

# Breaking the Silence

## Battered Women's Perspectives on Medical Care

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**Objective:** To determine the barriers to identification and management of domestic violence from the battered woman's perspective.

**Design:** Qualitative research method using semistructured focus groups.

**Setting:** Urban and suburban community-based organizations serving women and their families in the San Francisco Bay (Calif) area.

**Participants:** Fifty-one women with histories of domestic violence comprised eight focus groups divided as follows: two groups of Latino (n=14), two groups of white (n=14), Asian (n=14), and two groups of African-American (n=9) women.

**Results:** Participants from all ethnic groups identified major factors that affect identification and management of battered women in the health care setting. Factors that interfere with patient disclosure included threats of violence from the partner, embarrassment, adherence to gender roles, concerns about police involvement, and lack

of trust in the health care provider. One factor that predisposed a woman to seek help from providers was a need for the providers to exhibit compassion, awareness, and respect for the patient's need to make final decisions about her situation. Most participants said that providers should take the initiative to ask directly about domestic violence, establish a supportive patient-provider relationship, and refer battered women to available community resources. The major institutional barriers to using the health care system included the high cost of medical care and long waiting periods.

**Conclusions:** Many battered women experience social, institutional, and provider barriers to obtaining help from the health care system for problems related to domestic violence. Providers as well as institutions can overcome these barriers through an understanding of the social context of domestic violence and the victim's needs. Identification may be improved through a trusting patient-provider relationship and by direct questioning about domestic violence.

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**D**OMESTIC VIOLENCE, spouse abuse, and battering are terms that refer to abusive and controlling behaviors between people in intimate relationships.<sup>1</sup> These behaviors include physical, sexual, and psychological abuse; they are generally repetitive, and often escalate.<sup>2,3</sup> Domestic violence crosses all ethnic, sexual preference, and socioeconomic lines. Although many men are also victims of domestic violence, violence against women perpetrated by men is generally believed to be more prevalent and more likely to result in injury.<sup>4</sup>

Battered women make up a large proportion of patients in a variety of clinical settings. They account for 14% to 28% of women attending primary care clinics,<sup>5,6</sup> 4% to 17% of women attending prenatal clin-

ics,<sup>7-10</sup> and approximately 30% of women with nonmotor vehicle injuries presenting to emergency departments.<sup>11</sup> Abused women are more likely to experience physical injury, depression, substance abuse, attempted suicide,<sup>12</sup> chronic pain,<sup>13</sup> perinatal complications,<sup>7</sup> and homicide.<sup>14</sup> Despite the significant health implications of domestic violence, health care providers often fail to identify and manage domestic violence when signs and symptoms are present.<sup>15,16</sup> Furthermore, written hospital policies<sup>17</sup> and domestic violence curricula<sup>18,19</sup> are often inadequate.

Most of the current understanding re-

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## SUBJECTS AND METHODS

### FOCUS GROUP METHOD

The research reported herein was conducted using focus groups, a qualitative research method used to elicit the attitudes, feelings, beliefs, and behaviors of a targeted group.<sup>22</sup> The focus group approach, which is based on small group discussions on a specific topic, was used to gain an in-depth understanding of battered women's experiences within the health care system. Open-ended questions were formulated based on a review of the literature and were designed to elicit information about the participants' perspectives on the institutional, provider, and patient factors that facilitate or impede the identification and management of domestic violence in the health care setting. This study was approved by the Human Subjects Review Committee at Stanford (Calif) University, and informed consent was obtained from all participants.

### PARTICIPANTS

Women who lived in the San Francisco Bay (Calif) area were recruited from community-based organizations that included advocate groups for women's and family issues, battered women's resource centers and shelters, transitional housing programs, and drug rehabilitation treatment programs. Recruitment sites were chosen specifically to obtain a heterogeneous sample that reflected the racial and ethnic diversity of the geographic area.

The size of the focus groups ranged from four to nine women and each group was composed of women with the same ethnic and racial identity. To be eligible to participate, women had to be between ages 18 and 64 years, with histories of domestic violence within the past 2 years. Nine focus groups were conducted during a 6-month period. Although the original sample size was 59 women, one focus group was excluded from the data analysis owing to the poor quality of the audiotape, thus reducing the final sample size to 51 women.

Forty-seven participants provided detailed demographic information. Their ages ranged from 22 to 60 years (median age, 34 years), with formal educational backgrounds ranging from none to university level. Eighty-seven percent (40/46) of the participants had children. Of the 43 participants who responded to the marital status item, nine (21%) were either married or living with partners and 34 (79%) were either divorced, single, or separated.

The participants came from a variety of ethnic and racial backgrounds. Twenty-three (45%) of the participants (all of the white and African-American women) were born in the United States. The Latino groups consisted of immigrant women from Mexico, El Salvador, Guatemala, and Colombia who had lived in the United States for 15 years or fewer. The Asian groups consisted of immigrant women from China, Vietnam, Korea, the Philippines, and Taiwan who had lived in the United States for 22 years or fewer.

### DATA COLLECTION

Each focus group was facilitated by two moderators, at least one of whom matched the ethnic and racial makeup of the group. The two focus groups of Latinos were conducted in Spanish. One focus group of Asian women was conducted in both Mandarin and Cantonese. All other groups were conducted in English. Each focus group lasted approximately 90 minutes and was held in a confidential familiar location.

The participants were asked to discuss definitions of domestic violence; sources of help for problems related to domestic violence; and the attitudes, feelings, and behaviors that may predispose battered women to seek, or to avoid seeking, help from health care providers. Demographic information was gathered at the end of the interviews, and participants were reimbursed for their participation.

### CODING AND ANALYSIS

Initial analysis of the transcripts consisted of repeated readings with the aim of identifying prominent themes. Transcripts were independently read by seven readers chosen for their familiarity with domestic violence issues: battered women, community workers involved with domestic violence, and professionals from various disciplines (psychology, medical anthropology, social work, and medicine). A list of codes was constructed to encapsulate topics discussed in the focus groups, such as sources of help, types of barriers to help, and positive experiences within the health care system.

Each transcript was coded by women matched for ethnicity and race with the focus group participants, as well as by persons outside the culture. All coders were trained by one of us (M.A.R.), and transcript excerpts were coded to check reliability. Coders looked for repetition of specific words and the subject matter within participants' narratives in accordance with standard analytic convention.<sup>23</sup>

After all transcripts were coded, coders and authors met to critique the process, review themes, and evaluate validity.<sup>24</sup> Coded data were organized using Ethnography 4.0, a computer software program designed for qualitative data.<sup>25</sup> After initial analysis, preliminary conclusions were shared with battered women, community workers involved with domestic violence, and professionals from various disciplines in a review process as a further validity check. In this article, we present the major factors affecting health care experiences shared by a large percentage of participants in all four ethnic and racial groups. While some differences were found between ethnic groups, this article focuses on the predominant similarities among battered women of different ethnicities. Although factors will be discussed separately, the participants often expressed them as complex and interrelated phenomena. To illustrate their comments, quotes from the transcripts are included below, selected to equally represent all four ethnic groups.

garding barriers to identification and management of domestic violence in the health care setting is derived from the medical provider's perspective. Physicians have identified several factors that they feel contribute to battered

women's infrequent disclosure of domestic violence: lack of initiative, unresponsiveness, and/or denial by the patient<sup>20</sup>; and feelings of helplessness and/or lack of time by the health care provider.<sup>21</sup> Few studies have at-

tempted to address battered women's health care system experiences, perceptions, and needs. This report examines issues common to women of different ethnic groups that influence identification and management of domestic violence.

## RESULTS

Forty-four (86%) women discussed previous interactions with physicians or nurses. Participants initially focused on the difficulties with disclosure and acknowledgment of marital or partner abuse within the medical encounter. The underlying factors associated with this problem included psychological, social, and health care system barriers. Participants then discussed specific ways that health care providers and institutions can overcome some of these obstacles to identification and subsequent intervention.

While all of these factors are intimately intertwined to create the social and structural context of the battered woman's experience in the health care system, examining each separately provides insight into approaches for improving the medical response. Also, while many factors that shaped participants' experiences were similar among different ethnic and racial groups, the manifestation of those elements was highly individualized.

### THE SILENCE

In this article, the silence represents, in the words of one participant, "the unspoken agreement" between battered women and other members of society to not disclose or address their battering. This silence is manifested in the health care setting in three ways: the patient's inability or unwillingness to seek medical help, the patient's withholding of information from the health care provider, and the health care provider's failure to ask the patient about battering. Thirty-six (71%) participants discussed lying about the source of their injuries or withholding information. "I was kicked, and cracked two ribs in that situation. And the doctor asked me how it happened and I told him I fell down a flight of stairs." "At first, when I went to the doctor, I said I just bumped myself at home. Later on, when I was more swollen, I told the doctor that I fell but I didn't say anything and no one knew. For 9 years no one knew . . ."

### BEHIND THE SILENCE

Participants identified a wide range of psychological, social, and institutional factors that affect their willingness to seek help (**Table**). These factors often operated simultaneously and interactively to make disclosure to health care providers extremely difficult.

In many cases, the motivation for the participants' silence stemmed from fear of bodily harm or death. The most common reason for not telling providers about domestic violence, given by 24 (47%) participants, was the fear of escalating violence and abuse from the partner. For many participants, keeping quiet was a strategy for survival. "My husband beat me a few times, but I did not dare to go to the doctor. I didn't have any money of my

**Behind the Silence: Major Factors Responsible for Lack of Disclosure or Acknowledgment of Partner Abuse Identified Across Ethnic Groups**

Factors	Specific Examples
Psychological	Fear of escalating violence Shame and embarrassment Low self-esteem
Social	Adherence to gender roles (obligation to family/partner)
Health system	Economic dependency Cost of health care Long waiting times Possible police involvement

own. I was afraid so that the next time he beat me, I was afraid to tell anyone, because I was afraid that if I told anyone he would beat me again."

The participants identified their psychological vulnerability (eg, low self-esteem) as one of the underlying reasons for not disclosing their abuse. Because of the stigma associated with wife battering, many participants felt ashamed and embarrassed. Some participants felt responsible for their abuse and guilty for staying in an abusive relationship. Many of these women did not want other people to know about their battering, often anticipating misunderstanding and judgment. "It's really embarrassing to go to someone and say, 'My husband's abusing me.' To a doctor, to your family . . . anybody. I don't know what their idea of abuse is. You only know what you're feeling." "I was afraid people were going to treat me bad for staying there as long as I did. I took it personal; I thought I deserved it for letting this go on."

Battered women's sense of family responsibility strongly influenced their help-seeking and disclosure to health care providers. Many women felt pressure to fulfill their traditional gender roles within the family: protecting the children, partner, and, above all, keeping the family together. In addition, the perceived difficulties of single parenthood and prospects of economic insecurity that potentially result from ending the relationship often kept women silent about their abuse. Some women sacrificed their own interests to protect their partner, the relationship, or the children. "What makes it difficult is because after you've been abused, you kinda scared to tell the doctor 'cause you in love with that person and it ain't like, you really don't want to see that person get in trouble. . . ."

Several economic and structural factors within the health care system adversely affected the participants' ability to seek and receive medical care. Lack of health care insurance or money to pay hospital bills, long waiting periods, and busy provider time schedules were cited as important barriers to seeking and receiving care from medical institutions. "It used to be I didn't dare to go to the doctor's or the police. The doctor also cost a lot of money and I didn't want to spend so much money. I just endured it, but then it hurt so much that I could not endure it anymore." "You think about how long it takes

when you get there . . . a long waiting period. You get there and it takes so long you leave.” “A lot of times I went to my doctor, he was just too busy. He had so many people waiting, he just didn’t have time to ask, ‘How did you get this bruise?’ . . . .”

Many participants discussed their concerns about police involvement and mandatory reporting by health care professionals to police. In some cases, the participants neglected to seek medical care because they believed that police intervention would have dangerous consequences for them. These participants believed that providers should uphold confidentiality and allow battered women to make decisions about involving the police. “What made it difficult for me to confide was the fact that I feared for my life, you know. And I knew that if I was to tell them what actually happened, that they would call the police and I would have to file a report and they couldn’t guarantee me that they would be there 24 hours to protect me from this maniac. So, therefore, I wasn’t taking that chance on my life.”

### BREAKING THE SILENCE

Participants identified important roles for health care providers and institutions for helping battered women. Creating a supportive environment through compassion and understanding, asking directly about abuse, offering referrals, and providing continued support when possible are ways that providers can facilitate identification and intervention. Institutions can provide staff education and social services to battered women patients.

Many participants described the importance of a good patient-provider relationship that involved a complex interaction of trust, compassion, support, and confidentiality. Forty-four (86%) participants identified at least one of these elements as integral to identification and intervention for battered women. The participants believed that through a good patient-provider relationship, providers can begin to break the silence and facilitate the process of healing from both the injury and the abuse. “. . . just the compassion is going to open up one door. And when we feel safe and are able to trust, that makes a hell of a lot of difference as compared with being run through the system.”

The participants identified several ways that health care providers could build a good patient-provider relationship. Many participants emphasized that providers need to be supportive and nonjudgmental, and take the time to listen to battered women patients. Interestingly, participants did not identify the gender of the health care provider as a major factor in creating the rapport needed to discuss abuse. The health care provider’s facial expression, eye contact, and tone of voice were identified as subtle but important ways of showing concern and developing trust. “It is uncomfortable when you are asked, ‘How are you?’ without a meaningful look; at times, we don’t even tell the truth because we want to leave this situation since we are already depressed and sad. We feel abused. It’s just that many times a look is a great support . . . to know that somebody is paying attention.”

In addition to the elements of trust, compassion, support, and confidentiality, 35 participants (69%) ex-

pressed that health care providers should have a deeper understanding of the psychological and social issues surrounding domestic violence and abuse. Specifically, providers should be aware that battered women should not be blamed for their circumstances and that the silence within the medical encounter and decision to remain in an abusive relationship is influenced by powerful societal and interpersonal pressures. The participants believed that this understanding serves as the basis for provider empathy. “Give them insight into what happens. And then it’s easier to make supportive statements. It’s coming from a base of understanding and getting away from all those stereotypes.”

Thirty-nine participants (76%) favored direct questioning in situations when the patient has obvious injuries, when signs are more subtle, or as a means of routine screening. Participants who favored direct questioning also stipulated the need for a supportive or subtle approach to asking about the abuse. Many of the participants’ negative experiences were shaped by the health care provider’s lack of direct questioning or apparent avoidance of the problem. By simply performing the medical procedures or prescribing drugs without trying to understand the underlying problem of abuse, many women felt as if their abuse was unimportant or embarrassing to the provider. “When I was physically hurt, I was put into the hospital and the physicians there did absolutely nothing to help me realize I was battered—or took time to talk to me. They just took care of what the injury was at the time and that’s it.” “. . . I think it depends how they say it. I think it’s one thing for somebody to say, ‘Hey, I’m seeing a pattern here. She’s been here several times. What do you want to do about this?’ Instead of saying, ‘Hey, what’s up with you? What’s the matter with you? Can’t you get yourself together? How many times are you going to come in here like this?’ I mean, I think it’s going to make it harder for you to go back the next time.”

Participants discussed several important ways that health care providers are able to assist battered women. For example, 23 participants (45%) specifically mentioned the importance of offering referrals to community agencies that provide battered women with shelter, counseling, and social and legal services. While the participants were aware of the time limitations placed on medical providers for offering support, they emphasized the importance of doing basic intervention by listening and giving referrals. “If the doctor is willing to ask for an explanation for the symptoms, I think this is very important. I realize that it is not his sole responsibility, but he can refer us to someone who can help us with our problems. The doctor’s time is very limited, he’s very busy, but he can.”

To be more effective at intervention, the participants believed that health care providers should be direct and persistent, but at the same time patient and supportive. The participants explained that the process of leaving an abusive relationship can be difficult and prolonged. They believed that health care providers can help by continuing to offer assistance, while realizing that change takes time. Furthermore, the participants emphasized that while the health care provider can facilitate the healing process, final decisions regarding ac-

tions taken on her behalf should remain with the patient. ". . . people just don't understand. So, they like, 'If you want to get out, get out.' It's not that easy. You walk around in a cage. And it's a real cage that you walk around in."

In discussing ways that health care institutions can improve care given to battered women, 26 participants (51%) identified staff education and hospital social services as important resources. Many participants believed that hospitals should have educational programs to sensitize medical staff, improve skills, and inform health care providers about community agencies that provide services to battered women. In addition, the participants recommended improvements in hospital services that may facilitate interventions and overcome barriers. Specific services mentioned included providing social workers, counselors, or advocates for battered women.

#### COMMENT

Violence against women is an important concern among health care personnel. In the midst of setting research agendas and revising institutional policy, it is important that the voices of women who experience violence are heard. Regardless of ethnic or racial background or immigrant status, the battered women in our study identified several common factors that affect their health care. The importance lies not only in the fact that this research includes these women's voices but it also highlights the critical importance of social and institutional factors that interfere with providing optimal patient care. Previous research on physician perspectives identified the patient's lack of disclosure as a major reason for not detecting domestic violence.<sup>20</sup> The battered women in our study confirmed this finding and described its origins. Furthermore, the women thought that the health care provider's failure to ask directly about domestic violence contributes to the silence. In addition, the women identified other important provider and institutional factors that affect identification and management of domestic violence.

For many battered women in our study, 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 and may have contributed to the women's silence. Although these particular barriers are not unique to battered women, they may magnify the psychological consequences of fear, lowered self-esteem, and sense of shame. These psychological consequences interacted with the women's practical concerns such as lack of resources, social isolation, and responsibility for children to further create barriers to battered women seeking medical care. To break the silence, health care institutions can introduce policies that recognize domestic violence as a potential emergency; this might allow victims of domestic violence to avoid long waiting periods. Nonphysician personnel could provide on-site counseling and referrals. The women in our study wanted referrals to community

and other resources, which suggests the need for stronger hospital and community linkages.

The participants in our study were sensitive to physicians' time constraints and did not expect a lot of time; they encouraged a gentle, direct inquiry regarding domestic violence. They indicated that they want the medical provider to acknowledge the existence of abuse and make an appropriate referral. The battered women in this study believed that providers have enormous power to set the stage for conversations on domestic violence through trust, compassion, support, and confidentiality. The women in our study believed that battered women are helped most by medical providers who understand the fears and concerns that battered women have, and how these might influence their help-seeking. Given the psychological state and practical concerns of battered women, establishing rapport requires a conscious effort that may go beyond the normal dynamics of the patient-provider relationship. Family physicians and other primary care providers are in ideal positions to provide battered women with support, options, and information about resources through ongoing relationships with patients.

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. Medical providers can help the woman evaluate her situation by educating her about abuse and its potential effects, as they do about other health-related behaviors such as smoking. Empowering the battered woman to make decisions may be an important way that medical providers can help build her self-esteem, encourage her process of resolution, and further establish the health care setting as a safe place. Guidelines have been developed by the American Medical Association that can help providers better understand their potential role.<sup>26</sup> However, mandatory domestic violence reporting laws in some states, such as California, may limit providers' opportunity to empower battered women to make decisions. For example, the women in this study have pointed out how police involvement can pose an important barrier to seeking help. More research is needed to evaluate the risks and benefits of policies such as mandatory reporting to police.

Our study illustrates that domestic violence places unique demands on the medical care system as a whole, on the medical institution at which a battered woman seeks care, and on the provider's relationship with the battered woman. With changes in health care, it is important to understand the nature of providing appropriate care to battered women while assessing the implications of health care system reform. For example, while managed care systems may increase access to primary care for some women, providers' concern for efficiency may conflict with the requisite of establishing a supportive, ongoing professional relationship with a battered woman. Using social workers and other battered women's advocates in emergency departments and other settings may necessitate increased community collaboration to provide knowledgeable persons dedicated to the counseling and

referral of battered women. Another possible collaboration could involve battered women in the medical education process so that providers can learn critical patient communication skills.

This study has several limitations. The recruitment strategy used may have yielded a biased sample of women who knew the system well enough to be involved in a program, and who were sufficiently safe and willing to discuss their abuse. However, the sample included battered women who had a range of violence in their relationships and who were in all stages of safety, including some women who were living with their battering partners and others living in shelters, some being stalked by their partners, and others with restraining orders on their partners. In addition, using a variety of recruitment sites prevented reliance solely on a specific clinic-based or shelter population, and it provided information on a range of experiences women have with the health care system. This method does not lend itself to exact replication of findings. More research is needed using qualitative and quantitative methods to complement our findings.

The findings from this study can serve as a foundation for ensuring the success of future interventions to help battered women receive better health care. An approach to battered women is needed that starts with understanding the origins of the women's silence and establishing a good patient-provider relationship to help break this silence. Improving the quality of care for battered women will require changes in education for medical providers, health care structure, community resources, and the social forces that allow women to be abused.

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