How to Improve Health Care Given to Intimate Partner Violence Victims From Victims' Perspectives

Shelly Maras

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HOW TO IMPROVE HEALTH CARE GIVEN TO INTIMATE PARTNER VIOLENCE VICTIMS FROM VICTIMS’ PERSPECTIVES

A Thesis
Submitted to the School of Graduate Studies and Research
in Partial Fulfillment of the
Requirements for the Degree
Master of Arts

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December 2018
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Intimate partner violence (IPV) is recognized as a public health concern in the United States. Women are most likely to be victims in intimate relationships and endure physical, mental, and sexual health related problems because of abuse that leads them to utilize health care at high rates. Scholars studying the intersection of IPV and health care argue that care given to victims must be improved, rates of identifying and referring victims to social services remains low. Moreover, women killed by partners often seek health care prior to their death. The purpose of this thesis is to shed light on how female victims think victims should be treated and responded to by health care professionals when seeking care for symptoms of abuse. However, researching victims of IPV is difficult as there are many ethical and methodological concerns and challenges to consider which is also a focus of this research.
ACKNOWLEDGEMENTS

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I would not have made it this far in my academic career without my grandmother, Sylvia Maras, and my mother, Sherrie Maras. To each of you, I owe my sincerest gratitude. Thank you for being my shoulders to lean on and keeping me grounded. Love you both so much!
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CHAPTER ONE

INTRODUCTION¹

“We live in a world in which women are battered and are unable to flee from the men who beat them, although their door is theoretically standing wide open. One out of every four women becomes a victim of severe violence. One out of every two will be confronted by sexual harassment over her lifetime. These crimes are everywhere and can take place behind any front door in the country, every day, and barely elicit much more than a shrug of the shoulders and superficial dismay.”

- Natascha Kampusch, 3,096 Days

Intimate partner violence (IPV) is a significant public health concern. IPV is associated with various health problems, such as physical injuries, mental health problems, and sexual abuse – all of which lead abused women to seek health care often (Spangaro, Koziol-McLain, Zwi, Rutherford, Frail, & Ruane, 2016). However, the health care sector’s response to IPV has been described as ineffective and even harmful (Goodman & Epstein, 2008). Thus, some scholars call for improved health care to IPV victims; however, most research neglects the perspective of victims themselves and what they deem a helpful health care response in accordance to their needs and their situations.

The purpose of this study is to understand how health professionals can provide the most helpful response to women experiencing intimate partner violence from the perspectives of abused women themselves. Employing a qualitative research approach, I conducted phone interviews with female victims of IPV and asked them how to improve health care. I limited my

¹ Content from this chapter has been previously published. For reference please view: Maras, S. A. (2017). Towards a systems-based approach for intimate partner violence victims in health care settings. Sociation Today, 15(2), 1-21.
research to women, and excluded males, because women are most likely to be victims of IPV (Carmody, 2007). Complying with standpoint feminist theory, I focused on women’s perspectives, rather than health care personnel’s perspectives, to allow those at the bottom of social hierarchies to contribute to knowledge (Spangaro, Zwi, & Poulos, 2011).

My goal conducting this research was to allow IPV victims to have a voice about how to respond to IPV in health care settings as most current research focuses on the perspectives of those at the top of social hierarchies and how they believe care can be improved. For instance, a controversial debate among the literature in this area relates to the effectiveness of universal IPV screening (Carroll, 2016). Researchers and medical physicians use scientific knowledge to question the effectiveness of screening in detecting and referring women to social services without considering how IPV victims want to be treated within these settings. Thus, I seek to ascertain how abused women want to receive care in health care settings.

The suggestions made by the women in this study have the potential to improve health care for IPV victims regarding how health care providers should respond to victims, as well as systemic approaches to transform how the health care system handles cases of IPV. These suggestions will be detailed in Chapter 4. However, the findings of this study are limited because they are based on a small sample size of three due to recruitment issues which will be discussed in Chapter 3. Nonetheless, I have an ethical and personal obligation to tell the stories of and health care suggestions of my participants.

Intimate partner violence and domestic violence are often used interchangeably. Both are considered forms of family violence. Family violence is used to describe acts of violence between family members including parents, children, siblings, elders, and partners (The Family Violence Prevention Fund, 2004). IPV and domestic violence are terms used to specify violence
between partners in a relationship. IPV can also be referred to with the following terms: “partner violence”, “gender violence”, “abuse”, “wife abuse”, “battering”, “spousal abuse”, “violence against women”, and “interpersonal violence” (Martin, 2009). There is a lack of common terminology among scholars conceptualizing intimate partner violence, as all the terms I have mentioned refer to the same concept. Within my research, I use the terms IPV, abuse, violence, and domestic violence, which will be found throughout this thesis.

**Intimate Partner Violence**

Intimate partner violence (IPV), also known as domestic violence, is defined by the Family Violence Prevention Fund (2004), as a pattern of coercive behaviors to exert control over an intimate partner using “physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats” (p. 2). The World Health Organization (2013) offers another definition of IPV as a “self-reported experience of one or more acts of physical or sexual violence by a current or former partner since the age of 15 years” (p. 6).

Most research on domestic violence focuses on heterosexual women because they are five to eight times more likely to be victim of IPV than heterosexual men (Family Violence Prevention Fund, 2004). In the United States, a partner physically or sexually assaults a quarter of women, who are beaten, stalked, threatened, humiliated, kicked, shoved, slapped, and choked (Goodman & Epstein, 2008). Estimates report that 1.5 million American women experience IPV each year (Chang, Decker, Moracco, Martin, Peterson, & Frasier, 2005). Additionally, IPV is a social problem globally – 35% of women in the world have experienced physical or sexual IPV and as many as 38% of female homicides are committed by intimate partners (World Health Organization, 2013).
As abuse escalates in frequency and severity over time, women actively seek help from violence (Campbell, Rose, Kub, & Nedd, 1998; Goodkind, Sullivan, & Bybee, 2004). They seek help informally, through friends and family, and formally, through social services, police, and health care to ensure initial and ongoing safety (Goodkind et al., 2004; Meyer 2015). However, when seeking help from either informal or formal sources, survivors often face victim-blaming attitudes where they must prove they have not contributed to their own victimization to receive adequate help (Meyer, 2015). Unfortunately, this can occur in the medical field where women seeking help have felt alienated or have found the health care system unhelpful (Plichta, 2007).

IPV can lead to physical injuries, gastrointestinal disorders, depression, anxiety, chronic pain, gynecological issues, sexually transmitted diseases, and suicidal ideation, making health care a necessary resource for abused women who frequent health care facilities more often than non-abused women (Chang et al., 2005; Plichta, 2007). Women may be treated for health concerns without being asked by health professionals how they were caused (García-Moreno, 2002). Ignoring the cause of health-related problems is problematic because it allows abuse to remain invisible to health care providers. As a result, referrals to appropriate social services are not made making the response to IPV victims insufficient (Williamson, 2009).

Thus, acknowledging the health concerns caused by IPV and the lack of appropriate care received, I address how health care professionals can best help victims of abuse in medical settings from victims’ perspectives. Further, I address how health care and social services may begin to work together to improve abused women’s care comprehensively. Therefore, within this thesis, I explore how care can best be improved for IPV victims.
Statement of the Problem

There is growing recognition among scholars that the health care sector must improve its response to domestic violence (Williamson, 2009). Health providers treat domestic violence as a medical problem, rather than a social problem, a process referred to as medicalization (Conrad, 2007). The medicalization of abuse is problematic because it allows providers to neglect the source of health problems associated with IPV making abuse invisible in health care settings (García-Moreno, 2002). Abused women often require health care and social services simultaneously, so it is critical that health providers can detect abuse and refer women to social services (Haeseler, 2013).

However, detection is not feasible in the absence of asking women about the cause of their symptoms, a process referred to as screening. Universal screening is a controversial topic – scholars disagree over the effectiveness of detection resulting in intervention (McCloskey, Lighter, Williams, Gerber, Wittenberg, & Ganz, 2006). Those in favor of screening emphasize the increased detection of abuse, and those opposed to screening highlight a lack of evidence that detection reduces abuse (Spangaro et al., 2016).

Nonetheless, remaining in an abusive relationship predisposes women to increased violence and high health care utilization. For instance, Campbell (2004) argues that most women killed by a partner can be identified in the health care sector prior to their death. Thus, screening practices have the potential to help women achieve safety from violence and possibly save their lives. Despite the debate over screening, it is important to assess victims of IPV want when it comes to health care, as most who experience abuse do not tell anyone about it, including health providers, making screening difficult (Spangaro et al., 2011).
Women may not disclose abuse to health care professionals due to being afraid of their abuser, shame, self-blame, feeling trapped, fear of being reported to statutory authorities, not viewing the abuse as serious, and not feeling comfortable with the health provider (Spangaro et al., 2011; Spangaro, Zwi, Poulos, & Man, 2010). Therefore, women are unlikely to disclose abuse in the absence of direct questioning from providers (Bacchus, Mezey, & Bewley, 2003). Women may be more likely to disclose in situations where providers have knowledge about IPV, and there is privacy and understanding (Nicolaidis et al., 2008; Spangaro et al., 2016). However, Chang et al. (2005) find that some women will deny abuse even when asked, creating a barrier for health professionals to detect abuse.

Additionally, most professionals are ill-equipped to deal with cases of IPV. Health care providers are unprepared and lack the knowledge to properly respond to IPV, and they work in fast-paced environments where they face multiple priorities and high workloads (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Hamberger & Phelan, 2006; Minsky-Kelly, Hamberger, Pape, & Wolff, 2005). Thus, professionals may avoid asking about abuse as it is perceived as an unmanageable problem (Young-Wolff et al., 2016). The combination of women’s hesitance to disclose and the barriers professionals face to ask about abuse, leads to the invisibility of abuse and the absence of referrals to appropriate social services.

Nonetheless, health professionals are often the first point of formal help seeking for IPV victims, placing them in a position to intervene (Bacchus et al., 2003). Identifying abuse can lead to referrals ranging from giving patients information about local resources to referring them community agencies electronically (Garg, Boynton-Jarrett, & Dworkin, 2016). Interventions such as these have the potential to help women beyond immediate health care needs.
Thus, my study uses qualitative research to assess what abused women view as meaningful outcomes regarding health care providers’ response to IPV, from the standpoint of women who have experienced it. The research question guiding my research is, *how can health professionals provide the most helpful response to women who have experienced intimate partner violence?*

**Purpose of the Study**

The purpose of this study was to ask women how to health care sector’s response to IPV. The existing body of research adequately addresses the conditions in which women disclose IPV to professionals, barriers professionals seek to confront abuse, and the controversy over screening. While these research topics are important, there needs to be more research from the standpoint of survivors themselves when it comes to health care responses to IPV. Therefore, I examine if abused women want information about social services from medical providers, and what types of responses are most beneficial to them.

In addition, I address what help seeking is like for women. Where do women go when seeking help? What services do they need? While I am mainly concerned with medical help seeking behaviors, I was also interested in determining if women sought other services simultaneously as the literature suggests. Thus, if women were seeking multiple services, what was seeking care like navigating between various social services and health care? I wanted to understand the extent of their help seeking, so that I could assess how care can be improved in the health care sector in relation to these other factors.

Ultimately, the purpose of this study is to ascertain how health care can be improved for battered women overall. I analyze how health providers should respond to cases of IPV, and how providers can best inform women of available social resources that may be beneficial to
them when seeking help from an abusive relationship. Essentially, how health professionals can provide the most helpful response to women who have experienced intimate partner violence.

Significance of the Study

The significance of this exploratory study is that the findings contribute to knowledge about the health care sector and intimate partner violence. Most importantly, this knowledge comes from survivors’ perspectives, a piece that is scarce in existing literature. The significance of this research is that it focuses on what women value in responses to IPV in health care settings. The findings from this study can help to inform and create policies in the health care sector designed to meet women’s needs. However, more research such as this needs to be executed to formally influence policies on this issue. Nonetheless, the findings from this study constitute new knowledge being added to this body of research.

Research Question

The research question for this study is: “How can health professionals provide the most helpful response to women who are experiencing intimate partner violence?” This question aims to discover: 1) women’s experiences in health care settings; 2) the types of referrals and information that would be most helpful to abused women; 3) women’s experience navigating the health care sector and social service sector; and 4) women’s suggestions for how to improve health care.
CHAPTER TWO

LITERATURE REVIEW\(^2\)

“When he first said my diagnosis, I couldn't believe it. There must be another PTSD than post-traumatic stress disorder, I thought. I have only heard of war veterans who have served on the front lines and seen the horrors of battle being diagnosed with PTSD. I am a Beverly Hills housewife, not a soldier. I can't have PTSD. Well, I was wrong. Housewives can get PTSD, too, and yours, truly did.”


In this chapter, I synthesize extant literature related to intimate partner violence (IPV) and the health care sector. I begin by providing an overview of the health consequences and costs of IPV. Then, I discuss the health care sector’s role in identifying and preventing violence, including barriers to disclosure for women and barriers to identify IPV for health care professionals. Next, I highlight the controversy over universal screening for IPV in health care settings in the United States. Then, I explain comprehensive approaches to health care and IPV that some scholars argue is a better response to IPV than traditional responses as it connects health care and social service sectors. Next, I explain the theoretical framework – standpoint feminist theory – that guides my research question and my research design. I conclude by considering ethical and methodological concerns when researching victims of IPV, a sensitive population.

\(^2\) Content from this chapter has been previously published. For reference please view: Maras, S. A. (2017). Towards a systems-based approach for intimate partner violence victims in health care settings. *Sociation Today, 15*(2), 1-21.
Consequences of IPV

The National Center for Injury Prevention and Control (2003) recognizes IPV as a public health issue in the United States. Women who experience domestic violence endure physical, mental, and sexual health problems in the form of direct and indirect pathways of abuse. Direct pathways include physical injuries; whereas, indirect pathways include prolonged stress and more severe physical and mental problems. Severe abuse has a greater impact on women’s health as health conditions worsen over time (Dutton, James, Langhorne, & Kelley, 2015). This leads abused women to visit health care providers more frequently than women who are not abused, resulting in higher health care utilization and health care costs for women experiencing IPV (Black et al., 2011).

Health Consequences for Women

IPV leads to many physical, mental, and sexual health related problems for women who experience violence. IPV is a risk factor for frequently encountered health problems such as, but not limited to, headaches, back pain, vaginal infection, and digestive problems (Campbell et al., 2002). When women are physically abused, injuries most commonly occur to the face, neck, and head, and less commonly to the abdomen, back, and genitals (Sheridan & Nash, 2007). Additionally, Davis (2014) argues that repeated force from punching or kicking to a woman’s head and face may cause mild traumatic brain injury – an injury that is often unrecognized and unreported in health care settings. Overall, injuries caused by abuse may be more prevalent than any other type of injury including car accidents, mugging, and rape combined (McLeer & Anwar, 1989).

Not only do women suffer physical consequences, but women experience mental health problems such as depression, anxiety, post-traumatic stress disorder, and suicide ideation (Coker,
Reeder, Fadden & Smith, 2004). Further, Martin (2009) argues that abuse impacts women’s emotions, they experience fear, love, self-blame, and guilt because of abuse (Martin, 2009). Thus, the psychological stress that accompanies abuse may lead to suicide ideation. Haeseler (2013) estimates that as many as 35% to 40% of abused women attempt suicide in the United States.

Furthermore, physical and mental health symptoms of IPV may be exacerbated by sexual violence from a partner. Dutton et al. (2015) find that sexual violence is often found in cases of IPV, and as many as one in ten women have been raped by a partner. Rape by a partner can lead to psychological distress and often occurs in addition to physical abuse (Brown, Burnette, & Cerulli, 2015). Thus, sexual violence has profound impacts on women’s health as well.

Death is the result in extreme cases of IPV. Goodman and Epstein (2008) estimate that as many as 30% of women murdered in the United States are killed by a current or ex-partner. Additionally, Campbell (2004) finds that most women killed by their partners, can be identified in the health care sector before they are killed. For example, many women visit health care facilities for general health problems, mental health problems, substance abuse, or injuries from domestic violence prior to their death (Campbell, 2004). These findings indicate the importance of the health care sectors’ ability to detect IPV and provide women with resources to achieve safety.

**Consequences for Society**

Abused women seek health care services, such as mental health services, substance abuse services, and emergency departments, more frequently than non-abused women resulting in high health care costs for victims of IPV (Black et al., 2011; Rivara et al., 2017). The rate at which abused women use health care facilities leads to increased health care costs. For instance,
women who are abused exceed $5.8 billion annually in health care costs; they incur 2-2.5 times the cost as non-abused women (Bonomi, Anderson, Rivara, & Thompson, 2009; National Center for Injury Prevention and Control, 2003; Chang et al., 2005). In their study comparing health plans, Waetchter and Van (2015) find that women exposed to IPV generate 92% more costs per year than non-abused women. Furthermore, health care costs continue once violence has ended. For example, Bonomi et al. (2009) find that women who suffer from physical violence for five or more years spend 19% more on health care per year after abuse ends compared to women who have never been abused.

Work absenteeism is another cost associated with IPV. Abuse affects women’s ability to work and provide for themselves financially (Martin, 2009). Lacey, Saunders, and Zhang (2011) find that low income and unemployment are often reasons why women stay in abusive relationships. Thus, collectively, women miss nearly 8 million days of paid work annually which leads to lost labor and production for employers – averaging about $1.8 billion per year (Dagher, Mary, & Kozhimannil, 2014; Modi, Palmer, & Armstrong, 2014). Ultimately, IPV results in elevated health care costs, lost wages for women, and lost productivity for employers.

**Intimate Partner Violence and the Health Care Sector**

Health care professionals are in a unique position to respond to women exposed to domestic violence; health care facilities are often the first point of formal contact for IPV victims (Othman, Goddard & Piterman, 2014; Bacchus et al., 2003). Among scholars studying IPV, there is a growing recognition that the health care sector needs to improve its role in addressing abused women’s needs (Parsons, Goodwin, & Peterson, 2000). If violence goes undetected, health-related conditions can worsen (Chrisler & Ferguson, 2006). Not only can women’s health worsen, but there are important legal reasons to document abuse in health care. For instance,
when abuse is not recorded in medical settings, women do not have documentation of their injuries to use in court cases (Glass, Dearwater, & Campbell, 2001). This suggests that there is a lack of coordination among various services, such as health care and legal services.

It is important that IPV is identified in health care settings to refer women to other social services. Screening and assessment are critical first steps to identify violence in health care settings that needs to be met with the capability to refer and link patients to appropriate services (Dutton et al., 2015; Garg, Boynton-Jarrett, & Dworkin, 2016). However, there is a large discrepancy between the number of women using health care facilities because of abuse and the rates of detection and intervention (Warshaw, 1989). In medical settings, women are hesitant to disclose abuse without direct questioning and medical professionals face several barriers that leads to an inadequate assessment of abuse.

**Barriers to Disclosure**

IPV victims have a hard time disclosing abuse. For example, Spangaro et al. (2011) estimates that 20% of victims never tell anyone. Family, friends, and health providers can encourage disclosure by offering support to IPV victims (Martin, 2009). However, stereotypes about IPV often impede people’s ability to be supportive. For instance, Goodkind et al. (2003) found that women’s friends and family often do not believe them about abuse, blame them for abuse, or are too scared themselves to intervene. Thus, the negative perceptions surrounding IPV make it hard for women to disclose.

Further, the stigma surrounding abuse leads women to view themselves negatively; they blame themselves for staying in the relationship and label themselves as stupid for allowing abuse to happen (Enander, 2010). Studies suggest that some of the barriers to disclose IPV to health care professionals include fear of their abuser, shame, feeling trapped, fear of being
reported to statutory officers, not viewing the abuse as serious, and not feeling comfortable with the health provider (Spangaro et al., 2011; Spangaro et al., 2010). Moreover, some women fear disclosing abuse will allow health providers to discount their physical symptoms, which can lead to feelings of frustration when providers do not try to understand the complexity of violence (Nicolaidis et al., 2008). According to Othman et al. (2014), there is an unspoken agreement between providers and abused women not to address IPV.

However, Plichta (2007) finds when health providers probe about IPV women are more likely to disclose. In fact, 80% of victims will disclose abuse if asked, but are unlikely to disclose without direct questioning (Plichta, 2007). Research suggests that most women want to be asked about IPV, but some continue to be wary of health providers' intentions for asking (Chang et al., 2015). To combat this, Chang et al. (2015) argues that healthcare professionals should provide a reason for asking about IPV, which increases the likelihood for women to disclose. Other studies indicate that even if women do not disclose the first time they are asked, they would like repeated opportunities to disclose because they might be ready to upon persistent inquiries (Spangaro et al., 2011).

Nevertheless, disclosure can yield positive outcomes for victims of IPV if it is met with positive responses from health care providers, such as understanding and making referrals to social services (Spangaro et al., 2015). For example, Feder et al. (2006) argues that IPV victims want healthcare professionals to be nonjudgmental, understanding, and sensitive when confronted with IPV. Other studies suggest that there may be benefits to offering all women information about IPV, including brochures, flyers, or posters (Chang et al., 2005). Yet research shows that because of issues like physician and victim related barriers, screening practices and
intervention rates have remained low, with recent slight improvements (Hamberger, Rhodes, and Brown 2015).

**Barriers to Screening**

Hamberger and Phelan (2006) identify barriers that impede health professionals’ ability to detect abuse that include a lack of knowledge and training on how to handle domestic violence. However, even when training occurs, medical staff indicate that they do not have sufficient time to question patients about IPV or offer emotional support to victims due to fast-paced work environments, multiple priorities, and high workloads (Minsky-Kelly et al., 2005; Beynon et al., 2012). Additionally, Jeanjot, Barlow, and Rozenberg (2008) identify other barriers such as: abusive partners accompanying victims to health care visits; cultural and language barriers; and lack of information about referral resources. Thus, providers often have a difficult time deciphering the best way to treat IPV victims.

Among health care professionals, IPV has been described as a “wicked problem” because it is a difficult, complex, stigmatized, and seemingly unmanageable condition (Young-Wolff et al., 2016). Within the literature, scholars find that health professionals use metaphors to describe inquiring about IPV that include “opening Pandora’s box” and “opening a can of worms” (Sweet, 2015; Williston & Lafreniere, 2013). There is not a straightforward medical solution to treating IPV; thus, IPV provides challenges to professionals about how to serve women’s needs (Williston & Lafreniere, 2013). Therefore, practitioners may avoid asking about IPV because if it is not identified, it remains invisible.

One reason health professionals are wary about screening is because IPV cannot be cured with medicine. Sweet (2015) suggests that IPV has been increasingly medicalized. Medicalization is a "process by which nonmedical problems become defined and treated as
medical problems, usually in terms of illness and disorders" (Conrad 2007:4). When confronted with IPV, health providers may address physical symptoms of abuse rather than the underlying cause of symptoms. Medicalization of IPV grants health professionals the authority to treat abuse with medicine while simultaneously minimizing the social context behind it. This is problematic because victims of IPV may want providers to understand the complexity of abuse which cannot be done without addressing underlying causes of symptoms.

Scholars also suggest that there are gender differences regarding physicians' likelihood of screening patients for IPV. For example, Jonassen and Mazor (2003) find that compared to male physicians, female physicians are more likely to screen women for IPV. Not only do female physicians screen more, but they detect abuse earlier, assess the history of abuse more thoroughly, and are more likely to make referrals than their male counterparts (Saunders and Kindy 1993). This is significant because men dominate the healthcare sector (Ballou and Landreneau 2010). Rose and Saunders (1986) critique the patriarchal nature of medicine arguing that gendered norms create health care environments that (1) avoid addressing abuse, (2) only treat physical injuries, and (3) tend to rely on prescriptions for addressing insomnia, depression, or anxiety.

Despite the barriers that professionals face in their jobs such as lack of education, training and time, another commonly cited obstacle is patient nondisclosure and noncompliance (Waalen et al. 2000). When women do not disclose abuse to professionals, they are unable to detect it. Thus, scholars question the effectiveness of screening practices within medical settings. There is a debate around this where scholars either argue that screening does not lead to better outcomes for IPV victims, or that it does.
Controversy over Universal Screening

The Affordable Care Act includes screening and brief counseling as free preventive services to women (Miller et al., 2015). Despite this and evidence that IPV presents health risks to women, medical providers disagree over the need to routinely screen women for IPV. Those against screening cite a lack of evidence that screening results in reduced violence or enhanced health for those affected by IPV. In 2004, the U.S. Preventive Taskforce declared there was insufficient evidence that screening was effective, thus preventing them from recommending screening in medical settings (McCloskey et al., 2006). In 2013, the U.S. Preventive Taskforce renounced their conclusion from 2004, and began to recommend universal screening in health care settings (Moats, Edwards, & Files, 2014).

However, a universal screening policy has not been adopted by health care facilities. There are some structural barriers to adoption, such as inadequately trained staff, organizational cultures not conducive to screening, and the absence of protocols and processes that enable providers to screen (Ghandour, Campbell, & Lloyd, 2015). Traditional methods to incorporate screening into health care settings, such as clinical guidelines and training, have shown little improvement in identification, intervention, and referral (Young-Wolff et al., 2016). Consequentially, women often find the health care system unhelpful or feel alienated by health care providers (Plichta, 2007).

Current research continues to find contrasting results; some find interventions to be successful, others do not. For example, McCloskey et al. (2006) find positive results associated with screening, such that: 1) disclosing violence to health professionals is associated with women’s use of interventions; 2) women are more likely to leave their abuser if they receive interventions; and 3) exiting an abusive relationship is linked with improved health. Meanwhile
MacMillen et al. (2009) do not find support to implement screening in health care settings, concluding that screening leads to few benefits.

Regardless of the debate over screening practices, research such as that done by McClosky et al. (2006) demonstrates that screening can improve overall health conditions for women. Carroll (2016) argues:

We should stop saying that the USPSTF [United States Preventative Services Task Force] recommendations are enough. We should stop thinking that motivational interviewing for women who are in danger is enough. Doing so is wrong, especially when high quality studies exist that show some things do work … We may not always get the results we’d like, but discovering what doesn’t work is just as important as discovering what does (p. 1106).

Thus, screening has the potential to identify abuse, and identification can lead to preventive strategies. However, health care professionals need to be equipped to identify and refer patients to social services. Currently, only 17 states have laws that require domestic violence training for health care professionals, but each has their own variation in requirements (Dagher et al., 2014). As training and screening practices increase, it is important that health providers are able to link and refer patients to social services once abuse is detected – one way to ensure this is by applying a systems-based approach (Garg et al., 2016).

**Systems-Based Approach to Care**

Collaboration between health care services and social services in the United States is lacking. According to Sumner et al. (2015), medical facilities and social services have not created a mechanism to coordinate responses to violence. Women benefit from care that is holistic in nature because women often need help simultaneously from agencies that provide
protection, housing, health care, mental health care, legal help, education and/or job training, and children’s services (Haeseler, 2013; Vinton & Wilke, 2014). Because women need multiple services, there needs to be a coordinated approach between health care and social services when treating IPV.

One way to implement a coordinated response is through a systems-based approach. Systems-based approaches, sometimes referred to as comprehensive approaches, highlight a cross-sector collaboration whereby healthcare systems are connected to community and advocacy providers (Miller et al. 2015). Systems-based approaches incorporate screening at multiple levels and have institutional support; thus, O’Campo et al. (2011) find that systems-based approaches have effective screening protocols, ongoing training for staff members, and immediate access and referrals to onsite or offsite support services. Systems-based approaches yield more successful outcomes than those that are piecemeal (O’Campo et al., 2011).

Most systems-based approaches are still in early developmental stages; however, an exemplary model is found within the Kaiser Permanente Northern California (KPNC) health care organization. This organization serves 3.9 million patients. KPNC has made domestic violence part of everyday care through: 1) visible messages such as posters; 2) routine inquiry, intervention, and referral; 3) safety planning, triage for mental health, and follow-ups by behavioral health clinicians; 4) partnerships with IPV advocacy organizations; and 5) local leadership and oversight (Young-Wolff et al., 2016). As a result of their initiative, identification has increased eightfold since 2000 (Miller et al., 2015).

While a systems-based approach is ideal, it has not been achieved in the United States. Violence continues to remain hidden in most health care settings and abused women are often undetected (Pichta, 2007). Identification of IPV is largely left to the discretion of health care
professionals and idiosyncratic decisions to inquire about abuse. It is important to continue to research and evaluate programs that are successful (such as KPNC), as well as those that are not to find interventions to be adopted universally in health care settings.

**Theoretical Approach – Standpoint Feminist Theory**

Prior to the 1970s, research on domestic violence was nearly nonexistent and studies that were done lacked the perspectives of victims themselves (Sullivan & Cain, 2004). Since then, researchers have began to value the expertise that victims can contribute to the research done on IPV. Because of this, I wanted to understand how health professionals could help victims of IPV by asking women directly about their healthcare needs and how professionals should respond to domestic violence situations.

The theoretical approach guiding my research is standpoint feminist theory. Standpoint feminist theory was developed to serve feminist needs by reconfiguring the logic behind the Marxian standpoint of the proletariat (Harding, 2006). Standpoint feminism challenges the value of knowledge solely created by the dominant class and “suggests that those at the bottom of social hierarchies, make fundamental contributions to knowledge” (Spangaro et al., 2011, p. 151). Standpoint theory starts by assuming that people at the bottom of social hierarchies experience reality differently because of oppression. Oppressed people are attentive to both the perspectives of the dominant class and their own. Thus, they have the potential to create a more complete view of the social world by integrating the perceptions of both the privileged and the oppressed (Swigonski, 1994).

The central themes of standpoint feminist theory are what follows. The first is that life experience impacts one’s understanding of the world. The lives of oppressed people are rarely the starting points for scientific inquiry. However, standpoint feminism posits that those who
have lived through a phenomenon are more credible than those who have not (Swigonski, 1994). As Smith (2005) suggests, women have authority over their perspectives and the knowledge they gain through lived experiences. For example, the perspectives of abused women are more credible than the assumptions made about IPV from those who have not lived through it. Their perspectives may be more meaningful than individuals working to reform policies for abused women in health care settings that have no experience of what abuse is like.

The second tenet is that members of marginalized and privileged groups are likely to have opposing understandings of the social world. Suppressing the knowledge of marginalized groups allows dominant groups to rule by maintaining, reinforcing, and legitimating their understanding of the world (Collins, 1990; Swigonski, 1994). Oppressed groups have the potential to create more complete understandings of the world because they are not invested in maintaining power (Swigonski, 1994). A feminist standpoint approach intends to produce research that answers questions that arise from women’s lives (Harding, 2006). Hence, when it comes to IPV and health care, women can create a more complete understanding of how to treat IPV. In health care settings, this can counteract the medicalization of abuse, which gives medical professionals the power to define and treat abuse as purely medical, rather than social. Women can give a more complete understanding of how health professionals can help victims and their needs.

The third tenet is that the oppressed group’s standpoint is developed through hands-on-procedures of education; “knowledge emerges for the oppressed through the struggles they wage against their oppressors” (Swigonski, 1994, p. 391). To avoid assuming what abused women need from medical providers, it is best to ask them directly.
In all, standpoint theory is being used to answer questions about women’s experiences in the health care sector. Most research done on IPV and the health care sector focuses on the dominant group, the health care sector, and how they can improve the response to IPV. It is important to understand women’s experiences of IPV in health care settings to create policies and practices that are most beneficial to their needs. As suggested by standpoint theory, the experience of the marginalized group, abused women, in addition to the views of the dominant group, the health care sector, can provide the most complete understanding of IPV in health care settings and how health professionals can respond to women experiencing abuse.

**Women’s Perspectives**

There is a need to understand abused women’s experiences interacting with health professionals. More specifically, there is a need to understand how health professionals can best help women experiencing intimate partner violence. Thus, I use standpoint theory to guide my research with women to obtain their perspectives on how medical professionals can help them, and how this information can be used to improve the care given to abused women in medical settings. While women’s perspectives are most valuable to this research, women with a history of domestic violence can be hard to locate as most researchers rely on convenience samples obtained from domestic violence agencies, the courthouse, and health clinics (Bender, 2016). Thus, before concluding, I consider some of the ethical and methodological dilemmas researchers have encountered when studying women with a history of IPV.

**Researching Vulnerable Populations**

When conducting research involving sensitive topics and vulnerable populations, numerous problems may arise concerning ethics and methodology. According to Hill (1995), socially sensitive research involves conducting studies that may have social consequences either
directly to participants or to the class of individuals represented by the research. When researching sensitive topics, the participants are often considered vulnerable because the information they provide may place them in jeopardy (Hill, 1995). The population for this study, women with a history of domestic violence, fits the vulnerable category.

**Ethical Concerns**

Federal research regulations do not include women with a history of IPV within their category of “vulnerable human subject,” which includes prisoners, pregnant women, fetuses, newborns, children, and disabled persons (Mulla & Hlavka, 2011). However, survivors of IPV participating in research face potential harm when it comes to personal well-being and safety, an ethical concern for researchers to consider when designing their research. Women risk re-traumatization, distress, and anguish discussing traumatic experiences. They may also experience backlash from a partner if information about their disclosure of violence becomes known to an abuser (Bender, 2016). Thus, women may be considered a vulnerable subject because the information they provide may place them in danger.

Because of the risks associated with researching IPV victims, researchers must ensure that the benefits of participation outweigh the risks. This is done by ensuring privacy and anonymity to participants in addition to providing supportive information and referrals to participants who need it, such as those who experience distress discussing traumatic experiences. The World Health Organization specifies that community-based resources and services are essential for participants in the event of distress (Bender, 2016). Researchers may need to negotiate with institutional review boards to show that the research being conducted is designed within a framework of respect for participants’ privacy and confidentiality and demonstrate that the study’s finding will be of benefit to participants and those they represent (Hill, 1995).
Not only is there a concern for IPV victims’ safety, but there is often a concern for the researcher’s well-being. Researchers may also experience distress upon participants’ disclosure of traumatic experiences, this risk is greater if they are a survivor themselves. Researchers open themselves up to safety concerns if an abuser is made aware of a victims’ disclosure of abuse and wants to retaliate against the researcher (Bender, 2016). The study design should account for risks to both the researcher and participants to ensure safety is achievable for both.

One way to ensure participant and researcher safety is to conduct phone interviews or employ online data collection methods. For instance, Campbell and Adams (2009) find that when it comes to interviewing participants about sensitive topics, phone or online data collection methods offer more confidentiality, allowing participants to disclose private and sensitive information. Moreover, these methods protect the researcher from being easily identified. Thus, when researching sensitive populations, researchers must consider what method is most appropriate for their research and which will ensure safety for both participants and researchers; phone or online methods may be best for some research questions and populations such as research with IPV victims.

Methodological Concerns

The literature pertaining to qualitative, methodological concerns when researching IPV victims is scarce. This can be partially accounted for by the fact that most data on IPV is obtained from national surveys or secondary data, very little is known about qualitative recruitment strategies for IPV victims (Bender, 2016). Those conducting qualitative research tend to use small-scale or cross-sectional designs from convenience samples obtained from domestic violence shelters, health clinics, and the court system. According to Bender (2016), social scientists have not devoted sufficient time writing about strategies to locate victims.
Because of the lack of qualitative research on IPV victims and the lack of written work about how to locate victims, researchers hoping to gain access to this population may run into recruitment difficulties and experience low participation. In fact, it has been argued that those wishing to study IPV victims must be an advocate within shelters to gain victims’ trust and cooperation, suggesting that domestic violence advocates have the best access to this population (Schwartz, 2000).

Thus, within this study, I ran into my own recruitment issues that will be explored in depth within the next few chapters. Due to the lack of available literature on how to overcome recruitment barriers, I offer suggestions within Chapter Five, my discussion and conclusion, about how I may have gone about this research differently. However, before I offer my suggestions, I detail the research design I followed for this study, and the issues I encountered in the next chapter, Chapter 3 – Methods.

**Conclusion**

In all, IPV creates many health concerns for victims, leading them to seek out healthcare frequently. However, there is a need to improve care given to IPV victims in health care settings so that victims may be identified and referred to appropriate services. Referrals have to potential to help women locate services to help them leave the relationship, preventing repeat abuse, high health care utilization, and death. To date, most research focuses on screening practices, barriers to screening, and systems-based approaches to improving care. Qualitative research on this topic done from women’s standpoint is limited.

Thus, this thesis adds to the existing literature by asking women how health care professionals can best respond to cases of IPV. However, while conducting this research the ethical and methodological concerns I have described were encountered, and thus, became an
important aspect of this research. In the next chapter, I outline the research design for this thesis and the methodological issues I encountered.
CHAPTER THREE

METHODOLOGY

The purpose of this study is to use women’s voices to understand how health professionals can help women experiencing IPV. In this chapter, I describe the research design that facilitated answers to my research question: how can health professionals provide the most helpful response to women who are experiencing intimate partner violence? I include a discussion of my positionality as the researcher, my study design, my data collection, and data analysis. The content of this chapter underscores the process I took to obtain the findings from this study.

**Qualitative Research Design**

For my study, I employed a qualitative research design. I used a qualitative method because it allowed me to capture the viewpoints of my participants – women with a history of domestic violence. I applied a phenomenological approach because it allows researchers to understand the lived experience of participants, and in this case, abused women, a perspective that is currently underrepresented in the literature on IPV and health care (Patton, 2015).

Within phenomenology, the core inquiry question is: “What is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?” (Patton, 2015, p. 115). The main tenets of this qualitative framework are (1) capturing the meaning people make to social phenomenon and how they interpret events, (2) using in-depth interviews to capture people’s experience, and (3) the assumption that there are essences to shared experiences (Patton, 2015). Phenomenology assumes that individuals will interpret phenomenon differently; however, there is a shared experience, or an essence, at the core of the experience. Thus, I conducted interviews to understand women’s individualistic experiences.
with health care personnel, and aimed to address their shared experience, or a shared understanding of how women with a history of IPV should be treated in health care settings.

I chose to do interviews rather than another research method, such as a survey or use secondary data, because I wanted to understand health care experiences from IPV victims’ perspectives aligning with the assumptions behind feminist standpoint theory – those at the bottom of social hierarchies can contribute to knowledge (Spangaro et al., 2011). Thus, I used interviews to elicit in-depth responses about women’s experiences, feelings, opinions, and perceptions (Patton, 2015) related to seeking health care and how health care providers should respond to IPV. A semi-structured interview guide aided me during interviews to evoke the richest data possible from my participants. To view the guide, refer to appendix B. When necessary, I veered from the guide to probe participants on new topics that arose that I had not thought of prior to developing the semi-structured guide. Probing was also used to get participants to elaborate or clarify information they were telling me. In all, a qualitative research design with a phenomenological approach was the best design to answer my research question; how can health professionals provide the most helpful response to women who are experiencing intimate partner violence?

**Researcher Positionality Statement**

Traditional research assumes that knowledge exists independently of the researcher. However, qualitative research recognizes that the researcher has their own perspective. Reflexivity in research reminds me, as the inquirer, to “be attentive to and conscious of the cultural, political, social, linguistic, and economic origins of one’s own perspective and voice as well as the perspective and voices of those one interviews” (Patton, 2015, p. 70). Reflexivity tells me to ask myself how I know what I know and how my participants know what they know.
As a white, middle-class, female, graduate student I had some characteristics in common with the women that I studied, but I could not assume that my experience as a female was the same as theirs, especially because I have never been a survivor of violence myself.

While I have never been a survivor of violence myself, I did grow up in a hostile household. My mom and dad had an abusive relationship where my mom was the victim of my dad’s violence; however, the violence was more emotional than physical and to a lesser degree than the accounts I have heard from those I have interviewed. But I do have some memories of physical altercations such as shoving, pushing, and pinning my mom against a wall. My worst memory stems from watching my dad get arrested because he had pulled an unloaded gun on my mom to threaten her to stay with him. It is because of these memories that I am interested in studying those who have survived domestic violence. Just because I have witnessed abusive encounters, does not mean I know what it is like to be in a violent relationship, so I am both an insider and outsider when it comes to cases of IPV.

My interest in IPV, and specifically how it is handled in the health care sector, stems from my graduate course work. For a medical sociology course, I was required to write a paper for a policy recommendation for an issue of my choice. Because I did not know what I wanted to research, I began considering domestic violence and health care settings. Upon looking at the literature, I noticed a lot of scholars studying this issue, most concerned with the controversy over screening practices in health care settings. When I came across a study done by Campbell (2004) who found that many women killed by a partner could be identified in the health care sector prior to their death, a red flag rose for me. Something needs to be done to address this issue to improve the health care given to women experiencing IPV. As a result, I have dedicated
my thesis to gathering women’s first-hand experiences about how health care can be improved for them during their time of need.

As I conducted interviews for my research, I tried to remain mindful of my own biases and understanding of IPV. I did not try to act like I knew what it was like to be in a violent relationship, and I told my participants why I was interested in learning about their experiences. I actively listened to participants’ stories and tried to remain unbiased when asking questions. To assess my positionality throughout my research, I wrote memos after each interview to assess how I thought my participants felt, how I felt, and the things that stuck out to me the most from the interview. In all, I strived to be as neutral as possible in my role as researcher.

Furthermore, another way to assess biases in qualitative research is through progressive subjectivity. This is the act of recording what you expect to find prior to investigation. According to Guba and Lincoln (1989), this process mentors the researcher’s developing constructions so that they are not given privilege over those that emerge from participants. Prior to this study, I expected to find that abused women would have unfavorable experiences in health care settings. In health care settings, I expected women to be victim blamed while finding professionals unhelpful. I believed that women would indicate a need for more information about social resources from professionals and that women would have difficulties navigating between health care and social services; a system that the literature cites as disconnected. Some of my findings align with what I thought I would find, and others do not. Participants also shed light on issues that I had never thought of prior to conducting this research. The finding from this study will be outlined in depth during the next chapter. In all, my research confirmed some of my preconceived constructions and negated others.
Study Design

My study followed a qualitative research design with a phenomenological approach to understand how health professionals can best help women with a history of domestic violence from women’s standpoint. Interviews were used because they are the best way to collect rich data about women’s experiences; they probe participants for detailed responses about experiences, perceptions, feelings, and knowledge from their viewpoint (Patton, 2015). I originally aimed to interview 10 women, but due to recruitment difficulties, the sample size for this study consists of 3. Recruitment difficulties will be thoroughly discussed later in this chapter. However, the interviews I conducted allowed me to understand women’s interactions with health care professionals and how they believe health professionals should respond to women who experience domestic violence. The interviews I did were all conducted over the phone.

While face-to-face interviews are ideal in qualitative research, the vulnerability of my participants and the sensitivity of IPV, made phone interviews more appropriate. Women saw a flyer for my research either at a domestic violence shelter, a local courthouse, or social media and could contact me for an interview through the phone number I provided on the flyer. To view the flyer, please refer to appendix C. I recruited at domestic violence shelters and one courthouse for two months before seeking out social media in the form of Facebook. I waited two months because I recognized that I was targeting a different population of women through Facebook, those that may not be actively seeking help, have been in recovery for a long period of time, or have not had recent interactions with health care professionals. Facebook was a backup recruitment strategy, but needed to be used due to low participation. I used the same flyer at
both the domestic violence shelters and the courthouse, and an image format of the flyer for Facebook.

The flyer instructed women to call me if they were interested in participating. By having women contact me by phone, both participants and I remained anonymous. I wanted to ensure anonymity among participants so that I was unable to connect information they shared with me with their identity. This process protected the information I gathered from being subpoenaed in possible court cases and women from having their identity exposed.

I do not know any of my participants’ names or phone numbers as I used a software through Google – Google Voice – to create a separate phone number from my real one. Thus, my participants were given my Google number, rather than my actual number. When someone called my Google Voice number, it would be forwarded to my cell phone and my Google Voice number would appear on my caller ID, rather than the participant’s phone number. Thus, Google Voice allowed me to conceal any incoming caller’s number by displaying my own Google number instead. By conducting phone interviews through Google Voice, I ensured anonymity of my participants and myself.

**Inclusion Criteria**

For my study, I only interviewed women with a history of IPV. Women had to be at least 18 years old to participate to protect minors and exclude them from my research. I ensured that I was interviewing women over the age of 18 by asking them their age as part of my first interview question. Further, women had to have contact with health care professionals. The inclusion criteria for my research was: women with a history of IPV, 18 years or older, and had contact with health professionals. The inclusion criteria for my research was included on my flyer, so that women would know who could participate.
**Exclusion Criteria**

I excluded men from my research because women are 5 to 8 times more likely to be victims of domestic violence than men (Family Violence Prevention Fund, 2004). Women without a history of IPV, under 18, and with no contact with health professionals were also excluded.

**Risks and Benefits to Participants**

Women with a history of domestic violence are not considered a “vulnerable human subject” by the U.S. Health and Human Service regulations. But, the potential risks to women with a history of IPV were more than minimal. When designing this study, I was conscious of two risks that could occur while interviewing women about abuse and interactions with health care professionals.

The first risk pertained to an abuser discovering that a woman was disclosing about abuse. Women in abusive relationships often fear that disclosing abuse will be met with repercussions later which may prevent women from speaking out about abuse or seeking help to leave a violent relationship (Leone, Lape, & Xu, 2014). Thus, I opted to conduct phone interviews where women had to contact me for an interview so that I was not connecting with women at home or on a phone their partner had access to.

When conducting phone interviews, I took additional steps to keep my participants safe by imitating a design proposed by Gondolf (2000). Before starting the interview, I asked participants if they were in a safe place to talk. I instructed participants to hang up if their partner entered the room or could overhear the interview. I told women to tell their partner our call was about a “cosmetic survey” if a partner asked them about the phone call (Gondolf, 2000).
These safety procedures were written into my informed consent and read to women participating over the phone.

The second risk I was concerned with when designing my research was evoking distress in participants because I was asking women to share information that could resurface painful memories. I had the number for the National Domestic Violence Hotline readily available to me during interviews so that I could give women the number if they needed it. I had it written on both my informed consent form and interview guide, so that I had it if necessary. I also told women I had the number when reading my informed consent to them so they knew it was available. During interviews, I listened to women’s tone of voice to detect any distress. Each interview I had ended well with participants thanking me for my research, and no one seemed or sounded upset, so I did not have to provide any of my participants with this number. Nonetheless, I wanted to make sure I built steps into my research design to protect women against distress and provide resources if necessary.

While aware of the potential risks of my research as just described, my goal for my study was to outweigh the risks with benefits. Women who participated in my study provided valuable information about how health professionals should respond to women with a history of domestic violence. This information has the potential to impact policies developed in the health care sector regarding screening and referral practices. This can improve the treatment given to IPV victims in the future. Despite my small sample size, I have an ethical obligation to tell my participants’ stories and how they believe health professionals should respond to women with similar situations as theirs – thus I believe the benefits of this research outweighed the risks.
Recruitment of Participants

I originally aimed to interview 10 women for this project, but was unable to do so due to recruitment difficulties and time limitations. To recruit participants, I asked for the help of local domestic violence agencies and a courthouse. These agencies will remain anonymous in the discussion of their involvement. My flyer was given to 6 domestic violence agencies and one courthouse. They posted the flyer for me and at their domestic violence shelters and they announced the flyer during support groups. I was unable to actively recruit participants beyond this as agencies would not let me on site to attend support groups, so I had to ask agencies to advocate for participation in my research. The flyer I used included information about my study: overview of project, who can participate, how to participate, brief information about myself, and my contact information.

To recruit participants, I used a convenience sampling technique. Convenience sampling is a strategy in which participants are selected based on their availability (Patton, 2015). In fact, many qualitative investigators studying domestic violence rely on small convenience samples due to the intensity of interviewing about IPV (Bergen, Edleson, & Renzetti, 2011). I obtained my convenience sample from domestic violence agencies, a courthouse, and social media.

Using social media was my back-up strategy for recruitment if participation in research was low. I had to utilize this strategy after obtaining only one interview after 2 months of recruitment through domestic violence agencies and the courthouse. I was wary to use social media because I was potentially targeting a different population of IPV victims. By going to social media, I was not targeting women actively seeking help, but women from different locations and stages in life. I only used Facebook pages affiliated with local pages for domestic violence, most were affiliated with a domestic violence shelter, and two were of personal use. I
messaged Facebook pages to ask if they would share my flyer, the same one given to agencies, but in an image file that was compatible with Facebook. Of the 10 pages I messaged, only 4 pages shared my flyer, 2 would not because of confidentiality, and the other 4 did not respond to my message.

Once pages shared my flyer, I received two more interviews. While I was concerned that these women may be drastically different from the participant I obtained from recruiting through shelters and the courthouse, I did not notice any concerning differences. All 3 participants were separated from their abusive partners, but still in the process of healing from abuse. Nonetheless, they were willing to share their stories with me so that other women may be helped in the future.

Furthermore, I tried to use respondent-driven sampling to recruit participants. Respondent-driven sampling is a strategy where initial participants are asked to recruit new contacts in their network; this strategy is often used for sensitive topics where confidentiality is crucial (Patton, 2015). I asked participants to pass along my contact information to other women they knew that may be willing to participate. Each participant indicated that they would, however, I do not believe this strategy resulted in additional participants, as each participant for this study indicated that they saw my flyer at a shelter or on Facebook. Because I did not have participants’ phone numbers, I was unable to follow up with participants to see if they had passed my contact information along. In all, I recruited participants for about four months and only obtained three interviews.

**Recruitment Setbacks**

As indicated, I had a very difficult time recruiting participants. I began recruiting as soon as I received IRB approval, which originally only included three site approval letters from two shelters and one courthouse who agreed to post my flyer. After two weeks, I did not receive any
calls for an interview, so I began to contact more shelters to help me recruit. Even doing this was difficult as it often took a few calls to get a hold of the executive director at shelters, or I was told they could not help me due to confidentiality concerns. There was a limited number of shelters located in my vicinity, which also hindered the number of shelters I could reach out to. In the end, my flyers were posted at six shelters and one courthouse.

I tried to remain in frequent contact with the shelters where my flyers were posted to ask about potential interest from women in my study and to ask advocates to re-announce my research at support groups. When conducting follow-up calls, many executive directors and staff members were hard to get in contact with; I left a lot of voicemails that never got returned. The low response rate from staff members could be because many domestic violence programs are understaffed. When domestic violence shelter workers are asked to assist researchers, staff members must divert valuable time away from their work at the program (Sullivan & Cain, 2004). According to Sullivan and Cain (2004), many researchers are unaware of how disruptive their requests for assistance are to domestic violence programs. In this sense, it is understandable why I had such a hard time keeping in contact with shelter staff members to address probable interest in my study. In all, I had a very positive experience working with two of the shelters where personnel were very responsive and had a more difficult time with the others. Regardless, I am very grateful for each agency that tried to help me in lieu of their busy schedules at the programs; my research would not have been possible without them.

So, after about two months of recruiting through shelters and only conducting one interview, I sought out Facebook pages to share my flyer. As described previously, I contacted local domestic violence Facebook pages either affiliated with agencies or maintained by survivors themselves. This recruitment strategy was slightly more successful where I obtained
two more interviews. Due to the difficulties I encountered recruiting participants through shelters, the courthouse, and social media, I began to think about why women were not participating and sought some existing literature to help explain what I was experiencing. I found that women may be hesitant to participate in research efforts for various reasons.

One reason for low participation in IPV research among victims is lack of incentive. Logan et al. (2008) found that women feel they should be compensated for the time they give up participating in research. Not only are they giving up their time, but their participation may be emotionally difficult when asked to share intimate and traumatic details about their lives (Sullivan & Cain, 2004). When informally discussing with a shelter advocate why women were not participating in my research, I was told that women do not have an incentive to participate; they do not think much past their immediate needs when seeking help in shelters.

Therefore, providing women with monetary compensation is one way to provide an incentive (Logan et al., 2008). Monetary compensation should be high enough to show women their experiences are valuable, but not so high that it coerces them to participate (Sullivan & Cain, 2004). So, providing an incentive may have increased participation in my research. However, due to my own time and monetary limitations, I did not offer women an incentive to participate. Given the opportunity to start over, I would have applied for a research grant to be able to offer women monetary compensation in return for the time they were giving up participating.

In addition to a lack of incentive, women may not understand the nature of the research they are being asked to participate in. Logan et al. (2008) found that women need to know their participation has the potential to help others. In a study done with rape survivors, women were motivated to participate to help other women (Campbell & Adams, 2009). The women in this...
study felt that it was important to tell their stories to let others know they were not alone, and to bring awareness to sexual assault and the changes that need to be made regarding social services for survivors. I found this to be true for the women who participated in my research. For example, one woman wants to become more involved in advocacy when she reaches a point in her life that she feels she is ready to, and the other is already actively involved in social service work with fellow survivors. Thus, IPV victims who want to help others participated in my research while it is likely that other victims who are not ready to have their voices heard chose not to participate in my research. To attract more participants, I should have made it clearer in my flyer that participation had the potential to help others in the future.

Logan et al. (2008), found that when using recruitment ads, the ad should focus on women’s voices being heard, making a difference, and helping others. The flyer should inform participants how the information they share could benefit society and other victims of domestic violence in the future. The flyer used in my study aimed to do this, but the message could have been more blatant. For example, I included a statement that reads, “I am interested in learning about your experiences because I want to improve care given to women who have experienced domestic violence in health care settings”. This statement hints at the potential to help others, but could have been worded more strongly. I may have written, “Your participation in this research has the potential to help future survivors seeking care in health care settings”. My ad should have emphasized making a difference and helping others and is something I would do differently given the opportunity to start over.

Beyond not understanding the nature of my research, women may not have participated in my research due to a fear of aggravating their partner. Research participation could pose a threat to women’s safety upon a partner finding out about participation in research (Logan et al.,
Logan et al. (2008) suggest research protocols to ensure women’s safety such as choosing neutral study sites, sending two interviewers, and practicing how to respond to risky situations when conducting face-to-face interviews. But when it comes to interviewing participants about sensitive topics, other studies have found that participants prefer phone or online data collection methods because they are perceived as more confidential and more convenient to disclose private and sensitive information (Campbell & Adams, 2009). For my own research, I decided it was best to conduct phone interviews for both participants and my own safety and confidentiality.

Because I conducted phone interviews, I followed a safety protocol set forth by Gondolf (2000). Under this protocol, I ensured participants were in a safe place to talk prior to starting the interview. Then, I instructed participants to end our phone call in the case of a partner entering the room where they were talking to me and to tell them the phone call was about a “cosmetic survey”. Gondolf (2002) suggests taking these steps to establish safety of women during phone interviews and were worked into the discourse of my informed consent that I read to participants over the phone. I did find that all participants in my research were currently separated from an abusive partner, so there was no risk of a partner listening to the conversation, but I followed the preventive strategies nonetheless. It may be that women who were still with a partner were choosing not to participate in my research to avoid retaliations from a partner later.

I tried to avoid reaching women who were still with a partner by recruiting through domestic violence shelters, but this may have played a role in low participation rates as well. Survivors seeking services in the criminal justice system and shelters are dealing with recent trauma and may be more hesitant to share their experiences (Campbell et al. 2011). Campbell et al. (2011) find that survivors of sexual assault are less likely to participate in research when they
are recruited at first-response sites such as medical care, the criminal justice system, and crisis centers. Participation in studies recruiting from first-response sites ranges from 12% to 69%; however, most rates are less than 45%. Campbell et al. (2011) also finds that incentives increase participation at first-response sites. Because of these findings, conducting a more general form of recruitment, such as placing my flyer in a newspaper to access women outside of first-response sites may have been a more successful method. Facebook aimed to do this, but I do not think that the Facebook posts reached many women as my flyer was only posted once, so only survivors who were on that day or recently likely saw it.

I cannot say for certain why participation in my research remained so low; however, it was likely a combination of all the things previously mentioned – lack of incentive, lack of knowledge about my study, safety concerns, and the locations that I recruited from. Nonetheless, I obtained three interviews for my research and have an ethical obligation to tell their stories. Despite my low sample size, the information obtained from all participants is valuable as they shared their experiences and perspectives pertaining to how health professionals should respond to instances of IPV in health care settings. What follows is a description of how I collected my data and carried out interviews with my participants.

Data Collection

I collected data by conducting phone interviews with survivors of IPV. Women contacted me by calling the Google number provided on the flyer I distributed. Interviews were either scheduled for another time or done on the spot at the time of the phone call – this decision was based on what was most convenient for the participant and if I was in a confidential spot at the time of the phone call. If interviews were scheduled for another time, participants had to call
me on the same number for the interview to take place. I had five women total call me, two never called me back at our scheduled interview time.

Prior to the interviews, I built rapport with participants by explaining to them my interest in my research question. I then provided them the opportunity to ask me any questions. After this, I would read them my informed consent, which included permission to record the interview. Once I read the informed consent, I asked participants to state that they agreed to participate in my research. I began recording as I started to read the informed consent so that I could record their consent and keep it on file in accordance to federal regulations. My informed consent was kept brief and more conversational because I had to read it to them, (To view the consent I read them, please refer to Appendix A.) After reading the informed consent, I gave participants the opportunity to ask me additional questions before starting the interview.

During the interview, I followed a semi-structured interview guide to help me conduct the interviews and to ensure I asked each participant the same questions. When necessary, I let participants explore the topics they brought up, especially if it pertained to topics I had not thought about prior to developing my interview guide. Each participant was asked the same questions and each interview lasted from 30 to 45 minutes.

After each interview, I recorded memos to ensure the quality of my data. According to Patton (2015), the immediate post-interview review is the time to record details about the interview. I recorded notes about where I was during the interview, how the interviewees reacted to questions, how I did asking questions, and the quality of the information I received. I used these notes to make notes of the strengths and weaknesses of each interview as I was interpreting it later.
Within a few days of conducting an interview, I transcribed it verbatim using a software to assist me called, “Record and Transcribe”, available through Windows 10. This software enabled me to slow down the pace of my recordings, making it easier to transcribe each interview. After I transcribed each interview, I made more memos about the quality of the interview and about emerging themes that I was noticing. These helped me to start my data analysis process. To analyze my data, I used content analysis.

**Data Analysis**

The goal of qualitative research is to analyze the data by capturing patterns and themes provided by participants. To analyze my interviews, I used a strategy called content analysis. Content analysis involves a systematic way of coding information into categories within written documents to make sense of the data and identify core concepts, themes, patterns, and meanings (Cozby, 2009; Patton, 2015). Coding refers to a way of “analyzing, naming, categorizing, and theoretically organizing the data” to develop an inductive analysis (Kuckartz, 2014, p.43).

Coding my data occurred in multiple waves. The first-step was to go through and line-by-line code each interview transcript. Next, I went through and hand-coded pieces of data within my transcripts using a color-coding system to highlight excerpts that would correspond with a particular code. Next, I exported codes into separate word documents, one for each code, by copy and pasting colored excerpts from interviews. From my identified codes, or themes, I began to write my analysis.

According to Patton (2015) there is no formula or standard series of steps when conducting content analysis. Thus, my system for coding may differ from other qualitative researchers. However, qualitative researchers ensure that their analyses are grounded in the data by continuing to revisit the data (Patton, 2015). Thus, while beginning to write my findings, I
was continuously revisiting my recordings, transcripts, and codes to ensure that my analytical process was “data driven” (Patton, 2015, p. 66).

The results of my analysis are presented in the next chapter. My analysis revealed suggestions on how women believe that health professionals can provide the best help to IPV victims – the core investigation of my study. However, participants also revealed other themes about help-seeking in general and disclosing abuse to health professionals. These themes were not necessarily anticipated but add to my overall analysis and are included within my findings.

**Conclusion**

In accordance with standpoint feminist theory, I conducted qualitative research in the form of telephone interviews to obtain the perspectives of IPV victims about how they think health care professionals can best help women experiencing domestic violence. Qualitative research has the potential to capture participants’ experiences in a meaningful way (Patton 2015). My goal was to capture participants’ experiences seeking health care for IPV symptoms and allow participants to provide recommendations for how to best help IPV victims within health care settings based on their personal experiences. Thus, what follows in Chapter Four are the findings from this study.
CHAPTER FOUR
FINDINGS

To answer my research question, *how can health professionals provide the most helpful response to women who have experienced intimate partner violence*, I conducted interviews with women who have experienced intimate partner violence. However, due to recruitment issues, the findings presented here are based upon a small sample size of three women – Maria, Lucy, and Pam³.

While information about Pam arose during our interview, namely that she was a social worker, I do not have much information about my other participants and why they chose to participate in my research. Nonetheless, each woman I spoke to seemed open and honest with me about their experiences interacting with health care professionals. I can only assume that each woman has a passion for helping other women in similar situations, which led to their willingness to participate in my research. For example, as Lucy told me informally at the end of our interview, she wishes to be an advocate for other women once she is healed from abuse. Thus, because of my participants’ willingness to share their stories with me, I feel that I gained a preliminary understanding of how health care can be improved for women who have experienced IPV as informed by my participants.

Not only did I learn about how health care can be improved, but I learned about my participants’ experiences seeking help from other sources, such as friends and family. Women told me their help-seeking stories including being victim-blamed due to people’s misconceptions about abuse. Victim-blaming plays a role in victims’ ability to seek help because it makes them

³ Names used throughout this thesis are pseudonyms.
feel guilty and responsible for their victimization, propelling them to stay in the relationship longer.

Eventually, all my participants did seek help, and recalled that as they did, they needed more than one service such as medical care, therapy, and financial support, and they often had to locate these services on their own. As the women I interviewed reflected on their navigation between various resources, they highlighted a lack of communication among outlets of support. Some women found that various services were unaware of what other agencies had to offer victims, which sustained and perpetuated a lack of knowledge about resources throughout the social service and health care sectors.

Furthermore, my participants provided detailed accounts about their interactions with health care professionals, and from their interactions, they made recommendations for how care can be improved in medical settings. Because of my small sample size, most suggestions were unique, as each woman had a different experience seeking medical care. However, there were some commonalities among their help-seeking behaviors and suggestions to improve care – I present these within this chapter.

Help Seeking

When I initially started my research, my intent was not to find out what seeking help in general was like for my participants, but rather how health care can be improved for IPV victims. Nonetheless, my participants spent a great deal of time discussing what seeking help was like for them, and it would be an injustice to ignore this aspect of my research. Thus, I think it is important to detail the experiences my participants had seeking help from family, friends, social services, and the medical community, and in addition to this, the victim blaming that each encountered in their survival from domestic violence.
Victim Blaming

Victim blaming refers to the idea that victims are responsible for the crime inflicted upon them; for women who experience domestic violence, the responsibility of abuse gets put on women, rather than the abuser (Meyer, 2015). According to Meyer (2015), women experience victim blaming because of their intimate relationship with their abuser which prevents them from being viewed by others as blameless during their time of victimization. The women I interviewed spoke of victim blaming quite often, which they often received from their friends, family, and law enforcement.

Thus, outsiders often view the victim as responsible for staying with their abuser, and in turn, believe they deserve the abuse they endure. Lucy described this to me and she said,

If [people] stop thinking of it as oh, she is just with a jerk of a boyfriend or husband and she won’t leave him, [and start] thinking of it as a crime that it is, a violent crime. And try to understand what is going on.. and just because a woman goes back doesn’t mean she deserves it… [Abusers are] very clever criminals, is what they are. And they count on society blaming the woman so they can continue to do what they do.

Because IPV is not seen as a violent crime, women are perceived as responsible for what happens to them, especially when they remain in the relationship or go back to the abuser, as Lucy explained. It is hard for women to seek and receive help when their victimization is not seen as legitimate by others. Unfortunately, victim-blaming comes from various informal and formal sources, “My family, my parents, my best friend, um, and the police. And all of them shamed me. And your mind is not well, so you believe them. You do. Why wouldn’t you? These are the people you love and trust” (Lucy).
Seeking Help Informally and Formally

According to the literature, women may seek help from informal and formal sources. Informal sources include friends and family; formal sources include health care, police, and various social services. Informal sources such as family and friends can stigmatize women who experience abuse by blaming them rather than offering their help (Goodkind et al., 2003). This was true for participants who sought help from informal services first, their family shamed and blamed them. For example, Lucy told me, “My father laughed in my face, he said no way, you are disgusting, you deserve it, his only daughter.” Women such as Lucy who are victim-blamed by their family and friends often translate that blame into self-blame (Enander, 2010). Lucy went on to tell me, “I would blame myself, and I stayed in it for another year, and that’s when the abuse got worse and worse.”

In accordance with victim blaming, family members may try to punish victims by isolating them. Maria believed that her family isolated her thinking that this would make her leave her abuser. Maria explained,

I lost half my family because my dad would beat him up and then after a while they would just see that I would have broken fingers and black eyes and strangle marks, and they just quit talking to me. They thought if they didn’t talk to me, I would leave him.

Women may also seek informal support from colleagues which was the case for Lucy who ultimately lost her job because of abuse. She told me:

I lost my job of 15 years where I was making pretty good money, close to like 45, 50 thousand a year. Nobody there helped me. After a while, I didn’t even care if they saw the bruises on my arms… And, um, instead of anybody [at my job] reaching out to me, saying we think this is going on, they all took me off of Facebook, blocked and deleted
me. Again, there was the message, you are doing something wrong, you should be ashamed of yourself, and my life spiraled again.

The lack of support from friends, family, and co-workers may lead women to self-blame and avoid further care. However, when women do reach out to formal sources of help, they may experience the same type of victim-blaming. For example, Maria told me, “I never really asked for any help, I mean I had numerous times where I asked the cops for help, but the cops didn’t do [anything].” Thus, when seeking help, women often find help from law enforcement inadequate as well. For instance, Lucy told me that she had called police a few times before they put her abuser in jail, she said:

He was arrested for the one time I called the police and they arrested him. Actually, I called them a couple times, but this time they arrested him and put him in jail… the police, um, people who should know better, still treat it as like a relationship that is a private matter when they need to start treating these men as criminals.

When women reach out to law enforcement, their situations are not rectified legally; thus, women from my study perceived the police as unhelpful. Women encounter setbacks, such as family and police being unhelpful or unsupportive, which makes help-seeking a continuous process of reaching out to both informal and formal sources. Therefore, help-seeking for victims often occurs in a cycle. For example, Lucy explained to me,

People I reached out to initially shamed and blamed me, so I was so embarrassed to go [to health professionals] again. It went on another year before I got the courage and that’s when I reached out to health care providers including a therapist I found… It took me a long time to accept that I had these issues (panic attacks and anxiety), just like it took me a long time to admit that he was abusive, believe it or not. And so, I, once I started
accepting it, you know, I went to my doctor and she was like I said, my doctor was amazing. She was wonderful. And she helped me get disability, um, she reminded me, I liked what she said to me, there is no problem in asking for help. Cause I felt embarrassed.

Thus, when women are victim blamed by various informal and formal services, they feel they deserve abuse. As a result, help seeking may occur in a cycle, seeking help from various informal and formal services multiple times before the relationship ended. However, when women are met with understanding people they reach out to, they can receive the help they need to leave. Nonetheless, victim blaming ultimately prevents women from getting the care they need, when they need it, and it occurs because people do not understand IPV and instead rely on misconceptions when encountering IPV victims.

**People’s Misconceptions**

People often think it is easy for a woman to leave an abusive relationship. However, it is often hard for women to do because of an intimate connection with a partner, shared kids, or financial dependence on the partner. Nonetheless, people do not understand why women stay with abusive partners or believe they could leave if they really wanted to (Meyer, 2015). People forget that despite the abuse, the partner is often someone that the survivor cares for deeply. As was the case for Lucy who told me,

People think it is so easy to just say have him arrested, but this is someone who bonded with you. It isn’t just like a new person and you need them, it’s someone who takes the time to gain your trust and your love and you start to understand them, you don’t want to put them in jail.
Victim-blaming and peoples’ misconceptions go hand-in-hand as they allow people to view IPV as easily escapable. The questions asked is – *why doesn’t she just leave?* Pam explained this to me by saying,

I think that the question in society is, why does she stay? Why doesn’t she leave him? Rather than, why is he being allowed to do these things to her and not being held accountable? And so, the victim is often blamed, and um, I think it is because people just don’t understand how you’re emotionally brainwashed and gaslighted and manipulated to a point to where you think you’re the crazy one and it becomes like an addiction to this person because of the intermittent reinforcement they use, they love bomb, and then they beat you. And then you get high on love, and then they beat you.

Pam used the metaphor of addiction to explain to me what being in an abusive relationship was like for her. Similarly, lay people often believe that an addict can just quit their addiction, just like a victim can just leave their abuser. However, it is not this straightforward and simple in real life as described by Pam.

Thus, people tend to blame the survivor and place the responsibility to end victimization on them, rather than the perpetrator (Meyer, 2015). As suggested by Pam, society is asking the wrong question when it comes to IPV. Because women are blamed for remaining in abusive relationships, people in formal support services who hold the same misconceptions about IPV may blame women for staying with abusers instead of the offenders for abusing. Thus, navigating the medical field can provide new obstacles for women who are scared to disclose abuse or view health professionals as insensitive; however, it can also be beneficial when women are met with health professionals that take the time to understand their situation and provide help.
Help Seeking in the Medical Field

To participate in my research, I required that participants had contact with medical professionals at some point while experiencing IPV to answer my research question. However, physical, sexual, and mental health complications that accompany abuse that have been well documented by previous scholars, so it is likely that many women who have experienced IPV have sought medical care for health concerns related to violence. My participants sought care for different physical injuries and mental health concerns, so each experience is unique; however, there are similarities among their experiences which I describe below. The first similarity was frequent health care utilization.

High Health Care Utilization

I did not seek to discover how frequently women sought medical care, but rather what their experience seeking care was like. However, upon analyzing each interview I noticed that each woman told me of at least two separate instances of seeking health care because of abuse, if not more. For instance, Maria sought care at separate times for a broken finger, a bite mark, cracked ribs, and injuries from being thrown out a window. Lucy sought care at an emergency room (ER) for panic attacks and PTSD, but also sought care from her primary doctor after the abuse had ended because she had long-term injuries to her back from physical abuse. Pam sought care at an ER for mental health and suicidal ideation and sought care from her primary doctor when her partner assaulted her. Hence, each woman sought care more than once for various reasons ranging from physical injuries to mental health concerns.

High health care utilization findings are supported by the literature; Black et al. (2001) argues that that women who experience domestic violence frequent health care settings more than women who have not endured abuse. Moreover, Bonomi et al. (2009) suggests that health
care utilization continues even when the abuse has ended, which was also true for some of my participants who sought care for physical care and mental health concerns once the relationship was over. Thus, my research supports existing literature as my participants utilized health care for physical and mental health concerns at a high rate. Nonetheless, my participants had different interactions with health care professionals, especially pertaining to their ability to disclose abuse to health care professionals.

**Barriers to Disclosure**

Two of three participants in my study disclosed IPV to medical professionals. For those that disclosed, their primary health care providers were also female. Moreover, a positive patient-physician relationship facilitated both women’s decision to tell their doctor about abuse because they trusted them. For example, Lucy told me, “I started reaching out to my doctor who I have a very good relationship with, a woman.” Similarly, Pam told me:

> I went to my primary care physician the day after I was assaulted, and I didn’t need to, like it was a lot of contusions and bruising, and she was very very good, but she is also Canadian, so I don’t know if there is a different philosophy or mind-frame about domestic violence in Canada, but she was highly empathetic, and she understood, she totally got it.

Thus, a positive patient-physician relationship can encourage women’s disclosure of abuse; whereas a negative one can dissuade disclosure. Additionally, women may not disclose to protect their abuser, this was the case for Maria who did not disclose. She lied to doctors about abuse and always had an excuse. For example, when talking about one of her various injuries she said, “I kept lying and saying I did it myself, and I said that I accidentally put my hand through the window.” When I asked her why she kept lying to health professionals about how she got hurt she
said, “Because, I loved him and I just figured, well there were a lot of times where I would apologize in the morning for making him mad at me… I just figured he would always say he was sorry” (Maria).

Similarly, prior to seeking care from her doctor, Lucy refrained from seeking help for a long time to protect her abuser. She said to me,

There were plenty of times I should have went to the doctor for my injuries, but I didn’t… I wasn’t going in unless my tooth fell out or I passed out or something because I protected him… But I was never treated when he would hurt me, so I never went at that moment.

Thus, women may protect their abuser by being dishonest with health professionals or refraining from seeking any help. Part of their reason to protect their partner could stem from fear of retaliation from an abuser, which also affects women’s ability to disclose. Seeking help can be very dangerous; for instance, Pam stated, “That is the most dangerous time, when someone might be disclosing, and they might be thinking about leaving, and they’re showing up at the hospital looking for help like that. That’s dangerous, in and of itself.”

The literature supports the idea that seeking help is dangerous to women, or at least that they perceive seeking help as dangerous. For instance, Liang, Goodman, Tummala-Narra and Weintraub (2005) find that 26% of women IPV victims who do not call the police when abused cite fear for their own or their children’s’ physical safety as reasons for avoiding the police. Seeking help is dangerous and places women at risk, so they may avoid disclosure or lie to health professionals in lieu of retaliation from their abuser.

Thus, the patient-provider relationship, being in love and/or not ready to leave the relationship, and fear intersect and influence abused women’s decision to disclose to health
professionals; however, there are likely other factors that other women outside of this study experience as well that were not captured by my participants. However, my analysis indicates that women are likely to disclose if they have a good relationship with their doctor. Moreover, they are less likely to disclose if they are not ready to leave the relationship or fear they may be retaliated against if they either seek help or disclose when seeking help. Despite barriers to disclosure for women, scholars argue that health professionals should still screen women for abuse while displaying empathy and compassion (Spangaro et al. 2011). Spangaro et al. (2015) argue that screening can lead to interventions, such as referrals to social services, which has the potential to get women the safety they may be seeking when attending medical facilities.

**Screening**

Each of my participants supported screening women for IPV in health care settings. While not every participant disclosed to medical professionals, they still supported this practice. As indicated by the literature, barriers to screening include women’s lack of disclosure; however, many women believe that health professionals should still screen and provide women with information about social services in the absence of disclosure. However, health care professionals cannot be pushy when trying to screen women, especially when women are not ready to come forth about abuse. For instance, as Maria told me:

So I guess [the health professionals] did do their job to what they could do except for like, yeah, they probably could have handed me papers that said, if you feel like your threatened... Maybe [health professionals] can just go, “here are different places you can call to get help with mental health.” Maybe it can start there, ‘cause they’re really not allowed to accuse, but just offer you help with somebody you can talk to [for] mental health.
Even though Maria was dishonest with health professionals about the source of her injuries when seeking help, she indicated that some information about social services would have been beneficial. Health professionals must balance a fine line between asking women about abuse and being overbearing. However, health professionals also cannot ignore abuse while treating women for symptoms of IPV. Avoiding underlying causes of symptoms — abuse — allows medical providers to medicalize abuse, which leads to repeat abuse and consequently, high health care utilization for abused women.

Medicalization of Abuse

Medicalization of abuse which refers to defining and treating a nonmedical problem, such as IPV, as a medical problem (Conrad, 2007). Medicalization of abuse involves the process by which health providers treat physical symptoms rather than the underlying cause of symptoms. Health professionals are trained to treat physical injuries, and they do their job well. However, when health professionals encounter survivors and do not address the cause of health concerns, IPV, they do not always respond in the most helpful manner. The ignorance of abuse can lead to a lack of referrals to social services or a retraumatizing experience for women; meanwhile, recognizing abuse can lead to positive outcomes.

Medicalization of abuse was apparent in Maria’s case in which health professionals did not address what was causing her injuries. However, Maria played a role in this as she was never honest with health professionals about how her injuries occurred. She sought care at the same hospital numerous times for physical injuries, but the doctors never gave her any information about social services even though they suspected that she was lying about the cause of her injuries as she explained to me.
Moreover, health professionals also medicalized abuse in Pam’s case when she sought care for mental health concerns. They treated her as a typical case of mental illness accompanied by suicidal ideation without accounting for the domestic violence that led her to seek treatment. When Pam tried to tell the doctor her story, the doctor did not take her seriously, and Pam felt re-traumatized by her experience being guarded by a male for suicidal ideation. This is her account of seeking health care:

When I went to the ER presenting with you know, suicidal ideation because of the trauma two weeks after the incident and not being able to leave the house, without having a panic attack, wanting to die every day because I missed him so much, the whole recent loss of it all, and then being treated like a quote un-quote crazy person that was suicidal and oh, here’s another one needing the psych hospital, oh ya know, put a guard on her. It’s not like that. Its, your, my first time ever being there, and then you have a man guarding me and a man hearing my story, and you know, like that whole experience was completely humiliating… I felt like I was a criminal, I felt like I was in jail.

Thus, treating cases of IPV like a medical condition, or as mental illnesses, can further stress out women who are experiencing violence. Medicalizing abuse ignores the context of the participants situation by assuming that medicine is the only answer to social problems – guarding women who are experiencing suicidal ideation puts the blame on the victim for the situation and is dehumanizing, as it was for Pam.

However, my intent is not to suggest that health professionals always medicalize abuse; in other instances, they do not, as was the case for Lucy who sought medical care after her injuries occurred. Lucy never sought care during the time she needed it, in her words she “would have had to been near death” to seek care because she protected her abuser. However,
when she sought care post-injuries and post-relationship, medical professionals took X-rays to ascertain the damage to her back and neck. And with this information, health care professionals helped her receive disability. By addressing the abuse that caused her injuries, professionals not only helped her physical injuries, but they helped rectify her social situation by helping her gain disability.

Thus, abuse remains invisible when it gets medicalized. Medicalization occurs when the cause of physical injuries is not detected or when health professionals do not take the time to listen to women’s stories. Not taking women seriously is problematic because it re-victimizes and victim blames abused women, which prevents them from seeking future help. Pam’s experience of not being listened to led her to suggest that health professionals receive more training to recognize and understand dynamics of abuse to avoid medicalization. As Pam explained:

For like that whole professional side, to have people more fully trained on the psychological piece of it so women aren’t, um, ashamed to seek help or even to go to the hospital in the first place because they feel like it’s their fault because they already feel like it’s their fault, so they get that negative energy from the hospital, from the doctors and social workers too that just don’t understand the dynamics of domestic violence...

‘cause I think just people are afraid of it and so it’s easier to blame the victim… [when] I told my story about why I was there and the doctor was sitting there like “uh huh, ok”. It wasn’t very validating or empathizing.

In all, health professionals risk medicalizing abuse when they only know how to treat symptoms of abuse with medicine and ignore the violence that caused the symptoms. Moreover, medicalizing abuse does not facilitate referrals to social services that could be beneficial to IPV
victims. A lack of referrals is indicative of a larger problem that was identified by my participants as well – a lack of collaboration among medical and social services for abused women.

**Lack of Collaboration Among Services**

When women are seeking help from various sources such as social services, legal services, and medical services, they often experience a lack of collaboration where they must navigate each outlet independently (Haeseler, 2013). This was true for the women I interviewed. When seeking the various services each needed, they often had to find resources themselves, which took both a lot of time and effort during a difficult time. In the words of Lucy, she said,

> I became my own best friend, my own best advocate. Um, I googled and just kept googling and googling, but in the beginning, my mind couldn’t even think straight, so I didn’t even know. [As] time went on and I started to heal, I started finding services myself and they’re all over the place on google, and maybe it’s too bad there can’t be one central something, I don’t know, handbook or something.

Because there is a disconnect between service providers, women are unaware of what is available to them, and often, service providers are also unaware of the various resources available to survivors outside their realm of specialization. This prevents women from seeking out and receiving services that may have been helpful to them during their time of need. For example, Lucy became aware of unemployment for survivors of domestic violence after she had lost her job and all her savings trying to achieve safety from her abuser. She told me,

> [My therapist] could’ve told me, “oh, you know there are services for you because you lost your job to domestic violence,” but she didn’t know. I don’t know why these people don’t know, but they should… Another thing I didn’t realize, and the victims advocate at
the court didn’t tell me this, was that you know, if you cooperate with us, you get like, uh, domestic violence compensation for cooperating

When service providers are unaware of the services available to women, women miss opportunities that could have been beneficial to them in their time of need. Similarly, women are unaware of services that are free to them to get help from IPV. For instance, Maria was not referred to any social services from medical providers, but she began telling me what it would have been like had she been:

If [health professionals] would have said, “wait, we can get you help, you can go to these people,” my first thought [would have been], I don’t have a lot of money, I can’t go talk to anybody. So maybe if it’s known that there are outlets out there that don’t cost money.

Women need to know that there are free services available to them, without this information, women may feel helpless until they get the energy and courage to find the information they need. Additionally, the lack of communication between social services, legal services, and medical services leaves women to locate resources on their own. As Lucy explained,

Like I said, my own therapist didn’t know the services that were available to help a woman if she had like lost her job. So like, why isn’t there this communication between one another? I don’t know, I wish there were. I had to find this out on my own... [services] should know the laws and what’s available to these women, um, within their own state at least. All counselors who counsel and all advocates and shelters should know the laws and services, what’s available to the women that come there and give them a booklet or something with all the numbers. What is so difficult about that? I found that online, but like I said, it took me a long time because in my state of mind, ya know?
Pam described the lack of collaboration between services as well,

I think one of the missing links is the medical community in the social justice world…

Doctors and nurses, could, like, work together with the district attorney’s offices and help them understand this is what we see, acutely when women come in, or I guess men too, when people come in, I don’t know if there should be more education in that realm, because I think that the doctors and nurses see the worst of the worst of it, but by the time it goes to trial, we are often recovered, and they don’t see the face of it, of battering.

Thus, cross-sector collaboration has the potential to connect abused women with other services as well as provide information across sectors, for example, medical information during court trials. The benefit of cross-collaboration is that when women seek care at one facility, they can obtain information about services available at another that would otherwise be left unknown, saving women time and energy locating services on their own and prolonging abuse.

However, there are structural barriers that inhibit cross-sector collaboration from occurring. For instance, there is understaffing both in social services, especially domestic violence shelters, and in the medical community where providers are faced with multiple priorities and high workloads (Beynon et al., 2012; Sullivan & Cain, 2004). Actors in both realms have hectic schedules due to understaffing that leads to time constraints on their ability to work together.

Nonetheless, in an ideal situation, various services should collaborate to help women experiencing IPV. Collaboration has the potential to inform abused women of available resources, especially free services. Moreover, collaboration may save women time and energy trying to locate services on their own – a referral to from one site to another can help women
achieve safety and help in a timely fashion. As my participants indicated, survivors want better communication between resources to improve the overall care women receive.

**Women’s Suggestions to Improve Health Care**

The main initiative of my research was to use standpoint theory to allow abused women to contribute to the knowledge about how to care for abused women in health care settings. The main question quidding my research was, *how can health professionals provide the most helpful response to women who have experienced intimate partner violence?* Thus, I asked women questions to elicit responses about how to best help abused women seeking health care. As a result, I found both similarities and differences about how to improve care among my participants. What follows are the suggestions the women I interviewed offered.

**Respond with Empathy**

My participants conveyed that health providers should respond to IPV situations with empathy and understanding, rather than further shaming and blaming abused women. My participants desired health professionals who understood what they were going through and why they were seeking health care. According to Pam, health providers should respond “in an empathetic, validating, compassionate way. Using understanding and non-shaming, and non-blaming.” It is important to survivors that health professionals try to understand and respond to abuse in an empathetic manner.

Lucy elaborated on this by explaining to me that her doctor never made her feel embarrassed as she already felt so when seeking help. She told me,

I think it is important for the woman to know that [health care providers] understand, that they are not going to judge her. So say, ‘we understand and you can feel comfortable talking to us, we aren’t going to judge you.’ Also, maybe give her, ya know, some
information of what is normal in this situation, to still care about this person and go back. Ummm, to not feel guilt or shame. Don’t blame yourself, they need to let her know that. They also need to let her know that if she goes back, to not be embarrassed to call them again. I never felt that with my doctor, I felt a little embarrassed, but they never made me feel embarrassed.

For Lucy, her doctor understood the cycle of abuse and encouraged her to seek help again if she went back to her abuser, rather than victim-blaming her for remaining in the relationship. Because Lucy’s doctor understood, she sought help from her doctor various times before the relationship finally ended.

Thus, my research suggests that women want health providers to respond to IPV in a positive manner with empathy and compassion – to try to understand abused women’s situation. Women seeking help may feel embarrassed, guilty, and shameful, so they do not want their doctors to exacerbate those feelings. Rather, they want providers to be supportive; as Maria suggests, health professionals should ask abused women they encounter:

Hey, how are you? Hey, we are worried about you. You know? Do you want to talk to someone… do you feel safe where you are? Are you sure you fell down the steps? You know you can talk to someone and here is the phone number.

As mentioned previously, survivors’ friends and family can be unsupportive due to misconceptions about abuse, so having health providers offer support could make a huge difference for abused women by encouraging them not to feel embarrassed and to seek future help to leave the relationship. However, as I highlighted in my literature review, health professionals are often untrained to properly respond to cases of IPV, so more training may need to occur for health professionals to respond in a helpful way.
More Training

My research aligns with previous work that suggests that health professionals need more training to respond to abused women in the most helpful manner. Training can help providers understand what abuse is like for women who experience it. As Pam explained to me,

There needs to be more specialized programs in graduate programs, or doctors and nurses should be required take courses to understand [the dynamics of abuse] a little better. To know it’s not as easy as, oh this person punched me or kicked me, and now I just need to, ya know, break up with them. There is so much more that comes into play, and people don’t get that…I think that it should be part of, maybe, even your higher training, like your agency training, or your hospital training, you need to take this 4-hour course on domestic violence and this is how you need to address it, if you have a patient coming in with those symptoms.

Without specialized training, health professionals may behave in the same manner as laypeople who hold misconceptions about abuse being easy to escape. To prevent this, comprehensive training on domestic violence for professionals should be implemented as it has the potential to improve care given to women who seek health care for IPV symptoms. Furthermore, more training may increase health providers’ ability to utilize my participants’ other suggestions to improve care, such as database detection of IPV.

Database Detection

Maria offered a unique idea to identify battered women by using electronic databases located within medical settings. She suggested that if a woman presents to the same ER multiple times, with symptoms indicative of abuse, they flag her through this database and automatically refer her to speak with someone from social services. This process would also account for
women who are reluctant to disclose abuse by automatically referring them; however, providers could not force women to speak to someone if they did not want to. According to Maria,

I don’t know if I did go into some database or something showing that I was coming in there. It kicked over to, you know, like, was my name put aside? Like, how they put aside people who go to the emergency room seeking drugs. Like, do they also have a database for people they know who are abused and beat? I don’t know. They should have something like that. They should, like a red flag… Health professionals would maybe even say, hey, you have been in here, this is the fourth time in five months, this is so and so from [this] shelter, [they] want to talk to you. They can’t make you…If someone has like an injury [such as] arm prints, a black eye, or the brachial plexus, that is another thing like a guy grabbing you under your arm… Rotator cuffs, if you’re grabbed under your arm and pulled that is a common injury, guys grab you there. You don’t know, but I guess I do. Certain things that can indicate [abuse], they should just automatically give you paperwork.

Using a database detection system could help professionals identify abuse in lieu of or in addition to routine screening practices. As previously discussed, some women are reluctant to disclose abuse to professionals, and a flagging system could help professionals identify individuals who are making repeat visits because of abuse. Especially if women are frequenting the same ER multiple times and not seeing the same doctor. By entering injuries into a database, women repeatedly visiting facilities with injuries associated with abuse can be identified. Upon identification, health professionals may be required to follow a protocol to distribute information to abused women about social services available in their area.
Specialized Services

Both Maria and Pam indicated that it would be helpful to have someone on site at medical facilities who specializes in dealing with domestic violence, similar to a medical advocate; “Maybe that would be good to just have a separate person working at the hospital just focused on abused or battered women” (Maria). Having someone at medical facilities, especially hospitals, would be ideal to women so that they are interacting with someone who is trained to understand and appropriately care for women who experience abuse.

Pam suggested that women attending medical facilities for mental health related problems due to abuse should not be treated the same as patients with other mental illnesses. According to Pam,

I think there should be a specific section, or, um, individuals who are dealing specifically with women that are going in with trauma for domestic violence because I was just lumped into a bunch of people that have chronic and persistent mental illnesses that cycle in and out of psychiatric hospitals.

Pam, like other abused women, wanted health professionals to understand what she was going through; thus, she felt that having someone available on-site, who was trained to respond to domestic violence, would be beneficial. Pam also suggested that this person be available 24/7:

Maybe the social worker should be trauma informed and domestic violence informed and whoever is on the 3-11 or 11-7 or 7-3 shift, ya know, round the clock kind of hospital would have that knowledge, so that they can walk the doctors and nurses through that, or maybe even sit with [you].

An on-site social worker would address some of the barriers that doctors have in treating abused women such as lack of time and knowledge of available resources. Doctors would not
necessarily be responsible for handling the aftermath of identifying abuse, such as making referrals, the social worker could do this. Social workers could also be available to sit with patients and hear their stories, so that patients feel like their situation is validated, as my participants wished theirs was in the cases when it wasn’t.

However, some hospitals do have social workers, or medical advocates, but my research suggests that the availability of an on-site medical advocate is not as widespread as it should be as none of my participants encountered a medical advocate when seeking care in the medical field. Thus, future research should address this issue, and I discuss this more in my conclusion chapter.

Help for Fellow Professionals

When I began my research, I had not come across literature related to medical or social workers seeking health care for their own cases of IPV, and possibly because I was not searching for it or aware of the issue. However, help seeking for fellow professionals was brought to my attention by Pam who is a clinical social worker. I think it is important to highlight the suggestions she made to improve care for professionals, such as herself, as it is an issue that is not often discussed within the medical help-seeking literature.

For Pam, the last thing she wanted to do was seek care from a fellow colleague or seek help where her clients were. She explained to me,

[It’s] really humiliating coming in as the client on the other side of it, which is humbling because it helps you understand the perspective of what it is like to be a client, but I also know as a professional in a small community, news travels fast regardless of how many layers of HIPPA there are… The horrifying piece for me was being a professional, working with my colleagues as a client.
Pam emphasized the idea of having someone on-site at medical facilities to deal with domestic violence, and especially someone who could work with other professionals. As she said, maybe there needs to be a person that works strictly with other professionals, ya know, maybe that would be helpful... a liaison specific to professionals or something in the hospital, then I wouldn’t have to drive 2 and a half hours south to a community where I am unknown.

If a liaison was employed through the hospital, rather than a social service, women who work in social services would not run the risk of being a client to a colleague when seeking health care for domestic violence. Furthermore, professionals risk being treated by a co-worker when seeking social services for themselves. For Pam, social service options were unavailable to her because of the small town she was from:

I would have liked to gone to support groups in my area, but I couldn’t because the only support group in my community, I had clients attending. So that’s where I’m like, what is there for professionals when you can’t sit in on the support group and you can’t see a therapist because your clients are seeing those therapists and support groups.

Thus, resources for professionals are likely scarce, especially for those living in small communities like Pam. I was taken aback upon hearing Pam’s story because it was something I had not considered prior to our interview. Understanding the experiences of social service professionals who are also victims of abuse warrants a separate study to learn how care can be improved for professionals in both the medical and social service realms. From Pam’s experience, it is clear to me that future research is needed to understand the experience of social service workers seeking help as a victim of abuse.
Findings Conclusion

In conclusion, my participants revealed topics to me that I had not intended to address prior to starting this research such as help-seeking, victim blaming, and lay people’s misconceptions. While these themes do not answer my research question directly, I think they are an important aspect of what seeking care is like in general that translates into the medical field, especially when women encounter misconceptions and victim-blaming from health care providers. Moreover, I did not anticipate interviewing someone like Pam who worked as a social worker who revealed her experience seeking health care as a victim, but it was an important discovery that warrants future attention.

Nonetheless, my participants provided me with valuable information about how health care can be improved for survivors. The most important way to improve care is improving how health care providers respond to cases of IPV. That is not to say that all providers respond negatively, because that was simply not true for all three participants. In all, providers need to respond to women with empathy, compassion, and understanding, which was important to all participants, not just those that had bad experiences seeking health care.

Furthermore, my participants offered innovative suggestions for how to improve care, such as detecting women by using hospitals’ databases so that they can make more referrals to women for social services. Another great suggestion was having someone on-site 24/7 who is trained to respond to cases of domestic violence. While this is not something entirely new, and there are medical advocates that do go to hospitals, it should be more widespread as the women I interviewed did not interact with a medical advocate, and had they, their experiences may have been improved. And finally, a medical advocate should be able to work with other professionals, so that women who work in social services are not humiliated to seek care or required to travel to
avoid being seen by a colleague. If a medical advocate worked for the hospital, rather than an outside agency, this problem could be avoided.

In all, there is potential to improve health care for women who experience domestic violence. The gratitude that each participant expressed to me for doing this research was indicative of the need for more research on this topic. However, my results are limited based on my small sample size. Nevertheless, my participants’ stories and ideas deserve to be heard, as they provided first-hand knowledge about how health providers can best help women who experience domestic violence based on their personal experiences.
CHAPTER FIVE
DISCUSSION & CONCLUSION

The purpose of this study was to ask intimate partner violence victims how health care can be improved from them – using standpoint feminist theory to shed light on their perspectives by allowing participants to contribute to the body of scholarly work on this topic. I conducted qualitative research through telephone interviews to ask victims what they deem as the most helpful response to IPV, in terms of health providers’ interactions with them and receiving information about and referrals to social services. The research question for this study was, how can health providers best help women who have experienced domestic violence?

The themes presented in the findings from the previous chapter should be received with caution as they were derived from a very small sample of three women. Furthermore, they are only representative of heterosexual women survivors of IPV, not men or those in same-sex relationships. They are also only applicable to women who have sought health care for symptoms of abuse, and not of those who have not. The findings from this study must only be understood in the context of my sample and their experiences. The women I interviewed had a range of different experiences when it came to seeking health care, and it is very likely that other women would convey varying stories; however, my goal was to find shared experiences among women’s interactions with health professionals and their suggestions to improve care. Essentially, my findings are only representative of the women in my study.

Nonetheless, because of recruitment issues, I had the opportunity to explore some of the methodological concerns located within the literature on studying this sensitive population, even though the available literature in this area is scarce. Future scholars need to fully understand methodological setbacks, such as sampling recruitment, to determine how researchers might go
about overcoming them. Thus, after conducting my research and reviewing the available literature pertaining to studying IPV victims, I have compiled ways by which I would conduct my research differently, given the opportunity to start over, that future researchers may take into consideration.

### Probable Revisions

My sampling time lasted for about 6 months whereby I had to end my recruitment due to time limitations. In that timeframe, I was only able to conduct three interviews. The nature of my study put me in a passive role, waiting for women to contact me for a phone interview, setting up a time for the interview from there, and depending on the women to call back at our scheduled time. I went about my research in this manner to protect the anonymity of participants as well as their safety for disclosing their stories to me. However, this process only garnered three interviews; five women in total called, two did not call back for their scheduled interview time, two did call back for their scheduled time, and one was done at the time of the initial call.

When conducting qualitative inquiries, Patton (2015) warns to be prepared for major forks in the road; this was exactly what I encountered with low participation rates in my study. As a result, I have reflected on ways I could have changed my research methods given a longer timeframe. Had I known how difficult it would have been to recruit participants I would have changed my research design in three key ways that may have increased participation in my study: (1) immersed myself into domestic violence settings prior to my research, (2) offered compensation for participation, and (3) sought out other outlets for recruitment.

To obtain a larger sample size, I would have immersed myself in the domestic violence community by volunteering at the local shelter and being an advocate for IPV survivors prior to beginning this research. As indicated by some of the workers I was in contact with at IPV
shelters, women seeking help at shelters are in a vulnerable place – they do not want to tell their stories to just anyone, including researchers. Thus, I would have immersed myself in these settings to gain the trust of women that may have facilitated a quicker recruitment time; women would have had the opportunity to become familiar with me, recognize that I am non-threatening to them, and feel comfortable disclosing intimate details about their stigmatizing situation. Given the chance to start over, I would have done volunteer work before my research, which may have given me the opportunity to be more proactive in my research by having access to this population.

Moreover, I would have applied for grants to be able to offer women compensation for participating in my research as an incentive. Based on speaking with advocates at shelters, women seeking care in shelters are often busy trying to navigate life after abuse whereby they do not think much past their immediate needs. Participating in an interview may not have been beneficial to them at that time, so an incentive may have encouraged participation by providing women with some type of monetary compensation, or gift cards, to help them in their time of need. Being able to compensate women would be another way that I would change my research methods for this study.

Furthermore, locating women outside of domestic violence shelters may prove fruitful. I had the best luck recruiting from social media, but I acknowledge drawbacks of this method as well. Facebook posts are only seen on individuals’ timelines for a certain period; after that, posts can only be seen by looking at the specific page in which the post was made. Moreover, pages devoted to domestic violence advocacy are often as hesitant to share researchers’ advertisements as many shelters are. However, locating women through other public outlets such as newspapers, craigslist ads, and radio show announcements may be a good recruiting strategy.
Women accessed through these sources may still be recovering from recent abuse but may not be experiencing recent trauma as those seeking help in a domestic violence shelters for immediate needs to their safety and well-being, making them more likely to participate in research.

Nevertheless, I was able to obtain three interviews from my research design and may have been able to garner more with more time. The information I gained from these three women was still valuable as many supported what previous researchers suggest for improving care given to IPV victims in addition to providing other suggestions. Thus, this thesis sought to shed light on my three participants suggestions.

**Discussion of Findings**

Utilizing standpoint feminist theory allowed me to give my three participants a voice on this topic. While my findings are limited due to my sample size, I was able to capture the complexity of seeking help from IPV more generally, and more specifically, seeking help from health care professionals – two help seeking pathways that are intertwined into one complex cycle. Allowing women to have their voices heard enabled me to understand what this experience is like for women who have been abused by intimate partners. Moreover, it allowed women to contribute to the knowledge about seeking help and health care for IPV, to explain what they feel is the most helpful response to IPV, and to provide their own unique suggestions to improve health care. What follows is a discussion of my findings from interviewing women about how to best help IPV victims seeking help in health care settings.

**Help Seeking**

As women seek care from abusive relationships, they need to be received by informal sources of support, such as family and friends, with empathy and understanding. Drawing from the literature on rape and the role of social support, Campbell et al. (2001) find that positive
reactions from family and friends can have a positive effect on victims’ healing and well-being, whereas a negative reaction, such as victim-blaming, can be harmful. This literature can be translated to IPV victims; victims need positive social support to leave the abusive relationship and seek future formal help that may enable them to leave, as positive reactions from informal support can often lead to seeking help from formal sources (Evans & Feder, 2016). Thus, victim-blaming attitudes from family and friends can discourage women from seeking care from formal sources, such as health care professionals.

However, women may experience the same type of victim-blaming attitudes from personnel working in formal sources of help, such as police officers and medical professionals. As found within my research, this is because formal personnel are people too, who may hold misconceptions about IPV, making them prone to victim-blaming behavior. However, victim-blaming by professionals can have a profound negative effect as it can be retraumatizing as suggested by my participant, Pam. Within the literature, victim-blaming from formal sources of help is referred to as “secondary victimization”, whereby community service providers, such as police and medical staff, treat victims of rape or domestic violence with victim-blaming attitudes and behaviors, creating more trauma for the victim (Campbell, 2005). When victims are met with negative reactions from formal support sources they feel “guilty, depressed, anxious, distrustful of others, and reluctant to seek further help” (Campbell, 2005, p. 56).

Informal victim-blaming and secondary victimization play into a complex cycle of help seeking behaviors. Within my research, a level of complexity arose from my participants’ help seeking stories due to victim-blaming from both informal and formal sources of help. When victims are met with negative reactions from sources of help, they enter a cycle of help seeking behaviors. Women seem to engage in two different cycles, one for informal help-seeking, and
one for formal help-seeking; the first cycle seems to transition into the second cycle at some point. More research needs to be done to see what mechanism leads to the transition from the first to the second cycle, maybe it is finally receiving support from informal services that encourages women to seek formal services; however, this is only a speculation. Furthermore, more research needs to conclude whether the cycles are separate, or part of one continuous cycle. Nonetheless, based on my findings, I have created a visual, *Figure 1*, to represent the cycle most representative of my participants’ experiences.

*Figure 1.* The help-seeking cycles.

Thus, women may seek out informal sources first and when they are met with victim-blaming attitudes from the people they love and trust, they are discouraged to seek help from formal services where they fear they will be met with the same kinds of attitudes. Women may stay in this informal cycle (on the left) before entering the formal cycle (on the right). Nonetheless, women do eventually seek services from formal services, so the question becomes – what changes? What encourages them to finally seek formally services?

One possibility is that women transition when they hit “rock bottom.” According to my participants, this occurs when the abuse intensifies and when they cannot endure anymore. Thus, for some IPV victims, when this happens they become resilient, and seek out formal sources on their own, such as shelters, therapy, and health care, to free themselves from abuse. Hence, it
seems that each cycle ends for women when they hit rock bottom, this leads to a transition out the first cycle; moreover, it could be that hitting rock bottom also transitions women out of the second cycle and out of the relationship. In all, more research needs to be conducted to flesh out what informal and formal help-seeking cycles look like, the mechanisms of transitions between them, and when each cycle ends.

It must be noted, however, that not every IPV victim has the same help-seeking pathways, and this pattern can vary. For instance, Kaukinen (2004) finds three types of help-seeking behaviors for IPV victims: (1) minimal to no help seeking; (2) moderate informal help seeking; and (3) high help seeking through informal and formal sources. Additional studies suggest that as violence escalates in severity, women move from private strategies to deal with violence, to informal strategies, to more formal strategies (Liang et al., 2005). Nonetheless, the diagram represented above is indicative of the complexity of the help-seeking cycle, and it represents the general pattern that arose for my participants when seeking help from IPV.

**Empathy**

When women do seek health care, they may feel as though health care providers do not understand IPV and be wary to disclose abuse to them. Thus, my participants strongly suggested that health care professionals respond to cases of IPV with empathy and understanding. Empathy falls under what Mechanic and Meyer (2000) refer to as interpersonal competence. In their study with patients, Mechanic and Meyer (2000) found that patients are more likely to trust physicians when they display interpersonal competence – “understanding patients’ individual experiences, caring, communicating clearly and completely, [and] building partnerships and honesty with respect for the patient” (p. 662). Similarly, my participants communicated that they wanted health professionals to understand their individual stories, to be heard, and to be
empathized with. Thus, if IPV victims are met with interpersonally competent health professionals, it is likely that they will trust them and be more willing to disclose abuse, which has the potential to connect victims with necessary social services.

What the women from my study wanted most out of their interactions with health care professionals is empathy and understanding, a solution that seems so simple. But ironically, the culture of our health care system devalues emotional labor, such as responding to IPV with empathy, placing a greater emphasis on biomedical knowledge and treatments. Thus, such a straightforward solution is not built into the health care system, making this response to care a limited suggestion. I discuss this limitation in more detail within the next section, under “empathy limitations.”

Nonetheless, health care professionals need to become more informed about the cycle of abuse and the cycle of help-seeking victims go through to best help victims of IPV and avoid retraumatizing victims through secondary victimization. Thus, there is a larger problem here to be addressed – how do we destigmatize IPV and get people, as well as physicians, to understand to complexity of abuse?

**Training and Screening**

To increase empathy, more training for health professionals is needed. Training may also increase their ability to effectively screen women for IPV, especially if they are behaving in an interpersonally competent manner. Consistent with the literature, the participants in this study supported screening practices for IPV within healthcare settings, despite barriers to disclosure when they were not ready to leave the abusive relationship. Women’s hesitation to disclose was due to people’s misconceptions they had encountered about abuse, and fear of health care professionals not understanding the dynamics of abuse. Thus, my participants suggest that
health professionals are trained to properly respond to cases of IPV so that women may feel comfortable disclosing when screened. Most importantly, this training would educate providers about the complexity of IPV to avoid judging victims based on common misconceptions, such as the idea that abuse is easily escapable.

**Medicalization of Abuse**

Moreover, when health professionals medicalize abuse, they risk making conditions worse for women when they ignore abuse and do not take victim’s situation seriously, as was the case for Pam. Thus, screening has the potential to avoid medicalizing abuse. This is important because ignoring abuse can lead to prolonged violence and increased health care usage, so my participants suggest that health care professionals remain consistent about probing women, but in an empathetic and understanding manner, and provide women with information about social services regardless of disclosure.

**Comprehensive Approach**

Within the literature, there is a call for a more comprehensive approach to treating victims of IPV that includes a cross-sector collaboration between various services such as health care and social services (Miller et al., 2015). The participants in this research support this idea, claiming that collaboration among services would be helpful. For instance, Lucy explained to me that she had to locate all the services she needed through google and may have been able to leave the abusive relationship sooner if services worked together or were knowledgeable about the services that other sectors have available to IPV victims. Thus, a collaboration among services may help victims locate various services more quickly enabling them to leave the relationship sooner.
Participants’ Recommendation

Finally, my participants provided two unique recommendations to improve care in health care settings – an electronic database IPV detection system and specialized IPV services. The electronic database would help health professionals identify IPV. Specialized services would be tailored specifically to victims in medical facilities presenting with IPV, and have people trained to properly respond to victims. However, there are limitations to both suggestions that I describe below.

Findings’ Limitations

From my interviews, women recommended how to improve care given by health care professionals. Nonetheless, there are limitations to these suggestions and how they might be implemented – specifically regarding the suggestions for responding with empathy, an online database, and specialized services.

Empathy Limitations

People seek out health care services for physical and mental conditions. However, patients do not want just their health care needs to be addressed, they want to be cared for by people who help to comfort them as health alignments can be scary. Mechanic (1986) argues that physicians are trained to view illnesses in an objective manner without measuring a patient’s overall well-being. As a result, the culture of the health care system makes emotional labor a low priority for physicians; instead, in the United States, we depend on a patient’s family and friends to provide this type of care. This creates an institutional barrier for physicians to respond to cases of IPV with empathy; it enables them to avoid the overall well-being of the patient, they objectively treat symptoms of IPV with their biomedical expertise (Apesoa-Varano & Varano, 2014).
Addressing all the needs of IPV victims consists of what Apesoa-Varano and Varano (2014) refers to as emotive caring, or care that goes beyond curing or treating an illness; it refers to bedside manners, comforting patients, and caring for their overall well-being. Emotive caring is seen as the work of individuals, or an individual tendency to be compassionate. In Apesoa-Varano and Varano’s (2014) study in an urban hospital, physicians referred to emotive caring as either not their job, or not what they were there to do, making it a low priority since emotive caring is not objective – it cannot be standardized and practiced uniformly. Thus, emotive caring is seen as the job of nurses or social workers where this type of care is central to their occupation.

Thus, the culture of our current health care system needs to change for more health care professionals to respond to cases of IPV with empathy. More training could help to combat this by informing physicians and other health care workers about the complexity of abuse. However, without addressing the current state of our health care system, having medical advocates (whose job incorporates emotive care) address IPV victims’ needs in health care settings may be more feasible. Nevertheless, there are limitations to this as well, which I discuss below.

**Specialized Services Limitations**

As for the specialized services that women suggested, some exist in select sites in the form of *medical advocacy*. Women recommended that hospitals have specific personnel who are trained to respond to cases of IPV. Their suggestion parallels the work of medical advocates who provide onsite services to IPV victims seeking care in hospitals, clinics, or other medical settings; such service specialists can also provide training to nurses and physicians (Domestic Violence Crisis Center, n.d.).
However, medical advocates are usually employed through Medical Advocacy Projects at the State level. For instance, the Domestic Violence Crisis Center (DVCC) established the Medical Advocacy Project (MAP) and is specific to the state of Connecticut with a partnership with Stamford Hospital. To provide another example, Hugl-Wajek, Cairo, and McCreary (2012) detail an emergency department in Illinois that employs an advocate. There, the advocate performs screening, provides support and materials to victims, and frees hospital staff from addressing IPV. Ideally, this would be what a medical advocate does in every medical setting that an IPV victim attends.

The above examples indicate that medical advocacy is not as widespread as it should be; it is state, program, and hospital specific. Moreover, none of my participants encountered medical advocates when seeking care, suggesting a lack of availability to women. The lack of availability led my participants to suggest that medical advocates be available to IPV victims in health care settings without directly referring it as medical advocacy; however, that is exactly what they were describing. Additionally, the lack of knowledge about this service indicates its lack of availability.

Thus, it is reasonable to deduct that medical advocacy should be more common and available in all health care settings that women frequent. Why is medical advocacy not as widespread as it ought to be? Once again, the answer may lie within the culture of our health care system. According to Apesoa-Varano and Varano (2014), there is a hierarchy of workers within medical settings whereby those at the top of the occupational hierarchy have the expert biomedical knowledge and authority to dictate diagnosis and treatment, despite the idea that all professionals in a hospital comprise a “team.” This hierarchy places physicians at the top, then nurses, then those with other specialized training, and finally social workers at the bottom.
Emotive caring is central to the work of social workers, but since they lack biomedical knowledge, their work is devalued within the healthcare culture. Social workers must struggle to validate their role in a field that is marked by biomedical knowledge and a culture that devalues emotional labor (Apesoa-Varano & Varano, 2014). One reason medical advocacy may not be widespread is because this type of work is not supported by the culture within the healthcare system. According to Apesoa-Varano and Varano (2014), physicians hold power and autonomy when it comes to medical practices. Conflicts may arise when medical advocates are brought into medical environments to give their professional advice about how to best treat victims of IPV; their expertise is seen as less authoritative than medicine. In all, without larger shifts in the culture of medicine, the suggestion to integrate medical advocacy into hospital services will have a limited impact – the same applies for the next suggestion, a database detection system.

**Database Detection Limitations**

To review, an electronic database would flag women with multiple visits to a health care setting presenting with IPV symptoms. There are two limitations to this that are clear to me. First, there would have to be an agreed upon set of IPV symptoms that would help to flag women. One way to overcome this, would be to conduct research to decide upon common symptoms. Elsewhere, Plichta (2004) has identified the types of injuries commonly associated with IPV, such as scratches, bruises, broken bones, and burns, and the locations of physical injuries are likely to occur on the face, neck, and head (Sheridan and Nash, 2007). These physical symptoms could help identify victims of IPV.

However, mental health symptoms unique to IPV, such as depression, PTSD, anxiety, and suicide ideation, would also need to be identified under a detection system, not just physical symptoms. Yet, the medical community is notorious for inattention to both physical and mental
health, often favoring the former. The culture of the health care system that favors objective physical health problems often devalues comprehensive care, which includes caring for mental health issues (Apesoa-Varano & Varano, 2014; Mechanic, 1986). Thus, there would need to be an agreed upon set of physical injuries and mental health symptoms to be looked for within the database system, and providers would have to increase the attention they pay to IPV victims’ mental health symptoms.

Nonetheless, if symptoms of IPV were agreed upon, the detection database system could be built into electronic health records (EHR), which are currently used in most health care settings to maintain patient files. Karakurt, Paten, Whiting, and Koyutürk (2016) argue that EHRs can help providers identify symptoms of IPV. In their study, they used the national EHR data provided by the Explorys platform to identify health problems that co-occur with IPV. They found that “symptoms could be organized into four main classes: acute injuries, chronic symptoms and disorders, gynecological related problems, and mental and behavioral health issues” (Karakurt et al., 2016, p. 80). Thus, they claim that these findings can be used to assist health providers in screening. Integrating the database detection system into EHRs can automatically flag women presenting to medical settings with repeat symptoms of abuse.

Second, an electronic database system will only be effective unless it is shared across providers and delivery systems. Moreover, the timing of when records are shared could also be a limitation to this. If databases among providers are shared in a delayed fashion, rather than in real-time, then women attending more than one facility frequently could still go undetected. Until various providers and delivery systems share patient records with one another in a timely fashion, an electronic database detection system may be most useful to detect IPV victims in areas where there is only one health care facility for women to go to.
Nevertheless, I think that this is still a valid suggestion, and may prove more useful for detecting IPV than doing nothing at all or leaving screening practices up to individual health care professionals. Additionally, as stated previously, this detection system could be easily implemented into electronic health records to assist providers in identifying and flagging women.

**Sampling Limitation**

Finally, my findings are also limited because of my sample size. Most suggestions were unique to each participant and it was difficult to find shared suggestions among my participants with such a small number. Thus, findings should be received with caution as they are based on a less than ideal sample size for qualitative research making these findings unlikely to be generalizable to the wider population.

**Future Research**

Despite sampling setbacks, I still believe there is room for more research in this area. Each woman I interviewed thanked me for doing this research, suggesting that there is a need for this type of research. Too often we allow those at the top of social hierarchies to dictate how to treat those at the bottom. Standpoint feminist theory challenges the culture of the medical field and the assumption that “doctor knows best.” There is a lot to be learned from asking those at the bottom what they want and what they need, rather than policies and practices being imposed on them, that might not necessarily be beneficial.

It is not just female victims of IPV that fall at the bottom of this hierarchy, but it is all laypeople, whose voices are not given priority when it comes to dealing with matters of their own health. The culture of the health care system gives those in power, such as physicians and those in management positions, the authority and expertise about how to best treat medical and social issues, such as IPV (Apesoa-Varano & Varano, 2014). I think it is important for future
research to be conducted with guidance from standpoint feminist theory to allow the voices of those at the bottom of hierarchies to be incorporated into the literature. Future research should continue to ask IPV victims how care can best be suited to their wants and needs.

Future research should also address how to destigmatize abuse. How do we get lay people and physicians to understand the complexity of abuse? Much like the controversy surrounding drug addiction – a disease versus a choice – many people believe staying in an abuse relationship is a choice, and is the problem of the victim, rather than a social issue. Future research should examine what advocacy programs are doing to address the misconceptions about abuse in both the public and the health care sector, and how effective they are. What can be done to educate people about the complexity of abuse and help-seeking cycle?

Further, research should address what the help-seeking cycle looks like. Are informal and formal help-seeking cycles part of one continuous cycle, or can it be broken down into a few cycles? I have tried to display what these cycles look like; however, more research needs to be done to flesh out what these look like.

Moreover, future research should identify and evaluate comprehensive approaches to IPV, such as collaborations between health care and social service sectors. One approach is a healthcare organization utilizing a systems-based approach is Kaiser Permanente Northern California (KPNC) that links health care and social services. Are there other organizations out there that do this? Are they effective? Researchers should continue to evaluate these types of programs so that successful ones can be imitated and disseminated to more health care facilities.

Finally, future research should follow up with the suggestions made by the participants in this study. For example, a question that warrants consideration is, are electronic databases and EHRs being used to detect IPV and disseminate information about social services? There may
already be types of electronic databases that are being used to aid health professionals, and if so, how effective are they? Additionally, researchers should examine the availability of medical advocates – my participants alluded to this type of service which already exists but was not available to them. What medical settings are medical advocates present in and how helpful are they? What exactly is the role of a medical advocate in medical settings? Do they struggle to validate the care they provide? Are medical advocates a better option than having health care professionals detect and intervene in cases of IPV? In conclusion, this research yields suggestions for how to improve the care given to women who experience IPV in health care settings while also raising new questions for future researchers to consider.
References


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Appendix A

Informed Consent Form

I am asking you to participate in this study because you can provide valuable information about how doctors and nurses can help women who have experienced intimate partner violence. I want to learn what you think is the most helpful response to women who have experienced domestic violence.

Your participation in this interview is completely voluntary. I will be asking you about your experiences with doctors and nurses and how they should respond to women who have experienced intimate partner violence. The interview will last approximately 30 to 45 minutes. Also, I ask your permission that this interview is recorded.

You may decide you do not want to participate at any time. Given that we are discussing your experiences with health professionals, you may experience distress. I will provide you with the National Domestic Hotline number at the end of the interview if you wish, you can also go to the domestic violence agency you are familiar with for additional support.

So you are aware, I will be taking steps to ensure that information you tell me and your identity will be protected. First, I am not collecting any information about you; I do not wish to know your name so that you may remain anonymous to me. Your privacy will be protected if your identity remains anonymous.

If an abuser enters the room during our interview, please hang up the phone. If they ask about the phone call, tell them it was about a cosmetic survey.

If you decide you do not want to participate at any time, please let me know and you will not have to continue. At that point, I will destroy any interview information. The information obtained from this interview may be published in scientific journals or presented at meetings. This project has been approved by the Indiana University Review Board for the Protection of Human Subjects (724-357-7730). If you are willing to participate in this study, please state that you agree to participate in my research.

National Domestic Violence Hotline, 1-800-799-7233
Appendix B

Semi-Structured Interview Guide

Introduction:

Before we begin, I want to make sure you are in a safe place to talk to me today about your experiences with doctors and nurses. Are you in a safe place? If an abuser enters the room during our interview, I want you to hang up the phone. If they ask about our phone call, please tell them it was about a cosmetic survey.

I would like to thank you for agreeing to take the time to talk to me today. Your insights and experiences are very valuable information. Because you are going to be sharing information about yourself with me today, I would like to share a little bit about myself with you. As a child, I witnessed intimate partner violence between my mother and father; however, I do not know what it is like to be in a violent relationship myself.

As a graduate student, I became interested in the ways that health care providers respond to intimate partner violence. This research initially started as a class project. I started researching how health care providers respond to women who have experienced violence and wanted to learn how their response may be improved. That’s why I would like to know more from you how health providers could be more helpful.

At this time, I will read you a form that explains what my study is about so that you can make a decision about whether you would like to participate. ** Read informed consent and gain verbal consent.

Do you have any questions for me at this time?

1. Would you mind telling me a little bit about yourself – your age, about your job if you’re currently working, kids, if you have any, things like that?

Okay now I’d like to know a little bit more about your experience in health care. As I mentioned before I’m interested in what you feel would be helpful for doctors or nurses to do to help women who have experienced violence in a relationship.

1. First, can you give me some examples of times you have been to the doctor, hospital, or clinic?
   a. Where did you go?
   b. What were your reasons for going?
2. Thinking back to your own experiences, can you recall being asked about a history of domestic violence?
   a. Would you have liked to have been asked about intimate partner violence? Ok can you tell me why? Can you tell me why not?
3. In an ideal situation, what do you think is the best way for doctors and nurses to ask women about intimate partner violence?
4. Thinking about your own experiences with health providers, what would have been
the most helpful thing a health professional could have done for you?
   a. What information or resources might have been helpful for you to hear about?
   b. Can you tell me about the various services that you needed during the time you were seeking help?
   c. Can you describe what it is like trying to get help from multiple services?
5. Can you describe any obstacles or challenges you have faced seeking help from health care services and social services?
6. In an ideal world, what would health care services and social services working together look like?
7. In the United States, when we send people home from emergency rooms and hospitals, for example a woman who has just given birth, we assume that there are family members there to help her through. What do you think about health care workers that followed up with patients after they are released, especially with women who are in violent relationships?
8. When it comes to experiences in health care, is there anything that I haven’t asked you that you think I should know?

National Domestic Violence Hotline, 1-800-799-7233
Appendix C
Flyer

PARTICIPANTS NEEDED FOR STUDY
INVESTIGATING HEALTH CARE AND
DOMESTIC VIOLENCE

I invite you to participate in an important study. I am studying how health professionals can help women experiencing domestic violence.

Who can participate?

Any woman 18 years or older, who has a history of domestic violence, and has had contact with health care providers.

How you can participate:

I invite you to participate in a phone interview with me. You will remain completely anonymous in your participation in this research so that your identity and information is protected. I suggest you call from a neutral phone number, for example, a friend’s phone or a phone where you are seeing this flyer, so that your call may not be traceable by a partner. Please call the number below if you wish to participate in this study.

About the researcher:

My name is Shelly, I am a graduate student at Indiana University of Pennsylvania. I am interested in learning about your experiences because I want to improve the care given to women who have experienced domestic violence in health care settings. Feel free to call me with any questions. This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724/357-7730), Protocol Number: 16-28