Objective
To explore women’s perspectives about how to enhance services for those who experience intimate partner violence (IPV) and how to improve the links between such services and the health care setting.

Methods
We conducted 6 focus groups involving 67 women in both rural and urban settings in North Carolina. A standardized interview guide was used to investigate the women’s perspectives on the study objectives. Coding and theme analyses were conducted to assess new ideas and/or common themes among the groups.

Results
Participants identified currently available services for women experiencing IPV, including health care providers, police and the legal system, domestic violence shelters, and churches. Participants discussed existing barriers to addressing violence within the health care system, including cost of medical services, risk of having social services remove their children, violence being too personal to discuss, and doctors’ inability to provide what they thought victims really needed. Participants agreed that the most important role for providers would be referrals to useful services (advocacy, job training, and financial support). Participants also emphasized the need for community-based prevention efforts.

Conclusion
We found a striking lack of support among women participants in our study for using the health care setting as part of the service response to IPV. Participants believed that the health care system is not set up to allow providers to provide the level of individual assistance that they thought would be most useful. Participants did have hope that women’s risk of future IPV would decrease if they were provided with useful community-based services and if community-wide prevention efforts were implemented. (JAMWA. 2003;58:185-190)

Women’s Perspectives on Intimate Partner Violence Services: The Hope in Pandora’s Box

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Despite numerous recommendations for screening women for intimate partner violence (IPV) during health care visits, there is ongoing debate about how to best address IPV through clinical settings. Often the debate centers around the constraints in provider training, interest, or knowledge in assisting women who have experienced IPV, the constellation of issues sometimes referred to as “Pandora’s box.” Additionally, as two recent reviews have found, there is little scientific evidence regarding an effective approach for addressing IPV in primary care settings.

Many health care organizations emphasize the importance of addressing IPV in clinical settings because of the potential to identify and assist women experiencing IPV. This “window of opportunity” exists because women frequently have contact with health care providers. Past research has found numerous barriers to disclosing IPV during health care visits and to seeking help, including: embarrassment, denying the abuse or its seriousness, feeling disempowered, fear of retaliation from partners, fear of law enforcement involvement, and belief that abuse is not a medical problem.

Women who disclose IPV report a variety of provider responses, ranging from none to receiving referrals. Currently, most IPV protocols recommend that providers refer women to other health care providers (eg, psychiatrists), other health service providers (eg, substance abuse treatment), community-based violence prevention agencies (eg, shelters), or other community resources. A community-coordinated response has been advocated because IPV is so complex. Unfortunately, health care providers may not be aware...
of community-based services for women who report IPV, and this may limit their ability to best meet victims’ needs, especially if there are no established referral systems between the health care setting and community-based services.

Despite the pervasiveness of IPV and its associated negative health outcomes, little is known about how the health care setting can best link women at risk of IPV to services or what these services should include. To address this issue, we explored women’s perspectives about how to enhance services available for those who experience IPV and how to improve the links between these services and the health care setting. For the purposes of this study, we defined “useful” services as those that participants thought women would be most likely to use and that would best protect women from future IPV. We investigated participants’ perspectives on: 1) past encounters—the types of encounters women have had when seeking help at existing services and 2) what services would work—what types of services would be most useful for women experiencing IPV. Participants were asked to describe how the health care setting could be used to enhance services.

**Methods**

We decided to use focus groups, a qualitative data collection method that uses moderated group discussions focused on a topic of interest, to obtain detailed information about participants’ perspectives on appropriate services for victims of IPV. The technique is particularly appropriate for gathering information about sensitive topics and for generating new ideas or hypotheses.

Based on the high prevalence of IPV within the general population, we anticipated that the focus groups would include women with a variety of experiences with violence, including women who had experienced IPV, women with family members or friends who had experienced IPV, and women who had experienced IPV but who had not disclosed it or used services. We included this last group of women in order to investigate how services might reach women who had experienced violence, but had never used services. This is a critical perspective to consider when designing future services because these women’s needs have not been identified and are likely unmet.

We conducted 6 focus groups for adult women in easily accessible and safe sites in both urban and rural settings in North Carolina from June to August 2002. The sites included the Triangle area (urban area of Raleigh, Durham, Chapel Hill), the Triad area (urban area of Charlotte and Mecklenburg County), and the very rural Northeastern section of the state.

### Focus Group Discussion Guide

1. If a woman is experiencing violence from her partner, who would she want to turn to for help or who would she want to talk to about it?
   - Probe: Will she tell about her experiences of violence? Why or why not?
2. In your community, what are some available resources or services that might help a woman deal with domestic violence (DV)?
3. What might make a woman who is experiencing DV use these resources?
4. Why might a woman who is experiencing DV not use these resources or services?
   - Probe: Does use of these services endanger a woman? If so, how?
5. In what settings could these services be placed to best meet women’s needs?
6. How, or what, would be the best place for women to learn or hear about these services?
7. Describe your own (or those of someone you know) experiences of trying to get help. What kinds of things helped you (or someone you know) feel safe?
8. OK, now think about the health care system; by that I mean anywhere that people might go to get health care, like a doctor’s office, clinic, health department, or even the emergency room. What kinds of things do you think that health care providers can do to help women who are experiencing DV?
9. What kinds of DV services do you think should be available for women in health care settings?
10. How could health care providers make it easier for women who are experiencing DV to get the help they need?
11. Is there anything else you would like us to know about how to make DV services more available and more acceptable to women in your community?

Participants were recruited through an extensive network of community contacts, many of whom worked in social service agencies, or through flyers posted in community settings. Recruiters and flyers invited women to come to a 2-hour discussion about improving health and community services for women. Although study participants who had experienced IPV and who knew others who had experienced IPV were of primary interest, recruiters did not ask about participants’ experience of violence. Recruiters were asked to be mindful of the demographics of the local community and to recruit women within those parameters; however, no women were excluded based on race or ethnicity. Women were excluded if they were unable to speak English or if they were younger than 18. Incentives of $30, refreshments, and child care during the groups were provided. The Institutional Review Boards of the University of North Carolina at Chapel Hill and Duke University approved the project.
One of 2 trained facilitators moderated each group, and a second project team member was responsible for note taking and audio-recording. The moderator used a standardized interview guide with 11 open-ended questions about services for women who are experiencing IPV (see table). The moderator was charged with keeping the discussion focused on issues related to the research questions and used probes, as needed, to direct the discussion.

Audio tapes of the focus groups were transcribed verbatim. Three study investigators (RP, KM, KG) reviewed the focus group transcripts and met for initial discussion of major codes and themes that emerged from the first review of the data. After developing a draft coding scheme, the same 3 investigators (RP, KM, KG) independently coded the transcripts and then met to reach agreement on the final codes. After completion of coding and theme analysis, a fourth investigator (KAC) compared the coding among the first 3 investigators, resolved any discrepancies, and entered the findings into Atlas.ti, a text analysis program. Atlas.ti was used to perform “code and retrieve” analyses, in order to sort transcript excerpts by coded categories and to combine these categories across the groups. This process allowed us to compare how women in the different focus groups spoke about similar service issues.

Results

Sixty-seven adult women participated in the 6 focus groups. Although women were not specifically queried about their experiences of IPV, information shared during the focus groups revealed that almost all women either had histories of IPV or had family members or friends who did.

Participant characteristics [n (%)] included the following:

<table>
<thead>
<tr>
<th>Age</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>28 (41.8)</td>
</tr>
<tr>
<td>25-54</td>
<td>35 (52.2)</td>
</tr>
<tr>
<td>No response</td>
<td>4 (6.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>58 (86.5)</td>
</tr>
<tr>
<td>White</td>
<td>4 (6.0)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (3.0)</td>
</tr>
<tr>
<td>No response</td>
<td>3 (4.5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site of typical health care</th>
<th>n (%)</th>
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</thead>
<tbody>
<tr>
<td>Private clinic</td>
<td>27 (40.3)</td>
</tr>
<tr>
<td>Public health department</td>
<td>15 (22.4)</td>
</tr>
<tr>
<td>Community health clinic</td>
<td>6 (9.0)</td>
</tr>
<tr>
<td>Emergency room</td>
<td>1 (1.5)</td>
</tr>
<tr>
<td>Do not receive care</td>
<td>7 (10.4)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (4.5)</td>
</tr>
<tr>
<td>No response</td>
<td>8 (11.9)</td>
</tr>
</tbody>
</table>

Past Encounters at Existing Services

Participants identified a number of places, services, and people that women could contact if they experienced IPV, including health care providers, police and the legal system, domestic violence shelters, and churches. Women discussed barriers to using each of these sites and services, as well as negative and positive experiences they had had or had heard about.

Barriers to discussing violence with health care providers included humiliation, cost of medical services, risk of having social services remove their children, violence being too personal to discuss, lack of confidentiality, and doctors' inability to provide what victims really need because of limited training, interest, or resources. One woman said, "[The doctors] just fill out reports and call police but …they ain't going to ask me if I want any help as far as trying to get out of the relationship."

One participant echoed the feelings of many when she stated, "I don't see the doctor as someone to tell something to." Other women described feeling that "the doctors are not there for domestic violence." Some women reported not wanting to address IPV with their doctors because they believed that doctors liked to treat violence as:

an open secret… If you probe into it, you've got to expose it. Okay, as long as you don't talk about it and they don't talk. If I don't tell you I'm abused and you've seen all these bruises on me, and I tell you I fell and you allow it to go, that means less paperwork.

Specific barriers to asking for assistance from the police included frustration because the police are slow to respond to IPV calls, that once they arrive nothing happens, and that they do not explain options for the victims. Other barriers included fear of revenge from the perpetrator and a lack of support for victims including simultaneous arrest in some cases. Some participants described the “48-hour rule” which, in their communities, meant that both the woman and the perpetrator were sent to jail for 48 hours when police responded to an IPV call. Participants who pursued legal options when seeking help described a lack of privacy and protection.

Although domestic violence shelters provided an important service and a safe environment, participants reported not wanting or not being able to leave their homes because of job- or child-related commitments. One woman who had experienced IPV said,

And at that time of me being the victim I didn't feel like I should have to leave my home to be secured from this person that's being violent to me, you know. I didn't like that. I felt violated. I got to leave my home for this person?
Many participants reported that women experiencing violence would turn to their church community or church leader. Some participants described positive experiences with their pastors; however, many indicated that clergy were not adequately trained to deal with IPV and that church members were not supportive of victims. One woman reported:

“I’ve ended up being the victim... I was like, “I haven’t done anything!” You know, I’m not the one that’s causing anything and being verbally and mentally abusive and playing mind games. I’m not that person, but when I went to my church family to help me it was like it didn’t exist. “Hush, hush, we don’t talk about that.” You know, “It’s going to be alright baby, God’s going to work it out. You got a good husband, just stay there.” And you know, like she said after a while I was like, “Look God, You got to hurry up and get me out of here. Either I go or he goes. One of us got to go.”

What Services Would Best Address IPV?

When participants were asked to describe services that would be useful for women who were experiencing IPV, they were first asked to limit their comments to the health care setting. Participants generally did not mind being asked by their health care providers about IPV, and, in fact, many supported it. Participants also said health care providers could serve a role in providing more information about violence and giving referrals. However, many participants reported that they would not choose to disclose their risk of IPV because they felt health care providers could not meet their needs. Participants agreed that if women were to disclose IPV, the most useful role for the provider would be appropriate referrals to services.

When participants were asked to describe what services they should be referred to, they described the need for individual attention for IPV victims. Participants felt strongly that services should be individualized to a woman’s specific situation and should include advocacy, job training, and financial support. Participants described the need for 24-hour access to professional advocates who understand IPV, are aware of legal options, and are not judgmental. The advocate must be someone with whom women could share very personal information without experiencing negative consequences (eg, losing custody of their children, being pressured to notify police).

Participants also suggested that services would be most useful if they would improve women’s self-esteem. One participant emphasized, “You got to be able to help yourself first. If you don’t want to help yourself can’t nobody else help you.” Another participant echoed the sentiment of many when she said, “if she [the victim of IPV] could find something that can pull up her self-esteem it will pull her out of that [the violence]. It will pull her out of that slump of being brainwashed and being abused.”

When participants discussed services that would be helpful for women who were experiencing IPV, they shifted from direct care to community-based prevention efforts. Examples included changing men’s attitudes toward violence and educating all women in the community regarding the characteristics of IPV. In order to influence men’s attitudes toward violence in relationships, women suggested posting messages that IPV is not acceptable (eg, “Love shouldn’t hurt”) in schools, churches, and communities. One group of participants came up with the idea to include these messages on brown bags in liquor stores. Participants also suggested other “places where all women go” as possible venues through which women could receive education about characteristics of IPV and available services, such as churches, grocery stores, parks, and post offices. Participants also recommended that community-based educators offer seminars on a wide range of health topics that included IPV prevention. Having a community-based educator who was knowledgeable about violence and the potential resources available was seen as critical. Participants stressed that educational sessions regarding IPV were extremely helpful, especially when the facilitator “empowered them to talk” and when information helped debunk the myths associated with IPV. One woman stated, “And [they] still keep talking about all that new information and it finally sinks in and gets you stronger.”

One participant suggested using a community-based educator to educate men in the community this way: “get 10 men this week to come. Ten men that week to come ... and have a little conference. And maybe then 10 men might go tell 10 more men (group agreement).” Another woman
Another participant described a tactic she saw as useful for reaching women in the community:

"It would probably help. One room, one person, ... 10 men, talk to them."

This study is limited by the disproportionate number of African American women who participated. We expected that using community-based recruitment would result in a sample that more closely reflected area demographics. The percentage of African American women in North Carolina is higher than in the rest of the county (21.6% v 12.3%), especially in the areas chosen for study recruitment. African American women may have also been more likely to participate because we recruited through social service agencies. Many women heard about the groups through peer groups, which may have resulted in more women of one racial background hearing about the groups.

Our findings suggest that screening is useful if it is combined with referrals to services.

Our findings emphasize that resource allocation to community-based, advocacy type services is essential for addressing IPV. This will, however, not be easy. Currently there are a limited number of community-based services available for women who experience violence and many barriers to using them.37 This is especially true for the specific services, such as extensive advocacy, that the participants in this study suggested. If the health care setting is to be used to decrease women’s experiences of IPV, the pathway from screening and disclosure must include the existence of community-based services that can provide the individual attention that the study participants suggested are so critical in decreasing women’s risk of future IPV.

Comments from participants led us to reconsider the recurring question of whether or not screening for IPV in a health care setting is useful. Our findings suggest that screening is useful if it is combined with referrals to services. Although some exemplary programs link health care settings to case management and advocacy programs,27,38 these services are not widely available. Resources are needed so that agencies can provide effective services at the end of the referral line.39 Providers should advocate for and assist in the development and support of services, including financial and legal assistance, that participants have suggested will be the most helpful in assisting victims of IPV.

Participants emphasized the need for community-based prevention efforts in addition to the need for referrals from health care settings. They wanted community-wide educational efforts emphasizing that IPV is wrong and not the fault of the victim. They wanted to change the attitudes of
perpetrators who think that IPV is socially acceptable. They suggested the use of posters, commercials, billboards, television, and flyers in addition to increased training of teachers, church leaders, health educators, and doctors. This study suggests that participants do have hope that women can decrease their risk of future IPV if they are provided with useful services. Participants’ hopes for helpful services need to be balanced with the reality of how limited these services currently are, however. These women provided suggestions for how to design intervention and prevention services for victims of IPV. Their suggestions may assist program planners in finding the most cost-effective ways to address IPV – such as comparing the effect and cost of expanding 24-hour advocacy services to expansions of shelter capacity. Evaluations of future intervention and prevention strategies could assess the degree to which they are appropriate for a variety of target populations.

Acknowledgments
This project was supported in part with funding from the Program on Health Outcomes at the University of North Carolina at Chapel Hill.

References