanned or crisis pregnancies. More than 25% of all the women experiencing a crisis pregnancy were identified as abused, and close to 90% of the women identified as being abused were experiencing a crisis pregnancy. Although this outcome was predicted to be the case, the number of women who were experiencing both abuse and crisis pregnancy was unexpected. All but two women identified as 'abused' were found in the crisis pregnancy group.

What is not clear from the results is how domestic violence against women influences unplanned or crisis pregnancies. It may be that women involved in abusive relationships have limited or compromised access to effective contraception (due to an abusive

partner's deliberate attempts to deny contraceptive use, poor self-esteem, or the experience of sexual assault). Therefore, if contraceptive use is compromised or denied, unintended pregnancies can result. But, it could also be the case that the decision to terminate a pregnancy is made based on the type of relationship a woman is in. That is to say the pregnancy may only become a 'crisis' when the woman considers the type of environment in which her child would be raised. Therefore, in this case, domestic violence against women may not influence the occurrence of crisis pregnancies per se, but influence if a pregnancy is perceived as a crisis or not. Once again the data does not permit a definitive statement as to why the experience of domestic violence against women negatively influences the occurrence of unintended or crisis pregnancies, the above are suppositions, and further research is required to determine if they are accurate or not.

C: Domestic Violence and Contraceptive Use:

It was hypothesized by this researcher that women in abusive relationships would be more likely to abstain from contraceptive use or use the least effective methods. The results revealed that there was no significant difference between abused and non-abused women with regard to contraceptive use. In order to properly identify contraceptive use in the past year both most effective forms and least effective forms used were examined. However what soon became an obvious problem was with whom to compare the abused women to. Simply comparing them to the non-abused group was problematic for two reasons,; 1) Some of the non-abused women were in the non-crisis group and were

therefore not expected to use contraception and, 2) Some of the non-abused women were in the crisis pregnancy group and were therefore known to be poor users of contraception (as evidenced by their appearance at an abortion clinic or pregnancy counselling agency). Therefore it seemed illogical to compare them to either, however I did choose to compare the abused group to the non-abused women in the crisis pregnancy group (to see if the abused women had poorer contraceptive behaviour than the non-abused/crisis group).

When looking exclusively at women in abusive relationships and the most effective methods used in the last year, 16.7% used effective methods, 8.3% used moderate methods, and 1.7% used ineffective methods of contraception. When one considers that close to 90% of these women were experiencing a crisis pregnancy it leads one to assume that it is unlikely they were using the effective methods either correctly or consistently. When considering the least effective contraceptives used in the past year the picture changes. Six point three percent used effective methods in the past year, 31.3% used moderate methods in the past year, and 62.5% used ineffective methods. So it seems that women in the abused group were either using effective methods haphazardly or incorrectly, and/or combining the method with an ineffective method (such as nothing or chance).

However since there is no logical group to compare these women to it is difficult to interpret the findings. Surely it is significant that the vast majority of women in the abused group were experiencing a crisis pregnancy, and this is likely somehow related to contraceptive use. But without a logical group of non-abused women to compare

them to a conclusive statement about the influence of domestic violence against women on contraceptive use is impossible. This may be an area for further research. It would be helpful to look at non-pregnant women and compare abused and non-abused women's contraceptive behaviour.

D: Domestic Violence and Total Pregnancies:

As with contraceptive use, no significant difference was found between women in abusive relationships and those in non-abusive relationships with regard to total pregnancies. It was hypothesized that women in abusive relationships would have a higher number of total pregnancies, but this was not the case in this study. It was felt that this may be due to the younger mean age of the women in the abused group, however regression analysis controlling for age failed to detect a significant difference.

E: Domestic Violence and Pregnancy Outcomes:

Due to the questions regarding obstetric history asked in the survey information was gained about the differences between abused and non-abused women with regard to pregnancy outcomes. It appears that the outcomes of a pregnancy varies depending on the existence or non-existence of abuse in a relationship.

For instance, it was found in this study that women are more likely to carry pregnancies to term if they are in a non-abusive relationship. And, on a percentage basis, women in abusive relationships carry fewer pregnancies to term than women in non- abusive relationships. So, although women in abusive relationships do not have

significantly more pregnancies than women in non-abusive relationships they do have significantly less births.

Why women in abusive relationships have fewer live births was not evident from the data collected. However perhaps the experience of being involved in an abusive relationships may be so overwhelming that the thought of parenting a child may seem an impossible prospect. Women in the abused group were slightly younger than the non-abused group and were primarily single, this too may affect the decision to carry pregnancies to term or not.

It stands to reason that if women in abusive relationships are not as likely to carry pregnancies to term then they must be either terminating pregnancies or miscarrying. The data did reveal that women in abusive relationships differ from women in non-abusive relationships in that they are more likely to terminate pregnancies and have a higher percentage of abortions per number of total pregnancies. Once again a definitive reason for this result is unknown. Women in abusive relationships may become pregnant unintentionally (due to affects on contraceptive behaviour previously discussed) and choose to terminate the pregnancy. Or they may become pregnant by choice and following discovery of the pregnancy consider the type of environment they would bring their child into should they carry to term. If the relationship the woman is involved in is an abusive one she may feel this is an unsuitable environment for her child and subsequently choose to terminate the pregnancy.

In this study no significant difference was found between abused and non-abused women with regard to miscarriage. This finding was unexpected as it had been found

in other research that a physical outcome of domestic violence against women is miscarriage (Ontario Medical Association, 1991). Why this result was not found in this study is unknown. Perhaps abused women in this study were terminating their pregnancies before a miscarriage could occur.

F: In Sum, Domestic Violence Against Women and Reproductive Health:

Overall it appears that domestic violence against women does impact negatively on reproductive health. The data shows that women in abusive relationships are more likely to experience crisis pregnancies than women in non-abusive relationships. In addition women in abusive relationships are less likely to carry pregnancies to term and more likely to terminate pregnancies than women in non-abusive relationships. The issue of contraceptive behaviour was not clear due to the way in which it was studied . However as the majority of women in abusive relationships were found in the crisis group it is likely that they are poor contraceptors.

It is unclear how and why the experience of being involved in an abusive relationship affects the reproductive health of women, but the fact remains that it does. It was hypothesized by this writer that domestic violence against women interferes with the use and effective use of contraception, thereby leading to crisis pregnancies. The results show that no significant difference existed between the abused and non-abused group. However, as previously discussed, the women in the abused group were unlikely using their contraceptive methods properly or consistently, as they reported using highly effective methods yet were experiencing crisis pregnancies.

It is possible that domestic violence against women does not interfere with contraceptive behaviour. Instead it may impact on a woman's perception of a pregnancy. That is to say, a women involved in an abusive relationship may be more likely to perceive a pregnancy as a crisis than a woman in a non-abusive relationship. Domestic violence against women may impact on a woman's perception of her ability to cope with a child, or the decision making process regarding pregnancy options. An abusive male partner may demand she terminate a pregnancy by overt threats of violence, or subtle references of withdrawing emotional or economic support should she choose to continue the pregnancy. It is unclear as to what mechanism domestic violence against women uses to negatively affect reproductive health. I have discussed some possibilities, these are not definitive statements as to the process, and should not be read as such.

II: IMPLICATIONS FOR PROFESSIONALS:

A: Medical Professionals:

The data collected shows that domestic violence against women does have a negative impact on reproductive health. Therefore persons in the medical field must be aware of the possibility that some of their patients are involved in abusive relationships, and that this abuse could have implications for their reproductive as well as physical and emotional health. Medical professionals working with women should be alerted to the

possibility of domestic violence when presented with a patient who has terminated a number of her pregnancies. Similarly it is important that professionals working in abortion services inquire about domestic violence, as this study showed that more than one quarter of the women presenting at abortion service facilities were involved in an abusive relationship. It is also important that professionals in the medical field are aware of the resources available to women who are victims of domestic violence in order to refer those women who are confirmed or suspected of being involved in an abusive relationship.

B: Domestic Violence Professionals:

As with medical professionals, domestic violence professionals (social workers, and others working with battered and abused women) need to be made aware of the link between domestic violence against women and reproductive health. In order for intervention and counselling to be complete and holistic, a component relating to reproductive heath and sexuality is mandatory. Teaching regarding the effective and appropriate use of contraception is important, as is information regarding human reproduction in general. In order for women to feel comfortable and confident with their own bodies it is necessary to encourage women to discuss how the experience of being involved in an abusive relationship has affected their sexuality. It may also be important to teach women that they have the right to refuse sex with their partners, and that coercive or forceful sex is not only abusive but illegal. Sexuality is the cornerstone of one's personality. It reflects how one feels about themselves, and how they feel about

others, if one's sexuality is somehow denied or degraded, the resulting affect on one's personality may be tragic, as appears to be the case in this study.

III Implications for Future Research:

Domestic violence against women appears to have a negative impact on reproductive health. However what is not clear from this thesis is how or why domestic violence against women impacts on reproductive health. The data collected revealed that women involved in abusive relationships are more likely to have a crisis pregnancy when compared women involved in non-abusive relationships. Further women involved in abusive relationships are more likely to terminate their pregnancies and less likely to carry pregnancies to term when compared to women in non-abusive relationships. What would be an interesting area to research is why this is the case. Why is it that women involved in abusive relationships are more likely to choose abortion as opposed to parenting? Similarly, what specifically is it about domestic violence that influences the occurrence of crisis pregnancies in victims of abusive relationships? Is it the abuse that somehow causes women to become pregnant when they do not wish to be, or does the violence influence a woman's perception of a pregnancy, turning it into a negative event which under different circumstances would not be a crisis?

In addition, further research is indicated in the area of contraceptive behaviour. As previously discussed this study focused on women who were known to be poor contraceptors (women at the abortion clinic or Calgary Birth Control Association) or women who were known to be trying to become pregnant and therefore not likely to be

using contraception (women at the obstetrician's office). Due to the women used as subjects a realistic interpretation of the contraceptive behaviour of women in abusive relationships was not possible. What may be an area for future research is surveying women at a woman's shelter about their contraceptive behaviour, and compare their behaviour to women known not to be abused.

This thesis focused on one area of sexuality, namely reproductive health. Other areas of sexuality may also be negatively impacted upon by domestic violence against women, and this may be an area of future research as well. Areas such as body image or sexual relationships also may be affected by the experience of being involved in an abusive relationship.

IV Conclusions:

This thesis was both eye opening and tragic in its findings. Women involved in abusive relationships have been shown to suffer from poor reproductive health. They are more likely to experience crisis pregnancies and less likely to give birth when compared to women in non-abusive relationships. This is a tragic outcome, and one that must be avoided. Those individuals working with battered women, those who are friends of battered women, and those who work in the medical field must be aware of the implications that abuse may have. The most intimate of all human acts is the act of creating and giving life. Women in abusive relationships must not be denied this powerful and wonderful experience. Therefore, in order to see that abused women have positive and healthy reproductive lives individuals must reinforce the criminality of abuse.

Reproductive teaching, specifically on contraception is a must, as is education and advocacy regarding the existence of and illegality of marital rape. In addition counselling with regards to positive and healthy sexuality is essential for women who have made the courageous step to leave an abusive partner. Women who are or were involved in abusive relationships require support and encouragement to help them develop and enjoy healthy sexuality and reproductive health.

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Appendix I

CONSENT TO PARTICIPATE IN RESEARCH STUDY

My name is Tanis Newsham. I am a graduate student at the University of Calgary and I am completing the requirements for my Master of Social Work degree. This study is part of those requirements and will be included as part of my thesis.

The purpose of this study is to examine the existence of domestic violence in women seeking reproductive health care. With your help I would like to explore this idea further.

You have been chosen for this study because you have sought reproductive health care. If you agree to participate you will be asked to complete a survey package which contains a number of questions regarding violence in relationships. The survey should take 10 - 20 minutes to complete. Once the data has been analysed I will destroy the surveys. No attempt will be made to identify participants, and all answers will be kept in the strictest of confidence.

It is important for you to know that you can change your mind at any time. If you wish to stop you may do so, and if you do not wish to answer a particular question you may leave it blank. You will not be pressured to finish any more than you feel comfortable finishing.

Before you can begin filling out the survey I will need you to sign this consent form. By signing this form you are stating that you understand the nature of the study, and you are aware that you may stop participating at any time. If you have any questions concerning your participation in this study, please contact the University of Calgary Research Services office (220-6354) and ask for the Chair of the Conjoint Areas Research Ethics Committee.

I,_____,understand and agree to participate in this study. I have read and understand what is involved in participating, including my rights and the fact that the information gathered will not be traced back to me.

_____ _____

Signature Date

Appendix II

Interpersonal Relationship Survey

_____ Date _____

The purpose of this Survey is to secure more in-depth information about how you and your partner relate to each other. Please read each item carefully and decide which response most accurately reflects your relationship, using the scale provided. Mark your responses by circling the appropriate number to the right of each statement. Do your best to provide a response to each item.

		Rarely or Never	Sometimes	Often	Always
My husband/partner:					
1.	finds the role of breadwinner satisfying	1	2	3	4
2.	is frustrated about our economic situation	1	2	3	4
3.	accuses me of deliberately trying to attract other men	1	2	3	4
4.	starts arguments with me about matters in the home	1	2	3	4
5.	slaps or pushes me during a fight	1	2	3	4
6.	uses drugs (like marijuana or pills)	1	2	3	4
7.	gets along well with others	1	2	3	4
8.	has problems with sexual functioning	1	2	3	4
9.	accepts changes I make in our homelife routine	1	2	3	4
10.	drinks alcoholic beverages	1	2	3	4
11.	slapped or shoved me while we were dating	1	2	3	4
12.	tells me I'm inferior as a homemaker or mother	1	2	3	4
13.	is considerate of my sexual needs	1	2	3	4
14.	changes jobs or is out of work	1	2	3	4
15.	shows concern for my health needs	1	2	3	4
My husband/partner and I:					
16.	maintain close contact with our families	1	2	3	4
17.	discuss problems when they arise	1	2	3	4
18.	get upset if we don't have enough money to do the things we enjoy	1	2	3	4
19.	have satisfying sexual relationships with each other	1	2	3	4
20.	argue a lot	1	2	3	4
21.	share recreational activities	1	2	3	4
22.	discuss minor problems before they blow up	1	2	3	4
23.	argue about trivial or silly matters	1	2	3	4
24.	get upset because we don't have enough money to buy the things we need	1	2	3	4
25.	plan for our future needs	1	2	3	4

Appendix III

This questionnaire is designed to measure the degree of abuse you have experienced in your relationship with your partner. It is not a test, so there are no wrong answers. Answer each item as carefully and accurately as you can by circling the most appropriate response.
1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Frequently, 5 = Very Frequently

My husband/partner:

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

Appendix IV

The following questions are about your reproductive history. Please answer as best you can.

1) How long have your been with your current partner (please circle)?
   a. less than three months
   b. 3 months - one year
   c. 1 - 3 years
   d. 3 - 6 years
   e. 6 - 9 years
   f. 10 years or more.

2) What is the total number of times you have been pregnant?
   Note: if you are currently pregnant please include this pregnancy.
   _____

3) Of the total number of pregnancies (excluding if you are currently pregnant) please indicate the outcomes of these pregnancies.
   Number of live births _____.
   Number of children placed for adoption _____.
   Number of abortions _____.
   Number of miscarriages _____.

4) In the past year please indicate which contraceptives you have used (please circle all that apply).
   a. nothing/chance b. withdrawal c. rhythym method
   d. condom e. condom & foam f. Today sponge
   g. condom & sponge h. diaphragm i. cervical cap
   j. I.U.D./coil/loop k. the birth control pill
   l. tubal ligation m. vasectomy n. morning after pill
   o. other_____

5) Prior to this visit, what was the most recent form of birth control you were using?
   a. nothing/chance b. withdrawal d. rhythym method
   d. condom e. condom & foam f. Today sponge
   g. condom & sponge h. diaphragm i. cervicall cap
   j. I.U.D./coil/loop k. the birth conrol pill
   l. tubal ligation m. vasectomy n. morning after pill
   o. other_____

6). What do you plan to use for future birth control (please circle)
   a. nothing/chance b. withdrawal c. rhythym method
   d. condom e. condom & foam f. sponge
   g. condom & sponge h. diaphragm i. cervical cap
   j. IUD/coil/loop k. the birth control pill
   l. tubal ligation m. vasectomy n. morning after pill
   o. other_____

7). Prior to this visit was your partner aware of which type of birth control you were using?
   a. yes
   b. no

8) If the answer to #7 was 'yes', did your partner approve of this method of birth control
   a. yes
   b. no

Appendix V

9) Have you and your partner ever disagreed about using birth control?
   a. yes
   b. no

10) If the answer to #9 was 'yes' do any of the following situations describe the disagreement?
   a. I wanted to use birth control and he didn't want me to
   b. I wanted him to use birth control and he didn't want to
   c. I didn't want to use birth control and he wanted me to
   d. I didn't want him to use birth control and he wanted to.
   e. other_____

11) Current marital status. Circle one
   a. Single
   b. Married
   d. Divorced
   e. Widowed

12) Number of years married or involved in current relationship:_____years.

13). With whom do you live? Circle one.
   a. Husband
   b. Male partner
   c. Live alone
   d. Husband with children
   e. Male partner with children
   f. Parents
   g. Other (please specify)_____

14) Age_____ Husband or partner's age_____

15) Within the last year, have you ever been hit, kicked, punched or physically assaulted in other ways by your husband or partner?
   ____ Yes ____ No

16) Within the last year, have you been emotionally abused (verbal threats, put-downs) by your husband or partner?
   ____ Yes ____ No

17) Within the last year, have you been raped (forced to have sexual intercourse or other forms of sexual penetration) by your husband or partner?
   ____ Yes ____ No

18) Have you ever been raped, emotionally abused, or physically abused by a husband, male partner or other male relative?

For rape	____ Yes	____ No
For emotional abuse	____ Yes	____ No
For physical abuse	____ Yes	____ No

THANK YOU FOR YOUR CO-OPERATION!

Appendix VI

The following are resources available in Calgary. Should you or anyone you know find these numbers useful, please detach this sheet.

Family Services

Alberta Assoc. of Services to Children and Families		244-6114
Calgary Women's Emergency Shelter Association		232-8717
Family and Child Abuse Hotline Zenith 1234		Dial 0,
Parents Annonymous Stress Line		265-1117
Social Services	Emergency (After Hours)	266-8849
	Advice/Informaiton/Direction	268-4656

Reproductive Health Services

AIDS/STD Info line	1-800-772 AIDS
Calgary Birth Control Association	283-5580
Calgary Health Services Family Planning Clinic	264-3454
	264-3631
STD Clinic	297-6562

Emergency Services

Calgary Sexual Assault Centre	244-1353
Distress/Drug Centre (Crisis and Suicide Line)	266-1605
Suicide Crisis Line	252-3111
YWCA Sheriff King Home	266-0707

THANK YOU FOR YOUR CO-OPERATION!