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ORIGINAL ARTICLE

Escaping the triple trap: Coping strategies of pregnant adolescent survivors of domestic violence in Mulago hospital, Uganda

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Abstract

Objective: Why domestic violence survivors develop adverse outcomes following domestic violence during pregnancy is unclear, but may depend on how survivors cope with the stress of violence. The objective was to describe strategies pregnant adolescents employ in coping with domestic violence. *Methods:* This was a qualitative study involving 16 in-depth interviews with adolescent domestic violence survivors who attended the antenatal clinic in Mulago hospital, Kampala, Uganda, from January to May 2004. Theoretical sampling, necessitated by the emergent theory from sequential data collection and analysis, further provided diversity of experiences from adolescents of different ages, parity, pregnancy duration, and socioeconomic status until saturation was reached. Data were analyzed using grounded theory. *Findings:* Survivors described varied experiences of physical, sexual, and psychological violence. Coping strategies employed were analyzed as: *Minimizing damage* – decreasing impact and severity of violence, *withdrawal* – physical or social withdrawal, *seeking help* and *retaliation (fighting back)*. Coping strategies were influenced by adolescence and pregnancy, and are explained in relation to theories of coping with stress. *Conclusions:* Coping strategies adopted by pregnant adolescent survivors range from problem-focused approaches to emotion-focused approaches. Coping strategies are influenced markedly by adolescence and pregnancy.

Key Words: *Adolescents, coping strategies, domestic violence, pregnancy, stress, Uganda*

Introduction

Domestic violence during pregnancy has been associated with adverse pregnancy outcome ranging from spontaneous abortions, low birth weight (LBW), premature rupture of membranes (PROM), and preterm labor [1–4]. Complications of domestic violence may arise directly or indirectly [4]. Directly, a physical or sexual assault involving abdominal trauma can cause abruptio placenta leading to fetal death, abortion, PROM, preterm labor, and delivery of a preterm infant [4,5], while indirectly, adverse outcomes may arise from associated prenatal stress [5]. For low birth weight and preterm labour, the actual mechanism involved has been linked to maternal prenatal stress [5–8].

Studies and literature reviews [9–12] have highlighted the public health importance of domestic violence in pregnancy [10] in both industrialized and developing countries [10,11], identifying violence as a priority public health issue for research (12). Research using a public health approach to explore coping with violence in pregnant adolescents may provide information for guiding policy and practice on management of domestic violence survivors [9–11]. First, it may provide information on magnitude, characteristics (perceived or actual), determinants, and consequences of violence. Second, it may

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identify factors associated with adverse outcomes, especially factors modifiable through interventions. Third, qualitative research on experiences or coping strategies [13] may provide data on acceptability and likely cost-effectiveness of such interventions.

There is limited information from developing countries such as Uganda on coping with domestic violence. Why and how adverse outcomes arise as a consequence of violence-related prenatal stress [5–8] is not clearly understood but may depend on adaptations used to cope with violence [5]. Behaviors that adolescents adopt in response to violence may affect their safety or health, consequently influencing the risk of adverse outcomes [9]. The general objective was to describe experiences of pregnant adolescent domestic violence survivors and, specifically, to describe strategies employed by them in coping with violence. Exploring adolescents' coping strategies may provide insight into adolescents' decision-making. Ethical clearance to carry out the study was obtained from Makerere University Higher Degrees Committee, Karolinska Institute Ethics Committee, Mulago Hospital and Uganda National Council of Science and Technology. Participants were offered psychological counseling for domestic violence and given health education on how to improve personal safety. Those who needed further counseling were referred to professional counselors.

Material and methods

Setting and subjects

This study was carried out in Mulago hospital, the national referral hospital in Kampala, Uganda from January to May 2004. Of the women who attend the hospital's antenatal clinic, about 40% are adolescents, several of whom already have children. Sixteen in-depth interviews were conducted with pregnant adolescent domestic violence survivors attending antenatal clinic. Participants were identified using the Abuse Assessment Screen [14]. Severity of the violence was assessed using the Severity of Violence Against Women Scale [15]. Adolescents who answered in the affirmative to two of the questions related to the physical, sexual, or psychological domain of violence were requested to participate in the study. For coping strategies, we probed participants' actions to counteract violence and whether such actions differed from those used prior to conception. Theoretical sampling was used: after each interview, data were evaluated to decide the next interviewee, until data saturation (no new data regarding coping strategies). Interviews were carried out in English or Luganda (a local language), lasted 45 to 60 minutes, and were tape-recorded.

Theoretical framework

The theoretical framework was adopted from research on determinants of adolescent decision-making developed from studies of South African pregnant adolescents [16]. Understanding what dictates adolescents' decision-making is key to understanding how, why, and which adolescents are at risk. Second, though some decisions are habitual, instantaneous, or global, the decision-making process for adolescents is influenced by the social context. Third, understanding the perspective of the decision-making (for adolescent domestic violence survivors) requires exploration of actions, attached meanings, and interpretations.

Data analysis

Using Easy Text software for data retrieval, analysis involved an inductive process of developing codes (open coding) according to key concepts from transcripts and field notes. Related emerging codes were identified by selective coding and grouped into categories by constant text comparison as described by Corbin [17]. Whereas some of the codes were descriptive of the coping strategy employed, others were interpretive (the desired consequence of the strategy) or explanatory (reason why the chosen strategy was employed). A model of coping was developed, here referred to as *escaping the triple trap*.

Findings

Adolescents described a wide range of past and recent domestic violence experiences that included sexual coercion, stalking, restriction of movement and physical violence from spouses, in-laws and relatives. Regarding triggers of violence, the commonest reasons reported were perceived disrespect or related to negotiation of sex:

> When you are pregnant you may have no appetite, may be vomiting or may hate some food. In the first months you feel weak and have no desire for sex. You just want to rest all the time. Yet he may not know this. (Mother of two)

The main reasons for the latter were feeling unwell, lack of interest or fear that the unborn child would be injured as exemplified below:

> I was worried that the baby will be injured. (Mother of one-year-old child)

> I had no desire for sex, actually I did not even want to look at him sometimes. Yet he never seemed to understand this and would accuse me of loving other men. (Primigravida)

For some survivors, violence continued until they moved away. For others, pregnancy led to reduction in violence (spouses/partners reduced on their own or after survivors mobilized assistance). Pregnancy and adolescence influenced violence experiences. All participants expressed anxiety about injury or adverse pregnancy outcomes, especially spontaneous abortion and preterm labor. Some participants felt unable to cope with the stress, being adolescents with limited social and financial resources to stay on their own. For others it was the changing aspects of violence (frequency, increased severity, or fear related to further violence) with progression of pregnancy that characterized the reported experiences.

Coping strategies described were placed into four main categories during analysis, namely:

1. Minimizing damage: minimizing the impact or severity of violence.
2. Withdrawal: leaving the relationship, social withdrawal or resignation to fate.
3. Retaliation (revenge and fighting back).
4. Seeking help or social support.

Minimizing damage

The goal of this strategy was to reduce the negative impact or intensity of violence. The adopted behavior included placating behavior, keeping silent, distraction, feigning sickness, or self-protection (used alone or in combination). Placating behavior was used to prevent arguments, stop fights, or reduce stress (after or before violence). Keeping silent was reported by several respondents who described it as ''keeping quiet'', ''refusing to talk'', ''avoiding answering back'', ''not talking to him'' and is exemplified by one respondent, a young primigravida:

> I was very worried about my safety and that of my baby. I had nobody to protect me or help me. So I had to do everything possible to avoid being assaulted. If this meant apologizing immediately, even when he was the one in the wrong, I would do it.

To the above respondent, the main motivation for her behavior was worry about her safety and that of the unborn baby. Yet for others it was mainly personal safety, especially on realizing that they became progressively weaker as pregnancy advanced or because of pregnancy-related ill-health. This is exemplified by two respondents:

> Before I got pregnant, I would hit back if he assaulted me. I felt that pregnancy made me weaker, and so avoided any fights, or doing anything to provoke him. So I became more quiet as I didn't want to say anything to annoy him. (Primigravida)

> I had persistent vomiting in the first months. But even after it stopped, I would always pretend to be very sick at any opportunity. Then he could allow me to go to the hospital or visit my sisters. Afterwards, whenever his moods changed, I complained of sickness so he could not beat me. (Second pregnancy)

Withdrawal

Withdrawal and keeping away was a common strategy used by pregnant adolescents. Many respondents reported using any excuse and any available opportunity to leave their partners temporarily, sometimes for the whole remainder of the pregnancy period (temporary separation). Though some left without the consent or approval of spouses, others left with the spouses' knowledge but avoided meeting them and only did so when it was very necessary or inevitable. Others reported just disappearing and hiding among their relatives, implying that their spouses were unaware of where they were staying. This was a form of social, physical, and emotional isolation. For some, withdrawal was conditional, such as when the spouse was drunk (when they would escape to neighbors). Sometimes leaving was planned, while at other times leaving was spontaneous following an incidence of assault. Some adolescents expressed experiences of low moods, repressed anger, and resignation to violence. Resignation reflected inability to predict when violence may occur as well as to understand the changes that were occurring rapidly in their lives, from the changes of adolescence to those of pregnancy. It also reflected inability to disentangle

themselves from the emotional attachment of the relationship, as exemplified by these participants:

> It is hard to know when he will change. Sometimes he is very kind and treats you like a baby. He even used to brag to his friends that he will soon be a father. So you have to do your best to make things work. (Primigravida)

> I can't do anything to prevent the violence. (Primigravida)

> I have no one to turn to and nowhere to go. I am an orphan. I don't think anyone can help. (Mother with two-year-old child)

While prior experiences as an orphan influenced behavior in the latter, low self-esteem, lack of financial independence, or belief that the man will change were some of the reasons in others. This is exemplified by one respondent:

> It is hard to leave because you can not stay alone and look after yourself when pregnant.… He will change.… Sometimes you are forced to go back by circumstances, but would not if you could survive on your own. (Primigravida)

Others expressed worries about doubtful paternity if they left in early pregnancy as exemplified by another respondent:

> Suppose he denies later that he is the father of the baby, what do you do? (Primigravida)

This adopted behavior was characterized by loss of self-esteem, hopelessness, and reluctance to seek social support or healthcare. Three participants reported drinking alcohol in amounts that they thought were excessive but were unwilling (or unable) to stop, though they were aware of dangers of alcohol consumption in pregnancy. Substance abuse was not reported. Adolescents' responses and behavior demonstrated the futility and desperation of their situation.

Retaliation (revenge and fighting back)

Some respondents reported preoccupying themselves with thoughts of revenge, while others reported some form of retaliation against partners. This coping strategy included fighting back, informing police or local council leaders (with a view to having the spouse penalized or reprimanded) or destroying property. Those who reported fighting back in the first months of pregnancy had left their spouses and were currently staying with parents or other relatives.

Seeking help

Another coping strategy used by pregnant adolescents was reaching out to neighbors, health workers, family members, friends, local council (civic) leaders, and religious leaders. These people could intervene by reprimanding the assailant. Whereas this was sometimes of immense help to some participants, it worsened the adolescents' predicament in some situations, as it made domestic violence worse. Some respondents discouraged it and identified it as one of the factors that worsened their stigmatization. To such women, their image seemed more important than the health risk. For others, as exemplified by one respondent, it had temporary or doubtful benefit:

> I reported him to the Local Council chairman. Initially, they just rebuked him. Later he was given a fine – some money and local brew. Things went on well for just a few days and the beating started again. When I could not stand it any longer, I left him. Now I stay with my grandmother. (Mother of two)

For those who reported physical assault before pregnancy, pregnancy complicated their plans to leave their spouses. Such respondents, however, reported seeking help from either relatives, civic leaders or the judicio-legal system. This is exemplified by two respondents, one of whom who felt the strategy used was useful and recommended it, while the other thought it had limited use:

> I decided to inform family members. My father-in-law was very supportive and advised me to spend the rest of the pregnancy period with my mother-in-law. After a few weeks, I went back, and he never assaulted me again. So my advice would be that women should not keep quiet if assaulted. Usually men have someone influential to them whom they respect and listen to. (Second pregnancy)

> I informed my brothers and they threatened him, and when he persisted, I made up my mind and left him, now I have another man. (Second pregnancy)

Some of the reasons prompting a change of strategy were worsening (severity of) violence, persistent

violence, increasing restriction of mobility, and fear that violence may eventually endanger the life of the woman or her pregnancy. For some women, persistence of physical violence as the pregnancy advanced made them change the coping strategy. For others, it was the consideration for their children that made them stay in the relationship despite the ongoing violence. In the emergent theory, some of the behavioral adaptations were characteristic of the often impulsive behavior (such as fighting back) and decision-making characteristic of adolescence. Second, violence experiences (persistence, severity or type) and appraisal of the violence threat or consequences influenced behavioral adaptations. Third, pregnancy influenced the adaptations more than adolescence or violence. Some adolescents appeared unable to cope with their situation, hence appearing 'trapped' in situations with which they were trying to cope by any means, hence the ''escape''. The behavioral adaptations thus appeared like coping with the three stressors that participants experienced, namely adolescence, pregnancy, and domestic violence. Strategies employed by participants varied in contributing to safety. While some are reasonable and helpful, others appear risky and counterproductive. Strategies have social costs such as isolation or (likely) incarceration for survivors (or spouses), worsening stress, and loss of support (from peers, family members, or healthcare providers).

Discussion

This study describes behavioral modifications adopted by pregnant adolescent domestic violence as occurring in four coping strategies: minimizing impact, withdrawal, seeking help or support, and retaliation (fighting back). These modifications can be viewed as coping with the three stressors or contextual factors (also metaphorically referred to as the *triple trap*), namely adolescence, violence, and pregnancy. The coping strategies are also metaphorically referred to as '*escaping the triple trap*'.

Stress refers to circumstances that place physical or psychological demands on an individual. In the *conservation of resources theory*, Hobfoll et al. [18] described stress as occurring in contexts where resources are lost, threatened, or invested without gain. Lazarus & Folkman [19], in their *transaction theory* of coping with stress, described coping as occurring in two ways: (1) problem-focused (approaching): action-oriented (overt) behavior aimed at reducing stress; (2) emotion-focused (dissociating): covert actions whose primary goal is achieving emotional balance. Accordingly, coping is classified depending on characteristics of the coping process, which exhibits both behavioral and cognitive reactions organized sequentially into episodes.

The coping strategies and behavioral adaptations described are in agreement with the theories of coping with stress. Problem-focused approaches described by participants (such as *seeking help* and *fighting back*) indicate action-oriented overt behavior, whereby the individual does something to relieve the stress [20]. In contrast, emotion-focused strategies (such as *withdrawal* or *minimizing damage*) are mainly covert with the primary goal of restraining emotions arising out of the situation or of maintaining emotional balance [20].

The coping strategies described are also in agreement with previous research on coping with violence, adolescence, and pregnancy. Regarding coping with violence, the coping strategies described by adolescents are related to the process described in adults. Landenburger [21] described a complex four-stage process of coping with violence in adult women. In the binding stage, there is rationalization with a focus on the positive relationship aspects. In the enduring stage, there is cover-up and self-blame. In the disengagement stage, there is help-seeking. The recovery stage is marked by leaving. Regarding coping styles for adolescence, Myors et al. [22] found that most adolescents exhibited the optimistic (emotion-focused) style rather than the problem-focused style. Hesitation in decision-making reflects poor problem-solving skills typical of adolescents and indicates problems in making strategic decisions [23]. Many adolescents lack life skills that facilitate negotiation or decision-making [22,23]. Pregnancy per se is a stressful event [24] and individuals differ in their response to stress [24]. Huizink et al. [25] found that emotion-focused and problem-focused styles were simultaneously used for coping with (the stress of) pregnancy. Pregnancy affects appraisal of negative or stressful events, such that events which occur in early pregnancy may be deemed more or less stressful than if similar events occurred in later pregnancy [26]. Due to neuroendocrine changes, emotional responses change as pregnancy advances [27].

Why participants manifested different coping behavior at different times could be further explained by theories on coping with chronic stress. *Seeking help* and *fighting back* strategies appear to correspond with problem-focused approaches while *minimizing damage* and *withdrawal* correspond with emotion-focused approaches. Factors that may have influenced the coping responses include available resources in the individual's violence context, such as emotional attachment, social support, or financial

independence) [18,22,23]; pregnancy-related factors such as gestation age, pregnancy wantedness, and parity [26,27]; and violence-related factors [24,25] such as nature, persistence or severity of violence, perceived danger threat of violence, extension of the violence to family members (especially children), or fear of worse violence if the survivors left. The foregoing factors may also determine how much attention the survivor pays to the stressor and how many ''coping resources'' are available. Evidence for this view is Miller's *monitoring and blunting theory* [28]. According to Miller [28], individuals' responses depend on the attention directed to the stressor. Individuals employ avoidant cognitive strategies (distraction or denial) by lowering arousal response, to present with blunting coping (stressor controllable) or monitoring coping (uncontrollable stressor). Adolescence affects self efficacy [22,23], pregnancy induces physical, emotional, and physiological changes [26,27], while violence per se affects ability to function [9,10,12,13,29] by affecting self-esteem and emotional attachment [30]. It is difficult to comment on whether coping strategies of pregnant adolescents are comparable to those of adults.

Conclusions

Coping strategies adopted by pregnant adolescent domestic violence survivors are influenced by pregnancy and adolescence. The gestation age at which violence occurs, the severity or nature of the domestic violence, adolescents' prior experiences regarding violence, the available resources (in terms of social or emotional support), and adolescents' emotional growth (level of maturity) may explain the different manifestations. Coping behavior may enhance or decrease violence or associated stress.

Study implications

The study findings demonstrate challenges and opportunities in management of violence survivors in vulnerable groups such as pregnant women and adolescents. Counseling of pregnant adolescents should include information on changes of adolescence and anticipated pregnancy changes and how adolescents could cope with them. Coping processes in prenatal stress may influence healthcare decision-making and healthcare seeking and subsequent mothering behavior. Likewise, survivors' partners require counseling concerning such changes. Therefore pregnant adolescent survivors need counseling on pregnancy changes, adolescence changes, and domestic violence. Problems in making strategic decisions or identifying sources of support are the manifestation of failure to cope. Sources of support that must be harnessed include partners, friends, parents, and health workers. Adolescents require counseling on life skills that could improve their self esteem. Finally, management should be tailored to the individual needs of the survivors.

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