Three steps forward, two steps back: Personal health perceptions and needs of female domestic abuse victims and their access and utilization of health services

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Notes

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Abstract

Using semi-structured interviewing of female domestic abuse survivors and health care providers, this study investigated relationships between female domestic abuse victims' (1) abusive environments, (2) health perceptions and needs, and (3) access to and use of health care services. The results provide evidence that the abusive partner and the health care system are the two major barriers that women face in seeking medical attention for abuse- and non-abuse-related illnesses. Moreover, victims who are mothers reported experiencing slower rates of recovery from abuse and lower overall health status than victims who did not have children. Health care provider interview data indicate a pattern connecting victim perceived health with the victim's confiding of abuse to the provider. Additionally, data reveal issues surrounding the health care providers' frustration in treating victims who remain silent about their abuse and the empowerment that victims receive from confiding their abuse.

Introduction

Domestic violence is a serious social problem that can be described in epidemiological terms as an extreme public health dilemma. Although domestic abuse claims victims of both sexes and all ages, most research has focused primarily with the victimization of women. Violence is the second leading cause of injuries to women between the ages of 15 and 44 (Velsor-Friedrich, 1994). As compared with women who are not the victims of domestic violence, female victims receive more inpatient and outpatient health care for trauma and non-trauma related surgical conditions, medical and nonspecific conditions, suicide attempts, psychiatric treatment, non-trauma related medical emergencies, elective abortions, and miscarriages, resulting in increased use of resources that continues for years after the violence ends (Ambuel, Hamberger, & Lahti, 1996).

In recent research, Mary Koss found that victimized females were 2.5 times more costly to the health care system than women who have never been the victims of abuse (Garnett, 1994). According
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To studies conducted by Richard Gelles, Director of the Family Violence Research Program at the University of Rhode Island, the medical costs and productivity losses from family violence total from $5 to $10 billion annually (Mason, 1993). Based on an estimate from the National Crime Survey, domestic violence results in 100,000 days of hospitalization, almost 30,000 emergency room visits, and nearly 40,000 visits to physicians every year (Bowers, 1994).

This study investigates the relationships between (1) female domestic violence victims’ abusive environments, (2) health perceptions and health needs, and (3) access to and use of health care services. An analysis of these relationships will be used to construct a better understanding of the health aspects of the female victimization experience, point out new areas of research investigation, and attempt to bridge the gap between the domestic abuse research of different fields.

In the present study, qualitative data-gathering techniques were employed to explore the victimization experience from the viewpoint of both the female domestic abuse victim and the health care practitioner (i.e., physicians and nurses). Through systematic analysis of interviews with respondents from both categories, an examination of the above-mentioned relationships was conducted from the perspectives of both sociological and medical/public health orientations in regard to domestic abuse.

Victims of domestic abuse receive services from nearly every area of the health care system (Curnow, 1987). For example, domestic violence victims account for 21% of all women who use the emergency room (Dickstein, 1988). Further complicating their medical treatment, some of the women are pregnant at the time they sustain injuries. Recent studies show that 45% of battered women are abused during pregnancy (Garnett, 1994). These statistics are alarming; however, they do not fully reflect the problem because many victims do not report their abuse, and many health care professionals are not able to identify patients who are victims (Davison & Couns, 1997). Moreover, many physicians and nurses have not been trained in methods of identifying and helping victims and thus do not ask their patients about situations possibly involving domestic abuse (Ambuel et al., 1996). According to Dutton and Painter (1981), female domestic abuse victims can be very difficult to identify:

...[T]hey may appear evasive and depressed. They may be reluctant to self-identify because of embarrassment and stigma. They fear being demeaned, not believed, or made to feel responsible for the attack. They are afraid of reprisals from the batterer if they disclose, and they feel skeptical that anything can be done by outsiders. (cited in Tilden, 1989, p. 314)

Although domestic abuse is a serious social and medical problem in the United States, studies attempting to establish the rates of domestic abuse among the U.S. population generally have been inconclusive. The best current estimates suggest that at least three to four million women are the victims of physical abuse by their intimate partners (Harris & Cook, 1994). Nationally representative surveys of married or cohabitating persons found annual prevalence rates of domestic violence in the United States to be at about 16%, whereas lifetime prevalence rates may be as high as 28% to 54.2% (Ferris, Norton, Dunn, Gort, & Degani, 1997). According to the FBI, some form of domestic violence occurs in half of all US households at least once a year (Dickstein, 1988).
Why are data on domestic abuse inconclusive? Historically, domestic abuse has been downplayed and sometimes even culturally condoned in this country. During the colonial period, laws derived from English common law permitted a man to beat his wife if she acted in a manner that he deemed to be inappropriate. For example, until the end of the nineteenth century, the "Rule of Thumb" law permitted a husband to beat his wife with a stick that could be no larger than the circumference of his thumb (Dickstein, 1988).

The issue of domestic violence, especially wife abuse, first gained national attention in 1974 with the publishing of Scream Quietly or the Neighbors Will Hear by Erin Pizzey, the founder of Chiswick's Women's Aid (a shelter home in England for abused women). Pizzey's work stimulated feminist concern and outrage over wife beating, verbal abuse, financial restrictions, and social isolation of women by their husbands (Utech, 1994). Shortly thereafter, activists in the women's liberation movement, especially the National Organization for Women (NOW), advocated an end to domestic violence and sought improved social services for abused women. NOW also was actively engaged in promoting shelter homes and lobbying congressional leaders for legislation that would result in better treatment and protection of women's health and well-being (Utech, 1994). In their comprehensive study of domestic violence in 1978, Murray Strauss, Susan Steinmetz, and Richard Gelles concluded that 3.8% of women in over 2000 American families had been subjected to one or more attacks by their husbands in the previous year. According to Strauss (1985), "Violence is built into the very fabric of American society, and physical force is the ultimate resource on which most of us learn as children to rely if all else fails and the issue is crucial" (quoted in Ross & Faustini, 1989, p. 99). Despite the held assumption that violence occurs only in "minority" or "lower class" families, research continues to document the fact that violent conflict occurs at all socioeconomic levels and among all racial and ethnic categories in society (Bedard, 1992).

The problem of domestic abuse is intricately intertwined with the provision of health care. In recent years, health care providers, in coordination with the legal and social service professions, have attempted to combat domestic abuse. For example, in 1992, the Joint Commission on the Accreditation of Health Care Organizations, began requiring that all accredited hospitals implement policies and procedures that would enable health care providers to identify, treat, and refer victims of abuse to appropriate counseling and social services (Mason, 1993). This requirement included the implementation of in-service training programs for staff members in emergency departments and ambulatory care facilities (Mason, 1993). In 1994, members of 83 organizations, including the American Nurses' Association and the American Bar Association, met to identify gaps and barriers between the health care delivery and criminal justice systems in dealing with family violence cases. Among their recommendations were the following: a mechanism for community professional coordination in assessment to maximize family safety; the creation of community-based family violence coordination councils; and the need to establish a comprehensive, culturally sensitive, and accessible intervention system in every community for family violence that links health, justice, mental health, social service, and educational systems (Stanley, 1994). In addition, the American Medical Association (AMA) published guidelines to assist health care professionals in identifying domestic violence victims. Although the social, medical, and judicial systems have sought to work together to fight domestic abuse, one pressing problem remains. Research on domestic violence produced by one system often cannot be compared to, or connected with, research generated by the other systems.
Review of the literature

The problem with theories

Greater public awareness of domestic abuse has contributed to increases in research funding and development of intervention programs to help combat the problem. However, systematic study of this important social issue has consistently proven difficult because of limitations in existing theories and methodologies.

Since the 1970s, researchers have used various sociological and psychological theoretical approaches to explain the phenomenon of domestic abuse. Traditional theories on the causes of domestic abuse focus on factors such as people's individual characteristics and life experiences, including the presence of problems such as social and structural stress, social alienation, unemployment, poverty, substance abuse, past child abuse, personality disorders, psychopathology, and depression (Yegidis, 1992). However, many people with these problems do not engage in domestic abuse. Additionally, research has demonstrated that the elimination of such personal problems does not contribute to ending domestic abuse in a relationship (State of Iowa, 1994). Nevertheless, for the purpose of framing particular studies of domestic abuse, these theoretical approaches are still important. Due to each theory's weakness, it is important for researchers to adopt a theoretically holistic approach. The fact that each case of domestic violence is somewhat different from another calls for using a variety of theoretical orientations to better examine the nature and extent of this pressing problem.

While domestic abuse can be studied through "mental lenses" that are psychological or sociological in nature, it is important also to examine this issue from a medical/public health perspective.

Previous research problems: Integrating disciplines

Previous research on the subject of domestic abuse has uncovered numerous limitations for applicability to the current study. Sociological and psychological literature tends to focus either on understanding the household dynamic in which the abuse occurs and/or health perceptions of the victim, whereas health research on domestic abuse is still in its infancy (Ambuel et al., 1996). The majority of medical/public health research on domestic abuse focuses on how to identify victims of this type of violence, what kinds of intervention programs are most effective, and/or epidemiological studies of domestic abuse injuries and illnesses (Ambuel et al., 1996). Research is needed that seeks to understand the domestic violence victim in (1) physical/psychological health terms of the abusive environment in which the victim is immersed, (2) factors that prompt a victim to seek assistance from the health care system, (3) victim health perceptions and needs, and (4) victim experiences once they have received treatment---all as interdependent factors instead of independent details. Essentially, what is needed is a study of domestic abuse in relationship to health services that takes into account a variety of perspectives.
Victims' experiences within the abusive environment and health care implications

Domestic abuse typically follows a cyclical pattern which gives an even stronger meaning to the term "cycle of violence." In 1979, Walker identified three phases in the cycle theory of violence: tension-building, acute battering, and honeymoon. According to Walker:

*During phase one, the tension-building phase, the batterer becomes increasingly moody, hostile, and critical of his partner. Minor battering incidents may occur. During phase two, the acute battering incident, the [batterer] is likely to assault the [victim]. Major assault of the [victim], physically and psychologically, usually distinguishes the acute battering incident from the minor battering incidents that may occur during phase one... Shortly after the acute battering phase is the honeymoon phase. The batterer may apologize, beg forgiveness, or promise that [the] violent behavior will never happen again.* (Walker, 1984 and Saunders-Robinson, 1991 as cited in Curnow, 1997, p. 128).

Sally Curnow (1997) examined female domestic violence victims' experiences within this cycle to discover when help seeking and reality behaviors (that is, behaviors resulting from the realization of the violent situation) were most likely to surface. The results revealed that periods of help seeking and reality behaviors do exist within the cycle, occurring in a period referred to as the "open window phase," which takes place after the acute battering phase and prior to the honeymoon phase (Curnow, 1997). These findings have significant implications for health services investigation in discovering the best ways to provide victim health services and attract victims to those services, proving that the cycle of violence can be broken.

Presenting further implications for understanding female domestic violence victim experiences and the dilemma of prompting victims to leave their violent environments, Chang (1988) concluded that an explanation for why some shelter residents do not leave their abusers is "their failure to undergo successfully a transformation process to a self-saver identity" (p. 548). To become a "self-saver," numerous factors, both internal and external to the female victim, must be present, including a neutralization of ties to her abuser and an exposure "to intensive interaction and to ideologies committed against sexism and domestic violence, which she comes to accept, and is networked to supportive ties within and outside the shelter" (Chang, 1988, p. 549).

Research on the victim health care experience

As changes take place in the manner by which health care is delivered, health service researchers have begun to examine ways of reaching out to individuals who require special attention or care yet are unable to obtain it. This approach has also been applied to domestic abuse victim health services. With the number of injuries that domestic violence causes annually, the health care system has begun to see itself as an important link in helping the victims. The health care profession is in a position to identify abused women, administer the proper care they require, and refer them to necessary social services. Numerous articles report many health care professionals do not perform these services for abused women, especially in the emergency room (Curnow, 1997; Gerbert,
In research on domestic abuse among emergency room patients, Goldberg and Tomlavich (1984) discovered an inverse relationship between victim behaviors and beliefs. For example, even when they reported that the violence in their relationship was decreasing or had ceased, victims requested specialty services on the survey (i.e. counseling). In addition, victims requested pain medication more often than any other type of medical service (Goldberg & Tomlavich, 1984).

Studies by Drake (1982) and Lichtenstein (1981) found that female victims who had been abused were more likely to hold negative opinions of the emotional care that they received from health providers (Tilden & Shepard, 1987). They were especially critical of impersonal and insensitive treatment (Tilden & Shepard, 1987). In studies of hospital emergency departments, Goldberg and Carey (1984) and Rounsaville (1978) concluded that medical professionals often lack knowledge about domestic abuse and may be influenced by stereotypes and prejudices (Tilden & Shepard, 1987). In a study of four urban emergency departments, Kurz reported that in only 11% of the cases of probable abuse, staff responded therapeutically (meaning with concern for the woman as an individual, with sensitive interviewing, careful chart documentation, and with referral to resources) (Tilden, 1989). Further compounding this problem is the fact that when women seek medical help and are greeted by negative responses, their feelings of helplessness are increased (Hendricks-Matthews in Curnow, 1997). In addition, Hayden and colleagues (1997) found that more than a third of female domestic violence victims do not disclose their victimization if they know that health care providers are required by law to report such incidents.

Using ethnographic techniques, Sugg and Inui (1992) concluded that physicians who explored for domestic violence in the health care setting felt the procedure to be similar to "opening Pandora's box" in fact, 18% of the physicians interviewed used the phrase. The physicians participating in this study (the majority of whom were family practice specialists) reported such problems as lack of comfort in dealing with the issue, fear of offending the patient, a sense of powerlessness, loss of control, and time constraints, all of which constitute barriers to domestic violence recognition and intervention in cases of domestic violence seen in the primary care setting (Sugg & Inui, 1992).

Gerbert and colleagues (1996) investigated how female victims of domestic violence were treated in health care settings. The researchers identified three levels of barriers encountered by female victims: patient, provider, and organizational. On the patient level, many of the women interviewed chose to conceal their abuse from their health care provider due to shame or fear of retaliation from their partner. At the provider level, the patients believed that health care providers were apathetic regarding their problems. On the organizational level, some women felt that the health care system did not assist health care providers in handling domestic violence beyond treating the immediate injuries (Gerbert et al., 1996). While this qualitative focus was one of the first of its kind in the area of domestic violence victim health care research and these findings are important, the research does not analyze specific details such as individual homelife circumstances, medical history, and factors that led the victim to seek medical attention.
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Analyzing research that investigates health professionals' perspectives of domestic violence helps to confirm the startling reality that exists for victims seeking assistance. Sadly enough, as severe a health threat domestic abuse poses to women, many victims have been, or are currently, misidentified or met with apathy by health care professionals. This phenomenon is due to many factors, the most common of which includes inadequate training (many training programs do not even discuss domestic violence) and tendencies toward feelings of "victim blaming." Many health care professionals adopt the stance that domestic violence is a problem that falls outside the spectrum of their job description. These professionals view the ideology of the family as a private domain and believe difficulties inside the home can and should be settled by the family members themselves (Davison & Cowns, 1997).

**Psychological abuse and its implications for research**

Psychological abuse of the victim is an important area to consider in the development of domestic violence treatment and health services. Although psychological abuse usually accompanies physical violence, research tends to ignore its importance, focusing only on the physical trauma. This fact is ironic since most of the research to date acknowledges that emotional or psychological injuries are interconnected with the physical injuries that result from physical violence (Utech, 1994). Although the association of psychological abuse with physical violence is accepted, an absence of studies exists on psychological abuse itself. According to Utech (1994):

> While some scales attempting to isolate nonphysical abuse have been developed (Hudson & MacIntosh, 1981; Tolman, 1987), no research has taken the data yielded by these scales and attempted to correlate the behaviors with actual psychological/emotional injury. Nor have the types and degrees of psychological injury been scaled. Although it would seem self-evident that emotional injury is a consequence of verbal abuse, this major gap in the research does not permit empirically based assertions about the possible linkages between the phenomena. (p. 130)

According to Keller (1996), the connection between a history of abuse and psychiatric disorders has not been adequately attached to clinical psychiatric practice. Three factors that can prevent the victim from seeking medical care are fear, confusion, and acute feelings of powerlessness, the long-term effects of living in a violent environment. In addition, this problem is further exacerbated by common psychological symptoms and illnesses that can stem from victimization, such as chronic fatigue and tension, exaggerated startled reactions, and sleeping and eating disturbances (Keller, 1996).

In their analysis of social support and psychological health among abused women, Mitchell and Hodson (1983) found that increased levels of violence, minimal personal resources, lack of institutional and informal social support, and greater avoidant coping styles were related to lowered self-esteem and more severe depressive symptoms. Their research further suggested that stress (resulting from varying levels of violence) and personal resources may have indirect effects upon functioning through their influence on coping responses and the availability of social support (Mitchell & Hodson, 1983).
According to Bohn (1990) psychological trauma exists as a barrier to seeking medical care (as cited in Loring & Smith, 1994). The trauma that results from being battered bears close resemblance to that seen in disaster victims and, consequently, can cause a victim to wait days before seeking medical attention (Bohn, 1990 as cited in Loring & Smith, 1994).

Chemical dependency is another important issue within the realm of psychological effects of abuse. Many studies tend to focus upon the use of alcohol and drugs by the abuser and its role in the etiology of violence. However, it is not uncommon for female victims to rely upon alcohol or drugs (illegal or prescription) in order to numb themselves to the violence that they are experiencing. This practice can have serious implications for learned powerlessness, fear, and mistrust of anyone offering help, including health care providers. Very often, physicians prescribe pain medications or mild tranquilizers for battered women (Loring & Smith, 1994). However, Kurz and Stark (1988) recognized that the practice of prescribing these types of medication to domestic violence victims is not advisable due to the risk of suicide and drug or alcohol abuse (Loring & Smith, 1994).

Health perceptions of the female domestic abuse victim

Health perceptions have been frequently studied in many areas of sociomedical research; however, an established connection to domestic abuse victim health is clearly lacking. This area has important implications since many victims experience psychological as well as physical injuries. Farmer and Ferraro, in their structural equation modeling of mechanisms of health decline using a national probability sample of adults ages 25 to 74, found that a negative relationship exists between distress and perceptions of health (1997). While Strauss and Gelles' 1985 "Violence in American Families" national survey contained questions dealing with the effects of abuse on perceived health, multiple searches by the author on the "PsycLit" academic article search engine for the search words of "domestic violence" and "health perceptions", failed to find any articles that joined the two subjects (A.P.A., 1997).

Koss, Woodruff, and Koss (1990) explored the relationship between criminal victimization and health perceptions among female medical patients who had been the victim of a crime (not necessarily domestic violence). Their regression analysis indicated criminal victimization was an important predictor of health perceptions even after demographics and other stressful life events with known links to illness were taken into account (Koss et al., 1990). They concluded crime victimization history is related to health status, and primary care medical populations are "an important locus from which crime victims could be identified and their treatment options considered" (Koss et al., 1990, p. 147).

While investigating the relationship between the experience of sexual assault and physical health, Kimmerling and Calhoun (1994) found women who experience sexual assault report "more somatic complaints, poorer perceptions of physical health, greater psychological distress, and increased use of medical services" (p. 333). However, their study revealed victim use of mental health services was not significantly higher and that victims "continued to seek medical attention at the end of the year after the assault, when health perceptions and somatic symptoms were no longer sufficiently elevated" (Kimmerling & Calhoun, 1994, p. 333). The latter finding is consistent with previous research by Koss et al. (1990) and Golding et al. (1988)(Kimmerling & Calhoun, 1994). These
findings also correlate well with Koss who claims female victims of violence are 2.5 times more costly to the health care system than women who have never been abused (Garnett, 1994).

Females who have been physically assaulted tend to see their primary care physician two times more than females who have never been abused...The year following the year of an attack is when most abused females begin to increase their utilization of medical services. (Garnett, 1994, p. 3)

Social support was proved to have an impact upon victim health perceptions when studying sexual assault victims (Kimmerling & Calhoun, 1994). Their analyses showed higher levels of social support were related to higher self-ratings of health following victimization. This finding poses great implications for the hypothesis that outside factors can be important motivators for a domestic violence victim (whether sexually assaulted or not) to seek out medical attention. Some female victims may seek out medical attention later than others due to supportive friends that may contribute to feelings of control of the violent situation.

Finally, Calnan and Johnson's (1985) qualitative findings on women's perceptions of health, health risks, and inequalities revealed a more defined social class differentiation (due to the study's use of two groups of women: professionals and those with semi-skilled/unskilled backgrounds) in concepts of health when comparing definitions that women from varying classes attach to health itself. In this study, "social class" was defined by the occupation of the head of the household, which generally was the husband. Overall, the findings highlighted a connection between high social class and generally positive perceptions of health while women with lower social class status exhibited more negative health perceptions (Calnan & Johnson, 1985). These correlations present implications for health services utilization by female domestic violence victims since social class is an influencing factor in how a person perceives his/her health. This hypothesis may also relate to whether or not domestic violence victims from varying socioeconomic backgrounds choose to seek medical attention for violence-related illnesses, as well as how often these services are actually sought.

Research methodology

Hypotheses

This thesis project is inductive and exploratory in nature. It was the intention of the author to develop hypotheses as data were collected and the research progressed. The study's exploratory nature was prompted by the lack of literature and previous research in the area being investigated. Theory was not applied to this study until all data were collected and analyzed.

Populations

Qualitative data gathering techniques were used to interview eight adult, heterosexual, female domestic abuse victims and eight health care providers (in this case, four nurses and four doctors). It should be noted that this thesis studied adult, heterosexual, female domestic abuse victims only (heterosexual women over the age of eighteen who had been victimized by their spouse or significant other) since other variables such as legal minor status, homosexual or bisexual orientation, and
male gender would have complicated data collection and/or introduced new information that may have been outside the boundaries of this study. Criteria used for the inclusion of the domestic abuse victims as respondents were individuals of female gender who had been physically, sexually, and psychologically victimized by their male partners and who had utilized health services during their victimization experience.

The respondents for this study were accessed through the assistance of two central Texas domestic abuse shelters for female victims and a major teaching hospital in the Dallas, Texas metropolitan area which provided physicians and nurses for interviewing. It was not the intention of this study to interview patients at the teaching hospital since doing so might have violated patient confidentiality.

The director of the first former victim shelter approached for this study (the smaller of the two included) permitted the author access to interview all the women who resided in the shelter at the time of the study. This approval was granted by the decision of the director and the approval of the women residing in the home. These women had been living away from their violent environments for a significant amount of time?in fact, according to the director of the shelter, some past residents of the shelter had made public appearances speaking about their victimization experience prior to the study interview. However, since this home was in a transition period in terms of residents during the time of data collection, only four respondents were available for interviewing. As a result, the author petitioned another nearby shelter to provide the remaining four respondents and was subsequently granted access by the facility's director.

Physicians and nurses at the teaching hospital were selected randomly for interview participation by a designated agency liaison through employment rosters. The agency liaison approached these individuals in order to recruit them for the study and arrange interview times. A master list of these interviews was kept by the liaison, who was the only individual who had access to it.

**Qualitative data gathering**

While it is the general tendency of social research to understand behavior by quantification, qualitative methodology occupies an integral role in the social sciences as the definitive alternative to quantitative methodology. According to Berg (1998):

> Qualitative research properly seeks answers to questions by examining various social settings and the individuals who inhabit these settings. Qualitative researchers, then, are most interested in how humans arrange themselves and their settings and how inhabitants of these settings make sense of their surroundings through symbols, rituals, social structures, social roles, and so forth. (p. 7)

This form of data collection is deeply rooted within the theoretical orientations of symbolic interactionism, the school of social thought that views social interaction as the exchange and interpretation of symbols; and the meanings society, as well as the individual, attaches to these symbols. Qualitative methods are utilized to discover how individuals define their social reality.

Quantitative methodology, while scientific and, often, more "acceptable" within the research community, can often fail to discover underlying behavioral patterns and the feelings of subjects.
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that are essential for understanding a particular social phenomenon. In The Sociological Imagination (1959), C. Wright Mills argued that if social researchers studied their subjects in a fashion that downplayed the role of symbols and focused on statistics, a danger exists that findings may fail to fit reality.

Although criticized for allowing interviewer bias, qualitative methodology was selected for this study due to the need to understand individual perceptions, experiences, and subjective feelings. Employing quantitative methods would only have touched upon themes of experiences, while generalizing individual respondent perceptions and possibly overlooking underlying facts.

Interviewing instrumentation

For the former victim interviews, the women were asked open-ended questions regarding their abusive environments and medical history while involved in their abusive relationships. The subjects representing the health care profession were interviewed with similarly-designed, open-ended questions focused on their experiences in providing medical care to female domestic violence victims. The specific topics asked of the respondents in both groups can be found in appendices A and B.

All questions were asked in a semi-structured interview fashion. This mode of interviewing involves the implementation of many predetermined questions and/or special topics that are asked of the respondent in a systematic and consistent order, while granting the interviewer freedom to digress (in order to probe beyond the answers to the prepared questions) (Berg, 1998).

Protection of respondent anonymity

In the interviews, the author talked with the victims one-to-one and face-to-face, offering to have a third party present (usually a representative of the agency) if the third party made the respondent feel more comfortable. Respondent anonymity was the top priority. Respondents were asked to provide the author with a made-up first name only (for the purpose of communication and later data analysis). This name, as well as the number interview in which the respondent participated, was given to either the director of the victim shelter or the hospital liaison. Only these individuals knew the respondents’ real names (in the event that follow-up interviews were required and for the purpose of storing the participants' informed consent forms). The respondents were informed prior to the beginning of the interview that they did not have to answer any question for which they felt uncomfortable in responding. In addition, they were provided a legal consent form to sign that indicated and explained (1) the intent of the study; (2) their awareness of the purpose of the study; (3) their intention to participate in the study; (4) their understanding that participation is voluntary, and that they could, at any time, end their participation in the study and/or have their responses discarded in their presence (for any reason); (5) their intention to have their responses recorded by either audio cassette or paper-and-pencil format; and (6) their preference of whether or not to have a third party present for the interview.

The respondents were aware that the author of the study was a Sociology Master's candidate at Baylor University conducting research for his Master's thesis. This information was included on the form as well. Respondents were provided with three phone numbers: one in order to contact
the author; another to contact the appointed departmental thesis advisor; and a third phone number to contact the appointed thesis advisor from outside of the department/director of the committee on the research of human subjects, in order to answer any further questions about the study in which they were participating or to voice any comments on the study itself.

Upon signing the informed consent form and writing their made-up name on the top of the document, the individual was provided with an envelope, instructed to place the form inside it, seal the flap, and sign their made-up name over the flap before they handed it to the author, who then delivered it to the liaison of the agency from which the participant was selected. The liaison kept the consent forms of all participants as well as provided the participants with a copy of their own individual forms. The respondents were instructed to write their made-up names on top of the form before placing it into the envelope. This procedure was done to insure that if an individual wanted their interview destroyed one day or more after the interview but had forgotten their made-up name, they could look at the copy that the agency liaison provided them for their records, and contact the author at the Baylor University Department of Sociology, Anthropology, and Social Work using their made-up name and instruct him to destroy their interview (inasmuch as their made-up name, interview number, and date of the interview were the only information provided to the author). The author would then destroy the interview and deliver it to the agency liaison who would give it to the proper participant. This approach strictly followed American Sociological Association (ASA) guidelines for human subject research.

Data collection

Respondents were given the option of having their responses recorded by either audio tape or pencil-and-paper format. Where data collection via audio recording was concerned, each interview was catalogued on its own cassette and began with the time as well as the respondent's made-up first name (that was provided from the liaison of each agency). If a respondent felt uncomfortable having their interview recorded, they were given the option of having their answers recorded in pencil-and-paper format instead (which was catalogued in the same format). All interview materials were kept secured in the Baylor University Sociology department office for safety. Upon completion of this thesis research, all interview materials were destroyed.

Data collection did not begin until the study and instrumentation received the required approval of the research review board of the teaching hospital, the Baylor University Committee for the Protection of Human Subjects in Research, and the administrations of both domestic abuse shelters. The interviewing of all the victim respondents took place on three dates: January 30, February 3, and April 3, 1998. Physicians and nurses were interviewed on April 24, 1998.

Theoretical, methodological, and previous research problems

While previous domestic abuse studies have utilized a variety of research techniques, using quantitative and/or qualitative measurement, the area of domestic abuse research has been criticized for its sample selection criteria and recruitment which can both exhibit large variation on outcome findings. According to Rosenbaum (1988):
Selection criteria is but one source of sample variance. Systematic differences between these various samples are probable. Women seen in emergency rooms are more likely to have been physically injured; those in shelters have separated from their spouses, suggesting either greater strengths or perhaps more severe abuse. Court- or police-referred subjects may be angrier, more guarded, and more maritally dysfunctional. (p. 95)

Due to access constraints, the author limited his study to the former victims located in two domestic abuse shelters. The teaching hospital was selected due to its metropolitan location, number of patient visits, extent of health services, and reputation as a research facility.

It should be noted that some of the elicited responses of the respondents are merely opinions, perceptions, or estimates (especially in the case of the instrument used for interviewing the health care professionals). In the overall analysis of data, the author is aware that such limitations are recognized to present restrictions on interpretation and meaning. However, following the guidelines of proper qualitative methodology, patterns were recognized during the processes of data collection and analysis. As a result of these patterns, the opinions, perceptions, or estimates of the respondents can be generalized to a larger population.

Analysis of data

Theoretical orientation

As mentioned in the previous chapter, theory was not utilized in this study until all data were collected and analyzed. As previously stated, many sociological, psychological, and public health theoretical orientations possess shortcomings in describing the entire phenomenon of domestic abuse; however, feminist theory offered the most insights on the data obtained in this study. This theoretical lens was selected due to its particular focus on gender conflict, inequality, and oppression. According to Lengermann and Niebrugge:

All theories of gender oppression describe women's situation as the consequence of a direct power relationship between men and women in which men have fundamental and concrete interests in controlling, using, subjugating, and oppressing women; that is, in the practice of domination. By domination, oppression theorists mean any relationship in which one party (individual or collective), the dominant, succeeds in making the other party (individual or collective) the subordinate, an instrument of the dominant's will, and refuses to recognize the subordinate's independent subjectivity. (cited in Ritzer, 1996, p. 458) Thus, a feminist approach suggests that when viewing a social reality from the perspective of the subordinate, a relationship exists in which the assigned significance of the subordinate is merely a tool of the dominant to exert or maintain power (Lengermann & Niebrugge, 1995 in Ritzer, 1996).

Some feminist theorists believe that gender inequality results from patriarchy, a broad level of domination that is maintained by intentional, power-related goals (Ritzer, 1996). Essentially, patriarchy serves as the core ingredient of female oppression.
The data used for this study displayed overt patterns of patriarchy on the microsociological level. As will be explained in further detail in the following sections of this chapter, female oppression, whereby women were forced by men to assume the subordinate role, was clearly evident as the root cause of many of the social phenomena uncovered in this study, especially in the case of victims' limited ability to gain access to adequate health.

**The former abuse victims abuse survivor demographics**

A total of eight female, former victims of domestic abuse were interviewed (four from each domestic abuse shelter). The demographic characteristics of the respondents were as follows:

**Ethnic background:** 5 Caucasian, 2 African American, 1 Hispanic American

**Mean age:** 36.87 years

**Mean number of abusive relationships per former victim:** 1.87 (All respondents had been married at least once)

**Mean number of children:** 2.62 (All respondents were mothers)

**Approximate annual household income range (while living with an abusive partner):** $4,000 to $50,000

**Approximate current annual income range:** $0 to $13,000 (due to injury or unemployment)

**Religious background:** 1 Episcopalian, 3 Baptist, 1 Lutheran, 3 Catholic

No significant medical or psychological history for any of the respondents prior to being involved in their abusive relationships

**Level of education:** 2 with high school diploma/GED, 1 with vocational training, 4 with some college education, and 1 with an Associate's degree.

All respondents reported receiving both physical and psychological/emotional abuse from their partners. All are currently receiving psychological counseling for their victimization experience. One respondent is receiving counseling for drug abuse as well. While all respondents did report receiving some form of physical abuse, only two were, at the time of the interviewing, still receiving physical treatment/therapy for their injuries.

Analysis of the interview data revealed patterns of how female victims are not reached by, or avoid altogether, the health care system. In addition, since all the respondents were mothers, all made mention of, or discussed in detail, the effects of motherhood on recovering from their victimization and the resultant health perceptions.
Health services utilization

While not all the respondents were frequent users of health services as a result of injuries obtained through abuse, most of the women identified situations when they were injured (e.g. bruised, cut, or worse) and should have gone to a medical facility but instead cared for, or tried to ignored, their own injuries. The data revealed that these women were not identified through the health care system for any one of four reasons:

1. The husband (or significant other) kept them from going to a doctor for treatment of injuries that their partners’ inflicted. In this case, the abuser threatened further violence if the victim sought medical attention for fear that medical personnel might identify the woman as a victim of abuse, notify law enforcement officers, and increase the chances that the abuser might be arrested.

2. The physicians and other health care professionals at such medical facilities as an emergency room, clinic, or private doctor's office did not ask about the nature of the victim's injuries or health care providers were unsympathetic or apathetic to the victim's needs.

3. The victims did not seek medical care because, as a result of their poor health perceptions, they believed the injury was not serious enough to warrant seeing a physician.

4. The victims were scared of being identified as a victim of domestic abuse at the medical facility by health care providers or other patients in the waiting room, or by a chance encounter with someone they knew from the community at large.

Overall, these barriers to health care can be attributed to the abusive partner, the health care system, or the victim's personal health perceptions as the root causes of the victim's inability to obtain proper medical care.

The abuser as a barrier to medical care

According to many of the women interviewed, their abuser was a major obstacle to when they considered seeking medical attention not only for abuse-related illnesses but also for regular, preventive health care. To understand how victims can be blockaded from health care access, it is important to analyze the abuser. Power and control are two important resources that exist within the dynamic of the abusive household. The abuser can use physical and/or psychological abuse as a tool to gain or reaffirm his power and control in the family. All the victims interviewed stated that such power and control had been exerted by the abuser in their family. Areas of control in the abusive household included overall decision making, paying bills, and whether or not medical attention should be sought for situations in which physical abuse had occurred.

"Charlene" (Respondent #1), a 34 year-old former victim, recalled an incident in which her abusive husband threw her down the stairs, resulting in injuries so severe that she had to remain in bed for several days. Moreover, the husband refused to take her to a doctor out of fear that he would be blamed for her condition (Respondent #1, April 3, 1998).
"Betsy" (Respondent #2), a 36 year-old former victim stated that on one occasion of fighting, her husband bent her finger back to such an extreme that, due to the pain and extreme swelling, she knew something was wrong with it for months. However, she did not seek medical attention for fear of upsetting her husband. She recalls having other bruises that were sore for weeks yet she would refrain from seeking medical attention, because she feared her husband's rage. After fifteen years of physical and psychological abuse, she decided to go to a hospital after her husband struck her on the head with an electric iron (Respondent #2, April 3, 1998).

For many of these former victims, the fear of upsetting their abusive partner had severe implications for their own health. Ignoring their abuse-related injuries altogether was not an uncommon strategy.

**It will heal itself**

Respondents in the study frequently stated that they downplayed the severity of their abuse-related illness. Overall, they reported very few incidences of physical abuse that were followed by them seeking medical attention. Even though most of these women received numerous injuries, such as bruises, cuts, and black eyes, they continued on with their daily routines. This downplaying of injury severity can be theorized to originate from two sources: (1) the domineering presence of the abuser who threatens further abuse if medical attention is sought, thereby leading to the victim's denial of the severity of injuries and (2) the overall denial that the victim is immersed within a violent environment and is actually being victimized. It can be further speculated that both of these factors relate to the poor self-worth of the victim.

"April's" reasons for not seeking medical care concern overall denial of her situation as being the underlying cause for her lack of motivation to seek treatment for her injuries. She reasoned, "It would have never occurred to me to go to the doctor. I just waited and hoped it got better." "April" believed that denial of her abusive situation was one of her main coping mechanisms for subsequently dealing with it. According to "April," she would repeatedly affirm to herself that "this is a wonderful marriage," attempting to convince herself that everything was fine in her household. Refusing to seek medical attention emanated from the denial of her entire victimization. She claimed that her denial of the situation served as a form of protection from the world: "There were times I probably should have [seen a doctor], but you have this "like" house of cards and you're trying to protect yourself from anybody knowing?" (Respondent #5, January 30, 1998). However, living in denial of their situation can lead to serious consequences for the victim. While serving as a defense mechanism, denial may also lead to reinforcing the victim's belief that she does not need to remove herself from her abusive household, thereby leading to future incidences of abuse.

**What happens when they don't leave?**

Many victims either live in denial of their situation or just accept their victimization and thus refuse to leave their abusive household. However, it is important to consider this phenomenon as an integral part of the dynamic that prevents a victim from accessing health care as well as a major factor in the victim's personal health perceptions. In essence, the microsociological dynamic of the home is intertwined with the health and health-seeking issues of the victims. While victim self-worth is an important factor to consider in this relationship, it will be discussed in later sections.
The victim is faced with the domineering presence of her abusive partner that literally enslaves her as a prisoner within her own household. Lacking the resources, financial and otherwise, to leave her situation, she is trapped within a violent environment, one in which she has no option of roles to choose from but the role of victim. "Susan" described the experience as: "You live in fear of being there and you live in fear of leaving?It's real hard to leave when you don't have anyone to turn to" (Respondent #3, January 30, 1998). As a result, the victim is forced to accept her situation or live in continued denial of her victimization. The continuous abuse, both psychological and physical, reinforces the concept of subordination to the victim. "Jane" learned quickly to assume the subordinate role: "If I fought back, I got it ten times worse" (Respondent #7, April 3, 1998). In regards to this continued reinforcement, "April" discussed how her husband would hit her until she literally remained on the floor. This exertion of power was executed by her abuser to reinforce the concept that she had to be afraid of him. In regard to how this continuous domination affected her, she replied, "I lost so much of my personhood" (Respondent #5, January 30, 1998). "Lisa" had similar feelings about her repeated and forced submission: "Brainwashing? it's not really brainwashing but they can say stuff to knock you down?" (Respondent #4, April 3, 1998).

For some of these former victims, the control of the abusive partner was not just something that sporadic abusive episodes reinforced in them. Instead, these former victims had a household that resembled a prison---where the control of the abusive partner pervaded into almost every facet of the homemlife. For the last year of her abusive relationship, "Jane's" husband would not allow her to buy groceries, or even have her own checking account (only her husband worked and he had his paychecks directly deposited into his own account, leaving him solely in control of the money). In order to have food to prepare for her family, "Jane" would have to embody the subordinate role and prepare a grocery list for her husband. He would then go out and buy the groceries, but only the groceries that he thought she needed. If he didn't feel that she needed a particular item, then he refused to buy it. As a result, "Jane" would have to literally petition her husband for specific items. She believes that her husband's overbearing control and abuse were ways of reinforcing his role as the provider of the home (Respondent #7, April 3, 1998). "Francis" was also always in the house because her husband did the laundry and the grocery shopping. As a result, she hardly ever ventured outside of the home and thus had almost no chance of being identified as a victim (Respondent #6, February 3, 1998).

Related to the concept of being trapped within their abusive environment are the coping mechanisms that the former victims would utilize to survive day-to-day life. Overall, the former victims appeared to have two types of coping mechanisms: those for general survival and those for emotional well-being. The coping mechanisms that helped promote survival included such activities as hiding from their abusive partner, actively avoiding confrontation, taking five to six hour naps, drinking, and drug use. Several respondents also mentioned hobbies they used as coping mechanism. These were activities that provided some form of escapism for emotional well-being, such as intense reading, constantly having the television on (but not necessarily watching it), and spending money on unnecessary items (which was referred to as a way of getting "high").

Interestingly enough, one former victim had a way of winning back some of her identity from her abusive partner. "April's" husband constantly complained about her weight, how she was too heavy for his liking. As a result of this constant belittling that reinforced in her a belief that she was too
heavy, "April" would lose weight to appease her partner. However, the physical and emotional abuse continued once she lost weight as well, so, in an effort to rebel against her oppressive abuser, "April" would eat (and subsequently gain the weight back that her husband despised; Respondent #5, January 30, 1998).

Unfortunately, even if these women remained in their abusive environments and were able to get past the barrier of their abusive partner in an attempt to get medical care for their abuse-related injuries, their problems were still far from being resolved. Once they arrived at the medical facility, many of them quickly learned that their problems were just beginning. The health care system presented a different set of obstacles to overcome, relating directly and indirectly to their experiences within their abusive homes.

The health care system as a barrier to medical care

Some of the women interviewed volunteered information about their perceptions of how some members of the health care profession treat victims of domestic violence. Several reported at least one incident in which they believed they were met with indifference by their doctors. Although some respondents did not report this problem, for others it constituted a problem large enough that it may contribute to our understanding of why many victims of abuse are not identified early in the course of their repeated battering at the hands of spouses or others. In the research, a recurring theme among respondents was the perception that their physicians did not care about them. In addition, gender plays a strong role in the health care seeking habits of these victims. Due to the lack of trust of men in their lives, negative past experiences with male physicians, and/or the fact that their abuser(s) are male, several of the victims reported a definite preference for female health care providers. "I think that it is easier for me to deal with a woman [physician]," claimed "April," while "Francis" (Respondent #6) and "Charlene" say that they both prefer a female health care provider for comfort (Respondent #5, January, 30, 1998; Respondent #6, February 3, 1998; Respondent #1, April 3, 1998).

"Susan" (Respondent #3), a 43 year-old former victim, cited male physicians as being the main cause of her problem with gaining attention to the underlying cause of her health problems. She reported: "Most of the doctors are male---all of my doctors are male...and they are not very supporting. It's embarrassing." Elaborating further on the issue of health care provider gender as an underlying cause of apathy toward domestic abuse, she adds about primary care physicians:

Well, it used to be that you could go to your family physician and tell them anything and "they were sympathetic and they understood" or you thought they did. A lot of them now...or maybe it's just me...it just seems like as I've grown older my doctor doesn't, you know, a male doctor...just does not understand and is not sympathetic. They...are very cold when it comes to something like that...they don't understand at all. And it's a real hard situation to understand anyway unless you've walked in that person's shoes. (Respondent #3, January 30, 1998)

"Lisa" (Respondent #4), a 27 year-old former victim, shared similar feelings: "They need to work on...how to treat people?" (Respondent #4, April 3, 1998). The consequences of this lack of concern are frightfully evident in the case of "April" (Respondent #5), a 33 year-old former victim who was
hospitalized twice for syncope from dehydration. The episodes resulted from the nervousness of her victimization that inhibited her desire to eat. No one at the hospital probed her about why she had not been eating. Instead, she was just treated for her physical ailments and released (Respondent #5, January 30, 1998). This attitude toward health care professionals can be blamed on lifestyle habits that do not include regular medical visits for annual check-ups. It can easily be assumed that these women would not go to a doctor for any reason regardless of whether or not they have been victims. However, it should be noted that the women who expressed this dissatisfaction with their physicians' inability to seem concerned were accustomed to seeing a doctor for annual preventive examinations either currently and/or while growing up.

Not all respondents reported negative interactions between male physician and female victims. "Jane" (Respondent #7), recalled that her male doctor was very compassionate when she went to the emergency room for her last abuse-related injury. Furthermore, he was very attentive to the possibility that she was trying to cover-up the true nature of her injury. "I could tell that he knew I was lying," she remembers. According to "Jane," the doctor then slid her a piece of paper across the table and said "Just in case you need it." The document was a form for patients to fill-out if they had been abused but felt uncomfortable confiding the abuse to health care providers. Due to the convenience of the form, she filled it out and, consequently, did not have to admit anything verbally (Respondent #7, April 3, 1998).

While many of these former victims at least received necessary medical care for their injuries, many others did not. For the latter, the environment of the medical facility presents itself as a place that promotes fear and anxiety.

**Fear of identification**

Some respondents failed to obtain medical care for their abuse-related injuries for reasons other than their own denial or the presence of an overbearing spouse. Although these victims recognized that their injuries warranted medical attention and they believed they had the freedom to seek medical attention, they still ignored their injuries and carried on with their daily routine because they feared that they might be identified at the medical facility as a victim of domestic abuse. This fear can be related to a number of factors?factors that can also connect with the patterns discussed previously. First, being identified as a victim, by either a health care provider or another patient, could lead to a phone call to the proper authorities. Their identification could therefore result in the man they love, being arrested. Additionally, having the spouse arrested would lead to a break-up of the victim's perceived happy homelife. This would result in the victim confronting her denied reality, that she is truly being a victim in a violent household. Another possibility exists that can be conceptualized as a variation on the previous theoretical cause. Even if risking the chance of implicating her abuser is not an issue, the victim will still refuse going to a medical facility out of fear of embarrassment. This scenario presents an accompanying consequence as well since, besides embarrassment, she would also be forced to confront the fact that she is a victim (e.g. through stares and strange glances at her abuse-related injuries, like a black eye).

According to "Jane" and "Betsy," the waiting room of a medical facility can be an extremely horrifying place. Jane claims paranoia was the main reason for not seeking medical attention for her
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injuries. She did not go to a hospital out of fear that someone would identify her as a victim (Respondent #7, April 3, 1998). "Betsy" feels that being identified by patients is even more frightening than being identified by the doctors:

You do feel uncomfortable. They should have places for women...that have been abused...some health care for them...because sometimes they have other emergencies and then you're sitting there and...everybody's looking at you and then you just [have] gotten abused and then you really don't want to sit around?a bunch of people and...they [are] watching you and they [are] wondering and...looking at you and thinking, "Well, what happened to her?"...And you don't really want to be around it because [you're bruised and want someone from your situation]...That may be one of the reasons why I don't go. (Respondent #2, April 3, 1998)

Similar to the "I ran into the door," cover-up behavior that is common among abused children, "Jane," a 39 year-old mother of five children admitted to making up excuses for her abuse-related injuries in an attempt to eliminate suspicion by health care professionals of being a victim of domestic abuse:

If there's not a plausible excuse that you could come up with...if you don't look like you've been beaten up, then you don't go because what if you go, and you're in [the medical facility], and you think you're being taken care of and the doctor leaves the room and you're thinking that maybe he's going to maybe come back with some medicine and he's in the hall making a phone call and then you walk outside and the police are there... It's a confrontational scene that you are not even prepared for...and it's extremely frightening and intimidating and it definitely keeps you from seeking help...I know that I can't be the only woman who must be thinking that. I certainly can't be the only one. (Respondent #7, April 3, 1998)

When taking into account the continued abuse that a victim receives, the inability to leave the abusive household, and the barriers to proper medical care presented by both the abuser and the health care system, it is easy to observe how these factors can directly impact the victim's health. These factors not only affect the actual health of the victim, but the perceived health as well.

Health perceptions

All of the victims interviewed were mothers. As a result, when asked to speak about their own health perceptions, all of the victims spent the majority of the time discussing the effects of motherhood on their recovery and personal health perceptions. It should also be noted that all of these women had children who were receiving therapy for psychological problems that resulted from either being abused, molested, or witnessing the abuse that their mothers had received.

While currently undergoing therapy to deal with her abuse-related psychological issues, "Susan" also has a son to care for who she claims is "needy" (i.e. he constantly has to know that she's there) and who is currently in therapy as well. She sees this situation as "very tiring" since her son's condition seems to perpetuate her problems for which she is seeking therapy: "If he's having a hard time getting past all this, I have a hard time getting past it all?I have to deal with this again" (Respondent #3, January 30, 1998). "Francis" expressed a very similar outlook: "Sometimes it feels like I am in an abusive relationship all over again." She attributes this feeling to bearing witness
to the after-effects of her abuse on her children getting played back repeatedly (Respondent #6, February 3, 1998).

Although she claims to be fully recovered from her victimization experience, "Lisa" still makes mention of dealing with the effects of her victimization upon her children. "I have to deal with [their insecurity]?[It] depresses me and makes me tired." She stressed the point of how a mother recovering from abuse has to help her children along (even despite the fact that they are receiving psychological counseling) (Respondent #4, April 3, 1998).

"April" feels that motherhood affects a recovering victim's situation by making "?you worry more." As a mother, she reports feeling guilty about keeping her children in a violent and unstable home: "I have a lot of guilt over the fact that I didn't get out of there sooner" (Respondent #5, January 30, 1998). "Rose" feels similar guilt over not leaving sooner than she did but feels that it is possibly her own children (now of young adult age) that are helping her through the recovery process (Respondent #8, February 3, 1998). Closely related, "Charlene" saw her role as more of a travel companion to her daughter on the road to recovery: "I have my pace, she has hers?I am helping her, and she helps me a lot" (Respondent #1, April 3, 1998).

"Jane" regards the combined responsibilities of recovery and motherhood as "extremely" emotionally draining. She attributes her emotional fatigue to her fear of losing credibility with her children after excusing and/or covering up the abusive behavior of their father for so long (Respondent #7, April 3, 1998).

While some women appear to have the tasks of recovery and motherhood organized (even though it is still a heavy load for them to handle), the duties are not as clear-cut for others. When asked specifically to comment on the effects of raising children while overcoming abuse "Betsy" responded that you have to "...try to keep yourself up for [your children because]...You really don't know what to do" (Respondent #2, April 3, 1998).

In response to an open-ended question, all the victims agreed that their recovery process and motherhood role related to an analogy of themselves and their child(ren) walking down a road together that ended at a destination (recovery). Since the mother is older, she will take larger steps than her child(ren), thereby allowing her to get to recovery faster. However, due to the responsibilities of motherhood, she must go back every few steps in order to help her child(ren) along and/or allow the child(ren) to catch up with her. The women who were asked about their opinion agreed with the author's overall perception when he proposed that recovering from abuse while being a mother is like taking three steps forward and two steps back?they move along to recovery, but at a much slower pace. This situational dilemma is one that presents many implications for not only the perceived health of the former victim, but her real health as well.

Health characteristics of the victims

Besides motherhood, many emotional and physical illnesses further exacerbate the problem of recovery. These illnesses are accompanied by a plethora of related problems and obstacles for the victims as they try to put their abusive pasts behind them. Fortunately, due to the facilities that
provide them protection, each victim is currently receiving psychological counseling for their problems (required by each shelter).

Although no one made direct mention of it, each former victim made allusions to her own poor health or poor perceived health in some fashion. Upon further probing by the interviewer to the allusion, the women were quick to mention several ailments, psychological and/or physical, that afflicted them. Most symptoms could fall under the loose umbrella term of post-traumatic stress disorder (PTSD), known to some as "shell-shock" (one victim actually compared living with her emotional ailments to "being in a war"). The symptoms reported included anxiety attacks, chronic fatigue, insomnia, stress, nightmares, and depression...all clinical symptoms of PTSD. According to "Jane": "I think that I have almost a post-traumatic stress syndrome...I feel almost like a [prisoner of war]...I have sleep deprivation...because I am under so much stress...It's like my brain will not shut off right now..." (Respondent #7, April 3, 1998). In addition to PTSD-type symptoms, "Susan" even exhibited, what her doctor diagnosed as pre-menopausal symptoms (i.e. hot flashes) that eventually subsided upon leaving her abusive partner (Respondent #3, January 30, 1998).

While the existing literature on domestic violence has frequently made mention of former victims' complaining of symptoms characteristic of PTSD, it is important to note the implications of the illness for this particular population. While these women are experiencing these ailments, they are also expected to fulfill the role of mother (and could also be suffering from physical ailments as well).

Besides PTSD, numerous other psychological problems can develop as well. These problems can present in ways that make the daily functioning (and overall recovery) of the former victim extremely difficult. "April," for example, finds herself extremely uncomfortable with being by herself in a room full of strangers and is terrified to sit in a room alone with a man. Struggling with trust issues as well, she continually expects friends to turn on her at any time (Respondent #5, January 30, 1998). "Francis," like "April" and several other former victims, is "defensive" and distrustful of men (Respondent #6, February 3, 1998).

Sadly enough, the phenomenon of parental modeling also becomes an issue when considering the relationship dynamic of a victim mother and her child. Similar to the mother, some children become distrustful of people. This occurrence poses some severe implications for the child as he/she develops into adolescence and adulthood. Consequently, the possibility of socialization and/or trust problems warrants early intervention of psychological counseling, before the psychological effects of victimization become learned, socialized traits that are passed on from one generation to the next.

The health care professionals' perspectives: Health care provider characteristics

A total of eight health care providers were interviewed at the teaching hospital. The four nurses (two males and two females, all Caucasian) interviewed in this study all possessed certifications in emergency and critical care nursing while specializing in trauma care. Several nurses had previous experience in the emergency room as well. The doctors (three males and one female, all Caucasian) interviewed were surgical residents in their trauma rotation, ranging from their first to fourth year
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of residency. Overall, these health care providers had treated a total of approximately 900 victims of domestic abuse, and they possessed a combined total of 69.5 years of work experience within the health care system. Their ages ranged from 27 to 36 years. Since this teaching hospital is an indigent care facility, the providers reported that the patient population is overwhelmingly from a low socioeconomic background. However, the nurses and doctors reported that they occasionally see victims from middle and upper class backgrounds as well. All the providers interviewed noted that the majority of the domestic violence victims they have treated are mothers.

Analysis of interview data from the health care providers revealed some patterns that complemented the perspectives of the abuse survivors with respect to health care utilization, whereas others contradicted some of the abuse survivors' perceptions. Overall, the provider comments added further validity to the reality described by domestic abuse survivors, particularly in regard to whether or not patients admitted to being victimized, or providers offered assistance (and empowerment).

The frustration of getting them to tell

While many abuse survivors spoke about their frustration with getting the health care system to recognize them, the health care providers pointed out that frustration is a two-way street. Several expressed distress that resulted from their attempts to offer assistance to victims’ offers that often went unanswered. Fortunately, this frustration does not mean that assistance does not get offered. According to "Kathy," a surgical resident (Provider #1):

*There is not much that you can do if they are not willing to admit that someone has abused them, but if I have a high suspicion, then I at least offer to them...I always assure [them]...that they always have a safe place to go once they are discharged and if they don't, or, if they would like some further assistance without telling me exactly what happened, I always refer them to the domestic violence social worker.*

"Eve" (Provider #2), a trauma nurse clinician, expressed her understanding with victims remaining tight-lipped about the cause of their injuries:

*Most of those women have got to feel some kind of trusting bond with the person who's talking to them or working with them or so forth. Even if [the question of whether they are being abused is] not asked, they have to feel like the person they are about to say that to cares. And if they don't feel that, they are not going to tell it to anyone. That's my experience.*

"Joe" (Provider #3), a surgical resident, expressed frustration over his help going unanswered. This distress was rooted in his awareness that victims do not seek care only once but many times (and in a facility as large as the one in which he works, that phenomenon leaves plenty of space for unidentified victims to fall through the cracks in the system):

*I worry about seeing these people again...And there's so many trauma doctors here...it's probably not me that's going to see them except in...rare cases. But I think what their health needs are mainly is?to not be traumatized...A lot of these people are young and they don't have a lot of comorbid disease that's of a serious nature that they can weigh in with the fact that they're getting pounded on...And I don't think that they always see that as...critical.*
Offering assistance to victims is a special skill all to itself that must be handled very delicately. All the providers stressed the importance of creating a good rapport with the patient and privacy within the examination area.

"Eve" (Provider #2) claims that how a health care provider confronts the victim can make all the difference. In getting a patient to admit being abused, "Eve" believes:

I think they're much more likely to open up without three medical students, two physicians, and a couple of nurses in the room...You can't jump on them and ask them the second they role in the door. Sometimes you have to wait for that...right time...[When that time does come, I have] bonded [with them and]...tell them what I am worried about or what I see...I don't harp on it...[Also] I try to get my physicians [to] not...keep hammering on them, to just let [the victim] think about what I said...[otherwise] they start feeling overwhelmed.

All the providers interviewed indicated that they are aware of the importance of patient rapport in getting the victim to admit her victimization; however, not all the providers considered themselves to be adept at that particular skill. In discussing how he confronts a domestic abuse victim, "Matt" (Provider #4), a trauma nurse, stated that he reports the patient immediately to another care provider or to the psychosocial nurse in his department because he believes that he is not "the most successful person in establishing a rapport with somebody that doesn't want to give up that information." Likewise, the importance of treating the victims' physical wounds often forces providers to adopt a life-over-limb philosophy toward their treatment and concentrate primarily on treating any serious or life-threatening injuries. As a result, the story behind how the injury occurred obviously becomes less important. In talking about how he knew if his patients were victims of domestic abuse, "Joe" (Provider #3) explained:

That's not a priority question that I ask them right off the bat...How this happened...I'm more interested in whether they can talk to me and how they're doing physically so I usually get the story from the [emergency medical services personnel].

"Mitch" (Provider #5), a surgical resident, shared similar feelings:

In the beginning, I just want...a quick story and physical to make sure there's no acute problems...Then...I usually go back and ascertain more of the story and what really happened. Sometimes you don't have a chance really to get into that. You let a social worker or one of the nurses know that she was a victim of domestic violence and then they go through another channel.

Providers reported encountering cases in which the victims openly admitted their victimization without being probed but still showed apathy toward offers of assistance. According to "Janet" (Provider #6), a trauma nurse, "There are several [patients] that just come in and say, 'Yeah, I'm abused,' but a lot of those people don't want help." "Eve" (Respondent #2) related similar feelings:

I think as emergency...and trauma nurses,...paramedics, and policemen...the most frustrating thing is that we don't get to see them leave...That is the very hardest thing...that we don't ever know if what I just said to her made any difference in her life...I think...it's never exactly what I say. I truly believe it's more in how you present yourself to them than it is exactly what you say [because] I
change it every time depending on [the victim]. How the victim perceives her own injuries and/or personal health can be a potential factor in understanding why she does not accept assistance when it is offered to her beyond treatment for her physiological.

Providers perceptions of how victims perceive their own health

The perceived health of the victim is potentially related to the perceived apathy of victims to accept services on top of standard medical care. While many domestic abuse survivors discussed the role of perceived health in their daily routine, the health care providers commented on how the victims' perceived health affects their medical care.

How the victims view themselves impacts how they view their injuries. "Jason" (Provider #7), a trauma nurse, supports this notion: "I think...they...feel unhealthier than what they are and I think some of that is emotional...because they haven't been...physically unhealthy other than their traumatic injury." According to "Janet," self-image relates concordantly to injury perception:

Usually their self-image is so low that they discount everything. [They tell themselves]: "It's not a big injury, it's not a big thing." They try to hide everything. They don't see it as something that could eventually become deadly...it's something that hurts now but will be better.

"Eve" (Provider #2) also reported noticing the relationship, but claimed that their downplaying occurs only when they are not in an "excited-over phase." In this phase: ...they're just freaking out ("He tried to kill me! He tried to kill me!")...if they're in that phase they're really thinking about their own pain, but if they've had a chance to...diffuse a little bit, they're totally unrealistic about their injury. Additionally, "Eve" (Provider #2) was quick to emphasize how the victim's image of herself was really her partner's image and not her own. She reported that the victims have a "skewed image of themselves?Whatever they are being told over and over...is usually their perception of themselves...When you ask them about them[soleses], you always get his opinion or his view rather than their's." On the other hand, "Matt" (Provider #4), also a trauma nurse, tends to feel that victims "think" that their overall health is "pretty good." He compared this attitude of abuse victim health perceptions to that of drug addicts.

Generally, the nurses in this study tended to pay closer attention to the health perceptions of the victims than the doctors interviewed. For example, when "Joe" (Provider #3) was asked about the typical health care perceptions of victims he encounters as patients, he responded, "...I spend so much time with them in the acute setting that I don't really...think those questions...come up in my encounters with them a lot as far as what their...long-term, ongoing health concerns are." In addition to understanding why a domestic abuse victim will remain silent even when offered help, it is important to examine victims' health perceptions as a possible link to developing ways to motivate victims (who are also patients) to take the very large first step toward leaving the abusive household.

Empowering the victim

As previously mentioned, victims' perceived health and self-concept often serve as motivating factors in understanding why abused women may remain in an abusive environment. According to the health care providers interviewed, women who are able to admit their victimization and accept
assistance often gain the tools of empowerment to make the first step toward a life-saving change. According to "Eve" (Provider #2) if the victims are "...feeling overwhelmed or smothered by [offers of assistance,]...they are not making their own decision...It's a life or death decision and they have to make it themselves." "Janet" (Provider #6) also reported that she sought to empower the patient by her overall style in confronting the victim when stories don't properly explain the wounds she has sustained. According to "Janet," she is "...bold enough to [ask], '...is there something else going on? ...It's not that I am going to make you press charges...[or] make you do anything but I would like to help if I can.'"

By confronting the abuse victim about her victimization and offering assistance, the health care provider can provide the support that victims need for leaving their abusive homes. This further adds to the importance of health care providers maintaining a close eye for any signs that may cue them on to the fact that their patient has been abused.

**Conclusion**

This study investigated patterns that exist between (1) female domestic abuse victims' abusive household environments, (2) health perceptions and health needs (as both victims and former victims), and (3) access to and use of health care services (as victims). These relationships were examined in order to construct a better understanding of the health aspects of the female domestic abuse victimization experience, point out viable areas for future research investigation, and integrate the domestic violence research of different fields. While, in quantitative terms, the sample's size (in addition to its regional location, range of socioeconomic status, and access points) present limitations that obviously prevent the findings from being generalized to a larger population, overall the study uncovered numerous social phenomena that are absent in existing domestic abuse literature. In addition, the data reaffirmed the findings of some previous studies. Consequently, all these findings helped to generate several associations in the areas of female domestic abuse victim health care access and utilization, as well as, the real and perceived health of both female victims and former victims. When looking at this study from a broad viewpoint, these associations propose that the sociological dynamics of the abusive environment are more interconnected with the health aspects of domestic abuse victimization than have been previously considered.

**Health care access and utilization**

The female victim's abuser can be a significant obstacle in preventing her from gaining access to medical care for her abuse-related injuries. The fear of upsetting her husband and receiving further abuse can prove to be a pivotal factor in a female victim not seeking necessary medical attention. This factor is another area of decision-making within the household in which the abusive partner feels a need to exert control, especially since he stands a good chance of being arrested if his partner is identified at the facility as being a victim and is reported to the authorities.

The barrier posed by the abuser can lead to the female victim's denial of her injuries. In addition, the downplaying of the severity of particular abuse-related injuries can be hypothesized to stem from the overall denial by the victim that she is immersed within an abusive environment and is
actually being victimized. As either an alternative or an accompaniment to denial, some victims will develop coping mechanisms for enduring the day-to-day routine of their abusive household.

Besides the barriers that emanate from the abusive household, the health care system itself can be another blockade preventing female victims from receiving necessary medical attention. Several former victims reported incidences in which their physicians showed apathy for their plight as patients and/or completely ignored their abuse-related illnesses. Furthermore, the gender of the victims' health care providers proved to have significance in whether or not they sought additional health care. In short, some female victims prefer to be treated (whether for abuse- or non-abuse-related illnesses) by a female health care provider. This preference may continue even after the female victim leaves, or is removed from, her abusive home environment. This preference (both during and after leaving the abusive situation) can be theorized to exist due to an overall lack of trust of men in their lives (in particularly, their abusers) and/or previous negative experiences with male physicians. Discovering the actual influence of each of these factors on male provider preference, as well the actual prevalence of provider gender preference are two areas with implications for health services utilization that warrant further research (both qualitative and quantitative).

In addition to the obstacles presented to female victims by individual health care providers, the medical facility itself also may be a significant hurdle for female victims seeking medical care. It can be theorized that even if a female domestic abuse victim believes that her abuse-related injury warrants medical attention and she has the freedom to seek medical attention, she still may neglect her injury out of the fear that she will be identified as a domestic abuse victim by either a health care provider or someone she knows at the medical facility. Adding to this presumption is the possibility that some female victims make up excuses for their injuries that bear a close similarity to children's cover-ups of abuse (e.g. "I ran into the door").

Additional research on the role of barriers to access and utilization of health services by female domestic violence victims may provide a better understanding of how health services for female victims may be improved. The programs and services that could potentially be developed from this specific sphere of research could help reach many of the female victims who currently slip through the hands of the health care system. The importance of reaching these women early cannot be underestimated because continued abuse often adversely affects their health and may endanger their lives.

**Health issues of female victims and former victims**

Since all the respondents in this study were mothers, it was found that motherhood itself may be a strong, oftentimes adverse, influence on the victim's recovery and personal health perceptions. The fact that all the former victims in the study had reported that they had at least one child in some type of psychological therapy shows the adverse effect of domestic abuse on children as well as their mothers. For the adult female victims, dealing with their own abuse and simultaneously caring for their children can pose negative personal psychological consequences. All the respondents agreed that their situation was similar to taking three steps forward and then two steps back in regard to their recovery and that of their children. Although recovery can eventually be reached, the women believed they were moving at a much slower pace than women without children might move.
Whether this assertion about motherhood and the effects of abuse (both during the time of victimization and upon leaving) is a common obstacle faced by other domestic abuse victims is a topic for future research.

Interconnected with the emotionally draining effects of motherhood under such adverse circumstances are the real health characteristics of the female victim, which may contribute even more problems as she tries to recover from being abused. For example, all respondents made at least one indirect reference to what they perceived to be their own poor health. Numerous psychological issues were a common complaint by the former victims. Many of these issues can be associated with PTSD. Some of these ailments could even be transferred from mother to child through parental modeling. This prevalence of domestic abuse-related psychological illnesses and the opportunity for some of these illnesses to be passed on from the victim to her children present a dire need for further investigation by psychologists, epidemiologists, and other mental health researchers. Additionally, the extent to which each of the factors of PTSD, motherhood, physical injury, and past victimization affect both the real and perceived health of the victim is an area of possible investigation worth considering for future research.

Health care provider perspectives

Including the perspectives of health care providers in this study further validated the perceptions of the former victims in terms of their victimization, health care access and utilization, health perceptions, and health needs. In regard to health care access and utilization, the providers recognized the need to offer a comforting environment for abuse victims, providing aid not only for their physical injuries but for their psychological needs as well (through offers of referral to social service personnel). Although this approach may work well for some victims, others may go unnoticed as the victims of domestic abuse (although with current national laws, the chance of this oversight occurring is substantially reduced). More research is needed to determine how well health care facilities are identifying and reaching out to abuse victims. Despite the fact that a large effort is made in some medical settings to identify victims and offer them assistance, providers often express frustration when their offers for assistance are refused or ignored. Many providers are frustrated when patients who have been injured as a result of abuse could have avoided that injury by taking their previous offers of assistance.

In the present study, the providers discussed the importance of women's perceived health in relation to their self-concept and how they handle their injuries. Analysis of data gathered from both the former victims and the health care providers lends credibility to the theory that there is a relationship between perceived health and the downplaying of traumatic injuries, the denial of victimization, and the inability of victims to leave their abusive environments. Additionally, perceived health can also be attributed to playing a role in the overall health seeking habits of the victims as well their real health (both short- and long-term). The impact of perceived health on this population is a fruitful area for future research, especially using a nationwide sampling technique. Additionally, this study should be replicated with former victims from different regional areas and health care providers from a variety of different departments in numerous medical facilities.
Implications

All things considered, domestic abuse can have a tremendous impact on the health seeking habits and access to health care of the female victim. This, in turn, can relate directly to the female victim's real and perceived health. When taking all these factors into consideration, domestic abuse has the potential to scar its victims with illnesses, both physical and psychological, which may take years to heal. In addition, the psychological scars can be spread to the victim's children, not only affecting them during their important years of development, but also coming around again, full circle, and further hindering the mother's recovery because of the children's needs for extra parental emotional (and possibly economic) support.

The female victims interviewed for this study provided some thought-provoking (and silencing) comments that summed up the effects of their entire victimization experience. While some have accepted that they were abused and are attempting to move forward, others are less content. "Rose" warned, "Get out while you're young. Don't waste your life" (Respondent #8, February 3, 1998).

After hearing the personal experiences of their victimization and the residual problems that developed from them, it might be easy to conclude that these women are "man-haters" who hold vendettas for their abusive partners. However, several respondents claimed to still love their abusive partners but knew that they could not live with them due to the abuse. "Charlene" was the only respondent who even mentioned the term "revenge," “The only revenge I want is...just for one time, [to have him] feel the fear that I felt...just for one time" (Respondent #1, April 3, 1998).

Overall, in understanding the obstacles that a female former domestic abuse victim faces in trying to recover from her experience (especially as a mother), "Jane" conceptualized it best by saying, "All I see in front of me right now are mountains that I don't know how I am going to get up on. It keeps you up at nights" (Respondent #7, April 3, 1998). Hopefully, they will all find recovery on the other side of the mountain.

Appendix A: Victimization questions

Family Background/Demographic Information:

1. Ethnicity

2. Date of birth

3. Household income

4. Current income (if removed from abusive spouse)

5. Number of children

6. Type of employment

7. Level of education
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8. How many abusive relationships have you been involved in (all that involved physical abuse)?

9. Type of partner (husband, boyfriend)

10. Marital status with abusive partner (married, divorced, separated, widowed)

11. Religious affiliation

12. Period of abuse (include dates if at all possible)

13. Did/does the abusive partner have an alcohol problem?


15. Partner's occupation

16. Was the abusive partner from an abusive family?

17. Did you grow up in an abusive household?

Health aspects:

1. What was your medical history prior to being in an abusive relationship?

2. How often, before being involved in an abusive relationship, did you see a doctor?

3. How about some type of psychological therapist?

4. When, after the violence started, did you start seeking medical help?

5. How about some type of psychological therapist?

6. How often, after the violence began, did you see a doctor?

7. How about some type of psychological therapist?

8. Tell me, in your best opinion, what medical/psychological problems you felt developed as a result of being in an abusive relationship?

9. Can you describe some ways that you would cope with being in an abusive environment [Used to analyze whether or not past history of alcohol abuse or drug abuse existed. Illegal/prescription (be sure to list specific drugs).]

10. (If chemical abuse existed) Was this before, during, or after being in an abusive relationship?

11. (If respondent has children) What effect did the violence have on you while you were pregnant?

12. Any long-term medical/psychological ailments as a result of the abuse?
Health care utilization:

1. Did anyone suggest to you to seek medical attention after the violence started or did you go on your own?

2. Who in the health care field did you first confide your abuse to? (Was it on your own or were you probed)?

3. What facility/facilities did you go to for medical attention before and after the violence started?

4. Did you have a preference of provider/provider gender?

5. What type of facility did/do you go to for medical care?

6. What, in your best opinion, was the approximate cost of treating your abuse-related illnesses?

7. Do you have health insurance?

8. Describe your experiences as a victim within the health care system. (fears, perspectives)

9. Were the providers understanding of your needs?

10. What were/are the effects on raising children while having abuse-related illnesses?

Appendix B: Health care provider questions

1. Level of the provider (Physician or Nurse)

2. Gender

3. Age

4. Ethnicity

5. Specialization (if Physician, i.e. family practice, OB/GYN)

6. Intern, resident, or attending?

7. Total time working within health care

8. To the best of subjects' knowledge, the total number of female domestic violence victims (who were also patients) whom they have encountered.

9. How did you come to know that the patient was a victim (i.e. did they confess to you?)

10. Describe the typical domestic violence victim that you have treated.
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11. Describe how you confront a female victim who has come to you for medical treatment but does not admit her victimization.

12. Have you noticed any discrepancies between the female victims you treat and the female victims you were taught you would encounter?

13. What is the background/home environment of the typical female victim you encounter?

14. Generally, when treating a female victim, what actions do you take to help the patient besides assessing/treating her illnesses?

15. Roughly, how many female victims do you encounter who are facing addiction problems with alcohol? With illegal drugs? With prescription drugs?

16. Have any victims come to you first as a means of getting out of their violent environment?

17. Are many of the victims you encounter pregnant?

18. Are many of the victims you encounter mothers?

19. Besides trauma that has an inappropriately explained cause, what are some other medical conditions that typically clue you in to the fact that a female patient is being physically abused?

20. What are some of the more common complaints that victims will present with?

21. Is it common to find that violence is not just directed toward the woman but at the children as well?

22. What are some of the perceptions that the female victims you see have about their health?

23. Please comment on whether discrepancies usually exist between their health perceptions and their actual health?

24. Please comment on whether or not discrepancies exist between their own health perceptions and the services which they are seeking.

25. Do female victims seek out the facility’s services more than the average female patient at your facility?

26. Do you find that female victims use your services after a certain time period elapses following the abusive relationship?

27. Why do you feel that a female victim will refuse to leave the violent environment?

28. Do many of the female victims you encounter suffer from any psychological problems as a result of the abuse?

29. Do many of them seek out psychological help/referral?
30. Do many of the female victims you see have insurance?

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