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# South Asian Victims of Intimate Partner Violence More Likely than Non-Victims to Report Sexual Health Concerns

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To assess relationships between intimate partner violence (IPV) and sexual health among South Asian women in Boston. Surveys assessed demographics, IPV and sexual and reproductive health outcomes of women in relationships with men ($N = 208$). In-depth interviews explored these issues with women with a history of IPV ($N = 23$). Subjects were majority Indian, non-U.S. citizens, and highly educated. Quantitative data were assessed by logistic regression, qualitative data by a grounded theory approach. About 21.2% of the survey sample reported IPV in the current relationship. These women are 2.6 times as likely to report discolored vaginal discharge in the past year (95% CI = 1.27–6.50), 3.1 times as likely to report burning during urination in the past year (95% CI = 1.52–6.31) and 3.4 times as likely to report unwanted pregnancy in the current relationship (95% CI = 1.33–8.66). Interviewed women described how abuse reduces sexual autonomy, increasing risk for unwanted pregnancy and multiple abortions. Study findings demonstrate the need for increased gynecologic health outreach to abused South Asian women in the U.S.

**KEY WORDS:** women's health; battered women; pregnancy, unwanted; female genital diseases and pregnancy complications; emigration and immigration; South Asian American women.

## INTRODUCTION

There is extensive evidence that physical and sexual intimate partner violence (IPV) is associated with adverse sexual and reproductive health outcomes for women, including pelvic pain, menstrual abnormalities, unwanted pregnancy and sexually transmitted diseases including HIV (STD/HIV) (see Heise *et al.* (1) and Amaro and Raj (2) for reviews). Although research has demonstrated the link between IPV and sexual and reproductive health concerns among women in the United States, this work has been limited to predominantly White, Black and Latino samples. The published literature is devoid of similar studies probing the relationship between IPV and reproductive and sexual health among Asian women in the U.S. or among recent immigrant communities. Given the increasing efforts to address these issues at a population level (3), it is necessary to understand the scope and landscape of IPV and its inter-relationship with sexual and reproductive health across diverse populations. The current study extends previous work to a new, predominantly immigrant population (4), assessing IPV and sexual and reproductive health in a community-based sample of South Asian women residing in Greater Boston.

The South Asian population in the U.S. has more than doubled the past decade to become the third largest Asian American group in the nation; there are now over 1.7 million U.S. residents of South Asian descent (4). Recent research with South Asian

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women in the U.S. suggests that two in five women in relationships have experienced physical and/or sexual IPV within the context of that relationship (5), a rate disproportionately higher than that reported by other racial/ethnic groups in the U.S., including Asian and Pacific Islanders overall (6). This rate is also higher than many of those observed in Indian provinces, which range from 18 to 45% (7), suggesting that South Asian women in the U.S. may be at greater risk than those residing in India. Yet data from South Asian women in the U.S. demonstrate low levels of help-seeking, and little is known about this population's IPV-related health needs (8).

While there has been no study of IPV and sexual and reproductive health among South Asians in the U.S., studies have examined these concerns from women in South Asia. Qualitative research involving women in India indicates that abused Indian women do not feel they can protect themselves from sexual risk from abusive partners and that the risk of violence as a consequence of their sexual negotiation is not worth potential protection from HIV (9). These findings are consistent with U.S. research demonstrating that abused women experience and fear negative reactions from partners towards requests for safer sex significantly more than do women not in abusive relationships (10, 11). Inability to negotiate and engage in safer sex is a major concern for abused women, especially given growing evidence that abusive male partners more frequently have sex outside the relationship (12–14), a factor likely further increasing abused women's risk for STD/HIV. Consistent with this research, history of IPV is associated with a self-reported history of STDs among women (11, 12).

Reduced ability to negotiate sexual protection can increase risk for unplanned or unwanted pregnancies, as well. A study conducted in India demonstrated significantly more unplanned pregnancies among married women reporting IPV as compared with those not reporting IPV (15). Recent research from a clinic-based sample of abused women in Massachusetts further suggests that higher rates of unplanned pregnancy are a consequence of reduced control over sexual decision-making, particularly decision-making about birth control use (16).

Lack of power in birth control negotiation results not only in unplanned and unwanted pregnancies, but also in induced abortion, sometimes forced by the partner. A Canadian study demonstrated that abused women are more likely to have had induced abortions and to have had multiple (three or more) induced abortions when compared to non-abused women (17), complementing a recent U.S. study indicating that abusive male partners may force women to have abortions subsequent to forcing unsafe sex (16).

Overall, these findings suggest that abused South Asian women in the U.S. may be at increased risk for sexual and reproductive health concerns. Thus, the purpose of this study is to assess the relationship between IPV and sexual and reproductive health outcomes including gynecologic health problems, unwanted pregnancy, sterilization, and acquisition of gynecologic care among a community-based sample of South Asian women residing in Greater Boston.

## METHODS

We conducted this study in two parts, 1) a quantitative survey assessment with South Asian women currently in heterosexual relationships ($N = 210$), and 2) in-depth interviews with South Asian women reporting a history of victimization from a male partner ($N = 23$).

We recruited participants in the cross-sectional survey ($N = 210$) via community outreach (fliers, snowball sampling, referrals) to participate in a South Asian women's health study conducted from August 2001 to January 2002; the recruitment strategies used did not allow the assessment of response rates. We collected survey data through 15-min, anonymous surveys offered either at locations deemed convenient by participants (e.g., participants homes or nearby libraries) or over the phone for women who preferred not to complete the survey in person ($n = 9$). The survey included demographic questions and assessments of history of IPV and health outcomes. All survey data were collected in English. Data included in the current analyses excluded two participants who did not answer IPV questions, yielding a sample size of 208 for the current analyses.

We recruited in-depth interview participants ($N = 23$) via referral from community leaders known for assisting battered women as well as via outreach to all participants of the cross-sectional survey; we asked women with a history of IPV to participate in a study of IPV in South Asian immigrant women conducted from August 2001 to May 2002. Two of the 23 survey participants were recruited from cross-sectional survey participants. Again, the recruitment

strategies did not allow assessment of response rates. We collected interview data on IPV, help-seeking, the immigrant experience, and health through 60–90 min confidential audio-taped interviews offered in convenient and secure locations of the participants' choosing; we also collected survey data on demographics, IPV and related help-seeking. Due to resource limitations, we planned to collect all data in English; however, some interviewees lapsed into South Asian languages for parts of interviews. We attempted to elicit repetition of the information in English, but when participants were unable to translate, we translated interviews upon transcription. We transcribed or translated/transcribed tapes and linked them to survey data via unique identifiers to preserve confidentiality.

We obtained written consent from all participants surveyed or interviewed in person; we obtained verbal consent from all telephone participants. All participants from both studies received a list of referrals for culturally-tailored IPV, mental health, and sexual health services upon survey or in-depth interview completion. Telephone participants received this list verbally at the time of the interview, and later received a copy of the list as well as the consent form and the monetary incentive by mail. South Asian women trained in women's health as well as survey and in-depth interview administration served as proctors and interviewers for the studies. All participants received $15 incentive for survey participation and $50 incentive for in-depth interview participation. The Institutional Review Board of Boston University Medical Center approved these studies.

### Sample

Participants in the cross-sectional survey ($N = 208$) ranged in age from 18 to 68 (median age = 30 years). The vast majority of participants (95.7%) were Indian; 91.0% were not U.S.-born. One-third of the sample (36.8%) were U.S. citizens; 26.3% were legal permanent residents and 21.1% were on spousal visas. Immigrants reported immigration from 1 month to 40 years ago (median = 6.5 years); 25.1% of the sample had immigrated within the past 2 years. The sample was relatively high-income and highly educated, with 66.5% reporting an annual household income of $50,000 or greater and 46.2% reporting post-graduate training; 12.9% of the sample reported a high school education or less. The majority of participants (82.1%) were married, and (94.6%) reported that their current partner was of South Asian descent.

In-depth interview participants ($N = 23$) ranged in age from 25 to 53 years (median age = 37 years). This sample was less educated and lower income than the survey sample. One-fourth of interviewees (26.0%) reported a high school education or less; 39.1% of the sample had post-graduate training. One-third of the sample (34.8%) reported an annual household income of $20,000 or less; 34.7% reported an annual household income of $50,000 or more. The majority of the interview sample (65.2%, $n = 15$) was Indian, and 30.4% ($n = 7$) were Bangladeshi; one participant was Nepali. All were non-U.S. born; 56.5% ($n = 13$) were legal permanent residents, 17.4% ($n = 4$) were U.S. citizens and 13.0% ($n = 3$) were on spousal visas. Participants had been in the U.S. for 5–20 years (median = 6 years); 56.5% came to the U.S. because of marriage. Approximately half of interviewees (47.8%, $n = 11$) were currently involved with their abusive partner.

### Survey Measures

#### *Demographics*

Single items assessed age, income and marital status.

#### *Intimate Partner Violence Ever*

Four items adapted from the Massachusetts Behavioral Risk Factor Surveillance System (18) assessed physical abuse, sexual abuse and injury from abuse by their current male partner; response options for these items were "Yes, 1–2 times in the past year," "Yes, more than 2 times in the past year, "Not in the past year but previously in our relationship," and "Never in our relationship." We created an "IPV ever" variable from a summation of these items and dichotomized it as "IPV ever" vs. "IPV never."

#### *Sexual and Reproductive Health Outcomes*

We measured sexual health concerns via individual items. Single items measured *frequency of discoloration in vaginal discharge* in the past year

and *frequency of burning during urination* in the past year. The 5-point response pattern ranged from never to always; we dichotomized it as "never" vs. "ever" for purposes of analysis. Single yes/no items assessed *unwanted pregnancy* and *sexually transmitted disease* in the current relationship and *Pap Smear acquisition* in the past year. Two yes/no items assessed whether the woman had obtained a tubal ligation or a hysterectomy; these were combined to create a *sterilization* variable.

Measurement for the in-depth interviews involved 12 open-ended questions regarding participant's relationship with the abusive husband, types of abuse experienced, perceived health-related effects of the abuse, present health status, and utilized or needed social, legal and health services.

### Survey Data Analyses

We conducted frequency analyses to assess prevalence of sexual and reproductive health outcomes for the total of cross-sectional survey participants and for sub-samples participants based on history of IPV. Adjusted logistic regression analyses controlling for demographics significantly related to the dependent variable in bivariate analysis assessed the relationship between IPV and sexual and reproductive health outcomes (discoloration of vaginal discharge in the past year, burning during urination in the past year, unwanted pregnancy, STD history, sterilization, and Pap Smear acquisition). We assessed significance using 95% confidence intervals.

We conducted qualitative analysis of transcribed in-depth interviews using a grounded theory approach to iteratively generate codes based on emergent themes (19). This technique provides the researcher with tools to link concepts, facilitating the development of a model for understanding human experience (19–21). Based on this approach, our qualitative research team (two trained coders and the Principal Investigator) read each transcript, identifying and recording ("memoing") themes. Following review of the 23 transcripts, memos were reviewed for recurring themes across transcripts. These were viewed as emergent codes. Following memoing, the two coders reviewed text for each code category and memoed linkages across categories. Inter-coder reliability was assessed using the technique used by Carey *et al.* (22). This technique involved the division of each transcription into segments; coders then independently coded the segments. Each segment could have multiple codes. In cases of discrepancy between coders, the coders worked to reach consensus; if consensus was not reached, the Principal Investigator made the final decision.

## RESULTS

### Survey Findings

One in five (21.2%) participants in the cross-sectional survey reported physical or sexual abuse perpetrated by her current male partner; 15.2% reported IPV in the past year from that partner. Of women reporting IPV in their current relationship, 54.6% reported physical assault, 90.9% reported sexual assault, and 29.6% reported injury from assault. No participants in this study reported a history of STD in the context of the current relationship; however, as seen in Table I, 25.1% reported burning during urination and 21.5% reported discoloration in vaginal discharge in the past year. Additionally, 11.1% reported unwanted pregnancy in their current relationship, and 6.7% reported acquisition of sterilization. Approximately one-third (31.1%) of

**Table I.** Cross-Sectional Survey with Community-Based Sample of South Asian Women ($N = 210$): Sexual and Reproductive Health Outcomes of the Sample as a Whole and Stratified by Victims and Non-Victims of IPV Perpetrated in the Current Relationship with Odds Ratios and 95% Confidence Intervals

| | Sample ($N = 208$) (%) | IPV victims ($n = 44$) (%) | Non-victims of IPV ($n = 164$) (%) | Odds ratios (95% CI) |
|---|---|---|---|---|
| Discolored vaginal discharge, past year | 21.7 | 36.4 | 17.8 | 2.64 (1.27–6.50) |
| Burning during urination, past year | 25.4 | 44.2 | 20.4 | 3.10 (1.52–6.31) |
| Unwanted pregnancy, ever | 10.7 | 23.3 | 7.4 | 3.39 (1.33–8.66)[a] |
| No Pap Smear, past year | 31.4 | 34.3 | 30.8 | 1.17 (.56–2.43)[a] |
| Sterilization | 6.7 | 11.4 | 5.6 | 2.01 (.60–6.79)[b] |

[a]Analysis adjusted for age.
[b]Analysis adjusted for marital status and age.

participants reported no Pap Smear acquisition in the past year.

Logistic regression analyses demonstrated significant relationships between IPV and sexual and reproductive health outcomes. As seen in Table I, victims of IPV as compared with women reporting no history of such victimization were 2.6 times as likely to report discolored vaginal discharge in the past year (95% CI = 1.27–6.50) and 3.1 times as likely to report burning during urination in the past year (95% CI = 1.52–6.31). Additionally, victims of IPV as compared with non-victims were 3.4 times as likely to report unwanted pregnancy in their current relationship (95% CI = 1.33–8.66). Although a significant relationship between sterilization and IPV did not emerge in this sample, a strong trend was evident.

## In-Depth Interview Findings

Survey data from in-depth interviewees, all of whom reported abuse by a male partner, revealed a 78.3% prevalence of physical IPV, a 73.9% prevalence of sexual IPV, and a 73.9% prevalence of injury from IPV.

### *Poor Gynecologic Health Outcomes*

Consistent with findings observed in the cross-sectional data, abused women participating in in-depth interviews reported poor gynecologic health outcomes, with 60.9% reporting burning during urination and 26.1% reporting discoloration in vaginal discharge. Qualitative data from these participants additionally suggest problems with pelvic pain, ovarian cysts and menstrual problems as a consequence of the abuse, particularly sexual assault.

> They gave me a sleeping pill without my knowing it. That was when he raped me and I was unconscious. Now, I think 7–8 years I had very bad bleeding. I went to Pune [India] and got operated over there, now I don't get my periods [for] almost 10–12 year[s] past.

> It's painful all the time if you don't want anything, and you always . . . he is getting on you all the time you, don't want him up, you know . . . Ok, once in a while I am willing to pay, but I am not paying you everyday, every, every second, every time you get angry, you cannot get on me and rape me. So that's exactly what he was doing . . . My period started getting white, you know.

### *Unwanted Pregnancy and IPV*

Approximately two in five (39.1%) women participating in qualitative interviews indicated that there was an unwanted pregnancy in their abusive relationship. Some women described how lack of sexual and reproductive control in the abusive relationship resulted in that pregnancy.

> So many times I told him that I don't want any more children, I don't want any more children. But he just forces me. Its like, its like a, like a raping. I told him. Because I was not happy. I didn't want any children . . . Because we had two girls, he wants boy. That was also force, that was also a force.

> He always comes and he doesn't use anything. He doesn't allow me to see the doctor, nothing. When I got married I was 14; after two months, I got pregnant . . . He always wanted so much baby. I don't know why; so much baby . . . [I had] one when I was 15, one when 16, one when 19. But between 16 and 19 I had so many abortions . . . Yes, I think 9 or 10.

> I had pregnancy right after the twins were born, within few months to three months I got pregnant again. So I had to have a D&C [abortion procedure]. Because the doctor advised me that I had just given birth to twins and there was no way another pregnancy is gonna be healthy for me or for the twins . . . I said no more . . . A lot times he would force himself, you know. I mean that was his way of, you know, control again.

Other women described being pregnant when the abuser did not want the baby. Women reported that some men were abusive as a response to the pregnancy, and in some cases this resulted in miscarriage.

> We started yelling at each other as we argued over my work permit. Then suddenly, without any warning, he slammed me up against our dresser and then punched me in my belly and screamed, "And I don't want that baby either!" As I stood there in front of him, bent over, weak and crying, my husband just ran out of the house . . . Around 10:30 or 11:00 pm that night, I noticed that I was bleeding.

> He used to hit me and all five months baby was miscarried. I was bleeding to death. Same thing happened now my third baby when she was five months in my womb, he hit me so badly in my stomach. I had to hold my stomach and I was running and running and went to the hospital. I don't know what happened but the water was flowing.

Women also reported feeling forced by their abuser to undergo an abortion when they did not want it.

> I did not want to go for abortion. I always longed to have children. I never thought I would go for an abortion because I, I mean it was a sort of forcing that I went for the abortion because . . . he used to speak bad and say like, "You know if this child is born, I don't know how I am going to react to that child. And I do not think I am worth having the child with you [it is beneath his worth]." . . . I did not want this child to be born and suffer and not receive the proper care.

> He said that he was not ready yet for us to have children. I told him that I was ready and that I could care for the baby with my family's help. I explained to him that I did not believe in aborting my own child, especially my first child. My husband became very anxious and started really pressuring me to have the abortion. He even called his sister to have her convince me to have an abortion . . . My husband started threatening me with separation if I did not agree to have an abortion . . . While he was pulling my hair, he kept yelling at me to sign the papers or abort the baby; he said I only had two choices: abort the baby or return to India.

### *Sterilization and IPV*

Quantitative data from in-depth interviews with abused women indicated that 8.7% had obtained tubal ligation or hysterectomy. Qualitative data suggests that, for some of these women, sterilization was a consequence of damage to gynecologic health resulting from sexual assault.

> I feel that when he raped me I was badly injured. My doctor told me after that and that was the reason for the operation. It became cancer type; it was in my uterus. The stuff I don't know, my doctor said we have to remove it before it spreads . . .

## CONCLUSIONS

Consistent with studies of U.S. women from other racial/ethnic communities (2), South Asian women involved with an abusive male partner are significantly more likely to report gynecologic health concerns and unwanted pregnancy. Notably, however, our findings demonstrate that acquisition of gynecologic care is not greater for women reporting abuse as compared with those not reporting abuse. Previous research demonstrates lower satisfaction with health care among IPV victims as compared with non-victims, and this may deter abused women in need from seeking care (23). These findings clearly outline the need both to address IPV in this population and to identify barriers to gynecologic health care acquisition for abused South Asian women in the U.S.

Data from in-depth interview participants support findings from the quantitative study. Consistent with studies from India and of non-Indians in Massachusetts (9, 15), qualitative data findings additionally suggest that gynecologic health concerns of abused women may often be a result of sexual assault. As seen in other IPV studies (7, 24, 25), history of sexual violence was high among both women in the cross-sectional survey reporting IPV (90.9%) and abused women participating in in-depth interviews (73.9%). Interviewees described how their lack of sexual and reproductive control places them at risk for unwanted pregnancy, which, in turn, appears to place them at risk for multiple abortions. Further, consistent with findings from other studies (9, 15), qualitative data demonstrates that when unintended pregnancy is unwanted by an abusive male partner, risk for abuse is increased and coerced abortion may result. Use of a small sample with small numbers of women reporting sterilization limits interpretation of data on associations between sterilization and IPV, but qualitative data suggests sterilization can be the outcome of gynecologic complications from assaults.

Overall, the pervasiveness of IPV in this population and the demonstrated heightened sexual and reproductive health risk among South Asian victims of IPV as compared with non-victims demonstrate the need for prioritization of sexual health and IPV intervention with this population. Specifically, efforts to increase Pap Smear acquisition among South Asian women in the U.S. are needed in light of the finding that nearly one-third of women in this study were not screened in the past year.

### Limitations

The primary limitation of this study is the use of a non-representative sample of higher socio-economic status, predominantly Asian Indian women. Due to varying immigration patterns across diverse populations, prevalence of concerns related to spousal visa status may vary by immigrant group. Another limitation of this study is its reliance on self-report. However, under-reporting of abuse is likelier than over-reporting. A previous study with a similar sample that used a more extensive measure of IPV and contextualized these experiences as "fighting" rather than "abuse" found a far higher (40% vs.

20%) prevalence of IPV (14). This important and oft-neglected issue merits additional research, both qualitative and quantitative, with larger and more representative samples from other immigrant groups.

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## REFERENCES

1. Heise L, Ellsberg M, Gottmoeller M: Ending violence against women. Popul Rep 1999; 27(4)
2. Amaro H, Raj A: On the margin: Power and women's HIV risk reduction strategies. Sex Roles 2000; 42(7–8):723–749
3. Intimate Partner Violence During Pregnancy: A Guide for Clinicians, a Screen Show Lecture Presentation Prepared by the American College of Obstetricians and Gynecologists and Centers for Disease Control and Prevention Work Group on the Prevention of Violence During Pregnancy, http://www.cdc.gov/reproductivehealth/violence/slides/sld001.htm, last accessed 1/23/2003
4. Indian American Center for Political Awareness, US Census Results now Available for Indian American Community; IACPA analyzes these figures, http://www.iacfpa.org/press/census515.htm, last accessed 1/23/2003
5. Raj A, Silverman JG: Intimate partner violence against South Asian women in Greater Boston. JAMWA 2002; 57(2):111–116
6. Tjaden P, Thoenes N: Extent, nature and consequences of intimate partner violence: Findings from the National Violence Against Women Survey, Washington, DC: Department of Justice, National Institute of Justice, 2000
7. Martin SL, Tsui AO, Maitra K, Marinshaw R: Domestic violence in northern India. Am J Epidemiol 1999; 150(4):417–426
8. Saheli: South Asian Social Support Network, Client Intake Records, Unpublished Data
9. Go VF, Sethulakshmi CJ, Bentley ME, Sivaram S, Srikrishnan AK, Solomon S, Celentano DD: When HIV-prevention messages and gender norms clash: The impact of domestic violence on women's HIV risk in slums of Chennai, India. AIDS Behav 2003; 7(3):263–272
10. Melendez RM, Hoffman S, Exner T, Leu CS, Ehrhardt AA: Intimate partner violence and safer sex negotiation: Effects of a gender-specific intervention. Arch Sex Behav 2003; 32(6):499–511
11. Wingood GM, DiClemente RJ: Consequences of having a physically abusive partner on the condom use and sexual negotiation practices of young adult African-American women. Am J Public Health 1997; 87(6):1016–1018
12. Bauer HM, Gibson P, Hernandez M, Kent C, Klausner J, Bolan G: Intimate partner violence and high-risk sexual behaviors among female patients with sexually transmitted diseases. Sex Trans Dis 2002; 29(7):411–416
13. El-Bassel N, Fontdevila J, Gilbert L, Voisin D, Richman BL, Pitchell P: HIV risks of men in methadone maintenance programs who abuse their intimate partners: A forgotten issue. J Subst Abuse 2001; 12(1–2):29–43
14. Raj A, Silverman JG, Amaro H: Abused women report greater male partner risk and gender-based risk for HIV: Findings from a community-based study with Hispanic women. AIDS Care 2004; 16(4):519–529
15. Martin SL, Kilgallen B, Tsui AO, Maitra K, Singh KK, Kupper LL: Sexual behaviors and reproductive health outcomes: associations with wife abuse in India. JAMA 1999; 282(20):1967–1972
16. Hathaway J, Willis G, Zimmer B, Silverman JG: Impact of Partner Abuse on Women's Reproductive Lives. JAMWA 2005; 60(1):42–45
17. Janssen PA, Holt VL, Sugg NK, Emanuel I, Critchlow CM, Henderson AD: Intimate partner violence and adverse pregnancy outcome: A population-based study. Am J Obstet Gynaecol 2003; 188(5):1341–1347
18. Massachusetts Department of Public Health, Massachusetts Behavioral Risk Factor Surveillance 2000, Center for Health Information, Statistics, Research and Evaluation
19. Glaser B, Strauss A: The Discovery of Grounded Theory. Chicago: Aldine; 1967
20. Strauss A: Qualitative Analysis for Social Scientists. New York: Cambridge University Press; 1987
21. Strauss A, Corbin J: Basics of Qualitative Research. Newbury Park, CA: SAGE Publications, Inc.; 1990
22. Carey JW, Morhan M, Oxtoby MJ: Intecoder agreement in analysis of responses to open-ended interview questions: Examples from tuberculosis research. Cult Anthr Methods J 1996; 8(3):1–5
23. McNutt LA, van Ryn M, Clark C, Fraiser I: Partner violence and medical encounters: African-American women's perspectives. Am J Prev Med 2000; 19(4):264–269
24. Rickert VI, Wiemann CM, Harrykissoon SD, Berenson AB, Kolb E: The relationship among demographics, reproductive characteristics, and intimate partner violence. Am J Obstet Gynecol 2002; 187(4):1002–1007
25. Mayer BW, Coulter M: Partner abuse of adult women: This is part one of a two-part article. Am J Nurs 2002; 102(5):24MM–24WW