

CREATING COMFORT: A GROUNDED THEORY  
OF INTIMATE PARTNER ABUSE SURVIVORS'  
PERSPECTIVE OF PRIMARY HEALTH CARE VISITS

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A DISSERTATION

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COLLEGE OF HEALTH SCIENCES

BY

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DENTON, TEXAS

DECEMBER 2000

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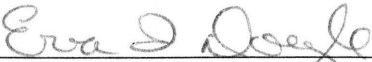
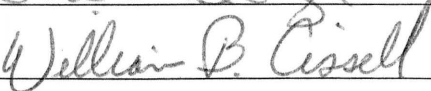
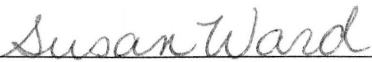
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To the Dean of Graduate Studies and Research:

I submitting herewith a dissertation written by Joy Rittmayer entitled "Creating Comfort: A Grounded Theory of Intimate Partner Abuse Survivors' Perspective of Primary Health Care Visits." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Health Studies.

  
Robin Rager, Ph.D.  
Major Professor

We have read this dissertation  
and recommend its acceptance:

  
  
  
Department Chair

Accepted: 

Dean of Graduate Studies and Research



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## ACKNOWLEDGEMENTS

I would like to acknowledge the true authors of this paper, the 18 participants who gave so generously of their time and so eloquently shared their insights. I regret that it is not possible to name them and give them the tribute they deserve.

## ABSTRACT

CREATING COMFORT: A GROUNDED THEORY  
OF INTIMATE PARTNER ABUSE SURVIVORS'  
PERSPECTIVE OF PRIMARY HEALTH CARE VISITS

JOY RITTMAYER, B.A., M.S.

DOCTORAL DISSERTATION, DECEMBER 2000

Grounded theory methodology was used to develop an understanding of the experience of primary health care appointments from the perspective of survivors of intimate partner violence. English-speaking females above the age of 18, who by self-report were survivors of domestic violence, were recruited via flyers distributed at sites selected to elicit a natural variation in socioeconomic levels, ages, ethnicities, and current status of abuse. In semi-structured interviews, the 18 participants (5 African American, 9 Caucasian, 3 Hispanic, 1 Nigerian) revealed that routine health care visits, rather than being therapeutic, frequently added to their stress. These women struggled with anxiety before the appointment,

disappointment with the caregiver's interaction, and frustration with the aftermath.

Through constant comparative analysis of the data, "creating their own comfort" emerged as the process used by the participants to cope with primary care visits that frequently ignored or denied the violence from their partners. Fears that the abuse would be reported to authorities or that they would be negatively judged caused most participants to choose silence as their best protection. Patients who did decide to risk exposure of the violence at home were often dismissed without support. When care providers offered validation and resource information, women were often moved to take action. Many patients grieved that failure to provide information in the primary care setting contributed to the continuation of abuse, simply because they did not know their rights and options. The participants urged care providers to practice sensitive communication skills, screen all patients for intimate partner violence, and distribute written information regarding reporting laws, the impact of domestic violence on children, and local resource referrals.

The proposed theory yielded many implications for change in practice, most notably that routine provision of written information may be at least as important as routine screening in breaking the cycle of abuse. This research also underscored the need for pediatricians to serve as another screening and information distribution point for intimate partner violence. Because this theory is grounded in the shared experiences of survivors of intimate partner violence, it is relevant from their point of view.

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## CHAPTER I

### Introduction

Intimate partner violence is a problem of epidemic proportions in the United States (Rosenberg, O'Carroll, & Powell, 1992; Koop & Lundberg, 1992). Primary care physicians have the best opportunity to identify and intervene with the cycle of abuse, but research reveals that this opportunity is rarely used (Hamberger, Saunders, & Hovey, 1992). Despite repeated directives for universal screening of all patients for abuse, health care providers remain resistant to addressing the issue (Parsons, Zaccaro, Wells, & Stovall, 1995). Attention in the literature has focused on why the proliferation of training programs for student and practicing providers has failed to increase their intervention efforts.

The nearly forgotten half of this equation is the patient. Few studies have examined the recommended mode of screening from the vantage point of the survivors of intimate partner abuse. If communication is a two-way street, what barriers are blocking the patient from raising the issue of partner violence? The problem this study addressed was the

lack of information regarding the needs and preferences of survivors of intimate partner violence in the primary health care setting.

### Purpose of the Study

The purpose of this grounded theory study was to develop an understanding of the experience of primary health care appointments from the perspective of survivors of intimate partner violence. By analyzing the patients' stories, a theory emerged that revealed the participants' basic problems inherent in this interaction and the processes they used to resolve those problems. The resulting theory will be utilized to prompt changes in provider training, protocol development, clinical practice, and patient education and support.

The population under study consisted of females above the age of 18 who by self-report fit the study's definition of survivors of intimate partner violence and who had experienced at least one primary health care visit during the period of abuse.

### Research Question

There are no hypotheses in grounded theory research. Instead, the study is driven by an over-arching research question. This investigation asked, "What is the experience

of survivors of intimate partner violence during primary health care visits?"

### Definition of Terms

These terms were defined as follows for the purpose of this study:

1. Intimate partner violence: Actual acts or threats of any of the following behaviors, perpetrated by a current or previous boyfriend, spouse, or partner, constitute intimate partner violence: physical injury, forced sexual contact, injury to property or pets, emotional or psychological torment, economic control, or social isolation (Flitcraft, 1995).

2. Primary health care provider: Any clinic, doctor, nurse, or physician's assistant defined by the participant as her primary provider (i.e., out-patient clinics, nurse practitioners, family practitioners, obstetricians/gynecologists, internists, etc.), excluding emergency care.

### Bracketing

The potential for interviewer bias was addressed by having the researcher identify the preconceived notions and values that she brought to the study. The conscious effort to set aside these beliefs is referred to as "bracketing" (Berger & Kellner, 1981).

The researcher's beliefs underlying this study were:

1. Care providers would be negligent in acknowledging intimate partner violence.

2. Participants would be angry with practitioners for not helping them deal with intimate partner violence.

If attention was not paid to these preconceptions, then there was a risk of missing the actual reality shared by the participants (Morse & Field, 1995). These personal biases were acknowledged before the study commenced, so that the researcher was vigilant to separate her opinions from the experience of the participants, thus increasing the validity of the findings.

#### Limitations and Delimitations

The limitations and delimitations of this study are as follows:

1. Findings of this study were limited to the actual participants and their recollections at the point in time when the data were collected.

2. Unconscious bias on the part of the researcher may have existed, even with an attempt to "bracket" prior convictions before analyzing the data.

3. Non-English-speaking women were excluded due to language barriers.

## Assumptions

As a qualitative research study, certain general assumptions were made which distinguish it from quantitative research (Creswell, 1994):

1. Process, rather than outcome, is the major concern.
2. The researcher is the instrument for data collection and analysis.
3. Qualitative research is descriptive, in that the interest is in showing how people make sense of and process their experience.
4. Qualitative research is both inductive and deductive as the researcher develops abstractions, hypotheses, and theories based on the data collected.

The following assumptions were relevant specifically to the use of the grounded theory method (Charmaz, 1990):

1. Reality is a social construct.
2. People experiencing common circumstances share a common reality.
3. The theory emerges from (is "grounded" by) the constant comparative process of collecting, coding, and analyzing the data. The data reveal the reality that the participants see.

## Rationale

Nearly one third of the women in America experience intimate partner abuse and 9% have suffered severe violence, according to a meta-analysis of the literature by Wilt and Olson (1996), who suggest that these staggering statistics may be subject to underreporting. Total victim-related expenses attributed to intimate partner abuse are estimated at \$67 billion annually (Miller, Cohen, & Wiersema, 1996), with medical costs alone conservatively figured at \$44 million per year (Randall, 1990). The human costs are inestimable.

Over the past decade, domestic abuse has been addressed in nearly every social science and medical journal. The medical community has acknowledged that the epidemic existence of intimate partner violence and has called for health care providers to universally screen all patients for abuse (Sasseti, 1993), yet the literature reveals that a meager percentage of physicians conduct routine screening (Hamberger et al., 1992). Barriers that prevent physicians from complying with the recommendation to assess for abuse have been investigated (Alpert, 1995). More articles have addressed the need for revisions in medical training and continuing education to equip

physicians for the task (Chambliss, Bay, & Jones, 1995; Tilden et al., 1994).

In the study of medical intervention with intimate partner violence, the extant literature focuses on the patient/provider interaction from the physicians' perspective. The viewpoint of the survivors has been largely overlooked (Rodriguez, Quiroga, & Bauer, 1996). For patient/provider interaction to be effective, it is critical to consider the patients' input regarding their expectations and response to this exchange (Walsh & McPhee, 1992). If the goal of patient/provider interaction is to be empowering, it is imperative to elicit the survivors' experience and make them partners in the process (Thurston, Cory, & Scott, 1998). An examination of the patients' perspective provided by the proposed study will contribute a unique body of knowledge which can be used in the development of more effective protocols for intimate partner abuse identification, intervention, and education.

### Summary

This chapter outlined the purpose of the study and proposed grounded theory as an appropriate method to examine the issue from the perspective of survivors of intimate partner violence. A brief overview of the literature



illustrated the scope of the problem and the need for research from the patients' vantage point. Definitions, assumptions, limitations, and delimitations were presented.

## CHAPTER II

### Review of the Literature

This chapter examines the literature of the last decade that focuses on the impact of intimate partner violence on women's health. In light of the physical and mental sequelae of abuse, the need for universal screening for abuse by primary care providers is made clear. The actual implementation of routine screening is reported, along with explanations of why providers find it difficult to do. Finally, initial investigations into the patients' role in this exchange are presented.

#### Physical and Mental Sequelae of Intimate Partner Violence

The scope of intimate partner violence in the United States is staggering. It is the leading cause of injury to women between the ages of 15 and 44 (Lehrman, 1995). Approximately one-third of American females are assaulted by their partner on a date (Saltzman & Johnson, 1996). Partner violence is the leading cause of death for young African American women (Campbell, 1999).

Beyond injury, rape, and death, women suffering from intimate partner violence often experience vague, somatic complaints. "Somatization is often a defense mechanism that protects individuals from the emotional pain of directly acknowledging the facts of their victimization" (Hendricks-Matthews, 1992, p. 2033). Abuse survivors more often report symptoms of chest pain, back pain, sexually transmitted diseases, gynecological problems, headaches, and depression than the general female population (Campbell, Dienemann, Wynne, & Kub, 1999). There is speculation that survivors may also exhibit further delayed physical effects such as arthritis, hypertension, and heart disease (Wisner, Gilmer, Saltzman, & Zink, 1999).

Intimate partner abuse has been shown to promote conditions of chronic pain (Badura, Reiter, Altmaier, Rhomberg, & Elas, 1997). The majority of women suffering from chronic pelvic pain endured lifetime histories of sexual and/or physical abuse. Chronic pelvic pain accounts for 10% of out-patient gynecological visits, one third of laparoscopies, and up to 16% of hysterectomies.

Research clearly suggests that medical consequences of intimate partner violence extend far past the emergency room.

In the year of the abuse, survivors made physician visits twice as frequently as nonvictims, with outpatient medical costs that were 2.5 times greater (Koss, 1993). During the year following the abuse, the differences in medical usage were even more pronounced. Three years after the assault, physician visits had still not dropped back to pre-attack rates (Koss, 1993; Koss, Koss, & Woodruff, 1991).

Increased medical utilization was not limited to women who suffered serious physical abuse. Even low-severity violence produced more physical symptoms and psychological distress than evidenced in women reporting no partner abuse (McCauley, Kern, Kolodner, Derogatis, & Bass, 1998). Emotional abuse, not physical abuse, was found to be the unique predictor for increased physician visits and ongoing prescription usage in a large Health Maintenance Organization (Sansone, Wiederman, & Sansone, 1997).

#### Necessity for Screening by Primary Care Providers

Initial medical intervention studies into this epidemic focused on emergency room staffs' treatment of battered women (Campbell & Sheridan, 1989; Goldberg & Tomlanovich, 1984; Kurz & Stark, 1988). However, research soon revealed that the majority of medical visits related to intimate partner

violence are not to the emergency room, but to the primary care physician (Koss, Koss, & Woodruff, 1991).

Contrary to early assumptions, a study conducted in one major health plan found no difference in emergency room usage between abuse survivors and general female enrollees (Wisner et al., 1999). Higher health care costs for survivors of intimate partner violence were attributed to increased general clinic visits, out-of-plan referrals, and hospitalizations. A higher incidence of subsequent hospitalization for survivors was also reported by Kernic, Wolf, and Holt (2000).

Given the overwhelming prevalence of intimate partner violence in the general population and the high prevalence of health care utilization among abuse survivors, it was only logical that primary health care providers would be called upon to identify and intervene with this significant health problem. The Attorney General in 1984 and the Surgeon General in 1986 each produced reports validating the seriousness of this matter and urging physicians to intervene (Saltzman, 1990). The Journal of the American Medical Association, the "bible" for physicians, devoted a special section of the June, 1992, issue to draw heed to the problem

of battery. Earlier that year, the American Medical Association (AMA) had distributed "Diagnostic and Treatment Guidelines on Domestic Violence" (American Medical Association, 1992) directing primary care physicians to "routinely ask all women direct, specific questions about abuse" (p. 8). The Society of Teachers of Family Medicine sponsored numerous publications and educational conferences designed to encourage family practitioners to implement routine screening (Hendricks-Matthews, 1992).

In 1989, the American College of Obstetricians and Gynecologists mailed a technical bulletin on "The Battered Woman" to all its members with the recommendation that all patients be routinely screened for partner abuse (Saltzman, 1990). For young, healthy women the primary care physician is frequently an obstetrician/gynecologist (ob/gyn). Some element of primary care is contained in over 89% of ob/gyn visits (Hendrix, Piereson, & McNeeley, 1995). An annual visit to this specialist may be a woman's only contact with the health care system, making this an ideal opportunity for screening for intimate partner violence, validating its existence, and educating women as to their options for handling this problem. For pregnant women, the repeated

contact with the ob/gyn throughout the childbearing year provides the opportunity to monitor partner abuse and alert women to potential damage to both themselves and their unborn child.

#### Provider Resistance to Screening

Despite these repeated calls for universal screening for intimate partner abuse, a recent survey of internists, ob/gyns, and family practitioners revealed routine screening rates of only 10% for new patients, 9% for periodic check-ups, and 11% for prenatal care (Rodriguez, Bauer, McLoughlin, & Grumbach, 1999). Over half of the doctors participating in an online poll of screening habits reported that they only assessed for abuse if they suspected the patient was a victim (Medscape, 2000).

A survey of 6,568 ob/gyns revealed that the majority of these specialists do not practice routine screening for abuse (Parsons et al., 1995). With a response rate of less than 15%, it is possible that those physicians returning surveys were the most interested in intimate partner violence and thus reflect higher screening rates than those of their nonresponding colleagues. The disregard for routine abuse assessment is particularly troubling given

that ob/gyns were found generally to have an understanding of the issues involved with intimate partner violence and an appreciation that it is an important public health issue (Horan, Chapin, Klein, Schmidt, & Schulkin, 1998).

Barriers that inhibit primary caregivers from inquiring about abuse have been investigated so that these issues can be addressed in training and clinical practice. Sugg and Inui (1992) identified fear of offending, time constraints, powerlessness, lack of comfort, and loss of control as obstacles facing the family practitioners and internists in their study. Another study with family physicians and general internists found that while all participants agreed that finding and treating domestic violence is important, less than half thought that it was an important problem in their patient population (Reid & Glasser, 1997). The denial that intimate partner violence was an issue for their patients was even more striking for primary care provider teams in a large urban HMO. Fifty percent of the doctors and 70% of nurses and support staff believed the prevalence in their practice was less than 1% (Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999). Fear for their personal safety when discussing partner abuse was a concern for 20% of the participants. A



quarter of the respondents in the Sugg et al. study felt that the abused woman's personality led to the violence.

Victim blame was also a belief held by ob/gyns, with 7.9% agreeing with the statement that "women bring this on themselves" (Parsons et al., 1995). Lack of training (71%) was the most common barrier for screening given by ob/gyns. Other obstacles included type of patient (46%), lack of time (39%), and frustration that their efforts would not change anything (34%).

Rittmayer and Roux (1999) discovered similar barriers in their research with ob/gyns. In addition, they found that adherence to the medical model, which predisposed a bias to physical etiology, prevented physicians from considering intimate partner violence as a diagnosis until all physical diagnostic studies had been exhausted.

#### The Patient's Part in Disclosure

Research has recently begun to question what role the patient plays in the unsatisfactory assessment of intimate partner violence in the primary health care setting. To determine what physician behaviors survivors of intimate partner abuse find desirable or undesirable, participants in battered women's support programs were given an

inventory of specific behaviors to rate (Hamberger, Ambuel, Marbella, & Donze, 1998). Participants included those who had sought medical assistance from both primary and emergency care and also women who had sought no medical care. Most desirable ratings involved provision of resource information (shelters, legal services, safety plans) and a follow-up plan with the doctor. Least desirable were suggestions that women should make-up with the abuser, that women were responsible for the abuse, and that men could not help being abusive.

A standardized questionnaire administered to both abused and non-abused female patients at a veterans' walk-in clinic revealed that the majority of women believe that physicians should routinely ask about intimate partner abuse and that they would truthfully respond to such inquiry without offense (Caralis & Musialowski, 1997). The participants reasoned that doctors' failure to inquire was based on lack of resources, time, or knowledge; or on the belief that abuse is a private matter, the fault of the woman, or a threat to the doctor's personal safety.

Multiple-choice questionnaires completed by male and female patients in primary care sites showed that the

majority favored routine inquiry about physical abuse (78%) and sexual abuse (68%) (Friedman, Samet, Roberts, Hudlin, & Hans, 1992). Only 7% of the respondents had ever been asked about physical abuse and only 6% about sexual abuse. A history of physical abuse was reported by 16% and 17% reported a history of sexual abuse.

Gerbert et al. (1996) limited their qualitative study to women who had experienced physical or sexual abuse. They found that "the battered women in our sample highlight the less than optimal health care that many battered women receive" (p. 11). Barriers to optimal care were categorized into patient, provider, and organizational levels. On the patient level, fear of partner retaliation, fear of losing their children, and feelings of humiliation were primary reasons for not disclosing abuse.

A focus group study conducted in California found that women with histories of domestic violence were impeded from disclosing their situation due to fear of further violence, worry about police involvement, embarrassment, and lack of trust in the health care provider (Rodriguez et al., 1996). The women indicated that physicians should ask directly

about abuse, display compassion, and respect the patient's choices in how she would handle the situation.

Focus groups of women in group therapy for domestic violence were used to identify characteristics that impacted disclosure to clinicians (McCauley, Yurk, Jenckes, & Ford, 1998). Women were more inclined to raise the issue of intimate partner violence if they perceived the provider to be caring, easy to talk to, or protective. The most often mentioned physician barriers to disclosure were fear that the doctor would look down on them or blame them for the abuse. Signs that the practitioner was uncaring, uncomfortable, or rushed also blocked disclosure. The main patient barriers discussed were shame, denial, and the abuser preventing them from obtaining medical attention.

### Summary

The literature clearly illustrates the link between intimate partner violence and women's health. The necessity for routine, universal screening by primary care providers is well established. Governing organizations in both obstetrics/gynecology and family practice have instructed their members to assess for abuse and have provided educational materials to train their membership.

Failing to respond to this call, research has focused on identifying physician barriers that impede intervention with partner abuse.

Attention is shifting to explore patient expectations and preferences when addressing intimate partner violence in the primary health care setting. Initial studies identified care provider behaviors that survivors of partner violence perceive as helpful or hindering to disclosure and patient concerns that block sharing with the clinician. Additional research is needed to gain insight into primary health care encounters from the perspective of the survivors of intimate partner violence.

The voices of battered women are seldom heard in the published literature . . . . We need to learn what is effective, the barriers, and the outcomes from the women themselves . . . . As Paulo Freire, a leading scholar in empowerment theory has argued, practice without theory is as empty as theory that is not grounded in practice (Thurston et al., 1998, p. 303).

## CHAPTER III

### Methodology

This chapter discusses the grounded theory methodology that guided this qualitative study in relation to its participants, procedures used to recruit participants and collect data, and techniques used to analyze the data.

#### Participants

The study was set in the Dallas, Texas, metroplex. Participation was limited to English-speaking females above the age of 18, who by self-report were survivors of intimate partner violence and who had experienced at least one primary health care appointment during the period of abuse.

Interviews were conducted with 18 women. The participants ranged in age from 23 to 45 years, with a median age of 30 years. Five participants were African American, 9 were Caucasian, 3 were Hispanic, and 1 was Nigerian. Marital status was reported as 10 married, 4 single, 3 separated, and 1 divorced. Their formal education backgrounds ranged from elementary to graduate school.

Reported medical coverage was evenly split between private insurance, Medicaid, and no health insurance.

For the visits discussed, 6 women were seen in clinics, 7 each by obstetrician/gynecologists and family practitioners, and 2 each by internists, nurse practitioners, and oncologists (some participants identified more than one health care provider). Participants identified the reasons for their visits as follows: 7 each for annual check-up, headache, sleep problems; 6 for anxiety; 5 for pregnancy; 4 each for illness and fatigue; 3 each for injury and chest pain; and 2 each for eating disorders, stomach pain, and cancer treatment.

Only 2 participants reported being screened for intimate partner violence as a routine part of the primary health care visit. One was screened in a primary care clinic and declined to disclose because she was not comfortable with the provider's attitude. The other was asked in a WIC (Women, Infants, and Children) clinic and declined to disclose because the abuser was in the waiting area. The screening histories reported by the other participants are listed in Table 1.

Table 1

Participants' Screening History for Intimate Partner Violence

Provider and Patient Behavior	No. of incidents
Provider never asked – patient never told	9
Provider asked routinely – patient never told	2
Provider asked due to specific injury – patient told	2
Patient volunteered - provider validated	3
Patient volunteered - provider validated & gave referral information	3
Patient volunteered - provider ignored & offered no interventions	6

Note. Participants 2, 8, 10, 12, 13, 14, and 15 each reported 2 separate incidents.



The participants had experienced a range of physical, psychological, sexual, financial, and property/pet abuse, with physical and psychological abuse being most frequently noted. At the time of the interviews, the women were in all stages of safety. Some had terminated the relationship with the abusive partner, some were currently living with the partner, and some were in temporary or transitional housing.

#### Protection of Human Subjects

Approval to conduct the study was obtained from the Human Subjects Review Committee of Texas Woman's University. Each prospective participant was informed of the purpose of the study and the method of data collection (audio-taped interview). Written consent, as required by Texas Woman's University Human Subjects Review Committee, was obtained from each participant. Interviewees were informed that the researcher would transcribe and then erase the tape. All tapes were transcribed verbatim. Transcripts were kept in a locked cabinet in the researcher's office. Tapes and transcripts were numerically coded to further insure confidentiality. Participant quotes were cited with no identifying information.

Interviewees were advised that reflection on intimate partner violence might arouse strong emotions. Participants were informed that they could terminate the interview at any time without penalty. At the conclusion of the interview, each woman was offered a list of support services.

Women who met the participant criteria and signed a letter of consent received a \$10 gift certificate to a national bath and beauty shop as a token of appreciation for their time and input. The certificate was given prior to the start of the interview. All participants were invited to review and respond to a summary of the results. Eleven women accepted the invitation.

#### Recruitment and Data Collection

The participants were recruited through a flyer (see Appendix A) distributed at legal aid clinics, women's shelters, private physician offices, women's health clinics, university bulletin boards, a women's leadership organization's luncheon, and the protective order division of the county courthouse. The range of distribution points was designed to elicit a varied response representing different socioeconomic levels, ages, ethnicities, and current status of abuse. Diversity of participants was

sought not for statistical randomization, but to more accurately describe the social process by seeking natural variations. Flyers were distributed during March 2000. All interviews were conducted between April and July 2000.

Potential participants were screened for eligibility when they contacted the researcher on her private office phone. Those meeting the criteria scheduled interview times and sites that were convenient to them. Arrangements were made to meet participants at the county courthouse, restaurants, malls, offices, a women's shelter, a public library, a residence, and a grocery store. Interviews held in public locations were conducted in secluded areas. All interviews were audio-taped. No length was preset for the interview, but most lasted about 75 minutes. Consent forms were read and signed prior to the interview and the participant was given her gift certificate. After the interview concluded, each woman was offered a referral list for health, legal, financial, and emergency shelter services. Fifteen of the participants completed demographic information sheets at the end of the interview.

Field notes were transcribed as soon as possible after each interview. Researcher memos were recorded at each

listening/reading of the interviews and whenever the researcher had an insight into the accumulating data. The researcher's notes created an audit trail and were essential to the development of the emerging themes and theory.

In keeping with grounded theory methodology, the participants guided the interview. Actual interview questions changed as the core issues emerged. Data from earlier interviews suggested the direction for later interviews.

The initial interview questions were:

1. What have been your experiences with regular health care visits during the period of abuse?
2. How did the doctor, nurse, or other staff make the visit more or less helpful for you?
3. How did these experiences impact the abuse?

#### Treatment of the Data

This research was analyzed using grounded theory methodology, as defined by Glaser (1978, 1992; Glaser & Strauss, 1967). Grounded theory is a logical method for research that seeks to generate a new point of view in documented situations (Stern, 1980). Grounded theory assumes that people living with a similar experience share a specific social-psychological problem that is often unarticulated

(Hutchinson, 1993). Analysis of the experience as told by this group reveals a common process by which they resolve that problem.

The methodology of grounded theory directs the researcher to collect data in the field, code, sort, memo, modify, and integrate it all simultaneously. As is appropriate for a grounded theory study, data analysis occurred simultaneously with data collection. Each new piece of data (interview, observation, memo) was constantly compared to what had already been collected and guided future interview questions and participant recruitment.

Starting with the first interview, line-by-line examination of the transcripts asked the question, "What is going on in these data?" These initial substantive codes, often noted in the words of the participants, clustered into categories, and eventually collapsed into theoretical constructs. Analysis revealed that the core issue perplexing participants was that primary health care providers tended to either ignore intimate partner violence or to treat it insensitively. Glaser and Strauss (1967) refer to this central theme as the basic social psychological problem.

Further sampling, sorting, and memoing were guided by the core theme, until the method by which the participants processed their conflict emerged. This process, "creating comfort," is referred to as the basic social psychological process. Interviewing and analysis continued until no new ideas were generated or saturation of the data (completeness of codes) occurred. The process is illustrated by participant quotes, "grounding" the theory in their experiences.

### Rigor

The goals of inductive research differ from the goals of verificational research, and so do the techniques used to evaluate the achievement of those goals. "The goal of grounded theory is to generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved" (Glaser, 1992, p. 75). Hutchinson states the goal simply as "accurately perceiving and presenting another's world" (Hutchinson, 1993, p. 182).

The measure of the theory is in its ability to meet four central criteria: fit, work, relevance, and modifiability (Glaser, 1992). "Fit" refers to the reality the theory has for the participants, practitioners in the field, and other researchers. Hutchinson (1993) states that "a quality

grounded theory has codes that fit the data and the practice area from which it is derived . . . . Readers of quality theories can actually sense or feel this fit" (p. 206). "Fit" for this study was confirmed by the 11 women interviewed who read the findings summary (participants). A Ph.D. in nursing research validated the naturalness of coding for this study (researcher review). The executive director of a women's shelter and a social worker in the district attorney's office provided additional reviews (field practitioners).

A grounded theory "works" when it explains variations in the participants' processing of the problem. The "influencing conditions" illustrated in Tables 2, 3, 4, and 5, attempt to account for these behavioral differences. The data included a richly diverse pool of participants, representing a variety of ethnicities, ages, educational backgrounds, financial levels, and stages of abuse. Their varied life experiences shaped the perceptions and expectations that lead to their different choices of action.

In addition to accounting for variations, a theory that works "can predict what will happen under certain conditions or given certain variables" (Hutchinson, 1993, p. 207). An illustration from this theory is the prediction that abused

women who are ignored or discounted in the clinical setting will continue to remain stuck in their situation longer than women who are met with support and referral.

Glaser said that a theory that fits and works has "relevance" (Glaser, 1992). Another way to explain relevance is to say that a theory has "grab" for the participants (Wilson & Hutchinson, 1991). The consensus of participants who reviewed the theory was that it did represent their experience.

"Modifiability" exists in the flexibility of the theory. As the situation under study changes, the theory must be modified to integrate new data. The theory proposed from this research consists of four theoretical constructs drawn from 23 categories. It is the density of the theory that contributes both to its fit and its modifiability.

### Summary

This was a qualitative study based on the grounded theory method. Data came from in-depth interviews, field notes, and the researcher's memos. Data were analyzed using the constant comparative method of simultaneously collecting, coding, and sorting data. Participant quotes were used to substantiate the theory that resulted from this analysis.



## CHAPTER IV

### Findings

This chapter reports the experience of primary health care visits from the perspective of survivors of intimate partner violence. The participants' narratives are analyzed using grounded theory methodology. Block quotations taken from the interview transcripts are used to illustrate the constructs of the proposed theory, "Creating Comfort."

Routine health care visits, rather than being therapeutic, frequently added to the stress experienced by women who were living with an abusive partner. Anxiety before the appointment, disappointment with the caregiver's interaction, and frustration with the aftermath constituted the basic social psychological problem facing the participants:

It's scary to think what the world is coming to if this can happen and no one cares. You feel alone. Ashamed. I don't care if they can help me or not, just listen to me and actually be understanding . . . . Everybody's in an uncomfortable situation. [Participant 13]

Creating their own comfort was the basic social psychological process the participants used to resolve their dissatisfaction with health care encounters (see Figure 1). Comfort was created by controlling what would be revealed in the health care setting, either protecting self and others by nondisclosure of the violent situation or risking exposure in an attempt to obtain outside help. The women coped with the consequences of their degree of disclosure by rationalizing or grieving unproductive encounters and celebrating empowering ones. The closing phase of creating comfort came through a voiced commitment from the participants to share their insights with health care providers so that women in similar situations might receive more therapeutic care:

If I was a doctor, I would be comforting. "Are you okay? Do you have somewhere you can go? Do you need some help? What do you need?" I've never gotten that from anybody. I didn't get it from either doctor, really. [Participant 13]

#### Phase 1 - "Protecting through Silence"

The first phase in the process of creating comfort was characterized by the participants' determination to keep their violent situation a secret. The women felt that premature disclosure might put them, their children, their families, or even their abuser in jeopardy. They also

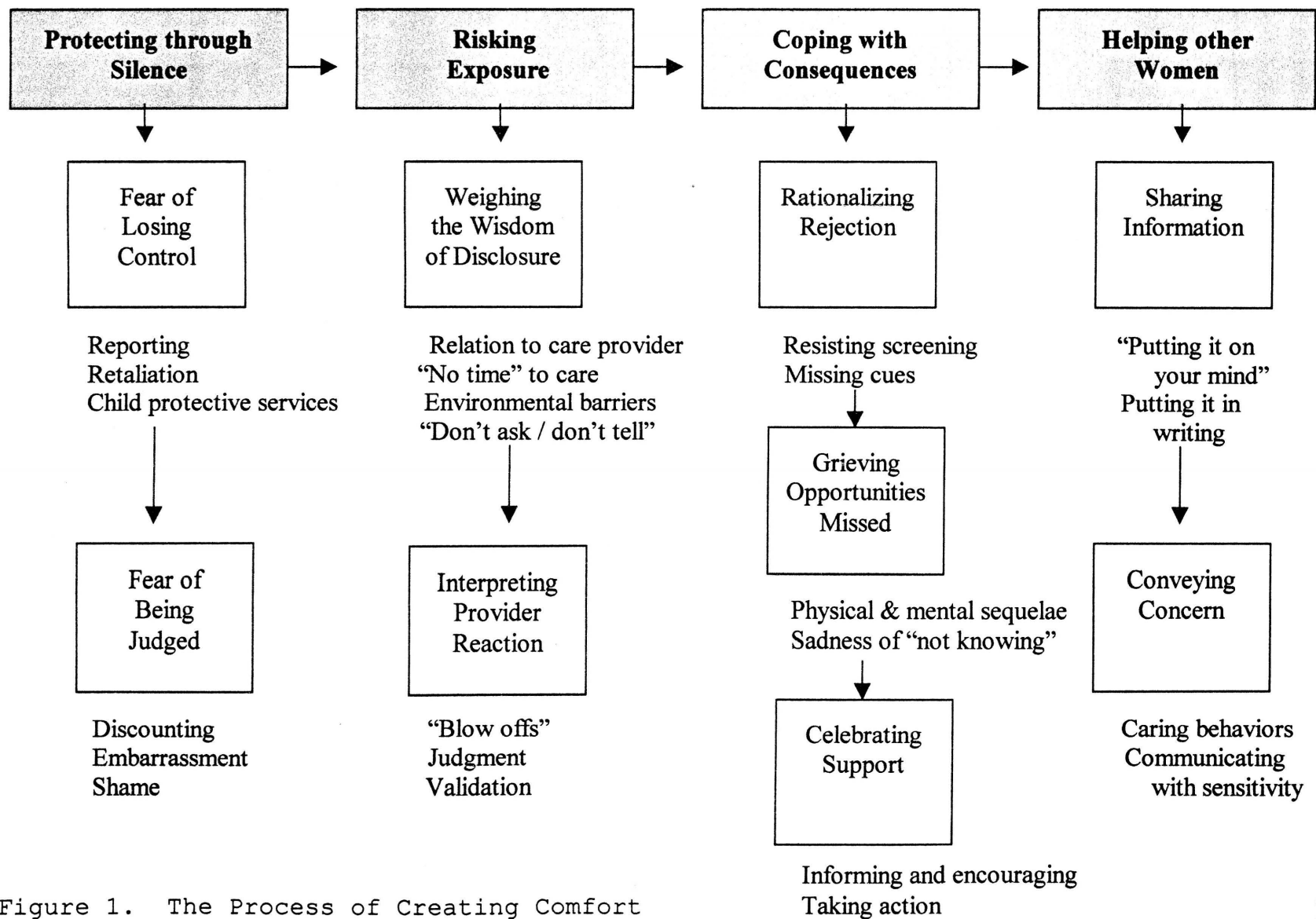


Figure 1. The Process of Creating Comfort

feared the humiliation of being judged negatively for continuing to live with an abusive partner.

Fear of losing control.

I didn't want anybody knowing that would harp on me to get rid of him, because I was doing what I had to do to get to that point [of being ready to leave my husband]. So if they had asked something like that [screening for abuse] I probably still wouldn't have answered them. [Participant 10]

I was afraid to go in, because I thought, "If I come up with a minor head concussion I'm gonna have to explain how I hit my head." I was trying to work things out with him, so that kept me from seeking treatment - not wanting to have to explain it. [Participant 16]

In a violent relationship, the abuser systematically takes over control of his partner (Sassetti, 1992). There are many reasons why a woman will remain in or return to a violent relationship (Buel, 1995). If the truth of the situation is made public before she is ready to take action, she fears outside intervention will make a bad situation even worse. Timing is critical in ending an abusive relationship and women need to decide for themselves when the time is right (Landenburger, 1998; Sassetti, 1993):

One day I got a clue and I just decided to go on my own. I thought it was time to go. And I didn't want anyone making that decision for me. [Participant 9]

When women felt they had control of their situation, they wanted to carry through with their own plans unhampered by others' advice:

I wanted my doctor to focus on my health . . . . I was going to a counselor to help me sort through what I needed to do and how I needed to do it . . . . I saw her role as "You document this stuff." He [the doctor] documents this stuff to take care of my health. An attorney to take care of my children and my will, just in case. And then I will take care of work and I will get rid of him. [Participant 10]

On the whole, the participants were erroneously informed on the health care providers' obligation to report intimate partner violence to the police:

I'm sure people will ask them not to say anything, but people who know that this is a reportable offense their whole fear is that the police officers are brought into it. [Participant 12]

I didn't know if they would try to get him arrested or something like that there. [Participant 2]

I didn't know that they didn't have to report it. . . . That would have helped me. That would have been good. [Participant 10]

Fear that law enforcement would be involved in the case without the woman's permission kept many women from revealing the violent situation to their primary care provider:

I was afraid that they would involve the police and that then, sure, they could put him in jail and once he got out of jail he'd just beat me up worse. It could be a lot worse next time, so I wasn't willing to

risk that. Most of the time I didn't want to say anything basically for that reason. [Participant 14]

I was more concerned that they would involve the police. And if the police came up there, then it would get worse, because he was already bad-mouthing about "idiots from law enforcement," officials, or anything like that. [Participant 10]

I was worried that it might be reported to the police and would come back to my spouse and there would be consequences for me from my spouse. [Participant 16]

Fear of retaliation was the most frequently expressed reason that participants did not want to disclose abuse. Although most voiced concern for their own safety, worry for the abusive partner was also evident:

I just thought, "Oh, I love him. I love him." And no matter if he hurts you, you don't want to see him hurt. Or you don't want to see him in trouble. [Participant 11]

He [a psychiatrist] said abused partners for some reason always feel sorry for the other partner and that's true. You feel sorry for them. Like I said, I don't want to cause problems for him. [Participant 17]

Although only 2 of the 18 participants were actually asked about abuse in a primary health care setting, the fear that they would be asked was a source of anxiety before the appointment:

Definitely the fear was there. [I was] A little nervous, scared that they were gonna ask me some questions about it. I was scared about that. [Participant 4]

Women made a decision prior to the appointment that if asked, they would not divulge their home situation:

I think probably most of them are like me. They don't want to say anything for fear that they will get it worse. [Participant 14]

They scared. If you tell about it maybe the doctor will, like the doctor will give you help. Maybe the guy will pick up the phone or he'll say, "Who you talking to?" [Participant 6]

Many of the participants acknowledged that they often deprived themselves of basic medical care out of fear of repercussions. A mother of two explained her late entry into prenatal care:

He didn't want me to go to the doctor and he actually got violent about it. So I put it off for awhile. I had been pregnant before so I kind of thought, "Well, I figure it's time," but I thought, "Well, it's better to go ahead and make him happy." And I put it off. [Participant 8]

One woman sobbed as she described the reason that she would not talk to her health care provider about the abuse:

A lot of women won't talk because they are afraid to. They're afraid it's gonna get back. You know when you've been hit in the head so many times, you'll do anything to not be hit again. Even if it means keeping your mouth shut.  
[Participant 16]

The fear of intensified and varied attacks was a powerful reason for women to conceal their situation:

A lot of women can hide it and they do. I know I did. I hid it because I was scared to say anything. Scared of what could happen to me. Scared of what could happen to my kid. And my family. At my work. Everything. [Participant 13]

Retaliation from the abuser was not the only retribution mothers feared. The possible loss of their children was a threat sufficient to keep the violence a secret.

A lot of women are scared that maybe the baby might get taken away . . . that they'll get CPS [Child Protective Services] and that's one thing no woman wants to go through. [Participant 11]

Dramatic depictions of Child Protective Services' interventions make an impression on the viewing audience. Women who lacked first-hand knowledge of this agency feared the rumors and reports they had seen:

You see so many TV shows where all of a sudden they take the child in for a broken arm and then here comes CPS whether you know what's going on or not. I think that frightens a lot of people. I think that perception of what happens on TV, I think that changes what people say and do in the doctor's office. [Participant 10]

One mother, who desperately wanted to know if the injuries she suffered during pregnancy had affected her



baby, ultimately decided not to divulge the abuse for fear of CPS intervention:

I actually thought about doing it [telling the doctor about the abuse] when I was there last Friday. I was going to ask and I had enough time. The doctor asked if I had anymore questions and I was going to ask, kind of tell her, and you know, I had a fear of well, if they found out that I was being abused while I was pregnant they might not believe that I'm not with the guy anymore and they might try to get Child Protective Services involved. So I kind of hesitated. Some people, I don't know, they might tell them to go and investigate or something like that and I didn't want to go through that and I didn't want to take my baby through that. [Participant 2]

Fear of Being Judged.

The participants found more comfort in keeping quiet about the abuse then in telling their care provider and leaving themselves open to being judged:

I did not say things to anyone because I just didn't feel comfortable talking to anyone there [the doctor's office] . . . I didn't feel like I was going to be met with the kind of attitude that I felt like I needed at that time, the kind of support.  
[Participant 14]

Past negative experiences with those inside and outside of health care caused the women to expect to be discounted or dismissed, even when they were wanting someone to recognize that they were in a violent situation:

A lot of times people are very judgmental about women who are abused. I don't think if someone sees a bruise that they should ignore it, like it was just

natural or normal, especially not a doctor or a nurse. Just ask. [Participant 2]

Nine times out of ten the people that you talk to are not gonna understand. They have not been there; they do not understand. Even a lot of women have a real bad attitude towards it like, "Well, you must like it or you wouldn't stay." Or you'll get this real judgmental, "Well, nobody would ever do that to me. If that happened to me one time, I'd be gone. I can't believe you." That type of thing. So it's real hard. I found it real hard to talk to anybody about it at all. [Participant 14]

The women interviewed who had confided their situation to other people were often punished for their effort. These past experiences caused them to question any possible benefit of sharing their circumstance with a health care professional:

I've had police officers say things. They act like, "Oh, you're wasting my time." It can be very discouraging even to call the police. [Participant 2]

It never crossed my mind [to tell the doctor] . . . . I really didn't see how anybody could help and basically it was his word against mine. When I told a friend of mine a little bit about it, it was almost like, "Well, that's no big deal. They're just words." [Participant 12]

These incidents not only blocked disclosure, they also increased the women's tendency to hold themselves accountable for the abuse:

I had an incident at school in the hallway where a teacher saw it [an abusive attack] and turned her head. You have something like that happen, you think "Hey, maybe I didn't do it. Maybe I caused it. Maybe I

started it. Maybe it's normal. Maybe it's okay. Maybe. . ." All kinds of stuff goes through your mind. [Participant 7]

It's degrading when a man hits you. You feel embarrassed. It embarrasses you. It's not your fault and you still feel like it's your fault. [Participant 17]

This is very embarrassing. If you've never been there you can't say, "Well, I would tell." No, you don't know. [Participant 14]

Some women expressed relief at not being screened for abuse in a primary health care setting, because it spared them the embarrassment of answering:

I was trying to keep it quiet and I didn't want anybody knowing, so it really didn't bother me. I was happier that they didn't ask me than to ask me. I still feel real embarrassed about it. [Participant 4]

Other women felt that routine questioning for an abuse history might relieve embarrassment and aid intervention:

I think that if it was a routine question maybe it would give some women the option, because it's easy for me to talk like this, but it's not easy for a lot of women. It has to be that person that you trust, because this is very embarrassing. [Participant 5]

Perhaps the most devastating legacy of intimate partner abuse is the toll that it takes on the survivor's self-esteem. Deep-seated feelings of shame prevented many women from revealing their situation and seeking help:

I think doctors should be more aware of what goes on in the world. That this happens and that women are scared to death. It's a very fearful situation. . . .

It's shameful. It took away all my self-esteem. For me and my kids. [Participant 13]

Even when women had a trusting relationship with a physician, the shame of being hurt by their partner often denied them permission to be forthcoming:

I was starting to have lots of problems with my stomach. You're ashamed to go tell a doctor the real thing that's going on, that you're having problems with your husband . . . . When they see you for so many problems, you say, "It's stress from work." When he gets womanizing with all these women, he gives you a chlamydia infection, well, what can you say at this point? "My husband messes around?" It's just very shameful to go and tell a doctor. I was ashamed to let anyone know what was going on. So I didn't tell [doctor's name]. [Participant 18]

The participants' decision not to tell their primary health care providers that they were living with intimate partner violence was influenced by their past experiences with disclosure, their understanding of reporting laws, and their expectations of help from the health care community (see Table 2). Other factors that prevented disclosure included the desire to protect the abuser from possible harm and to protect the rights of other women.

#### Phase 2 - "Risking Exposure"

Despite their expressed desire to keep knowledge of the abusive situation a secret from their health care providers, the participants were torn between their need to

Table 2

Variations in Phase 1 – “Protecting through Silence”

Influencing Conditions	Participant Statement
Awareness of abuse	I probably would have told him I wasn't in an abusive situation...because I had blinders on. I thought getting hit every now and then wasn't an abusive situation. I thought <u>constant</u> physical abuse was abuse. [Participant 3]
Ignorance of reporting laws	I think they are like obligated somehow to report anything like that. [Participant 14]
Past experience with disclosure	He has a past history of assault charges on him....He got 5 years for assault with a deadly weapon – probation. Another time with a deadly weapon he got 3 years probation. They always give him probation. He's never been punished for his crimes. [Participant 16]
	Some people got concern, some people just not concerned with what's going on in the home.... A lot of people just turn you away. [Participant 15]
Desire to protect other women	I didn't tell my doctor because I didn't want it documented, because of the cancer and all that. I know that they were doing cancer research and I know that because I had battled with mine for such a long time that I didn't want them to say, “Oh, well, we know she was abused” and you know, have that skew the research. [Participant 10]
Participant perception of provider	They are centered in their job. They're centered to do their x-rays, do their check-ups, write their prescriptions, and send you out the door. And collect their money. [Participant 16]
	I didn't think doctors were there to help you with this situation. [Participant 18]

maintain the safety of control versus the need to have someone to share their burden. The health care appointment often became a testing of the water to determine if the benefits of disclosure outweighed the risks. Cues that could tip the balance towards revelation included the patient's perception of her relationship with the care provider, the office environment, and the provider's willingness to hear the news. If the provider was informed of the existence of partner violence, the patient was then highly sensitive to the professional's response. The women were quick to interpret discomfort on the part of the care provider, being "blown off" or judged, or being validated.

Weighing the wisdom of disclosure.

A foundation of trust was frequently referred to as a prerequisite for honest communication about intimate partner violence. A woman being treated for a rare cancer saw a variety of doctors and had come to think of her oncologist as her primary physician. She explained why, when her situation became desperate, she chose to confide in him:

He's the one that I trust the most . . . .It was easy to go to him, because I felt a lot of embarrassment versus going anywhere else. There were others trying to get me to go to the emergency, but I felt more comfortable with my own oncologist . . . . He's a

God-fearing man and that's the reason why I know that he was somebody I could trust, because we both believe in the same maker . . . . It makes it easy for me to talk to somebody that we are on the same sheet of music. That's the reason why I trusted him so much. [Participant 5]

Despite the expressed desire for a trusting relationship with the care provider, too much history with the doctor became a barrier to disclosure:

As close as I was to [doctors' names], I could not tell them. I was too ashamed. [Participant 18]

As far as abuse, I just didn't want to talk to him about that, because he's been knowing me all my life and I just didn't want to tell him. [Participant 3]

Many of the participants said that they thought women would be more willing to confide in a female rather than a male provider. One woman explained her rationale this way:

Mens wouldn't understand about violence. I feel like they don't understand about that . . . . A woman has more feelings toward that than a man does. So I feel if it's a man doctor, he will kind of blow it off to the woman. "Oh, let my secretary take care of that," you know. But if it's a woman doctor . . . a woman doctor feels like women are equals and everything. I feel like a woman doctor will take her time and do it right. [Participant 6]

The perception that doctors did not have time to hear about a violent home situation was cited again and again as a major deterrent to disclosure:

It's unrealistic to schedule people every 10 to 15 minutes and do a thorough examination and take care of their health needs. [Participant 10]

It was the doctor that I didn't really spend a lot of time with. There was really nothing else that would have discouraged me [from telling]. [Participant 2]

Women interpreted schedule pressures as the reason that doctors did not inquire about partner violence:

If the woman doctor didn't bring it up, maybe she wasn't concerned about that or maybe she was just trying to push that person out of the way to get to the next person so she could probably go home. [Participant 6]

The expectation of "assembly line" medicine was often established at the initial visit:

The first time I went to the ob that delivered my son, when I met him I had nothing on from the waist down and that set a big stage. He worked on basic information, "Lay down, spread your legs, find out what's going on, and then you're out of here." [Participant 10]

Another woman spoke wistfully about her clinic treatment during her pregnancy:

They asked if I drink and that kind of stuff, "Do drugs?" That's about it. They really didn't ask a lot of questions just, "How's the baby doing? How are you feeling?" Didn't waste much time. Kind of like, "Hurry up. I've got a lot of stuff I have to do. Just hurry up and get you out. Let's work on the next person." Kind of, "don't get too personal." [Participant 4]

The women were split as to whether reverence for the doctor's time came from the patients or the provider:



They see them [doctors] as very, very, educated, which they are, but a lot of attitude comes through. It's almost like a god complex. "I'm the big doctor here and you're just a little patient. And I'm here seeing all these people and I'm oh so important that what's wrong with you is just sort of a few minutes of my time." And I know that when they see things on TV and movies that doctors in particular are put on a pedestal. [Participant 12]

He looks at me "ya-ya-ya" and gives you a prescription and you're out the door. He's been in there 5 minutes, yet you waited an hour to see him for 5 minutes. And we have to take off work. And we have to arrange our schedule to his schedule. So I think they think their time is more important. It's not the customer's attitude. [Participant 10]

For a few participants, the time issue rested squarely with patients who simply wanted to get in and out of the office visit as quickly as possible:

It's like, "Treat me and get me out of here and let me go on with my little life. The least people know about it, the easier it is for me." [Participant 5]

Feeling rushed in a clinical setting made women hesitant to confide the problems caused by living with a violent partner. The actual physical environment of the medical office also contributed to an atmosphere that was not conducive to confidences:

When you walk into a doctor's office they have all those glass encasements around them. That puts up a big wall of separation, even if it's see-through, because you walk up there and you have to stand and wait for them to open those doors to say it's okay for you to talk to them. Psychologically, that's a blockade. You cannot get through that glass. They

have to open it and give you permission. And so, you're not willing to openly talk to them . . . . That glass is still there, so that it says, "If I don't want to hear you, kwwwt [shutting sound], I can shut you out." [Participant 10]

Failure to provide a private physical space in which to inquire about abuse sabotaged the staff efforts in the few instances where women did report being asked about abuse:

They did ask about it. I lied about it, I think because he was there. I was somewhat embarrassed, but mainly because he was there. [Participant 2]

The same woman reported a similar situation that happened to her girlfriend:

I've had one particular friend years before me who was abused . . . . She went to the doctor, I think she went to a dentist because the guy had punched her in the mouth and knocked her teeth back. Now I don't know, I think the dentist just asked, "Who did this to you?" and of course she lied about it, because he was the same person took her up there! [Participant 2]

One of the participants who worked in a health care setting acknowledged the environmental problems in the way her institution screens for abuse:

That's a common question that's now asked automatically when you go for an out-patient surgery. We have to ask these questions, which before we didn't have to. It is useful, but when there's men around, it will not be. Cause we had one situation where we knew this lady was abused, but the guy was right next to her. [Participant 18]

Many women perceived what may best be described as a "don't ask, don't tell" policy towards reporting intimate partner violence to their doctors. The prevalent feeling was that physicians and staff did not want to hear about abuse. It was taken as an unspoken agreement that "I won't ask about it and I don't want you to tell me about it." When women were not screened for abuse in the clinical setting, the lack of questioning often left the impression that the doctor did not care:

When I was pregnant with my daughter, I went to my gynecologist and I didn't tell them what had happened, but they didn't even ask me! And at that point, it was serious. [Participant 13]

I really thought that I could get help where I went for help...nobody wanted to know why I was there. [Participant 7]

That was something that never came up. They never asked about the abuse. [Participant 5]

It's like my girlfriend, now. She tell me, if she happen to bring it up she might be able to get the doctor talking on it and stuff. But as far as him bringing it up? No, no. [Participant 15]

The doctor always asked you questions. You answer him. You leave. Sometimes I feel like I go to the doctor's and they don't even ask you. Like if I'm sick...they don't even ask you. So I don't volunteer the information. It's like they don't care. [Participant 17]

Even when patients presented with special circumstances like multiple bruises or an adamant plea for

a female practitioner, no explanations were sought by the care givers:

A lot of the times, I did want them to ask . . . . I guess when you are dealing with the medical profession, I guess you expect them to be a little bit more observant about the bruises and certain things like that. But a lot of the time they're just not.  
[Participant 2]

One woman described her scheduling ordeal with a large, public obstetric clinic:

If I had a male doctor, then it was over with. I finally tried to ask for a female doctor and they said, "Well, you know, you're in the clinic, you get whoever you get." I said, "Well, you don't understand. If I'm gonna be here then I need a female doctor. I'll wait all day if I have to." So I go to the appointments and it's all day. I mean it takes 8 hours when you go to the clinic. And then he [the abuser] wants to know where I've been and who I've been seeing and all that stuff. [Participant 8]

When asked how abuse screening might have impacted her violent situation, one woman sighed as she summed up the frustration felt by many participants when intimate partner abuse is not addressed in the health care setting:

People trust doctors. They think a doctor is to be there and would say, "Do you need anything? Is there anything I can do? Are you sure you're okay?" even if they feel uncomfortable [asking] . . . . It might upset some people, but it might save other people to actually ask, instead of saying "You're here for one reason." Like, I went for bronchitis. They just look at the bronchitis. They don't question what's going on at home. [Participant 13]

Interpreting health care providers' reactions.

When women did attempt to confide in their providers, they were often let down by the response they received. Several participants shared experiences where they felt that the abuse was "blown off" by the practitioner:

It's passed off very matter-of-factly. It doesn't affect them. "Here's your information and you know that I think that you should leave this person and oh, by the way, it's only going to get worse."  
[Participant 9]

I went to the doctor and I had bruises on me. I went for a check-up, because I thought I had bronchitis. And I told them what had happened and I mean, they really didn't seem too helpful . . . . He just kind of pushed it off. [Participant 13]

The nurse practitioner was very matter-of-fact and there wasn't much time spent talking with me. It was "Your ankle's not broke [sic], there are no marks on your neck, and here's your x-ray do you want a copy, and here's your prescription." [Participant 12]

If a patient made an honest attempt at communication and was dismissed by the doctor, then the door was closed to further attempts to get help from health care. This woman had a 23-year history of intimate partner violence and had never been questioned about it once during 10 pregnancies. The one time that she did reach out to her obstetrician for help she recounted the rejection that met her effort:

I went and I told the doctor. I said, "Something's wrong with me. I need help." I said, "I feel like killing myself." I told her. And she goes, "Well, do you feel like killing your baby?" because he was a newborn. And I said, "No, mam. It's me." And she said, "Well, as long as you ain't killing your baby, you're fine . . . ." I felt real bad. I felt - misguided. I straight out asked for help and she just flat out said, "as long as your baby..." I guess as long as the baby wasn't in danger what I did with my life - to me it seemed it didn't matter. And I told her and it was a good hospital and she was a good doctor . . . . I knew when I went to that appointment. I said, "If there's anybody I can talk to, it's the doctor. The doctor'll get me help." And it just didn't happen." [Participant 11]

Getting the medical staff to believe what they said was an obstacle to care for some of these women:

Why didn't I tell? Because they thought I was crazy!  
[Participant 7]

Some participants felt that media attention to intimate partner violence had lead providers to question women who did report it and wonder if they were only "crying wolf," as evidenced in the statement of this women:

The doctor acted like he didn't believe me . . . . He really didn't understand how women go through that . . . . I think so many women now use that kind of as a way out, maybe . . . . I don't think doctors believe women anymore. I think a lot of them have cried wolf and they don't believe us. I've been through this numerous times through relationships and this was the worse one and no one believed me. I told them what happened and what was going on and no one believed me.  
[Participant 13]

In an emergency room setting, the staff might be more ready to believe violence had occurred, but their judgmental attitudes not only compromised the care they delivered, but also made women reluctant to seek help from their primary care providers:

It just got to the point I'd go to the emergency room once a week, even when I was pregnant . . . . The nurses up there treated me like I was an idiot, which in hindsight, yeah, I was an idiot. I was 17, but still I was an idiot. I was an idiot for going back to that . . . . It was kind of embarrassing. . . and they treated it as such. [Participant 9]

In recalling her experience with emergency care, one woman said:

I just remember that at that point I really didn't want anybody to be shocked. It was bad enough without them saying, "Oh, you poor thing that you were a victim." [Participant 12]

The reaction she did get to her story, however, was far short of comforting:

The nurse practitioner asked me several questions, "Has this happened before? Describe what happened." She was questioning why I was being seeing for my ankle, because the physical assault was choking and I came in because of my ankle. To escape the situation . . . I jumped out of a moving vehicle. And she seemed a little surprised that I would basically inflict pain on myself. But I explained to her that at that point it was the lesser of two evils. It was either be driven back home where the abuse took place and he continue on with the abuse or him to carry out the threat to kill me, so I opted to get out of the vehicle regardless if it was moving or not . . . . But it just, it seemed like she thought I was a little

bit foolish that I would jump out of a moving vehicle . . . but she wasn't there and didn't know how I felt. Even though you try to explain it, it really doesn't sink in. When you are terrified, some things just don't matter. [Participant 12]

The inability of health care personnel to see the situation from the woman's perspective leads some women to resignation ("I think that they thought I deserved it." [Participant 12]), others to anger, and negatively impacted the health care of all:

The doctor was real mean to me and I was already feeling bad. He was mean to me because I didn't have insurance . . . he was real degrading to me. He said, "You knew what you were doing when you got pregnant. You should have had insurance . . . ." So I had to go through that. So I was already feeling stand-offish from the doctor and then when he [the abuser] came in he was mad, so it's like, "Fine. Let's just go." [Participant 8]

It was a lady doctor and she did ask me how I thought the problem started and I told her, "Well, I think it started when I took a blow to my face." She asked me if I had contacted the police. Of course, being in a domestic violence relationship, a lot of people don't understand that there are a lot of things that are easier said than done when you are the one that is in that situation. I have contacted the police numerous times for abuse. Each time I've been threatened into dropping the charges. [Participant 16]

The most common judgment passed was the verdict that the woman needed to leave the relationship. This was exactly the type of reaction that prompted women not to reveal the abuse in the first place:



There are a lot of judgments being passed and its very embarrassing that you are submitting yourself to this and when we go back after physical abuse it's really a tug-of-war of what you should do. Everybody is telling you that it should be ended and that's it, regardless of whether there is family involved or regard to how you feel. There are more things going on that just the clear cut "he beat you" or "he did this to you" that you should leave. There are more things that apply and have to be considered and people on the outside will only see, "Well, this happened and you should do this." Doctors and nurses and most everybody. [Participant 12]

Even psychiatrists were quick to level the same kind of judgments:

He said that men make you believe it's your fault. Abusive partners always tell you, "It's your fault. You make me do things." But don't believe them, because it's their fault. They're the one with the problem. And you're the one with the problem, if you keep doing it. He said it was my fault, if I kept him, if I did nothing about it. [Participant 17]

A mother of three told her story of judgmental treatment from insensitive primary care providers. It is a story that was repeated in varying degrees by many of the participants:

I went to a clinic one time. I had a real bad black eye and sprained wrist and a couple cracked ribs. It was pretty bad. I needed to go to the doctor because I had an infant to take care of at the time . . . . The receptionist when I went in just looked at me and kind of shook her head and I thought "Well, what is this about," but I just chose to ignore it. Then I overheard her saying to this other lady, something like "This is the 3<sup>rd</sup> or 4<sup>th</sup> one this week and all of them are dragging little kids with them and putting these kids through all this mess and what's wrong with

them and why don't they just get out and I would never put up with that type of thing." All this! I walked out. I mean, I just left. I just started crying because I couldn't stand it. Oh, the thing that got me was, it was not the receptionist that said that, I thought she was the receptionist, so I figured I could deal with it. It turned out she was the nurse, and I left. "Oh god! She's gonna be talking to me! She's gonna be examining me!?! Oh, forget it." I just couldn't deal with it, so I just left. And I just suffered through it at home. It was awful. I was in a lot of pain, especially with my ribs. But I just couldn't handle it. That was awful. I thought that was really cruel. [Participant 14]

Several months later, the same woman tried again to get care from another office:

I went to another doctor . . . . The nurse seemed kind of sympathetic and stuff, I had obvious bruises and things, you could see something had happened. She didn't ask. She seemed sympathetic, but then when she went out in the hall she was talking about it and she was saying, "Well, I wonder if this one is gonna lie to us or if she is gonna confess. It's pretty obvious somebody smacked her around." I thought, "Here we go again." [Participant 14]

Some women who risked telling their health care providers about the intimate partner violence found a compassionate response:

I told the nurse and she asked me if there was anything that they could do, if I needed anything and I told them no. I told her I didn't want it written down. I just wanted them to know for whatever they needed to know. [Participant 10]

He was worried about my health, so he did all the vital checks and everything and noted the abrasions on my body . . . . He was making sure that everything was okay with me, with my body first. And then we

went into the talking and he listened to what I had to say. And I like him because he gives advice also.  
[Participant 5]

Sometimes it was the provider who reached out to the patient, like this physician who showed special interest in a gentle, unassuming lady:

She had felt my shoulder and I told her it was a little bit sore. And she asked me what had happened and I told her. She acted like she was concerned more than any of the other doctors during my pregnancy and after the pregnancy. She just seemed like she really wanted to hear about the situation . . . . She said I was a nice, sweet, kind person and that's what I liked about her . . . . I thought maybe she couldn't tell [about the abuse], but she did by my facial expressions. She could tell. I wasn't going to say anything. I was just going to be quiet about it.  
[Participant 6]

Sometimes the providers acted on their own index of suspicion, like this labor nurse who recognized cues from her own experience:

The nurse in there noticed some bruises on my arms and my legs and she was really cool about it. She actually was ballsy enough to tell my ex, "Look's like you're gonna have to leave or I'm gonna have to call the cops." She was very pleasant with me... The old nurse just kind of figured it out. She said, "He did it?" It was one of those, "Yeah, I had a boyfriend once that used to hit me." I said, "Really?!" She says, "Yeah, I had bruises all the time . . . ." And lo and behold, even though she was a L&D nurse, she came up to my floor every day. Every morning, every evening. Checked on me. The day that I was going home and everything she said, "You know, you don't have to go back into that." Long story short, I did. She told me about some places. She's like, "There's

places out there that can help you." And she told them to me. [Participant 9]

Sometimes the break in the silence came from unexpected providers:

I've never had a doctor ask me if I got beat up, except for one doctor, but he was a psychiatrist. I used to clean apartments and houses. I went to his office that day and I tried to hide from him. I went on a day that the place was closed. He had walked in there to get something and he saw me and he sat down and talked to me. [Participant 17]

The factors that determined whether or not women would confide in their health care providers stemmed from a variety of influences (see Table 3). Ethnic background, providers' personal history with partner violence, and patients' prior support from medical personnel accounted for some of the differences in disclosure.

### Phase 3 - "Coping with Consequences"

To soothe the stress of the health care encounter, women utilized a number of coping strategies to create comfort. When attempts at disclosure had been rebuked, the participants rationalized reasons for the rejection. Consequences of nonintervention were grieved. Interventions that empowered women were celebrated as beginning steps towards regaining control of their lives.

Table 3

Variations in Phase 2 – “Risking Exposure”

Influencing Conditions	Participant Statement
Ethnic expectations	<p>Most black women, what they’ll do is listen to the man and they don’t believe in going and telling somebody else. [Participant 5]</p> <p>For Hispanic women...men are always the power, the earner. And you’re a always taught to be submissive. ‘Give me this, serve me this, bring me this, do this for me.’ That’s just how it goes. [Participant 18]</p>
Participant’s past experience	<p>Sometimes I do get angry with doctors, most of the doctors, because you go in there... and it’s like they don’t believe you. After I had the epidural, when I had my baby, I had migraine headaches. The nurse came in and told me, ‘You just don’t want to go home and take care of your child.’ That’s what she told me! She said I was making it up....I always think about that nurse that told me I didn’t want to take care of my child. [Participant 17]</p>
Provider’s personal abuse history	<p>That’s when I got my valium prescription....The doctor, as soon as she found out why I was asking for that, her attitude changed to being more open and receptive. She’s from Ireland and she had been there herself. [Participant 9]</p>
Deference to physicians	<p>I think people would be more comfortable talking to a nurse or one of the other medical professionals than the doctor, because they are busy people and can’t really be bothered, so they don’t feel comfortable doing that. I know that people have told things to the housekeeper, because they are not threatening. They see them more on their level. [Participant 12]</p>

Rationalizing rejection.

Being ignored when you are in distress adds insult to injury. Some participants took the sting out of the health care providers' apparent disregard by rationalizing justifiable reasons that their needs were overlooked.

Although the participants tended to approach their health care appointments determined not to reveal intimate partner violence, they were none the less troubled when no one asked them about it. "Lack of time" was the most common reason given to explain why the subject of abuse was not addressed:

I think the main important reason is time. Time is not on their side. They need to get down and find out what's wrong with that patient. Time won't permit it. Insurances won't permit that time for the doctor, especially with the HMO policies nowadays. I think they're too busy. I think the insurance companies - "How many can you get in and out?" I really think that's it. They're afraid it takes too much time. They don't think about it. The logical thing is maybe they're not taught that, but even if they were taught that, they don't have time.  
[Participant 3]

Maybe they don't have time [giggle]. Maybe they have like too many patients [laughter]. Nine out of 10 of them have too many patients. [Participant 6]

Physicians were also excused for not inquiring about abuse on the grounds that they were trying to protect their patients' privacy:

Maybe they thought I'd automatically let them know . . . or maybe they just think I didn't want to talk about it or didn't want anybody to know about it maybe.  
[Participant 4]

Doctors probably don't ask because they don't want to violate their [the patients'] privacy. I think they don't want to get involved. [Participant 14]

Some people may not feel comfortable with what's going on in your life. They feel like they shouldn't intrude in your life. [Participant 15]

Others were less charitable in excusing the doctors.

They attributed lack of abuse screening to a simple lack of caring:

For some doctors, it's just cut and dried. That's something that somebody else should handle. This is about the doctors. "I'm here to treat you for what's going on with you. Your personal life - that's somebody else's area." [Participant 5]

I don't know if they don't care, they don't think about it, they don't think it's a big problem, but it really is and they don't take it seriously.  
[Participant 16]

Fear for the physician's own safety seemed a plausible concern to prevent their intervention with intimate partner violence:

I think doctors are afraid to get into it. It's just kind of a sticky situation. If they ask the wife, "Is there violence at home?" and the wife goes back and tells the husband . . . . I don't know how they could ask it . . . but I wish I did. [Participant 13]

Let that person be counseled in another room, but let the doctor continue on with his medical treatments

with the patient. That won't hurt him with his time, plus the fact it will keep him out of the fray of being accused. You know, he doesn't know what these crazy men are gonna do. They may come up and shoot the doctor just because he questioning his wife.  
[Participant 3]

Some of the women rationalized that doctors just assume that women would lie about abuse or disregard their advice to leave the abuser, so that there was no point in asking since the doctor's effort would not change anything:

They might not ask either because they don't care, or they don't have enough time to go into it, or they don't think she'll admit the truth anyway, so what's the point? [Participant 2]

I guess they probably feel like I'm feeling. They gonna lie. Most women that are abused, that's the first thing they do is lie to protect their abuser. And they think, probably, "That's not my specialty."  
[Participant 3]

It's kind of a sticky situation for the doctor to come out and ask, "Are you being abused or not?", 'cause if you were violated, a lot of women are going to say "No . . . ." I might have tried to hide it. But there are ways that they can go around and ask you.  
[Participant 13]

This woman, and many others, showed insight into a common health care provider perspective on abusive intervention:

If you're on the other side of the table and you're the person that's listening and it's like, "Why are you taking him back?" and this person either doesn't know or tells you, "Well, I can't do this. I don't have an education. I can't get a job. He's all I've ever known. He's always taken care of me. We've been



together 20 years. We're raising kids." And you don't understand why. You're reluctant to listen to this person every time they want to tell you, "Johnny beat me up this weekend." "Well, whatever, because you're gonna go back, so why continue to tell me?" Sometimes I think it's just that people don't want to keep hearing that you are continually going back to this person . . . . After awhile it gets so old, people are like, "You're not serious . . . . You isn't gonna do anything about it. You just want somebody to hear you out." [Participant 5]

A mother of three eloquently summed up all the rationalizations that the participants used to explain why care providers neglected them in the area of abuse:

I think a lot of the time somebody feels like, "Well, she didn't come in for that, so I have other patients to see and we'll just deal with what you came in for because I don't want to spend any more time with her than I need to." Maybe sometimes they feel like it's not something that they can do anything about. And they figure, "Well, even if I mention it she may not take it, so what's the point?" A lot of people do give up on women who are being abused. I've heard a lot of different things even from my own family. I just think sometimes they may not care, because doctors and nurses are just like everybody else. They have their own opinions. They judge like anyone else would. So a lot of them just don't care or they may just assume that she doesn't feel comfortable discussing it and "I'll let her bring it up." You know most women that are abused are not going to bring it up unless it's the reason why they came and then even sometimes in those cases they will lie. So they might feel that the woman is going to protect the person and they're not gonna get a straight answer from her anyway. [Participant 2]

Without saying a word, the women sent out signal after signal that something was wrong that the doctor was missing:

Looking back on it now, I think people should have picked up on the trouble. [Participant 7]

Missed appointments, chronic headaches, depression, and sexually transmitted diseases were all "symptoms" of intimate partner violence that were overlooked in the clinical setting:

My husband doesn't carry insurance on me... . . . so there are lots of times that I've needed to go to the doctor that I am unable to go to the doctor.  
[Participant 16]

He just asked if there was lots of stress and asked me if anything at home was bothering me or something like that. I was constantly having headaches. So he said it was probably basically stress that was bothering me at home. And what it was was my ex-boyfriend with those beatings and not being able to work and wondering about how you gonna pay the bills and stuff like that! [Participant 15]

Nobody really addressed the emotional aspect that I was going through and I think that's part of the reason why I thought nobody really cared . . . . I was very emotional when I was there [the clinic], much more I think than a lot of the other people who were there.... I really felt like I was crying out for help at certain times...but no one asked, "Why are you acting this way? Why are you crying all the time? Why are you not eating? Why are you moody all the time?" Nobody really asked me "Why?" they just "treated" me.  
[Participant 7]

He used to fool around on me. When I was 14, 15, he'd fool around with women who were 33, the kind that hang

around the rivers and trains and stuff. And that's when I got syphilis. He got something and gave it to me. [Participant 17]

The only "symptom" that the health care providers seemed to recognize were bruises:

I don't think they would think to ask unless they actually saw the physical marks on you. [Participant 4]

Bruising could easily go unnoticed as these 2 participants testified:

The hospital, they never really looked me over all the way. On the clinic visits, it's like discussions. They ask me how I'm doing. It's the normal routine. They never really looked at my body. If they would have, they would have known. [Participant 11]

A lot of the times I would have a bruise on my arms, but I would always wear certain things to cover them and no one during the whole time I was pregnant did they ever ask about any type of abuse or nothing like that. I guess they didn't see any signs or symptoms or anything like that in all the times that I was there. I might wear a jacket. During that time it might be kind of hot and I would wear something long-sleeved. I wouldn't be examined every time, so I didn't have a problem going in there like that. [Participant 2]

These survivors are only too aware that the marks you can't see are the ones that leave permanent damage, as this participant tearfully explained:

A lot of your abusers will abuse a woman just enough to hurt them, but not enough for it to be visible. So there is a lot that people don't see, that they're not aware of, because you don't have a big black eye. You say "family violence" and they think we're supposed to

be beat up to where you can physically see it and that's not the only way you can be beat up...[crying harder] the emotional damage . . . that's there.  
[Participant 16]

Grieving opportunities missed.

Failure to identify intimate partner violence and to inform survivors of their options had costly consequences. Without support, without knowing what rights they had and what resources were available, the abusive situations continued unabated. As a result, these women endured years of related physical complications, survived through ongoing violence, and witnessed the toll it took upon their children.

The participants suffered from a variety of physical problems as their violent relationships continued:

I had ulcerative colitis which is stress-related and that was definitely a part of it. When we'd argue, I'd get a flare-up . . . . I was doing the best I could, following my diet, trying to exercise, doing anything they'd suggest, taking my medication . . . . I'm starting to see some slide backs where I do have problems and a lot of those are related to confrontations I've had with him. [Participant 12]

The Bell's Palsy . . . . I knew it was related to that, but I didn't dare say about it. [Participant 18]

When they told me that one of the reasons I was bleeding was because of having sex, I didn't tell them that it was forced on me. They told me like how to better lubricate and different things, so that when I was having sex it wouldn't do that. I just didn't

tell them that it was being forced on me and that I didn't have any control over that. So, I knew what the problem was and that helped me get my first protective order. Knowing those things helped me out in the long run, but it didn't help my medical treatment. [Participant 10]

For other women, chronic violence took a mental toll:

[When] you've been in it so long, it seems like it kind of takes your mind a little bit. You can't really think and I'm forgetful a lot. And I feel like I'm too young to forget so much. I feel like going through what I went through for years got me to where I am today where I can't even think like I want to. [Participant 15]

It was especially painful for mothers who realized that their children were the ones who bore the brunt of the prolonged abuse:

My oldest daughter, she's sad a lot, so I sent her to counseling . . . . They wanted to know what was going at home, "Does she play with her friends, with her brothers and sisters?" and different things like that . . . . They put her on a medication called Zoloft, I think . . . . She started acting better, but I think it was what was going on in the house, the violence . . . . You keep going through the hurt and anger, you know? And the kids see you going through it . . . . Basically, that's the hurting part for me, when the kids see what you're going through. The lady that just killed herself and her daughter? My daughter was a friend of hers. It's sad because the mother was having an abusive relationship and had been through so much and she felt like her daughter was going to go through it too, so she took her daughter life. [Participant 15]

One of the gravest outcomes of unidentified partner abuse occurred to a teen-ager who had an abortion because

she thought it was the only way to free herself from a violent boyfriend:

I really wanted someone to talk to me, because I really didn't want to do this. But I felt like if I didn't do this - I really thought it was my only option, because I couldn't be tied to him anymore.  
[Participant 7]

The participants grieved the years lost because they simply didn't know about their options. They saw that health care providers had had the opportunity to inform them of available resources and had neglected to do so:

A lot of times they just patch you up and send you on your way and you right back into it and you don't know what's out there available to you. It's like you have to seek it out on your own. And sometimes that can take a long time. I know it took me two years.  
[Participant 16]

I didn't know better . . . . I didn't learn at the beginning, when I needed to go, like when my daughter was growing up and stuff. I didn't know better. I didn't know better. [Participant 18]

The women speculated on how their lives may have been different if their primary health care providers had told them how their medical record could be used as a legal tool and had given them referrals to law enforcement, legal, and social services:

It might have made a difference. For other people it might make a big difference. . . . It would have helped me a lot. It would have helped with my divorce. It would have helped with my first protective order. It would have helped now.

[Increased banging on the table after each sentence].  
[Participant 10]

It [the length of abuse] might have been shorter.  
Much shorter! [Participant 13]

I think it would have helped me to see how my life was  
going and how to better myself and the kids.  
[Participant 15]

Maybe I know about this kind of a place I would have  
gone to that place for a long time than to wait until  
I'm being hurt. I didn't know anything about a  
shelter or something like that . . . . I was saying,  
"Oh, I wish I knew this kind of place was existing and  
I should have solved my problem for a long time." But  
I cannot but be thinking that I never know this kind  
of place was there. [Participant 1]

Many of the women cried softly as they revealed how  
desperately lonely they were during this time and how they  
had longed for someone to talk to about their situation and  
how disappointed they were not to find that support from  
their care providers:

I was scared, so I tried for the medical thing. And I  
wanted someone to listen to me. Just anyone to listen  
to me. I just wish they would have knew what was going  
on. It's hard to tell someone that somebody's mean to  
you . . . . That does kind of bother me that they  
never knew. [Participant 13]

Everybody used to look at me and say, "You're so sad."  
But that was it. If they had gone further with me...if  
someone was there to reach me, to talk to me . . . I  
hope someone will be there for my kids. [Participant  
11]

Sometimes we don't have anybody to talk to. You  
cannot deal with it. And it's just kind of building  
up, building up and you don't have anybody to talk to.

You don't know how to deal with it, constantly being in that relationship. [Participant 15]

Celebrating support.

When medical staff identified an intimate partner violence situation and responded by offering resource materials, they opened the door for their patients to take control of their lives again:

She was the nicest doctor. She was considerate. She told me about this place [Family Violence division of the District Attorney's office] that I didn't even know . . . . I didn't even know. I didn't know about that. [Participant 6]

One participant got the information from the medical institution in which she worked:

We started having all that material [from a women's shelter] upstairs and that's what educated me. That's what made me decide to go. The material that was laid out grabbed my attention. It took me that brochure to really learn that I could get help somewhere. [Participant 18]

The women drew strength to make changes from the validation and encouragement that they received from caring staff:

They would give me encouragement and that helped me a lot, because at times I feel like nobody cares . . . . She gave me a leaflet that you could read. Those words were very encouraging words to me. And by the time I finished reading it, something new started developing inside me. [Participant 1]

She shared the agencies that I could go and talk to the person about it and she gave me a bunch of



numbers. And she gave me pamphlets on domestic violence. She just gave me some encouragement, telling me to take care of myself. You know, 'Don't let that man do that to you, because it's not right.'  
[Participant 6]

The few participants who had received support from their health care providers expressed deep appreciation as they shared what they had done to regain control of their lives. One woman was helped by her nurse:

She helped me to get clean. That I could get through without drugs. She helped me go to court.  
[Participant 9]

Another woman shared the efforts made by her obstetrician:

She just was real comforting. She talked to me about domestic violence and then she convinced me to talk to somebody about it, because I wasn't gonna talk to nobody about it, I was going to just keep it at home . . . And she told me to talk to this lady at the abuse clinic and I talked with her about it.  
[Participant 6]

A maternal/child health educator provided the impetus for this mother to take action:

I went to the clinic and they had like a session and it was free when you were waiting in the waiting room, there was like a seminar or something. And the lady from the [local women's shelter] came and she goes, you don't have to say your name or nothing, but she explained that they were there for me and that was the first time that I knew that I had help. She gave everybody a card, everybody, no matter what. And I was one of the ones that the next time he abused me I called that number and they got me out of the house

and my kids and that was real good . . . . That's what got me started help for myself. [Participant 11]

As the participants struggled to salvage some comfort from their health care encounters, they were affected by a number of conditions. The coping strategies they employed were influenced by their openness to intervention, their care providers' sensitivity to abuse, and the support they received from other sources (see Table 4).

#### Phase 4 - "Helping Other Women"

##### Sharing information.

There was a particular officer that came out one evening over one of our domestic fights and he gave me a little blue book with numbers and just told me that "there's help available" and there's "a person that you can call to assist you, when you are ready to do something about this." He opened the door for me, by just letting me know. That's not something you get when you go to the doctor. And I think that that's something that should be there. [Participant 16]

Precious few of the women who participated in this study reported helpful interactions with primary health care providers, but all of the women felt strongly that these appointments should be therapeutic and they were eager to tell professionals what should be done "to make it better for other women." Sharing their ideas, feeling that their input might help other women, empowered the

Table 4

Variations in Phase 3 – “Coping with Consequences”

Influencing Conditions	Participant Statement
Provider’s sensitivity to cues	<p>I always thought, well, maybe it’s because they are in such a hurry that they’re not noticing that I have this bruise on my arm or why I’m wearing long sleeves and it’s so hot outside. I just assumed it was because they’re so busy. I understood that, them being busy. [Participant 2]</p> <p>When I got that beating, I said I slipped in the kitchen. I lied.... and they believed me! I mean, they believed me! I have found that women lie, when they are actually hurting. [Participant 18]</p>
Participant’s openness to intervention	<p>I’m glad they didn’t ask me [about abuse]. I’m glad they didn’t, cause I just would have felt worse about it. More guilt. I feel real guilty. [Participant 4]</p> <p>I was kind of hoping they would have some information on the bulletin board or something, because...I was pretty new to this town. I didn’t really know anybody or anywhere to go or anything, so that would have been real helpful. [Participant 14]</p>
Support from other sources	<p>The most influential person that I met that whole time was a man from the Protective Order division <u>to protect women</u>. He came out to talk to us. He didn’t come out to talk to us about <u>us</u> he came out to talk to us about our students and their parents and how to help <u>them</u>, and <u>I</u> learned from it. But I didn’t learn anything like that from doctors. [Participant 10]</p> <p>It [resource information] was well received from the police officer. It would have been nice if someone who was in the caring profession had helped with that part of the caring.... It would have been nice if one of them could help me out. [Participant 12]</p>

participants and helped to create comfort from their own experiences.

As overwhelmingly as the participants approached their appointments determined not to tell about their intimate partner violence, that is how strongly they were recommending that medical staff ask about abuse:

I think they should just ask about it. I really don't know any other way to inquire about it, but just to come out and ask. But ask in a caring way.  
[Participant 10]

The participants saw inquiry about abuse as a first step in helping those who were in denial:

He didn't hit me ongoing like some women. He never did that. He never really be mean to me or tell me "You're ugly" or "You can't have this" or nothing. It was just only when he did coke. [Participant 18]

Routine screening was seen as a way to jolt these women into recognizing the seriousness of their situation:

Sometimes you are not aware what's going on until someone actually asks you questions and you get to thinking and you go "No!", but then you think about incidents. Maybe if there was a routine thing to ask women, maybe the little red light would come on inside. Now that I think about it, there were signs . . . If it had constantly came up, it would make me think...and maybe it would have not escalated to this.  
[Participant 5]

Given the high rate of sexual abuse that accompanies physical violence, it seemed particularly pertinent to

screen patients who presented with gynecological complaints:

They never asked about things at home. Never. I guess they should, because a lot of women do go there because they have problems, sexual ones, with their husbands. I've heard people who have been there tell me things their husbands make them do and they won't leave them because they are afraid to leave them. It freaks me out. [Participant 17]

The participants suggested that routine screening for partner abuse would make it easier for women to request assistance:

I think if someone probably would have asked me, I would have asked for help. [Participant 7]

They voiced the opinion that acknowledging that intimate partner violence affects the lives of lots of ladies would give women permission to share their own situation:

It makes you want to tell someone else. I wish I did it a long time ago. It would have been a lot better than waiting 'til the last minute. [Participant 4]

[If women were asked about abuse] a lot more of them would say why they are there, would get the kind of treatment they want, and might have the courage to speak out and say, "Hey, I want something done about this. I need some help. Me and my kids need to get out of the house. This guy is like beating me up regularly in front of the kids." Or whatever. "I'm scared for myself, I'm scared for my kids . . . ." I feel like when you go to your doctor's office you should be able to get help like that. [Participant 14]

Put it in their heads. Or give them the idea. Or give them the option. "Do you have problems?" I think maybe more women would speak up. [Participant 17]

Again and again, the women emphasized the necessity to repeat the inquiry and offer referral information at each appointment:

If they were asked, I think it would make a big difference . . . . It might be the first visit, it may take up to the fifth visit, but someone letting you know that there are signs, that they are concerned about your welfare, that may make that person at ease and that will help that person to go on and take the next several steps. [Participant 5]

Along with "putting it on your mind" the participants also stressed "putting it in writing." They felt that the key issue was putting information about reporting laws, medical documentation, resource numbers, and emergency plans into each and every woman's hands. Written literature was seen as a sure way to inform everyone, even those who might deny an oral inquiry about abuse:

It would be more important to get information about options, because a lot of women will not say [they need it]. [Participant 18]

I don't think anyone would reject any information, even if they did deny [being abused] . . . . I don't think anyone should be offended by any information. [Participant 2]

If somebody asks...I would say that would do it. But they might be more inclined to read it. And if they have it in writing that "We are not permitted to tell

on them. That is up to you. In the event that you want or decide to get a divorce or you are going through protective order situations, documentations now will help you then." If they see it in writing, they'll believe it more than if I just said, [spoken in falsetto voice] "I'm the doctor and you can tell me anything. It won't go any further." [Participant 10]

Several of the women who had children felt that this was an especially important approach to use when seeing pregnant patients:

Maybe if they had asked me if I'd been abused, I could have denied it. But they could say, "Well, if you are, it effects your unborn child. You don't have to discuss this, but if you are being abused, it can effect your unborn child . . . ." Then give them some brochures or something about domestic violence and how it effects the unborn child . . . . I think that really would have helped. I'm the type of person, I take brochures and I call the numbers. At least I read them. [Participant 2]

Some liked the idea of addressing the topic of intimate partner violence through a questionnaire:

Put something on a questionnaire, like some of the symptoms that the men have - ridicule, embarrassment, get angry very fast...and questions, "Are you being abused at home?" "Does your husband call you names and embarrass you?" "Are you scared of your boyfriend or husband?" It's optional, if they want to . . . . I'd feel comfortable with doing that. Volunteering's not real easy, but I could fill something out. Then [they could be] helping you from there and giving you more information, like where to go and how to find someone to help. [Participant 4]

The participants offered a variety of creative ways to post or distribute written information. Including intimate

partner violence in a general folder on women's health issues was suggested as a way to help both providers and patients:

The doctors are so busy now, I think you should have a packet when you come in for your pap smear and stuff...that lets you know about the most common injuries or diseases or problems. [Participant 18]

Posting information was enthusiastically encouraged:

Having the information in the bathrooms would be great! . . . I think clinics and doctor's offices really need to have, most of them do have, bulletin boards. If they don't have a bulletin board, they need to put one up, and have just like a list of places to go for help for all types of situations...a general referral list. [Participant 14]

Many women called for dramatic posters in the waiting room to catch attention and break through denial:

When I see commercials on TV about domestic violence, that raises my brow. If there were posters showing the actual abrasions to a female of different races, I believe that a woman would see herself and maybe something that in effect tells them, "This is you. You can stop this, if you . . . " letting them know this is confidential and this has to stop. When I went to the office to get the form to fill out for my Protective Order, I saw the poster on the wall that says, "He beat me 150 times and the only time I got flowers was on this day." It's a casket and flowers is on top of the casket! I knew then I was not gonna turn around because that raises your brows like you don't want to die . . . . So many people are in so much denial, if they could just see that or something that says, "You've got to do something about this." I think that would kind of raise their brow of a lot of women. I could be wrong, but it would make you think. [Participant 5]



Women were willing to acknowledge their role in honest communication, but that they were also willing to point out the health care providers' responsibility:

It bothers me. Part of it is my fault, though, because I didn't say anything. But I don't know how they could have let me know those things, unless they posted them in the office or had some reading materials that they handed out to every person that came in. You know, like when you're filling out all those thousands of forms that you have to fill out, if it said "Tell us. These are the rights and responsibilities that you have. These are documentation tools that can help you if you are going through any of these symptoms. Ask me." [Participant 10]

Conveying concern.

The participants offered specific behaviors that doctors could use to set the stage for open communication. Body language sends a powerful message. To convey that the clinical setting was a safe place to share anything, the women had these suggestions:

If they greeted you and shook your hand and made eye contact, that's a big important thing. Also, sit down, even if it's just a minute or two interview for your annual check-up or whatever. If they sat down with you, it shows that they're not rushed and trying to get out the door. Just having good eye contact and good posture and showing that "I am listening to you. I am concerned about you. I'm here for you." [Participant 12]

This woman further recommended that physicians follow her business practice for making clients feel comfortable:

I've said to people, "You're the reason why I'm here. Without you there would be no job for me. You are very important." [Doctors should do] something like that to show that they respect that you came to them and that they want to try to help. A lot of that is body language, breaking the barriers that say, "I'm the super doctor, but I can shake your hand and tell you my name and say, 'Hello, Mr. or Mrs. Jones.'" And they don't have to sit across the desk. They can sit next to you and be a little more personal, not so authoritative. [Participant 12]

Phone etiquette was another issue the women addressed:

Just having the actual doctor make the phone call back sets a doctor connection, not just a relay of messages. That personal connection makes a big difference. [Participant 10]

One woman counseled doctors to be particularly alert for phone cues that could signal a violent home situation:

Pay attention to what she complains about on the phone. Sometimes a person will throw something out to you over the phone while she's in an abusive situation, but she's just afraid to say, "Look, I've been beaten today, but I need to come in because my arm's hurting." [Participant 3]

Women presenting in the office may also be afraid to say something. Many participants agreed with the suggestion that providers should look at their patients:

They might have you put on a gown or something . . . . That would have made it more impossible to hide stuff. [Participant 2]

Another proposal that was often repeated was to provide a person on site to counsel survivors of intimate partner violence:

I think they should have some type of certified psychiatrist or psychologist there, some social people that have been in sociology or something like that. They can get some type of license to give them information so they can question people. Let that just be a job and have an office for them within the doctor's office . . . . The doctor and that person work together for the good of that patient . . . . In the long run it would help our community. I feel like it would cut down on a lot of costs, expenditures, and it would just help the community as a whole.  
[Participant 3]

With doctors, a first start would have been to have someone like a therapist there. [Participant 11]

Doctors do not think that this is their job. The nurse practitioners should be the ones to talk to the women. This is very important and nurse practitioners could be the way to get this information to all women.  
[Participant 18]

The idea of an on site advocate was enthusiastically endorsed by this woman as well:

I think that there should be somebody on staff, I don't care if it's a nurse, I don't care if you give them a whole brand new title, and just put them in there at a desk and maybe do paperwork unless somebody comes in that they think has been battered and then they can bring them in to talk to them. I don't care what you call them, social worker, whatever you want to call them, just to be available to talk to people that they think are in this type of situation.  
[Participant 14]

To create a caring climate, the strongest advice that the participants had for physicians was "Pay attention":

The doctor needs to pay more attention to what we are saying. [Participant 17]

It would be nice, if they can actually make you feel that you are the only person in the world right now and you're what's important to them right now. And if you need them, they will sit there and listen to you a minute or two and at least let you express what you are feeling, what you are thinking. It may be beneficial to your care. [Participant 12]

When doctors communicated that they were willing to take the time to listen, they invited confidences:

The people at the V.I.P. [Victims' Intervention Program] Clinic, they pay attention. They listen more, everything you got to say . . . . Yes, it was really very different. They cared for me. [Participant 1]

When asked what her health care provider could have done to make the appointment more helpful, this woman's answer echoed the voices of her peers: "Have someone to talk to probably. Someone to listen." [Participant 7]

Knowing how to listen was the first step. Knowing what not to say was the second. This police officer modeled insensitive communication:

He's learned how to abuse without leaving physical evidence behind him, so when a police officer comes out he can say, "Oh, I didn't touch her. She's crazy. She's on Prozac." He always tries to blame it on that. "She's just a lunatic. She sees a psychiatrist. She's crazy." I'm not crazy. I had one officer ask me, recently, "Mam, have you had your medicine today?" I just wanted to hit him. I thought, "You idiot. You have no clue. Prozac doesn't work that way." And I felt like he was defending my husband and pointing the finger back at me. I thought it was wrong of him. He was out of line to say that to me, "Have I had my medication today?" "Well, maybe if you took your

medication he might not feel like this. Why don't you go ahead and take it and see?" Prozac takes weeks to get into your system. This guy did not have a clue. [Participant 16]

The participants offered a primer for providers at a loss for words. For those who were clueless on how to initially ask about intimate partner violence, one woman offered this basic advice:

The word "abuse" itself is very offstandish. If you ask them, "Is there a lot of argument at home? A lot of tension at home? Is there problems at home?", words other than "abuse," I think you would get a better response, a more honest response. But if you just come right out there and say, "Well, do you get abused at home?", well, most people think it's physical. There are other types of abuse and lots of people don't think about it. Like the thing about harming your pet. That doesn't sound like abuse to you, it's abuse to an animal, but that's abuse none-the-less and it could relate to you very quickly. People don't realize that kind of stuff. . . . Ask them, "Are things okay at home? Are there any problems?" If you have open-ended questions like that and this person knows that you are interested in their well-being, it would make a difference. [Participant 12]

This indirect approach was advocated as a way to ease women into a discussion of partner violence:

I feel like doctors should have some concern and say, "Is there another way I can help you? Is everything going great with your family?" or something like that. Just kind of get started like that and basically kind of get comfortable with talking about it. And let you know that they can give you referrals or they're there to help you or something like that. [Participant 15]

Fishing with vague questions was a frequent recommendation, but at least one woman acknowledged that it might not net results with everyone:

Beating around the bush doesn't always get you there. But it was the long way around that made me feel more comfortable. [Participant 9]

The participants stressed that providers needed to be observant and respectful of the patient's demeanor and gently invite them to confide their concerns:

"Why are you afraid? What are you afraid of?" I think if anybody would have just asked me what was going on with me, instead of telling me what was going on, it would have made a big difference. [Participant 7]

When you see somebody, when they come to the clinic, you look at the person. You know that the person is very, very distressed. You can ask the person, "Do you want to talk about it? Do you want to share what you passing through with somebody like me?" [Participant 1]

Once a health care provider became aware that the patient was dealing with intimate partner violence, the participants offered these comforting responses:

Encourage them that there is a way out. There is help available, even if you don't have the funds . . . . I think a lot of people are not aware that there are programs like this [a women's shelter] out there. I didn't know. [Participant 16]

Just mention what she can do to help herself. Whenever she feels ready. [Participant 4]

She [the doctor] just said, "You don't deserve that." I think when people say stuff like that, that's helpful, because it let's a person know that you don't deserve to be treated like that. No one has the right to use your body as a punching bag. I don't think it would hurt a nurse or a doctor just to talk to them like that. Even if they don't want to admit it or it sounds like it's not the truth, just say that, "There are people that are in your same situation that want to help. There are people out there that can help you. You don't deserve that. You're better than that." Just talk to them like that. [Participant 2]

If a care provider felt awkward discussing intimate partner violence, the recommended response was to admit their discomfort:

If you're uncomfortable say, "I don't know what I can do for you. Let me know what I can do for you." At least give a little comfort. The nurse acted like she didn't know what to do with me . . . . I think it would have gone over better if she said that this topic made her feel uncomfortable. It wouldn't make me feel so victimized again. I can understand that people have taboos about this or are afraid of this subject or shocked by the subject. It's easier, if you know where they stand. [Participant 12]

The essence of conveying concern was movingly captured by this tearful participant:

If they see a woman come into a clinic, no matter how the person looks or how she talks, you should really be open to care. You may not personally like how she does the marriage life these days in her relationship. But if you see a woman, you need to be ready to trust and give a little help to that person, because that little help means a lot to the woman. [Participant 1]

The participants' suggestions on how to improve primary health care visits for other women reflected their

personal experiences and beliefs. Variations in their recommendations can be attributed to personal preferences regarding written versus verbal information, value placed on education, perception of the provider's role, and other factors (see Table 5).

### Summary

This chapter used participant statements to illustrate the four-phases of "Creating Comfort," the process utilized by survivors of intimate partner violence to resolve their unsatisfactory experience with primary health care visits. The women approached these medical appointments with apprehension, fearing that disclosure of their situation would increase the violence.

To relieve anxiety and protect themselves, they resolved not to reveal the violence they lived with. The need for help, however, often prompted the participants to risk exposure and left them at the mercy of the provider's response. The women rationalized and grieved negative responses, celebrated positive ones, and thus created some comfort from the encounter. In the final phase, the participants poured out ideas for making primary health care a better, more therapeutic experience. They comforted



Table 5

Variations in Phase 4 – “Helping Other Women”

Influencing Conditions	Participant Statement
Commitment to screening	If you're scared and you're bruised up and someone's ignoring that, that's pretty sad, I think. There's no other way to approach the subject, but to just come out and ask. I think that would help. [Participant 2]
Preference for written information	Have it in writing somewhere. Let them see it in black and white. Let them see it. [Participant 16]
Preference for verbal screening	I think the verbal inquiry would be better, because if they would look at you when they asked it, they would see what's going on. It's much easier to cross 'no' with a pen instead of someone asking you and you have to look them in the eye and give them an answer. [Participant 7]
Value placed on time	Time is the biggest thing with the doctors. If they're not spending time with us, they can't possibly know what is going on. [Participant 10]
Commitment to staff education	The only answer is education. You have to be aware of these situations. I think the people in the office, the staff and the receptionist as well as the doctor, should have it. The doctor's gonna commit that in his office his whole staff, even the janitor that comes in and cleans up the room while people are in there, is trained on the signs to look for. [Participant 3]
Participant expectation of provider	I feel like that's your physician. Anything that has to do with you is his concern. That's what he is there for. If he can't give you the counseling, it's his job to get you to someone who can help you. If he can't help you, that's what referrals are for. [Participant 5]

themselves with the hope that lessons learned from their experience might make things better for other women.

## CHAPTER V

### Discussion and Summary

This qualitative study used the grounded theory method to gain insight into the experience of primary health care visits for survivors of intimate partner violence. This chapter discusses the findings reported in Chapter IV by tying the proposed theory to the extant literature. Comparing the categories and constructs derived from this study with existing works supports the theoretical adequacy of the proposed process, "creating comfort." Implications for practice and recommendations for further research are presented.

#### Discussion of the Findings

The theory presented is relevant to the experiences of the participants at this time. Naturalistic inquiry does not seek to produce generalizations, but rather offers a shared construction of a particular context that may serve as a stimulus for investigation for other researchers (Erlandson, Harris, Skipper, & Allen, 1993). While conventional research is concerned with "replication",

naturalistic studies encourage "expansion" research.

Subsequent studies may examine the transferability of this theory to other settings or groups, investigate these findings using different methodologies, or look at how this reality changes over time.

Comparing the results of this grounded theory research to the focus group studies conducted by Rodriguez et al. (1996) and McCauley, Yurk, et al. (1998) reinforces the findings of each. The triangulation of two different qualitative methods edifies the area under examination (Wilson & Hutchinson, 1991). Impediments to patient disclosure identified by the women in the Rodriguez study (embarrassment, fear of partner retaliation, and worries about police involvement) were also major barriers in this study. Adherence to gender roles and lack of trust in the provider, both factors in the Rodriguez focus groups, were of lesser concern for the participants in the grounded theory interviews. Both groups agreed on the need for clinicians to express compassion, awareness of domestic violence issues, and respect for the woman's choices as a prerequisite for communication about the abuse.

Women in the McCauley, Yurk, et al. study (1998) named the abuser blocking them from medical care as the major

barrier to disclosure. Such interference was reported by women in the current study, but it was not a major theme. Shame was a key issue preventing women from volunteering an abuse history in both groups, as it was in the Rodriguez et al. (1996) research.

McCauley, Yurk, et al. (1998) did not find fear of police involvement to be a concern with their Maryland focus groups, as it had been with the Rodriguez et al. (1996) Californian study, and speculated that the mandatory reporting law in California might have accounted for the difference. Texas does not have mandatory reporting of intimate partner violence, but fear of police involvement was still a major block to disclosure in the current study. Participants in both the McCauley focus group and the grounded theory group strongly endorsed the use of written materials as an aid to initiating discussion and informing women of their options.

#### Basic Social Psychological Problem

Grounded theory seeks to go beyond description of the actions of a group to understand their underlying problem and the process used to cope with it. Analysis of these data revealed that the core problem confronting these women

was that primary health care was far from a therapeutic experience. Implicit in the term "primary health care" is the promise that this encounter will provide frontline caring for the client's needs. Instead of overt caring, these women were met at best with indifference and at worst with scorn. In the few instances where patients did receive some support, it was usually the result of their own efforts.

#### Basic Social Psychological Process

The process the participants used to resolve their dissatisfaction with health care encounters was to create their own comfort. For these survivors of intimate partner violence, a primary health care appointment was not an isolated meeting, but a process that began before the encounter and continued long after it. In each phase, the women employed coping strategies that provided them with some solace, some comfort, that they desperately needed but were not getting from the health care providers.

The four phases of "creating comfort" run parallel to the four stages identified by Herman (as cited in Flitcraft, 1995) as the necessary components of trauma recovery. As the participants in the current study

processed their primary health care encounters, they worked through steps that achieved similar results (See Table 6).

#### Phase 1 - "Protecting Through Silence"

With the possible exception of pregnancy, hardly anyone looks forward to a trip to the doctor. For survivors of intimate partner violence, however, a clinical appointment can be the source of extreme anxiety. Many of the participants were apprehensive that they might be asked about domestic violence. Some were hoping that they would be asked. Others did not want to be asked, but wished that someone would just know. Only one participant, who had just suffered a violent attack and who had a trusting relationship with her physician, approached her appointment determined to tell about the abuse. All the participants were anxious about the meeting.

The vast majority had no intent of revealing the abusive situation they were living in. The reasons the participants gave were fear of retaliation from the abuser, fear of police involvement, fear of authorities taking their children, but this research suggests that the unspoken reason may be fear of losing control. Partner abuse is all about the abuser's systematic effort to take control of the other. Revealing the violence carried the

Table 6

Comparison of Stages of Trauma Recovery with Phases of Creating Comfort

Trauma Recovery	Creating Comfort
Stage 1: Establishing safety	<p>Phase 1: Protecting through silence            Women attempt to keep themselves and their families safe by controlling revelation of the intimate partner violence.</p>
Stage 2: Identifying the trauma	<p>Phase 2: Risking exposure            After weighing out the risks, women volunteer the truth of their situation, respond positively to a direct inquiry about their situation, or admit to themselves the nature of their situation. In doing so, they have identified the trauma and made the first outreach for help.</p>
Stage 3: Retelling the story	<p>Phase 3: Coping with consequences            Women go over the health care encounter and come to terms with it by rationalizing rejection, grieving over opportunities missed, or celebrating support.</p>
Stage 4: Reconnecting with the community	<p>Phase 4: Helping other women            Survivors find true comfort in using their experience to help make things better for other women in a similar situation. Volunteering their ideas for health care improvement is an important step in breaking down isolation and regaining a positive sense of self.</p>



threat of giving up what may have been the last bit of control they had. Many women believed that if they told about the abuse, then somebody else was going to try to tell them what to do about it. However well-intentioned, authoritative advice in this situation is not therapeutic:

Battered women are generally disempowered in their intimate relationships and part of their process of recovery may be facilitated by physicians encouraging them to make their own decisions (Rodriguez et al., 1996, p. 157).

Ignorance or misinformation regarding reporting laws caused the majority of women in this study to believe that telling their health care provider about the abuse meant automatically getting the police and possibly child protective services involved in their business. It is interesting to note that in no case was such involvement viewed as potentially helpful. Rather, the women saw this as interference that would only make matters worse. Their first priority was to keep themselves and their families safe. Ironically, documentation of intimate partner violence in the medical record may be "the only means for the victim to show that the perpetrator should not be given custody of the children" (Buel, 1995, p. 165). Keeping the secret meant keeping the status quo. Telling meant risking a situation that could be far worse.

Telling also meant opening oneself to negative judgment. One participant rolled her eyes with exasperation as she said, "You know everybody thinks you should leave." [Participant 9] Disclosure of intimate partner violence meant subjecting yourself to the shame of admitting that your significant other treats you horribly and you are not doing anything about it. From the women's viewpoint, nothing good was going to come from telling, so why tell?

It is important for researchers and clinicians to remember that battered women decide to whom and when to disclose their abuse . . . . A battered woman thinks in terms of safety . . . possible sources of help, future unintended consequences (such as losing health insurance), . . . and shame. (Campbell, 1998, p. 185)

## Phase 2 - "Risking Exposure"

Contrary to their adamant resolve not to disclose the abuse, participants sometimes confided in their providers anyway. Professionals who work with women's shelters suggest that:

Women want to disclose their battering, but are fearful of doing so because of past experiences with disclosure to health care professionals, family, friends, clergy, mental health professionals, and police. These past attempts may have been met with minimization and denial, or even blaming of the victim. (Loring & Smith, 1994, p. 335)

The decision to volunteer that one was living with a violent partner was influenced by a variety of factors, including relationship with the provider, the perception that the physician did not have time to hear the news, and environmental considerations. Institutional coldness was a barrier these women shared with the participants in the Rodriguez et al. (1996) focus groups: "Seeking help from large impersonal institutions was traumatic in itself. The high cost of health care, excessively long waiting periods, and brief consultations with a physician were not conducive to disclosure of domestic violence" (p. 157).

The most insidious factor, however, was the unspoken understanding of "don't ask, don't tell." Simply put, "The failure to screen for victimization by violence communicates a lack of permission to discuss these issues in the medical setting" (Koss et al., 1991, p. 346).

Women who did risk confiding were hypervigilant to the provider's response. If they were met with anything other than validation and concern, they were arguably victimized again. "Battered women who have sought help and been met with inadequate resources and responses may, for example, feel more trapped and disempowered" (Hall-Smith, Tessaro, & Earp, 1995, p. 181). Even worse, "lack of validation

discourages the battered woman from seeking additional curative and preventive help" (Loring & Smith, 1994, p. 330).

### Phase 3 - "Coping with Consequences"

The hurt of not having the pain that they lived with acknowledged by their health care providers was sorely apparent when listening to the women tell their stories. Perhaps as a defense mechanism, they offered a host of rationalizations explaining why physicians and staff did not ask about abuse or notice obvious cues.

The women in this study were largely empathetic to well-publicized restrictions on physicians. They sympathized with understaffing, HMO requirements, inadequate training, personal biases, and lack of time. They mirrored the participants in the Rodriguez et al. (1996) research who were:

. . . sensitive to physicians' time restraints and did not expect a lot of time; they encouraged a gentle direct inquiry regarding domestic violence. They indicated that they wanted the medical provider to acknowledge the existence of abuse and make an appropriate referral. (p. 157)

Participants were often bewildered at how medical personnel could miss what they felt were obvious cues to ask about abuse such as bruises, sadness, hints of stress

at home, or frequent visit or missed appointments.

McCauley, Yurk, et al. (1998) refer to these cues as "invitational disclosure," (p. 554) dropped in the hope that the provider will notice and ask more questions.

Limandri (1989) described the same strategy being used by patients with other stigmatizing conditions.

Again and again, the women shared poignant testimony to the continued abuse they suffered simply because they did not know about their options. Rarely did one have the energy to be angry with health care providers for failing to tell them that help was available. Mostly they just cried softly, murmuring, "I didn't know. I just didn't know." [Participant 18]

Perhaps the most painful consequences of not knowing about options and available resources were those that directly involved children. One woman cried as she recounted an abortion performed 15 years ago, because she was scared and abused and could not see any other way out. Recent research shows that women with an abuse history give "relationship issues" as the only reason for pregnancy termination much more often than women with no history of abuse (Glander, Moore, Michielutte, & Parsons, 1998), yet few clinics screen patients for intimate partner violence.

It became apparent during the course of this research that an important primary care provider had been overlooked. Mothers have continued contact with their child's physician, especially during the first two years of well-baby checks and immunizations. Pediatric providers who screen for domestic violence have recognized "that the safety of children is integrally tied to the safety of their mothers" (Culross, 1999, p. 111) and have taken a critical first step in intervening with the cycle of abuse. "Learning to sensitively and appropriately respond to the mother may be the best way to protect her children in the long run" (Wright, 2000, p. 432). The American Academy of Pediatrics Committee on Child Abuse and Neglect appreciates that intimate partner violence is in the purview of pediatrics and recommends that pediatricians screen and offer resource information to the mothers of their patients (Kerker, Horwitz, Leventhal, Plichta, & Leaf, 2000).

Children who live in environments of intimate partner violence are at multiple risks. An estimated 7 out of 10 batterers also beat their children (Attala & Warmington, 1996). McAfee (as cited in Barkan & Gary, 1996) found that when the mother is the victim of partner violence, the children are at greater risk of physical abuse from either

parent. In the research of Kerker et al. (2000), mothers who reported intimate partner violence were significantly more likely to admit hitting their children hard enough to leave a mark compared to mothers who did not report partner abuse. These women may be displacing their anger towards the abuser "safely" onto the children or they may be succumbing to the emotional exhaustion of chronic abuse (Triplett, 2000).

If children escape direct physical attack, they still face serious consequences from repeated exposure to family violence. Infants and toddlers may be irritable, have poor weight gain, poor sleeping habits, and exhibit regression (Triplett, 2000). Older children suffer from developmental delays, behavioral problems, and sleep disorders (Attala & Warmington, 1996).

The most devastating legacy of witnessing domestic violence is the generational continuation of abuse. Numerous studies support the contention that living with intimate partner violence during childhood produces the batters and victims of the next generation. In Wang and McKinney's (1997) research, 55% of their female participants reported that they were abused as children and 68% of their partners had histories of abuse.

The multigenerational cycle of abuse was made painfully clear through the story of this study participant:

When me and my brothers got older, about 10, then we started defending my mom. We couldn't defend her when we were younger because my dad would kick her out and we couldn't do anything, we were little . . . . When we defended my mom, we told my dad that he was gonna have to stop hitting my mom, that we weren't gonna let him do that anymore. So then, what he did was that when I got in front of him, my brother tried to grab him, he just kind of threw my brother across the room and then the punch came at me in my stomach. And I remember that first blow. I really do. I couldn't believe he did that, but we protected our mom . . . and then from that point on, I became my dad's target. So I guess when I reflect now, that's all I ever knew . . . . So I never had good male role models. I never knew any better. [Participant 18]

#### Phase 4 - "Helping Other Women"

When the study participants shared the ways that they would improve primary health care, they spoke with conviction. They strongly endorsed routine screening for intimate partner violence. They viewed asking about abuse as "putting it on your mind" . . . a way of opening the door to future discourse. The women acknowledged that patients might lie in response to abuse inquiry or even be offended, but they felt it was important none-the-less and that with repeated questioning even the most resistant woman might become comfortable enough to confess. These



sentiments reinforce the rationale for routine, universal screening that predominate the extant literature.

While the women advocated routine verbal assessment for abuse, they also campaigned for written materials. Waiting room posters would signal that intimate partner violence was common and important and that this office was a safe place to tell about it. Resource cards on bathroom doors, examination room counters, or bulletin boards could give the patient referral resources without the embarrassment of sharing their situation. Pamphlets or posters outlining reporting laws would help patients understand what the real risks would be in confiding in the clinician. Several women stressed that seeing this information "in black and white" made it more believable.

The strongest advice that the participants had for the providers was simply to listen and show that they cared. Since the health care professionals they had met were sorely lacking in communication skills and empathy, the women were eager to help them with specific examples of what to do, what to say, and how to say it. They called for eye contact, sitting down next to the person you are conversing with, and paying attention to what that person says.

Good clinicians know the importance of good listening skills. In Kidder's (2000) profile of Dr. Paul Farmer, a Harvard medical school professor whose resume makes Dr. Albert Schweitzer's dim in comparison, the good doctor's appreciation for listening is apparent:

The young man looked up. "Just talking to you makes me feel better. Now I know I'll sleep tonight." Clearly, he wanted to speak to Farmer some more, and just as clearly he was welcome to do so. Farmer likes to tell medical students that to be a good clinician you must never let a patient know that you have problems or that you're in a hurry. "And the rewards are so great for just those simple things!" (p. 40)

Women in general tend to be dissatisfied with physician communication, and survivors of intimate partner violence are even less satisfied (Plichta, Duncan, & Plichta, 1996). Empathy, receptive body language, validation, and information sharing enhance patient satisfaction. Asking open-ended questions, and allowing lengthy answers, builds a partnership with the patient and yields valuable information for the clinician. "Primary care practitioners should let patients tell their stories with far fewer interruptions, cut-offs, or returns to technical matters" (Borges & Waitzkin, 1995, p. 51).

Patients who are assertive ask for information and alternatives (Shaffer & Sherrell, 1995). Survivors of

intimate partner violence, with a compromised sense of self-esteem, are unlikely to have the assertion to initiate a request for help. They are desperately hoping that the offer will come from the provider. This observation by Plichta et al. (1996) reflects the experience of this study's participants:

Why does the burden of effective communication rest with health care providers, not patients? . . . In awe of providers, nervous and afraid during medical encounters, or simply respectful of providers' time and expertise, patients may not feel free to mention things clinicians need to know. Communication is a reciprocal process in which quiet patients and patients with the fewest personal resources are at a distinct disadvantage. (p. 301)

### Conclusions

The data revealed that the "care" in primary health care was largely missing for these survivors of intimate partner violence. The women resourcefully managed their health encounters to create for themselves the comfort that was not forthcoming from their providers. If the health professionals had offered their patients a shred of the empathy that these women expressed for them, the experience of primary care could have been very different.

It was strikingly obvious that these women want their regular clinicians to ask them about partner abuse. Direct inquiry allows survivors to decide for themselves whether

it is in their best interest to disclose their situation.

Not asking denies them that choice.

Even more important to the participants than being asked was being given information. They were filled with a terrible sadness over all the lost years and tragic consequences caused by simply "not knowing" about their legal rights, the value of medical documentation, shelter services, and financial aid. Every woman interviewed felt that it was the primary care provider's responsibility to offer that information and make her aware of her options.

#### Implications for Practice

The data yielded a wealth of suggestions to improve primary health care visits for survivors of intimate partner violence. The primary recommendation is for every doctor's office and clinic to implement a policy of routine assessment, documentation, and referral for intimate partner abuse. For implementation to be successful, it is imperative that all office staff participate in training not only on the proposed protocol, but also on the dynamics of domestic violence. This education demands collaboration with other community resources, including law enforcement, the legal system, shelters, and social services.

Primary care facilities should post or privately provide for every patient written materials that outline the state's laws concerning health care professionals' obligations in cases of intimate partner violence. The erroneous assumption that physicians must report knowledge of domestic violence to the police can seriously delay disclosure. Only with factual information on reporting laws can survivors make an informed decision to disclose.

Providers should post information on domestic violence (safety plan guidelines, the value of medical documentation as a legal tool, impact on children) in secure locations (bathrooms, changing stalls, exam rooms) where patients can read it unobserved. Small resource cards that can be hidden by the patient should be provided in these areas.

Displaying information that draws attention to intimate partner violence in public areas (posters, brochures) sends the message that this is an appropriate issue to discuss here. It also raises community awareness. The social stature of physicians is such that people who have never taken domestic violence seriously may begin to see it as an important issue if their doctor does.

This research suggests that clinicians should enforce an office policy that demands some time when the patient is

seen alone in a private place to allow for confidential disclosure. This may conveniently tie with a policy of having patient's disrobe and gown for consultation, so that bruises and injuries in multiple stages of healing or areas hidden by clothing would become visible to the attendant.

The presence of an on-site advocate to counsel with survivors serves the needs of both patients and staff. Depending on the size of the facility, the advocate could be a designated, trained staff member or a new position. This is another excellent opportunity to partner with other community resources.

Negotiation is needed with health care administrators and managed care plans to improve care for abuse survivors and financial reports for institutions. Education on the wisdom of reimbursement for longer visits and follow-up visits may prevent costs from increased visits and specialists appointments.

While this study did not address emergency care, several of the women shared horror stories from their ER encounters as the reason they would not tell their primary care providers about intimate partner violence. Their negative experiences reiterate the necessity for training

and sensitive protocols in the emergency care setting as well as in the primary care arena.

Finally, as noted earlier, the inclusion of routine screening for domestic violence in the pediatric setting may greatly improve identification rates and has the potential to prevent child abuse and neglect. This would require the addition of intimate partner violence to pediatric residency programs and continuing education programs.

#### Recommendations for Future Research

The data suggest a variety of areas that warrant further examination. Given the fears expressed by these participants regarding mandatory provider reporting of domestic violence, it would be enlightening to examine patient rates of volunteering abuse history and provider rates for screening for abuse history in states that require mandatory reporting compared with those that do not. It would also be interesting to survey both patients and providers in all states to determine how their understanding of reporting laws compare to actual fact.

The need for written patient education materials is clear, but it is imperative that they be developed and evaluated in collaboration with survivors of intimate

partner violence, community experts in law, law enforcement, shelters, and social services. Once distributed, the efficacy of the materials must be assessed. Of particular interest is the design of a quiz, along the lines of those frequently featured in popular women's magazines, that could help women recognize if they are living in an abusive situation.

A meta-analysis that aggregates the data on barriers and aids to screening or volunteering abuse history from both provider and patient perspectives is needed. Combining this data should reveal areas of conflict and agreement and should serve as guide for developing more effective patient intervention as well as more effective provider training.

There is a need to further establish the cost benefits of screening, referring, and counseling patients who are survivors of intimate partner violence. If a clear cost savings is indicated, then insurance providers and health care providers alike may take a more proactive role in early intervention of domestic violence.

The aversion shown towards child protective services suggests that the agency could benefit from a positive public image campaign. Research is needed to pinpoint



areas of strength and negativity and to develop strategies to correct problems and raise public awareness and support for the positive aspects.

### Summary

This grounded theory investigation asked survivors of intimate partner violence about their experience with primary health care encounters. In semi-structured interviews, the participants shared their perspective of these appointments. Their basic social psychological problem was that primary health care was essentially not therapeutic with regard to their violent situation. The concept of "creating comfort" illustrated the process these women used for resolution of their problem.

## REFERENCES

Alpert, E. A. (1995). Violence in intimate relationships and the practicing internist: New "disease" or new agenda? Annals of Internal Medicine, 123, 774-781.

American Medical Association. (1992). Diagnostic and treatment guidelines on domestic violence. Chicago, IL: American Medical Association.

Attala, J. M., & Warmington, M. (1996). Clients' evaluation of health care services in a battered women's shelter. Public Health Nursing, 13(4), 269-275.

Badura, A., Reiter, R., Altmaier, E., Rhomberg, A., & Elas, D. (1997). Dissociation, somatization, substance abuse, and coping in women with chronic pelvic pain. Obstetrics and Gynecology, 90(3), 405-410.

Barkan, S. E., & Gary, L. T. (1996). Women abuse and pediatrics: Expanding the web of detection. Journal of the American Medical Women's Association, 51, 96-100.

Berger, P., & Kellner, H. (1981). Sociology reinterpreted. New York: Anchor Books.

Borges, S., & Waitzkin, H. (1995). Women's narratives in primary care medical encounters. Women & Health, 23(1), 29-58.

Buel, S. M. (1995). Family violence: Practical recommendations for physicians and the medical community. Women's Health Issues, 5(4), 158-172.

Campbell, J. C. (1998). Abuse during pregnancy: Progress, policy, potential. American Journal of Public Health, 88(2), 185-187.

Campbell, J. C. (1999). If I can't have you no one can: Murder linked to battery during pregnancy. Reflections, 25(3), 8-12.

Campbell, J., Dienemann, J., Wynne, C., & Kub, J. (1999). Physical and mental health consequences of domestic violence survivors. In 1999 Nursing Research Congress Program and Abstracts (p. 128). London, United Kingdom: Sigma Theta Tau International.

Campbell, J., & Sheridan, D. J. (1989). Emergency nursing interventions with battered women. Journal of Emergency Nursing, 15(1), 12-17.

Caralis, P. V., & Musialowski, R. (1997). Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. Southern Medical Journal, 90(11), 1075-1080.

Chambliss, L. R., Bay, R. C., & Jones, R. F. (1995). Domestic violence: An educational imperative? American Journal of Obstetrics and Gynecology, 172(3), 1035-1038.

Charmaz, K. (1990). "Discovering" chronic illness: Using grounded theory. Social Science Medicine, 30(11), 1161-1172.

Creswell, J. (1994). Research design: Qualitative & quantitative approaches. Thousand Oaks, CA: Sage Publications.

Culross, P. L. (1999). Health care system responses to children exposed to domestic violence. The Future of Children, 9(3), 111-121.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). Doing naturalistic inquiry: A guide to methods. Newbury Park, CA: Sage Publications.

Flitcraft, A. (1995). From public health to personal health: Violence against women across the lifespan. Annals of Internal Medicine, 123(10), 800-802.

Friedman, L. S., Samet, J. H., Roberts, M. S., Hudlin, M., & Hans, P. (1992). Inquiry about victimization experiences: A survey of patient preferences and physician practices. Archives of Internal Medicine, 152, 1186-1190.

Gerbert, B., Johnston, K., Caspers, N., Bleecker, T., Woods, A., & Rosenbaum, A. (1996). Experiences of battered women in health care settings: A qualitative study. Women and Health, 24(3), 1-17.

Glander, S. S., Moore, M. L., Michielutte, R., & Parsons, L. H. (1998). The prevalence of domestic violence among women seeking abortion. Obstetrics and Gynecology, 91, 1002-1006.

Glaser, B. G. (1978). Theoretical sensitivity. Mill Valley, CA: The Sociology Press.

Glaser, B. G. (1992). Emergence vs forcing: Basics of grounded theory analysis. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. Hawthorne, NY: Aldine Publishing Company.

Goldberg, W., & Tomlanovich, M. (1984). Domestic violence victims in the emergency department. Journal of the American Medical Association, 251(24), 3250-3264.

Hall-Smith, P., Tessaro, I., & Earp, J. A. (1995). Women's experience with battering: A conceptualization from qualitative research. Women's Health Issues, 5(4), 173-182.

Hamberger, L. K., Ambuel, B., Marbella, A., & Donze, J. (1998). Physician interaction with battered women: The women's perspective. Archives of Family Medicine, 7, 575-582.

Hamberger, L. K., Saunders, D., & Hovey, M. (1992). Prevalence of domestic violence in community practice and rate of physician inquiry. Family Medicine, 24, 283-287.

Hendricks-Matthews, M. (1992). Family physicians and violence: Looking back, looking ahead. American Family Physician, 45(5), 2033-2035.

Hendrix, S., Piereson, S., & McNeeley, S. (1995). Primary and preventive care in a university obstetrics and

gynecology group practice. American Journal of Obstetrics and Gynecology, 172(6), 1719-1725.

Horan, D. L., Chapin, J., Klein, L., Schmidt, L., & Schulkin, J. (1998). Domestic violence screening practices of obstetrician-gynecologists. Obstetrics & Gynecology, 92(5), 785-789.

Hutchinson, S. A. (1993). People with bipolar disorders quest for equanimity: Doing grounded theory. In P. Munhall & C. Boyd (Eds.), Nursing research: A qualitative perspective (pp. 213-236). New York, NY: National League for Nursing Press.

Kerker, B. D., Horwitz, S. M., Leventhal, J. M., Plitcha, S., & Leaf, P. J. (2000). Identification of violence in the home: Pediatric and parental reports. Archives of Pediatric and Adolescent Medicine, 154, 457-462.

Kernic, M. A., Wolf, M. E., & Holt, V. L. (2000). Rates and relative risk of hospital admission among women in violent intimate partner relationships. American Journal of Public Health, 90(9), 1416-1420.

Kidder, T. (2000, 10/July). The good doctor. The New Yorker, (New York, NY), 40-57.

Koop, C. E., & Lundberg, G. D. (1992). Violence in America: A public health emergency: Time to bite the bullet back. Journal of the American Medical Association, 267(22), 3075-3076.

Koss, M. P. (1993). The impact of crime victimization on women's medical use. Journal of Women's Health, 2(1), 67-72.

Koss, M. P., Koss, P. G., & Woodruff, J. (1991). Deleterious effects of criminal victimization on women's health and medical utilization. Archives of Internal Medicine, 151, 342-347.

Kurz, D., & Stark, E. (1988). Not-so-benign-neglect: The medical response to battering. In K. Yllo & M. & Bograd

(Eds.), Feminist perspectives on wife abuse (pp. 249-266). Newbury Park, CA: Sage Publications.

Landenburger, K. M. (1998). The dynamics of leaving and recovering from an abusive relationship. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 27(6), 700-706.

Lehrman, F. (1995, February). Strategies for interviewing domestic violence clients. Trial, pp. 38-43.

Limandri, B. J. (1989). Disclosure of stigmatizing conditions: The discloser's perspective. Archives of Psychiatric Nursing, 2, 69-78.

Loring, M. T., & Smith, R. W. (1994). Health care barriers and interventions for battered women. Public Health Reports, 109(3), 328-338.

McCauley, J., Kern, D. E., Kolodner, K., Derogatis, L. R., & Bass, E. B. (1998). Relation of low-severity violence to women's health. Journal of General Internal Medicine, 13, 687-691.

McCauley, J., Yurk, R. A., Jenckes, M. W., & Ford, D. E. (1998). Inside "Pandora's Box": Abused women's experiences with clinicians and health services. Journal of General Internal Medicine, 13, 549-555.

Medscape instant polling: Poll results. (2000, 25/4). Available:<http://womenshealth.medscape.com/Home/Inst../QueryAPollResult.cfm?pollid=>.

Miller, T. R., Cohen, M., A, & Wiersema, B. (1996). Victim costs and consequences: A new look (Tech. Rep. No. NCJ 155282). Washington, D.C.: National Institute of Justice (1-28).

Morse, J. M., & Field, P. A. (1995). Qualitative research methods for health professionals (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications.

Parsons, L. H., Zaccaro, D., Wells, B., & Stovall, T. G. (1995). Methods of and attitudes towards screening

obstetric and gynecology patients for domestic violence. American Journal of Obstetrics and Gynecology, 173, 381-387.

Plichta, S. B., Duncan, M. M., & Plichta, L. (1996). Spouse abuse, patient-physician communication, and patient satisfaction. American Journal of Preventive Medicine, 12(5), 297-303.

Randall, T. (1990). Domestic violence intervention calls for more than treating injuries. Journal of the American Medical Association, 264(8), 939-940.

Reid, S. A., & Glasser, M. (1997). Primary care physicians' recognition and attitudes toward domestic violence. Academic Medicine, 72(1), 51- 53.

Rittmayer, J., & Roux, G. (1999). Relinquishing the need to "fix it": Medical intervention with domestic abuse. Qualitative Health Research, 9(2), 166-181.

Rodriguez, M. A., Bauer, H. M., McLoughlin, E., & Grumbach, K. (1999). Screening and intervention for intimate partner abuse: Practices and attitudes of primary care physicians. Journal of the American Medical Association, 282(5), 468-474.

Rodriguez, M. A., Quiroga, S. S., & Bauer, H. M. (1996). Breaking the silence: Battered women's perspectives on medical care. Archives of Family Medicine, 5, 153-158.

Rosenberg, M., O'Carroll, P., & Powell, K. (1992). Let's be clear: Violence is a public health problem. Journal of the American Medical Association, 267(22), 3071-3072.

Saltzman, L. E. (1990). Battering during pregnancy: A role for physicians. Atlanta Medicine, 64, 45-48.

Saltzman, L. E., & Johnson, D. (1996). CDC's family and intimate violence prevention team: Basing programs on science. Journal of the American Medical Women's Association, 51(3), 83-86.

Sansone, R. A., Wiederman, M. W., & Sansone, L. A. (1997). Health care utilization and history of trauma among women in a primary care setting. Violence and Victims, 12(2), 165-172.

Sassetti, M. (1992). Battered women. In M. Hendricks-Matthews (Ed.), Violence education: Toward a solution (pp.31-54). Kansas City, Missouri: The Society of Teachers of Family Medicine.

Sassetti, M. (1993). Domestic violence. Primary Care, 20(2), 289-304.

Shaffer, T. R., & Sherrell, D. L. (1995). Exploring patient role behaviors for health care services: The assertive, activated and passive patient. Health Marketing Quarterly, 13(1), 19-35.

Stern, P. N. (1980). Grounded theory methodology: Its uses and processes. Image, 12 (1), 20-23.

Sugg, N. K., & Inui, T. (1992). Primary care physicians' response to domestic violence: Opening Pandora's box. Journal of the American Medical Association, 267(23), 3157-3160.

Sugg, N. K., Thompson, R. S., Thompson, D. C., Maiuro, R., & Rivara, F. P. (1999). Domestic violence and primary care: Attitudes, practices, and beliefs. Archives of Family Medicine, 8, 301-306.

Thurston, W. E., Cory, J., & Scott, C. M. (1998). Building a feminist theoretical framework for screening of wife-battering: Key issues to be addressed. Patient Education and Counseling, 33, 299-304.

Tilden, V., Schmidt, T., Limandri, B., Chiodo, G., Garland, M., & Loveless, P. (1994). Factors that influence clinicians' assessment and management of family violence. American Journal of Public Health, 84(4), 628-633.

Triplett, J. L. (2000). Don't hit mommy. Small Talk, 12(1), 9-10.



Walsh, J., & McPhee, S. J. (1992). A systems model of clinical preventive care: An analysis of factors influencing patient and physician. Health Education Quarterly, 19(2), 157-175.

Wang, J. F., & McKinney, J. (1997). Battered women's perceptions of loss and health. Holistic Nursing Practice, 11(2), 50-59.

Wilson, H., & Hutchinson, S. (1991). Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. Qualitative Health Research, 1, 263-276.

Wilt, S., & Olson, S. (1996). Prevalence of domestic violence in the United States. Journal of the American Medical Women's Association, 51(3), 77-82.

Wisner, C. L., Gilmer, T. P., Saltzman, L. E., & Zink, T. M. (1999). Intimate partner violence against women: Do victims cost health plans more? The Journal of Family Practice, 48(6), 439-443.

Wright, R. J. (2000). Identification of domestic violence in the community pediatric setting. Archives of Pediatric and Adolescent Medicine, 154, 431-433.

## APPENDIXES

APPENDIX A

Participant Recruitment Flyer

# Let's Talk



## Partner Abuse & Healthcare Visits

**If your boyfriend, husband, or "ex" has hurt or threatened to hurt you with any of the following:**

- Physical abuse
- Forced sex
- Emotional/verbal abuse
- Injury to property or pets
- Financial control
- Social isolation

**And if you have had at least one "regular" clinic or doctor visit during the time of the abuse... we should talk.**

You may be part of a research study to help make "regular" doctor visits more helpful to women who are being abused by an intimate partner.

You would talk to one interviewer for about 90 minutes at a place and time that works for you.

You will get your choice of a bath gift set or a \$10 certificate to "Bath and Body Works" for helping with this study.

Your identity will be protected.

For more information, please call: **214-766-1785**

- Thank You -

## APPENDIX B

### Research Question and Summary of Answers to Core Interview Questions

Research Question	Core Interview Questions	Findings
What is the experience of survivors of intimate partner abuse during primary health care visits?	What have been your experiences with regular health care visits during the period of the abuse?	Primary care appointments were rarely therapeutic and frequently caused further stress.
	How did the doctor, nurse, or other staff make the visit more or less helpful for you?	Empathetic listening, validation, and providing option and referral information were actions viewed as helpful. Ignoring symptoms of abuse, dismissing disclosure of abuse, and judgmental decisions regarding patient actions were seen as less helpful.
	How did these experiences impact the abuse?	Support, validation, and especially the provision of information regarding options and resources encouraged women to take action. Participants who did not receive such information felt that lack of knowing options caused them to remain in the abusive relationship longer than they might have otherwise.