What Happens When Health Care Providers Ask About Intimate Partner Violence? A Description of Consequences From the Perspectives of Female Survivors

Objective
To describe positive and negative consequences of health care screening for intimate partner violence from the perspectives of female survivors.

Method
We conducted 7 semistructured focus group interviews with 41 women in battered women’s shelters or intimate partner violence support groups.

Results
Positive consequences of screening included: recognizing that the violence was a problem, decreased isolation, and feeling that the medical provider cared. Negative consequences included: feeling judged by the provider, increased anxiety about the unknown, feeling that the intervention protocol was cumbersome or intrusive, and disappointment in the provider’s response.

Conclusion
We found that both positive and negative consequences can result from screening for intimate partner violence and that they are related to provider behavior. The positive consequences described by the participants reflect changes in their attitudes, thoughts, and feelings that may precede help seeking. A better understanding of consequences can help providers tailor screening approaches and interventions for intimate partner violence. (JAMWA. 2003;58:76-81)

Advocacy groups and medical organizations have recommended that health care providers develop and use routine screening tools to detect intimate partner violence (IPV). Despite these guidelines, little is known about the results of such screening. Specifically, to our knowledge, no previous studies have examined the potential consequences of such inquiry, positive and negative, from the perspective of female survivors.

Most studies dealing with screening for IPV have focused on the rates of screening and methods to improve provider screening and identification of victims. Other studies have examined provider barriers to screening, including the provider’s uncertainty about his/her ability to help and frustration with the patient’s lack of response. Most studies of the medical encounter from the patient’s perspective have explored the barriers to disclosing IPV, including fear of escalating violence, feelings of shame and embarrassment, fear of losing the children, concern about confidentiality, and fear of police involvement. These studies focused more on the barriers that prevented women from disclosing IPV, however, and not on the realized consequences of discussing the issue with a health care provider.
We sought to understand how female survivors of IPV described the positive and negative consequences of their health care screening experiences. We theorized that identifying positive and negative consequences could help us develop more accurate outcomes measures in evaluating screening and intervention practices and allow us to tailor screening and interventions to individual needs.

**Methods**

**Study Design**

We used focus group interviews to explore the consequences of provider screening from the perspectives of women who have experienced IPV. We wanted the women to describe their positive and negative experiences spontaneously and using their own words. Qualitative research is helpful in understanding the social, emotional, and interpersonal dynamics associated with these experiences. Our objective in using this method was to collect a range of descriptions and use them to generate hypotheses rather than test them.

Focus groups promote interactive discussion among study participants, thus allowing them to challenge, expand upon, or clarify perspectives and topics raised by other participants. Additionally, focus group participants often provide mutual support in dealing with topics that may be considered stigmatizing. Our study used focus groups because we believed that participants would be more comfortable discussing this sensitive topic while supported by a group of women with similar experiences.

**Sampling**

We used a purposeful sampling strategy, specifically selecting women who had either past or current histories of IPV and were using group counseling services in community IPV programs in urban, suburban, and rural settings. We selected women who had used IPV services because we thought they might represent women who had experienced more serious abuse or who had fewer personal support resources. We recruited participants in 6 IPV programs in North Carolina and Pennsylvania. Victim-advocates at each of the programs assisted with recruitment by announcing the study during support group meetings and posting flyers and posters in shelters and counseling centers.

We conducted 7 focus groups with 4 to 9 participants in each group; a total of 41 women participated. Two focus groups were conducted in a large city in Pennsylvania, 3 in small to medium cities in North Carolina, and 2 in rural towns in North Carolina. Five of the groups were conducted in English, and 2 were conducted in Spanish. Four of the focus groups were conducted in support groups with nonsheltered women, 2 were conducted with sheltered women, and 1 was a mix of sheltered and nonsheltered women. We held the focus groups in the same locations where women attended their support groups to ensure a comfortable, safe environment.

**Data Collection**

The primary investigator (JC) moderated all 5 English-speaking focus groups, and a Spanish-speaking research assistant moderated the 2 Spanish-speaking focus groups. Both focus group moderators had previous experience performing qualitative interviews and underwent specific training in conducting focus group discussions. Each focus group was audio taped and lasted between 1 and 1.5 hours. The study used a list of core questions designed with input from several victims’ advocates and formerly battered women. The moderators made an effort to promote open, spontaneous discussion while occasionally redirecting the group when they strayed from the topic.

Before each focus group began, the moderator informed all participants about the objectives and format of the study, provided assurance of confidentiality, and obtained consent for participation. This study was reviewed and approved by the Committee on the Protection of the Rights of Human Subjects at the University of North Carolina at Chapel Hill and the Magee-Women’s Hospital Institutional Review Board at the University of Pittsburgh.

**Data Analysis**

Each session was transcribed verbatim, and both the moderator and observer reviewed each transcript to check if it matched their recollection of the discussion. The Spanish-speaking focus groups were first transcribed in Spanish, and then 2 translators independently translated them into English. Differences in translation were either discussed between the translators or arbitrated by a third Spanish translator.

Corroboration, also known as triangulation, is used in

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**Core Focus Group Questions**

| 1. | Has a doctor or nurse ever asked you about violence in your lives? What happened? |
| 2. | How did telling a doctor or nurse about partner violence change you or other things in your life? |
| 3. | What things happened to you that were good? |
| 4. | What things happened to you that were bad? |
qualitative analysis to ensure consistency and guard against bias.\textsuperscript{36, a, 7} We used various methods of corroboration, including having several people examine the data and the interpretation of the data. Two investigators (JC and MD) independently analyzed each transcript and assigned codes to individual words, phrases, sentences, and sections. They then met and compared their coding. Differences in interpretation were arbitrated by a third investigator (RP).\textsuperscript{36, 37} The codes were generated, added to, and edited in an iterative fashion, and a final coding scheme was developed. After we applied this final coding scheme to all 7 transcripts, we then examined the focus groups for data saturation and identified thematic trends. Saturation occurs when no new information emerges from the data.\textsuperscript{38, 139} No new themes emerged after the fifth focus group. We used Atlas.ti qualitative data analysis software to document, record, and organize our codes and categories.\textsuperscript{39, 40}

Additional steps to ensure consistency of our findings included review of analysis among the larger study group (JC, MD, SM, KM, RP, PF), review of analysis among a group of IPV researchers, 2 feedback sessions with IPV victims-advocates, review of findings with 3 women who had past experiences with IPV but did not participate in the study, and peer review in formal work-in-progress sessions and invited presentations. These reviewers found good corroboration with our themes based on their own experience and expertise.

**Results**

**Participants**

Forty-one women participated in the focus groups; their mean age was 36.6 (range 22-77). The table presents participant characteristics. All participants had experienced physical, sexual, or emotional abuse from an intimate partner during their lifetimes, and the majority had experienced IPV in the previous 12 months. Five of the 41 women, or slightly more than 10%, reported they were living with their abusers.

**Positive Consequences**

These female survivors reported a wide range of experiences with health care providers. They identified 3 consequences of IPV screening as “helpful” or “good”: realizing that the violence was a problem, a decreased sense of isolation, and feeling that the provider cared.

Participants reported that being asked about IPV contributed to their realization that it was a problem in their lives. Said one woman, “I needed somebody to make me see and remove the blindfold on my eyes.” Regardless of how the questions were delivered (questionnaire, brochure, poster, or in direct conversation with the provider), women felt this inquiry began to challenge their belief that violence was “normal” or “deserved.”

More than anything else, in order to talk about it, you have to realize that you have a problem. Because, many times … you think that it is … a normal part of daily life. But, they [the doctors] gave me a brochure, and I read it. And I started to see many things.

The women noted that this realization occurred gradually. When health care providers asked about IPV, the women said that it “planted a seed” and began “breaking down the fantasy” that their situations were normal or deserved.

A second positive consequence of IPV screening was a decreased sense of isolation. Women explained that secrecy was a common element of abuse and that in addressing the issue, health care providers offered an opportunity to break the silence. One woman said, “I wasn’t looking for any answers. I just wanted to get it off my chest and let everybody know what a rat he was, OK?” Another said, “Well, for me, I feel better … anytime I can get it off my chest, because it’s a burden.”

The women also reported that secrecy was a tool their partners used to control them, and thus disclosing the
violence represented a challenge to the perpetrator’s power.

When you start to talk, to tell them [the doctors] what you are really going through in your life, they [the perpetrators] they start to lose the control they have over you.

Women also reported feeling that health care providers cared about and valued them. One woman described how she felt when her obstetrician asked her about IPV during her prenatal care visits, “I felt pretty good to know that somebody was concerned about me, about my life, about my baby.” Some interpreted nonjudgmental inquiry about IPV as an indication that the provider was more interested in the woman “as a person” than in the disease or health complaints she presented.

Women reported that being cared about made them feel “worthwhile” and “supported.” They said that these feelings of worth and support often correlated with a provider’s validation of their experiences. A provider’s acknowledgement of the existence and seriousness of IPV confirmed that the woman’s concerns, distress, and fear were appropriate. When asked what kind of difference a provider made when IPV was discussed, one woman responded:

It helps us to believe in ourselves. People respect doctors, and when a doctor says something, you know it looks better on you that somebody that’s professional would actually believe in you.

Negative Consequences

Participants reported 4 negative consequences: fear of being judged by the provider, feeling increased anxiety over unknown consequences, feeling that the IPV intervention protocol was cumbersome or intrusive, and disappointment in the provider’s response.

The women reported that they often felt ashamed and embarrassed about their abusive relationships and worried that others would judge them poorly. They commented that they sometimes felt labeled and blamed when asked:

People are asking, “Well, are you going through this?” and you say “no” because people will just think you’re stupid for going through it … It’s the way they’re asking. Sometimes a lot of doctors are really condescending to people.

Another negative consequence was confusion and uncertainty about why providers were asking about IPV and what would happen if they disclosed it. Women described the stress of having to choose between keeping the abuse a secret and facing the unknown consequences of telling a health care provider. One woman described situations in which she felt the provider planned to act against her in the interest of her children:

Okay, sometimes when they ask, they say, “It’s not healthy for children to live in a violent relationship and a violent household.” And you then you think, “God, they’re going to take my kids away.” And then … you’re scared to tell them because we don’t know what the consequences are going to be.

The women also worried about the legal repercussions of revealing the violence. Explained one woman, “I got more confused because I didn’t know what my rights were for talking about it in that way.”

Some women reported dissatisfaction with an IPV intervention protocol that involved too many steps and too many people. They described feeling frustrated and “revictimized” when more people than they expected became involved in and privy to their situations. One woman explained that having to repeat her history to a nurse, several physicians, and a counselor before receiving any information or resources was “repetitive and irritating.” Another stated that the process of documenting her injuries from IPV was more complicated than anticipated, involving photographs taken at one location, x-rays at another, and meeting with a counselor at a third location.

Finally, women described being disappointed in the providers’ lack of response to or support for them. After disclosing the abuse, these women expected support and resources the provider did not offer. One woman shared her experience, “he only asked, but he didn’t … do something to improve the situation or tell me, ‘You can go to this place.’” Another woman reported that when she disclosed IPV to her physician, he responded by saying, “I don’t have time to talk about that right now.”

The women also felt that some providers did not understand the complexity of IPV and, perhaps inadvertently, placed the responsibility for abuse on the women themselves. They described feeling blamed when providers responded to their disclosures with such questions as “What did you do?” and “Why don’t you leave?”

A provider’s acknowledgement of the existence and seriousness of IPV confirmed that the woman’s concerns, distress, and fear were appropriate.
Discussion

Women in our study described their experiences and provided a language for the possible consequences of health care screening for IPV. From their words and narratives, we can obtain some understanding of how medical providers affect women experiencing IPV when the topic is addressed. Instead of such overt actions as leaving the abuser or going to a shelter, the positive consequences women experienced were internal: realizing that the violence was a problem, a decreased sense of isolation, and feeling that the provider cared. The positive consequences we found corroborate those described by Gerbert et al.40, 42 They found the physician-patient interaction helped victims recognize the problem and provided validation that the abuse was not deserved.

Several experts have found that seeking help for and finding safety from IPV may occur in stages or steps.21, 43-46 Thus a health care provider’s inquiry about IPV could contribute to changes in a patient’s attitude, thoughts, and feelings that may facilitate future help-seeking actions. This supports Gerbert’s recommendation42, 47-49 that we redefine the reasons for asking about IPV and consider these positive consequences as objectives in themselves. Screening need not “fix” or “cure” the violence, but rather give women “a preventive antiviolence message … that abuse is wrong, they do not deserve it, and their physician cares.”40, 160, 164 These more attainable objectives may also reduce provider barriers to screening.

To our knowledge, no studies have addressed the negative consequences of health care providers’ asking about IPV. A better understanding of potential negative consequences of screening can help us develop safe and beneficial methods of screening and intervention. The negative consequences we found (reinforced feelings of stigma, increased anxiety, irritation with cumbersome IPV intervention protocols, and disappointment in provider’s response) differed from barriers to disclosure described in earlier studies.12, 25, 26, 28 Women in our focus groups did not describe such adverse consequences as retributive violence, loss of child custody, or insurance denial. But our participants’ responses suggest that women who fear increased violence, unwanted police involvement, or loss of child custody are unlikely to disclose their violent relationships. This corroborates some of the findings from studies examining barriers to disclosure.12, 15, 26, 28 In this manner, women may have protected themselves from these adverse consequences by choosing not to disclose.

Our study does have several limitations. It is a descriptive qualitative study using a small purposive sample population; thus, the results cannot be generalized. Because we recruited women who were using IPV support group services, we cannot presume our results reflect the range of outcomes experienced by battered women who have not used IPV services. A broader range of consequences could potentially emerge from a larger sample; however, we did note that no new themes emerged after our fifth focus group. We did not explore the perspectives of the providers or the dynamics of patient-provider communication. Research examining how health care providers talk about IPV and how this affects female survivors is needed. Further exploration of how women who experience IPV seek, interpret, and receive help from health care providers is also necessary.

Clinically, the defined objective of any screening test is early diagnosis or identification of a condition before serious morbidity develops. To evaluate the net benefit or harm that may result from a screening test, one must understand the potential positive and negative consequences. Our participants described attitudinal or psychological outcomes that may affect a woman’s motivation and readiness to seek help. The positive consequences support the idea that asking about IPV in a compassionate, nonthreatening manner can be beneficial to victims in and of itself.42 The negative consequences, however, suggest that there may be harm in screening without conveying compassion or having an appropriate response to disclosure. Our findings suggest that women view IPV screening as more than a test to identify or diagnose a condition. Rather, it may represent a therapeutic opportunity for providers to give information, validation, and support.

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