IDENTIFICATION OF FACTORS THAT INFLUENCE THE DETECTION OF ABUSED WOMEN BY HEALTH CARE PROVIDERS

by

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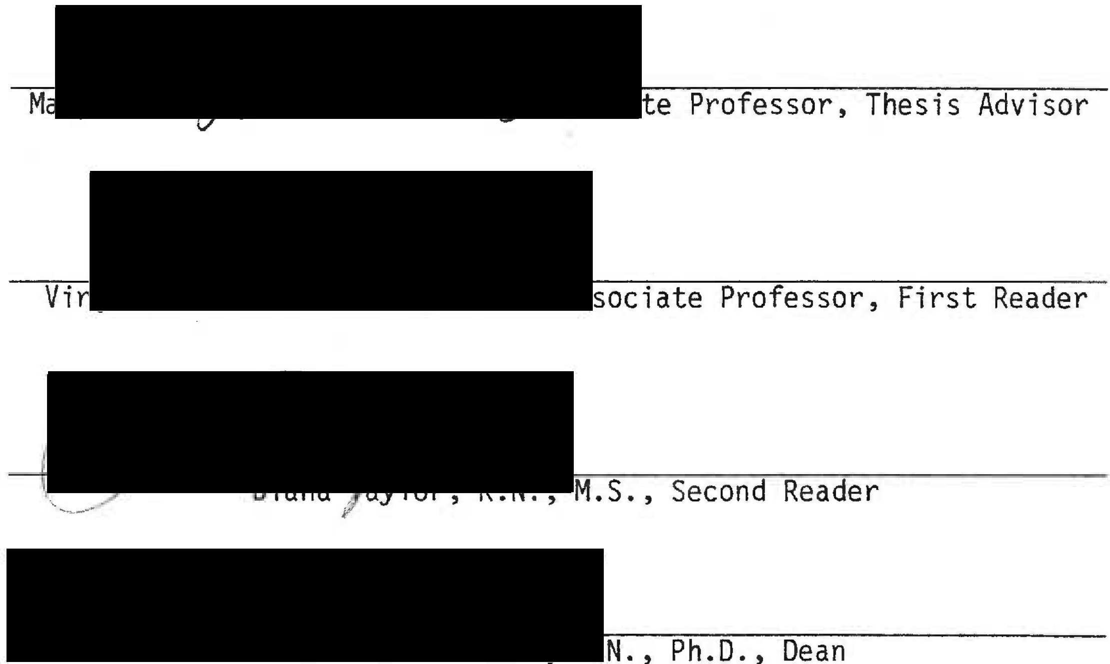

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CHAPTER I

Much of the violence that occurs in American society takes place within the home. The family is the setting for between 35-50% of all homicides (Allen & Allen, 1981; Wolfgang, 1958), and according to Gelles (1979), one is more likely to be murdered by a member of one's family than by anyone else. Violence between husbands and wives forms the largest single category of police calls (Straus & Gelles, 1979). Violence is more often a pattern of behavior within a family system than an isolated event (Allen & Allen, 1981; Gelles, 1976; Rounsaville, 1978). It is manifested in several ways within family relationships such as parent and child, husband and wife, or siblings, and often exists within more than one relationship (Gayford, 1975; Roy, 1977). Violence has been found to be a learned behavior; exposure within the family of origin predisposes the individual to violence as an adult, both within the family of procreation and outside the family as well (Gelles, 1974; Steinmetz, 1980).

In addition to the exposure to violence as a child, several factors have been cited as contributing to family violence. Alcohol abuse, mental illness, low socioeconomic status, and a patriarchal society have all been linked to violence between family members (Dobash & Dobash, 1979;

Hanks & Rosenbaum, 1977; Straus, Gelles & Steinmetz, 1980). Although major social changes are necessary in order to effectively reduce violence, changes at the family level can interrupt the pattern of learned violent behavior. A major step in this process of change is the recognition of victims of family violence. However, the concept that the family is a private institution helps hide the family's violence from public scrutiny. In the situation of women abused by their partners, violence is often undetected or ignored. The structure of society which often seems to define man as dominant and independent and woman as subordinate and dependent may contribute to society's acceptance of violence towards women (Stark, Flitcraft, and Frazier, 1979; Walker, 1981). Also, women themselves may not admit to abuse because of fear or guilt (Gayford, 1975; Roy, 1977). Further, the reluctance of outsiders to interfere in the private affairs of couples implies consent and allows violence to continue (Dobash & Dobash, 1979; Gelles, 1976).

The health care system can be an important setting for the recognition of and intervention with women who are victims of domestic violence. The emergency department is often the setting for abused women immediately after a violent episode. Abused women also seek the help of primary health care providers in non-emergency settings for either direct results or related symptoms of their abuse.

The private practitioner, who often sees a woman over an extended period of time, is in a particularly good

position for the detection of abused women. The potential exists for intervening before or offsetting severe consequences of abuse. If violence occurs within a marital or cohabitating relationship, it is most likely a recurrent feature, usually cyclical rather than an isolated event, and escalating in severity (Straus, Gelles, & Steinmetz, 1980; Rounsaville, 1978; Walker, 1981). Rounsaville suggests that women who do not seek help are at a risk for continued abuse. Further, there is a suggestion that women who are subjected to continued abuse may become depressed and suicidal and abuse drugs and alcohol (Stark, et al., 1979; Gayford, 1975). Women who are battered during pregnancy are at a greater risk for spontaneous abortion (Gelles, 1975; Roy, 1977; Rounsaville, 1978; Stark, et al., 1979). Straus, et al., (1980) found that many members of violent families suffer from chronic health problems. Homicide can be another tragic result of chronic abusive relationships (Allen & Allen, 1981; Boudouris, 1971; Wolfgang, 1958).

Rather than helping reduce the incidence of the abuse of women, it has been suggested that the health care system contributes to the continued pattern of abuse through nondetection or avoidance, and through improper intervention (Stark, et al., 1979; Pahl, 1979; Dobash & Dobash, 1979; Drake, 1982). Based on anecdotal evidence, some women would like to be more open with their health care providers about their abusive situations (Drake, 1982), although more often they hide or deny the problem (Dobash & Dobash, 1979;

Rounsaville, 1978). This study will help determine factors which contribute to the non-detection and improper treatment of abused women within the health care system. In addition, the issue of whether abused women desire identification by health care providers will be explored.

The outcome of this study has particular significance for nurses with whom abused women come into contact. Nurses within the emergency department setting are often the first to see women who present with injuries due to abuse. Women's health care practitioners and nurse midwives have the opportunity of developing relationships with women who are suspected to be abused when they seek routine gynecological or obstetrical care. Nurses within these settings are potentially important resources for abused women, offering either counseling or referral.

Review of the Literature

The following is a review of the literature on wife abuse related to the current study. The term wife abuse is used, although included is the physical abuse of women by their partners in either a marital or cohabiting relationship. Three areas will be discussed. First, the incidence of women abused by their partners will be discussed. Next, reasons for the non-detection of abused women will be reviewed, and in conclusion there will be a review of the role of the health care system in detecting and intervening with abused women.

Incidence of Wife Abuse

It is difficult to determine accurately the incidence of wife abuse. Indirect measures have been used to obtain estimates of the prevalence of the problem. These measures include obtaining reports of domestic violence in police records, court cases, and emergency departments. Incidence figures have been extrapolated from these inconclusive findings. The majority of studies on wife abuse involve small samples of self-admitting abused women. For this reason it has been difficult to generalize the results.

One study which attempts an estimate of the prevalence of wife abuse is that conducted by Straus, Gelles, and Steinmetz (1980) including the largest random sample to date. They interviewed 2,143 adult members of families selected through a cluster method of sampling. The sample included 960 men and 1,183 women. Respondents were questioned regarding the previous 12-month period and the duration of their marriages. The authors found that in one year, one out of every six couples (16%) had committed at least one violent act against his or her partner; and in the entire marriage, the figure increased to 28% of all marriages. Straus, et al., estimate that 1 out of every 26 wives is severely beaten each year. It was found that battering was not an isolated incident; 47% of the men who beat their wives did so three or more times during a year. Although women were sometimes found to be violent, the data did not describe what proportion of violent acts were in self-defense or in response to

blows. Men were found to have higher rates of the most dangerous and injurious forms of violence. The data are based upon self-reports of the individual family members, so it is likely that they underrepresent the true level of violence.

Another study that gives an indication of the prevalence of wife abuse was conducted by Rounsaville (1978). This study took place in a hospital emergency department that serves an urban and suburban population of 400,000. In a 30-day period, each woman who presented with either a surgical or psychiatric complaint was directly asked whether she had been recently abused by an intimate male partner. Thirty-seven women were identified within this period. The authors then projected this figure to 450 annually. As it is not known whether this was an average month, and with the likelihood that some abused women did not acknowledge their abuse, this projected figure must be questioned. It was found that violence was frequently longstanding; 70% of the women had been abused longer than one year, and 80% more than three times throughout the relationship. This was the first abusive incident in only 16% of the cases.

Using this same hospital setting, Stark, Flitcraft, and Frazier (1979) analyzed the records of 481 women who were seen within the emergency room over a one-month period. They found a total of 1,419 trauma events ranging from a frequency of 1 to over 20 per woman. These were classified into four groups indicating a relationship to battering: positive, probable, suggestive, or reasonably negative.

During one month they found 14 women (2.8%) with positive injuries, with an additional 72 women (16%) presenting with injuries considered probable or suggestive of abuse. From the complete medical records of these women, 10% of 481 could be positively identified as having been battered at least once; and an additional 15% had trauma pointing to abuse. They also found abuse to be an ongoing process, estimating that 92% of the women who had ever been in an abusive relationship were still subjected to violence.

Abuse of women by their partners has been found to be prevalent in every socioeconomic class (Straus, et al., 1980). Gelles (1974) notes that it occurs more frequently in families with less education, lower occupational status, and low income. Steinmetz (1980) agrees with this finding, but suggests that underrepresentation of reports in the middle class may be due to greater privacy and access to more resources. Similarly, Stark and MacEvoy (1970) suggest that altercations among the poor are more likely to become police matters and that middle class persons have the recourse of friends and professional counselors. They also suggest that there is greater privacy in the middle class.

It is difficult and probably impossible to give an accurate figure on the incidence of women abused by their partners. In every study reviewed, it was emphasized that the figures are most likely underrepresentations. Straus, et al., (1980) state that it seems likely that the true rate is 50 to 60% of all couples. Stark, et al., (1979) suggest

that whereas physicians in their study determined 1 out of 35 of their patients were battered, a more accurate approximation may have been one in four. They believe that wife abuse is probably ten times more frequent than the acknowledged incidence.

Non-detection of Abused Women

Based on the literature, there seems to be two major reasons proposed for the underreporting of the number of women who are abused by their partners. The first category is that society may at times be negligent in detecting violence towards women (Dobash & Dobash, 1979; Walker, 1980). The second category is that for many subtle and interrelated reasons, women may be reluctant to admit that they are abused (Gelles, 1976; Roy, 1977; Drake, 1982).

Gelles (1976) offers two reasons for society's neglect in detection of abuse: its attitude of official acceptance of violence between consenting adults, and the belief that violence is a private affair between couples. Because of these attitudes, many agencies that have direct contact with victims of abuse do not ask women about violence. Often if violence is known to have occurred, it is not recorded which contributes to the underrepresentation in recorded incidence.

The health care system has been identified as one of the institutions that contributes to the non-detection of abused women. Stark, et al., (1979) attributed the underrepresentation of women that are positive victims of abuse to the response of the physicians. These investigators

believe that abused women who present without obvious physical injuries are many times labeled only as depressed, suicidal, alcoholic, or hypochondriacal and are treated symptomatically rather than taking the abusive situation into consideration. Whether this is a misdiagnosis or an overt avoidance of the issue, it contributes to keeping the extent of wife abuse hidden.

Dobash and Dobash (1979) agree that the physician's response contributes to underrepresentation. They obtained retrospective data in the emergency department of an English hospital in 1974. Over a three-month period, medical students recorded 200 cases of women who spontaneously reported that they had received injuries from their partners. In a subsequent three-month period, the students interviewed each injured woman who sought treatment and asked whether she had been assaulted by her husband. By asking specifically about abuse, there was a threefold increase of identification. Although this was an informal, unpublished study, it gives some indication of the number of abused women who remain undetected within the health care system.

In a pilot study conducted by Drake (1982), 12 women within a battered women's shelter were interviewed to determine their interactions with the health care system. The study explored the following areas: whether they had sought medical care for abuse; if they were identified as victims of abuse; whether they offered the identifying information without being specifically asked. Eleven women had sought

health care for injuries related to abuse. Only two of these women reported having been identified in a medical facility as being abused, and both of these were due to self-report. None of the women was specifically asked if she had been battered or abused.

Dobash and Dobash give two explanations for the non-involvement of health care providers: 1) the impersonal nature of the medical system itself, and 2) the individual physician's experience, conceptions, and personal beliefs about marriage and wife beating. Some physicians, they claim, believe that what goes on in a marriage is a private affair and that they should not intervene. Rounsaville (1978) adds that lack of time and referral sources contribute to the non-involvement of health care providers.

The other major barrier to the detection of victims of abuse lies within the women themselves. Many abused women do not contact police or any other helping agency. Some women seek medical help but hide the true cause of their injuries. Research has indicated several reasons for their reluctance to seek help or make abuse known. Importantly, among these seem to be the degree of emotional and economic dependency of the woman upon her partner and the availability and use of resources. Embarrassment, guilt, a history of violence in the family of origin, and the length and severity of the abusive relationship also contribute to whether or not they disclose their abuse (Gelles, 1976; Rounsaville, 1978; Roy, 1977; Walker, 1980).

Several studies have explored factors which influence abused women's help-seeking. Gelles (1976) examined variables which distinguished between abused women who sought help from those who did not. His data were obtained from interviews with members of 80 families. His was a purposive sample; 20 families were selected from the files of a private social service agency in which violence was suspected; 20 families were selected from a police "blotter" of areas in which police had been summoned to break up violent disputes; and 40 families were selected from neighboring families of each of the other two groups. It is not representative of any larger population, however, it provides some valuable descriptive information. Forty-one women were identified as having been physically abused by their partners. Nine of the women were divorced or separated; 13 had called the police and were still married; 8 had sought counseling services; and 11 had sought no outside intervention. Three major factors that influenced the help seeking of these abused women were the degree of dependency upon her partner, which included the availability and use of resources; the severity and length of the abusive situation; and a history of violence in the family of origin.

Gelles found that the variable which best distinguished wives who obtained assistance from those who did not, was holding a job. While only 25% of those wives who did not seek help were employed outside of the home, 50% of wives who called the police or went to a social service agency

held jobs. Some women expressed the feeling that holding a job gave them a view of another world which made their own family problems seem less than normal and more serious. Gelles suggests that the less dependent a woman is upon her husband, the more likely she is to call for help. The fewer resources a wife has in a marriage, the fewer alternatives she has to the marriage, and the more entrapped she becomes.

Gelles also found that the more severe the violence, the more likely the woman is to seek outside assistance. This contrasts to Rounsaville's (1978) findings that women who sought help were no more severely abused than those who did not. However, the interviewers in this latter study felt that perhaps severity of abuse was perceived differently by each woman.

A history of violence within the family of origin also influenced help-seeking. Women who had experienced violence as children were less likely to view their present situation as deviant, and less likely to seek help. This view is supported by Goode (1971) who postulates that people who grow up in social settings of violence acquire higher predispositions to it, and the norms are less stringent against it.

Since Gelles' study was based on a purposive sample of people in whom violence was more likely to be present, the study's generalizability is limited. It is possible that different results would be obtained from another sample.

Rounsaville's (1978) study of battered women identified within an emergency department attempted to determine

differences in those who took advantage of an offer of additional help and those who did not. All of the 37 women identified as being abused were asked if they would like to talk with a psychiatrist or a social worker at the time of initial contact. The 28 women who agreed were interviewed for 10-15 minutes and offered free follow-up sessions to explore their options regarding the abusive relationship. The sessions included social work counseling, group discussion with other battered women, couples therapy, and other psychiatric services. The supportive issue-oriented nature of the services was emphasized.

All 28 women expressed interest in follow-up help; however, only 13 women actually kept their appointments. Those women who did not show up for their first appointment were contacted by phone or letter. After three missed appointments the case was dropped. Rounsaville contrasted those who followed through with those who did not. The groups were similar in racial, religious, and social class variables. The differences centered upon the history of the abusive relationship (i.e., length, marital status, etc.) and the social resourcefulness of women. Women who sought additional help were more likely to be separated or divorced and had been in an abusive relationship longer. These women were also more likely to have sought help before and were more likely to be employed and not be dependent upon their partner.

Those women who did not take advantage of follow-up

help were less likely to have called police, lacked telephones (suggesting less access to resources), and were more financially dependent upon their partners. In other words, the non-follow-through group had fewer options and had taken less advantage of the resources they had. Rounsaville proposed that a lack of resourcefulness in the non-follow-through group seemed to be a part of an overall pattern of doing little, and perhaps feeling that little can be done about a number of life problems. The small sample of this study makes comparison of the two groups questionable and limits the generalization of the results to the population of abused women.

Roy (1977) conducted in-depth interviews on 150 women who had sought help for abuse by calling a women's crisis line. The study analyzed factors which had interfered with women seeking help for and/or leaving the abusive relationship. The data were gathered over a one-year period, and the 150 women were randomly selected out of 1,000 total cases. The sample represents a cross section of women within the various socioeconomic classes and with varying lengths of relationships. The degree of violence ranged from verbal abuse to assault with a deadly weapon.

The two main reasons for staying in the relationship were a hope that the husband would reform and the feeling that they had no other place to go. Over 90% of the women had thought of leaving and claimed they would have done so had resources been available. A fear of reprisal was an

important reason for failure to seek help from police. Seventy-five percent of the women did not seek help from professional marriage counselors because of social, family or economic pressures. When asked to prioritize their reasons for staying in the abusive relationships, the following reasons were given:

1) A hope that the husband would reform
2) No other place to go
3) The fear of reprisal
4) Children made a move difficult
5) Financial problems
6) The fear of living alone
7) The attitude that divorce is shameful

As the women in this study had already sought some form of help by calling a crisis line, they cannot be compared to a group of women who sought no help at all. The results of the study are similar to several others, however, in that dependency and resource availability are primary factors which determine whether a woman will seek help.

Drake's (1982) study of 12 women within a battered women's shelter reveals several reasons why they did not seek help of health care providers. Although 11 of the women had sought health care at the time for injuries related to abuse, often they had gone without health care for injuries. When asked why they did not seek care, the women gave the following reasons: they felt that their injuries were not severe enough, their partners did not allow them

to seek care, they had no transportation, they felt ashamed and embarrassed, and they felt dissatisfaction with previous health care. The small sample of this study limits the application of the results; however, the same themes are apparent; that of being trapped in a relationship due to a controlling partner, and a lack of available or adequate resources.

The psychological effects of battering upon a woman influence help-seeking (Walker, 1981). The characteristics of abused women often include low self-esteem, denial, guilt, and passivity. Walker investigated a possible link between these psychological manifestations and a condition called learned helplessness. This condition results when people cease to respond to events over which they have little control. In the case of abused women, they perceive that they have little control over the situation and become passive. Walker speculated that this perception could lead to the psychological paralysis that keeps women from escaping from violent relationships.

Even when abused women do seek help, they often hide the true cause of their injuries. Factors influencing this behavior have also been explored. Drake (1982) asked the women in her study why they did not identify themselves as being abused when they sought health care. The most common reasons were: the embarrassment, shame, and guilt at having been battered; fear of further abuse; and feelings that no one would care.

Pahl (1975) interviewed 50 women in a shelter in England. Most had been physically assaulted for years and had made previous attempts to leave home. Some of these women had visited their general practitioners but did not mention abuse. Their reasons were: 1) they were ashamed or embarrassed, 2) they did not expect a sympathetic response, 3) they felt rushed and did not feel they had the time to talk, and 4) some were accompanied by their male partners and were afraid to reveal the cause of their injuries.

In summary, the two major reasons given in the literature for non-detection of wife abuse are a failure of official agents and helping professionals to identify abused women; and women's reluctance to seek help for or disclose their abuse. In particular, health care professionals are negligent in detecting abuse due to the misdiagnosis or avoidance of the issue. A woman's reasons for not seeking help center around the economic and emotional dependency upon her partner and the low availability and use of resources outside of the marriage. In addition, the fear, low self-esteem, guilt and passivity in these women help determine whether or not she will disclose her abuse.

Abused Women Within the Health Care System

Data from studies suggest that some abused women obtain medical treatment for direct or indirect results of their abuse. Pahl (1979) found that in many instances the general practitioner was the first person apart from the family to hear about the problem. Although not all of the women

disclosed the nature of their abuse, 32 out of 50 women had talked to the physician about their violent marriages. Pahl emphasized the potential resource that health care providers can be for abused women. He found that when a woman decides to involve others in her situation there are two stages to her help-seeking: help-seeking behavior while she remains in the home and help-seeking behavior in order to leave home. He includes visiting the physician in the first stage along with calling the police and seeking legal advice.

Gayford (1975) conducted interviews within a shelter in England with a sample of 100 physically abused women. He found that the majority had frequently visited their general practitioner with vague physical or mental symptoms rather than acute injuries related to abuse. He supported Pahl's finding that the health care system is a potential resource for abused women.

Abused women may come in contact with health care providers during pregnancy. There is a suggestion that abuse may increase or begin when women are pregnant (Gelles, 1975; Rounsaville, 1978; Stark, et al., 1979). In Gelles' study, of the 41 women who were abused, 10 were pregnant when the violence occurred. In Rounsaville's sample, although the question was not asked of all subjects, 16.2% of the 37 women stated they were beaten while pregnant. This was supported by the Governor's Commission for Women in Oregon in 1979. Within the sample of 97 abused women, 39.2% were pregnant when violence occurred. When asked how frequently

violence occurred during pregnancy, 13.4% answered between 6-25 times; 17.5% of the total pregnant women stated that violence occurred during more than one pregnancy. Based on such small samples, it is difficult to determine the relationship of pregnancy and abuse. The studies to date do not allow any conclusions to be made. However, the fact that it occurs at all during this time is of utmost concern. Gelles suggested several possible reasons for abuse during pregnancy. These include sexual frustration, family transition and stress, prenatal child abuse, and the defenselessness of women during pregnancy. Walker (1979) suggested that many abused women come to the attention of medical personnel during pregnancy as they seek routine obstetrical care. She believed this is an opportune time to confront women about suspicious bruises and to recommend positive alternatives.

The response of physicians is variable. As previously mentioned, often health care providers do not become involved with the problem of abuse. Other responses have been noted. In Pahl's (1970) study, 18 of the 32 women (56%) who had talked to their doctors said that the doctor had been very or quite helpful; however, 14 (44%) said that the doctor was not helpful. Those physicians that were found to be helpful were characterized as having listened carefully, approached the problem sympathetically, and offered appropriate advice, both medically and non-medically. Those that were not helpful gave inappropriate advice, were unsympathetic and prescribed drugs.

In the study conducted by Stark, et al., (1979), a predominant response to abused women was that of characterizing the battering as a psychological problem and labeling the patient with conditions that could be more easily managed. Although some women did present with symptoms of psychiatric disorders, self-abuse and personal stress, it was found upon the examination of medical records that the vast majority of these symptoms emerged after the first incident suggestive of abuse.

Another frequent response to abused women is the prescribing of medication. Stark, et al., (1979) found that nearly one in four abused women received minor tranquilizers and pain medications, in comparison to fewer than 1 in 10 prescriptions for non-battered women seen within the same facility. Dobash and Dobash (1979) found that 40% of the 87 women who went to the doctor spontaneously mentioned that they had received drugs. In Gayford's (1975) study, 71 out of 100 women were prescribed medication. The treatment of abused women with drugs is questionable at a time when they are in need of all of their physical and mental strength. The treatment of women for only clinical symptoms related to abuse is in essence treating the victim for the behavior of the batterer. Stark, et al., (1979) believe that this treatment is a reimposition of traditional female behavior, i.e., submissive and passive, and rather than help the situation, it actually compounds the problem.

There is some evidence that women want to be identified

within the health care system, but it is anecdotal and not conclusive. In Drake's (1982) study, when women were asked what the nurse or doctor could have done to help them, some women expressed a desire to be asked if they were being abused. One reason given was that being asked about the abuse removed the responsibility of having to initiate discussing their situation. One woman felt that if she were asked first, it would not be as if she were telling on her partner. Drake's perception was that abused women would be more receptive and honest had the health care provider demonstrated more sensitivity.

Pahl gives three suggestions to health care providers based upon responses in his study: 1) When possible, schedule more time with women who are suspected abuse victims, 2) obtain relevant information about the issue of wife abuse and available resources in the area, and 3) keep careful records on women who are vitims of abuse in case legal evidence is needed in her defense.

In summary, it appears that abused women may wish to disclose their abusive situations to health care providers. However, the nature of the health care system frequently does not encourage nor support this disclosure. By becoming more aware and sensitive to the issue of wife abuse, the health care provider is more likely to respond appropriately with women who are victims of domestic violence.

Summary of Literature Review

Because of society's tendency toward non-recognition of

abused women, and the reluctance of these women to disclose their situations, it is difficult to give an accurate estimate of the incidence of the problem. However, it is generally agreed that the incidence is grossly underrepresented.

The health care system would seem to be a good setting for the detection and intervention of abused women; however, a review of the literature suggests that this system tacitly maintains the problem through avoidance and/or non-recognition. Abused women who may be depressed, suicidal, or alcoholics are often treated symptomatically rather than being confronted with the issue of abuse. Drug therapy is a common mode of treatment, which may contribute to a woman's defenselessness.

Abused women are often reluctant to seek help for the violent situation. Their help seeking is influenced by several factors including the degree of dependency upon a partner, resource availability, a history of violence in the family of origin and length of the abusive relationship. In addition, the psychological characteristics of low self-esteem, passivity, shame, and guilt can interfere with disclosure of the abusive situation.

Data indicate that abused women may seek health care for indirect or direct results of abuse. There is anecdotal evidence that some abused women would like to be asked about the violent situation which would indicate that the health care system might be a valuable resource. It is possible that intervention may contribute to the offsetting of the serious consequences of abusive relationships.

Conceptual Framework

The adherence to traditional sex roles is thought to significantly influence behavior in abusive marital relationships (Dobash & Dobash, 1979; Gelles, 1976; Lichenstein, 1981; Walker, 1981). The concept of socialization into traditional sex roles and the ensuing characteristics can be used as a basis to explain why abused women might be reluctant to identify themselves to their health care providers.

Socialization is the process by which culture, including notions of appropriate sex roles, is transmitted. The primary socializing agents in western societies are parents, teachers, peer groups, and the media. A major part of socialization takes place in childhood as parents encourage children towards acceptable gender behavior. This socialization is reinforced within and beyond childhood through the media which further define acceptable sex role behavior (Goldberg & Lewis, 1969; Weinrich, 1978).

Within patriarchal societies, girls are socialized into roles characterized by nurturance, passivity, and dependency. Feminine self-esteem is often based upon relationships with primary others and women often value themselves as they are valued by others. The woman's role as the emotional caretaker of the family is emphasized (Bardwick, 1971). Common characteristics of abused women, such as passivity dependency upon the partner, and low self-esteem reflect this sex role socialization and influence behavior within the abusive relationships (Gelles, 1976; Roy, 1977; Walker, 1981).

If a woman's self-worth is based upon how she is valued within a relationship, it is probable that an abusive relationship will result in lowered self-esteem. Conflict within the abused woman is a result of the difference between the idealized role of women in this society versus the reality of being an abused woman. Often, abusive marriages are characterized by unrealistic demands of the batterer upon his wife. If a woman believes she should live up to all of her partner's expectations, but cannot, she is more likely to believe that she is at fault and therefore the cause of her beatings (Walker, 1981). It is likely that the resulting guilt or shame of a perceived failure in the idealized role influences a woman's desire to disclose her abuse.

Passivity can be a result of women's socialization (Bardwick, 1971). In the case of an abused woman, passivity can be reinforced as a result of a perceived loss of control over her own body and over the abusive situation in general. This could possibly lead to the psychological behavior of learned helplessness and explain why some women do not seek help (Walker, 1981).

A woman's dependency upon her partner can interfere with her help-seeking. She may be economically as well as emotionally dependent, which may result in the fear of being alone should she leave the situation. Dependency upon the partner may also contribute to a lack of awareness of alternatives to the abusive situation, as well as limit a woman's ability to use available resources.

In summary, the characteristics of traditional sex roles within which women in our society are socialized, have been found to influence whether an abused woman will seek help of any kind. The conceptual framework of this study holds to the proposition that socialization into a traditional feminine role and the resulting behavior influences whether an abused woman will seek the help of health care providers in particular. It is beyond the scope of this study to measure socialization itself; thus, it will be assumed that it occurs within this society, and only the resulting behavior will be studied.

Statement of the Problem and Research Questions

The health care system has been criticized for the non-recognition of abused women. However, clinical experience and the literature suggest that detection is not always an easy task. Non-detection within the health care setting may be due to characteristics of health care providers as well as of abused women themselves.

One way to determine the factors which may interfere with the detection of abused women within the health care system is by questioning women themselves. This study asked the following research questions:

1) What personal factors do abused women cite that influence the disclosure of their abuse to health care providers?
2) What factors in relation to the health care providers do abused women cite that influence the disclosure of their abuse?

3) Do abused women desire identification by their health care providers?

4) In what ways do abused women believe that health care providers could help their situations?

CHAPTER II

METHODS

The methods used in the present study will be discussed in this chapter. A descriptive factor-isolating design (Diers, 1979) was used to determine what factors may influence the identification of abused women within the health care setting. In order to view the problem from the perspective of abused women themselves, semi-structured interviews were conducted with residents in a shelter for abused women.

Sample and Setting

The sample consisted of 16 women who were residents of a shelter for abused women and their children in an urban northwestern American city. These women had been physically and emotionally abused by their male partners, either in a marital or cohabiting relationship. The sample was limited to women who had had health care during the abusive relationship. This was determined by asking women prior to the interview whether they had sought health care at anytime after the first occurrence of abuse. Thus, each woman interviewed had had an opportunity to disclose the abuse to a health care provider.

All residents of this shelter are self-admitted via phone interview with a staff member. Prior to admission, the staff member attempts to screen out women who abuse

drugs and alcohol. Women of all ethnic groups and socioeconomic classes are accepted as residents. The shelter has the capacity for 15 women and children at one time. Women can stay a maximum of three weeks. The fee for residing at the shelter is based upon a sliding scale according to the woman's income. An average of 20 women are sheltered in one month, with an average length of stay of seven to ten days.

Data Collection

Semi-structured interviews were conducted using a structured questionnaire as a guide (see Appendix A). The questionnaire was developed by the investigator following a review of the literature and guided by the conceptual framework. The questionnaire consisted of nine items. Four of the items gathered the demographic data of age, employment of the woman and her partner, length of the abusive relationship, and type of health care provider utilized. The remaining five items gathered data regarding the research questions. As can be seen in the questionnaire, possible responses were listed below the open-ended questions and were checked if the actual responses of the women were equivalent. However, the primary method for recording the responses was through detailed notes taken at the time of the interview. A tape recorder was not used as it was felt that this would cause some discomfort on the part of the respondents. No probes or suggestions were used to elicit answers.

Data for research question number one, "What personal factors do abused women cite that influence the disclosure of

Figure 1

Specific Questionnaire Items Which Gathered

Information for Research Questions

Research Questions	Questionnaire Items				
	2. Asked by provider about abuse	3. Spontaneously mentioned abuse	4. Provider's reaction	5. Would you want to be asked?	6. How can providers help?
1. Personal factors	X	X			
2. Factors re: providers	X	X			
3. Desire for identification				X	
4. Suggestions for Providers			X		X

their abuse to health care providers?" were obtained from questionnaire items 2 and 3. Item 2 inquired whether women had been asked about the abusive situations by their health care provider, and it asked what their reasons were for acknowledging or not acknowledging the abuse. Item 3 inquired whether those women who had not been asked about their abuse by their health care providers had chosen to reveal their abuse. Reasons were sought as to why they had or had not chosen to disclose their abuse spontaneously. Data for research question number two, "What factors in relation to health care providers do abused women cite that influence the disclosure of abuse?" were also obtained from interview items 2 and 3 (see Figure 1).

Data for research question number three, "Do abused women desire identification by health care providers?" were obtained from interview item 5. This item specifically addressed women who were not asked about their abusive situation by their providers and inquired whether they would have liked to have been asked about the abuse.

Data for research question number four, "In what ways do abused women feel that health care providers could help their situation?" were obtained from interview items 4 and 6. Item 4 described the women's perception of the actual responses of the physicians who learned of the abusive situations within this sample. Item 6 asked if the women felt there was anything a doctor or nurse could do to help abused women. This was asked in order to elicit information about

how health care providers can be more helpful to women who are abused. Although the focus of the study was the detection of abused women, it was anticipated that this item might generate questions for future research.

Procedure

Permission was obtained from the shelter director to conduct the study (see Appendix B). All information which would identify the shelter was removed from the consent letter to prevent any possibility of the identification of sample women. The investigator contacted the shelter frequently to ask about admission of new residents. Generally, women were not approached the same day of their arrival to the shelter in order to give them an opportunity to become accustomed to their surroundings. The investigator approached each resident individually, introduced herself, explained the purpose of the study, and determined sample eligibility. At this point, seven women were found ineligible. Four women were ineligible because they had not had health care during the abusive situation due to financial difficulties. The remaining three women stated that the abuse had begun recently and had not been a problem when health care was sought.

The women who were eligible were asked if they wanted to participate in the study. Two women refused; one stated that she was tired and the other said that under different circumstances she would have participated. The remaining 16 women who agreed to participate read and signed a consent

form (see Appendix C) which had been approved by the Oregon Health Sciences University Committee on Human Subjects. Interviews were conducted privately within the shelter office. The interviews lasted approximately 15 to 30 minutes each.

Analysis of Data

Responses to the interview items were compiled and descriptive statistics computed to describe the sample. Ranges and means were used to describe age and the length of the abusive situation. Frequencies and percentages were used to describe the employment status of the women and their partners and the type of health care provider involved. Dichotomous responses were also described using frequencies and percentages.

Qualitative analysis was performed on the remaining open-ended questions through the use of content analysis (Lofland, 1971; Polit & Hungler, 1978). Lofland describes the verbal productions of respondents as a significant unit of comprehension which transcends behavior (acts, activities, etc.). Verbalizations can define, justify and refer to behavior rather than simply describe it. The meanings from verbalizations can be obtained through content analysis. For this study, the responses were examined for recurrent themes that would suggest factors influencing the disclosure of abuse. These themes will be discussed in the next chapter.

CHAPTER III

RESULTS AND DISCUSSION

The purpose of this study was to describe what factors influenced the identification of abused women in the health care system. Factors which influenced this identification were determined by content analysis of the responses of abused women to interview items. In content analysis, recurrent themes are sought which might explain certain behavior; in this case the behavior to be explained was the disclosure or absence of disclosure of the abusive situation. Following a description of the sample, results are presented and discussed. In conclusion, the incidental findings are reported and discussed.

Sample Characteristics

The final sample consisted of 16 women who were residents of a shelter for abused women and their children. Only women who had sought health care after the onset of abuse were eligible for participation in the study. Subjects ranged in age from 19 to 39 years with a mean age of 26.3 years. Only four (25%) of the women and three (19%) of the male partners were employed at the time of the interview. In no instance were both partners employed. The length of the abusive relationship ranged from one month to six years with a mean length of 2.5 years. The majority of the women

(N=13) saw private physicians for care, while the remaining three women received health care from a public health clinic physician, an emergency department physician, or a naturopathic physician.

Analysis of Research Questions

This was a factor-isolating study. The principal method of data analysis consisted of content analysis of the responses to open-ended questions. When the data were analyzed, three major themes related to disclosure emerged; fear of the consequences of telling of the abuse, which included fear for self or for the partner; the shame of being identified as an abused woman; and an acceptance of the abuse which was evidenced by either a resignation to abuse or its acceptance as permissible behavior. In some cases, an individual woman's response to a particular question suggested more than one theme, such as fear and shame. Thus, a woman may be represented more than once in the analysis of one question. The responses of the women will be presented in terms of the research questions with emphasis upon the three themes that emerged.

Factors Influencing Disclosure of Abuse

Research questions one and two sought to identify factors which influenced whether women chose to disclose their abusive situations to their health care providers. Personal factors as well as those specific to the health care providers were sought.

Factors which promoted disclosure. Two of the 16 women

spontaneously mentioned their abusive situation without being asked first. Three women were asked about the abuse by their health care providers. Of these three, two women acknowledged that the abuse was occurring and one woman denied it. The woman who denied her abuse when asked was also one of the women who spontaneously mentioned her abuse at a later visit. Those four women who disclosed their abuse, either spontaneously or through acknowledgement when asked will be briefly described.

Two of the women who disclosed their abuse did so primarily to seek help for specific health problems related to the abuse. Included in this group is the woman who spontaneously mentioned her abuse after having previously denied it to her health care provider. The other woman who disclosed for health purposes did so after being specifically asked if she were being abused. From their responses, it did not appear that these women were asking for help for the abuse itself; they felt that the doctor could give more adequate care if the precipitating cause of the injury were known.

The remaining two women who disclosed their abuse did so because of a need to talk about the abusive situation. One woman spontaneously mentioned the abuse and the other acknowledged it when asked. The woman who spontaneously mentioned her situation did so because she believed the doctor was the only place she could get help as her husband did not allow her to make phone calls. She needed to talk to someone

and was ashamed to tell her parents. The other woman had no one else to talk to about the abuse: "I had to get some of the frustration and hostility out of me. I had no family or friends." In both instances the doctor was perceived as either the only help or a non-judgmental source of help. Due to the limited number of women who disclosed their abuse, generalizations cannot be made to any other population of abused women regarding why they might choose to disclose their abusive situations to health care providers.

Factors which inhibit disclosure. The majority of the women did not spontaneously disclose their abuse to their health care providers. When asked about their reasons for not disclosing their abusive situations, their responses suggested that there were common influencing factors which prevented disclosure. All major themes were evident: a fear of the consequences of telling; the shame of being an abused woman; and an acceptance of the abuse.

A fear of the consequences of telling was apparent in five of the responses. Three women stated that they did not tell of their abuse because of what the partner might do to them as a result. Two other women evidenced a fear for the partner when they stated that they did not tell because they did not want their partners to go to jail. These latter responses suggest that the women were possibly mistrustful of what the health care provider might do if the abuse was made known.

Other responses suggested that the shame of being

identified as an abused woman was a factor that prevented disclosure of the abuse. For example, one woman said that she did not want anyone to know because she was ashamed to be known as having been abused. Another woman said that she had never had care from the same doctor twice and was uncomfortable to disclose to someone whom she had just met.

Acceptance of the abusive situation was manifested either as a resignation or denial that the abuse was a problem. Resignation was exemplified by one woman who stated that she did not want to impose or be a burden on the health care provider; she felt that she was "just another person." Another woman felt that the abuse was "her problem." One woman exhibited a denial that the abuse was a problem:

> I didn't think it was that serious. I wasn't able to recognize it as an abusive problem. I didn't know that it didn't happen to other people. It took a long time to realize that it wasn't my problem.

Two women indicated that they believed that the health care setting was not an appropriate place in which to talk about the abuse. One woman stated that a professional psychological setting would be better. The woman who had denied her abuse when asked, did so because she felt that the health care setting was not an appropriate place to talk.

<u>Abused Women's Desire for Identification</u>

The third research question was aimed at determining whether abused women want to be identified. It is possible that abused women desire identification but do not identify

themselves without being asked first. This idea was explored in the interview question which asked, "If your doctor or nurse didn't ask about your abuse, would you have liked them to?" Of the 13 women who had not been asked about their abuse by a health care provider, 8 said they would have liked to have been asked and 5 said they would not. Due to the small sample size, these figures cannot be generalized to any other group of abused women. Although more women stated that they would have liked to have been asked, it is not known whether this trend would continue if the sample were larger. The factors which appeared to influence these responses will be discussed.

Eight of the women who had not been asked about the abusive situation stated they would have liked to have been asked about it by their health care provider. Four expressed a need to discuss the abusive situation with someone. Two of these specifically stated that they wanted to talk to someone outside of the family. The other women were concerned about the health care provider's reaction to the abuse and would have been more comfortable discussing the issue if the provider had initiated questions concerning the abuse. The remaining two women wanted the health care provider to ask about the abusive situation because they were seeking affirmation that the abuse was wrong and should not be happening to them.

Five women preferred not to be asked by the health care provider about the abusive situation. Some of the reasons

offered for this preference included: a sense that the health care provider would not be able to do anything about the situation; a desire for privacy; a feeling that unless there are obvious injuries, the issue of abuse should not be of concern to the provider; a fear that disclosure might worsen the situation; and a sense that the abuse was too infrequent to have warranted attention at that time.

Interaction of Health Care Providers and Abused Women

This section will include a discussion of the responses of the physicians who learned about the abuse of four subjects. The last research question which obtained information regarding health care providers in general will also be discussed. This question asked about ways abused women believe that health care providers can help their situations.

Providers' reactions. The four women who had identified themselves as abuse victims were asked, "If your health care provider learned of your abuse, what was his/her response?" Two of these health care providers (a naturopath and a private physician) learned about the abuse by asking the women. The remaining two providers were private physicians who learned about the abuse through the spontaneous disclosure of the women. One physician advised the woman to leave the situation, but gave no advice as to where to go. One physician referred the woman to a shelter. Three of the health care providers listened and talked to the women; the fourth provider did not discuss the situation with the woman. One of the physicians prescribed antidepressants which according

to the woman, "mellowed me out so that I didn't get uptight about what was going on." Another of the private physicians scheduled regular visits with the woman. In general, the women spoke favorably about the responses of the health care providers.

How providers can help. Responses to the questions regarding what women felt nurses or doctors could do to help abused women were compiled into three major categories. These were: ask about the situation, make referrals, and be compassionate and non-judgmental.

A frequent response was that health care providers should ask women about suspected abuse. Two of the women who had earlier stated that they themselves would not have wanted to be asked, responded that the doctor had the right to ask women about abuse. One woman's response suggested that asking was more than a right, it was an obligation:

> I think it should be asked of every woman about herself and her children. It should be a standard question and not limited to women who are poor or with obvious injuries.

Several of the women's suggestions indicated that asking should be done in a non-intrusive way. For example, rather than asking a direct question, it was suggested that providers ask if there were any problems at home. One woman suggested that completing a questionnaire in the waiting room would be a good place to 'spill out' the problem.

Several women felt that health care providers should

make referrals to shelter or crisis lines. It is possible that being residents of a shelter influenced this response. One woman pointed out that a phone number alone is not enough help; and that there was a need for more alternatives for abused women, although she did not give examples of what those alternatives might be.

It was stressed by several women that doctors and nurses should be compassionate and non-judgmental. For example, one woman stated that doctors and nurses are supposed to care and show consideration and understanding for the situation. Doctors and nurses should not pressure or make it seem as though the abuse were the woman's fault. One woman emphasized that the ultimate decision of what to do about the abuse is up to the woman.

Other suggestions were made that did not fit into one of these categories. One woman suggested that perhaps a report could be made in a woman's favor. She felt that if the partner were to say that he never beat the woman, the medical record could provide legal evidence to the contrary. Two of the women felt that modifications within the health care system were necessary. They expressed the opinion that there was not enough time in which to open up to the provider; and that they were always conscious of the cost of the visit, which ultimately limited their time. One woman felt that doctors and nurses should be able to provide information regarding the "facts and figures" related to the problem of abuse.

Discussion

The responses that women gave regarding their interaction with their health care providers contained recurring themes. These were: fear of the consequences of telling, including a fear for self or the partner; the shame of being identified as an abused woman; and an acceptance of the abusive situation which meant either a resignation to abuse or that abuse was regarded as permissible. These findings concur with those of Drake (1982) and Pahl (1975) who found that the embarrassment, shame, and guilt of being battered as well as feelings that no one would care kept women from identifying themselves to the doctor. Similarly, Roy (1977) found that a fear of reprisal from the partner inhibited abused women from seeking help.

Some factors specifically realted to health care providers that inhibited disclosure emerged. These were a mistrust of what the provider's response might be and a feeling that the provider did not have the appropriate counseling skills. In one instance, receiving health care from a different provider at each visit inhibited disclosure by causing the woman the discomfort in disclosing abuse to a stranger.

Two women indicated a factor that prompted disclosure which was not suggestive of any of the major themes. These women disclosed the abusive situation to their doctors because of health concerns that were specifically related to the abuse. It is possible that not all women who disclose

their abusive situations are asking for help for the abuse itself. It might be that these women were asking for help with the abuse, and they used health concerns as a means to broach the subject. However, this assumption cannot be made with the data available.

Of the 13 women who were not asked about their abuse, 8 stated that they would have liked to have been asked by their health care provider and 5 said they would not. Two of the subjects who would have liked to have been asked stated they would have been more comfortable about disclosing the abuse had the health care provider initiated a discussion. Similarly, Drake (1982) found that some women within her sample wanted to be asked first because it would have removed the responsibility of having to initiate discussing the situation, or it would have lessened the guilt of telling on one's partner.

The conceptual framework for this study defined characteristics of abused women that might influence the disclosure of abuse to their health care providers. They were dependency upon one's partner, passivity or learned helplessness, and low self-esteem. It could be that these characteristics may have influenced the ways in which women in this study responded to their health care providers.

There was no evidence of economic dependency upon the male partner from either the responses to open-ended questions or to the demographic question of employment. These findings do not support prior study findings that indicated

economic dependence is a factor which keeps abused women from seeking help. The majority of both the women and their partners were unemployed. However, the assumption that there was no economic dependency present cannot be made without the information of the actual income of the women and their partners throughout the entire abusive relationship. Emotional dependency might be an underlying factor in influencing disclosure. Gelles (1976) suggests that the fewer resources a woman has in her marriage, the more entrapped she becomes. Within this present study, the fact that some of the women stated that they had little or no help from others might suggest a resulting dependency upon the partner. It is also possible that dependency upon the partner might result in a lack of resources. In addition, the acceptance of the abuse as permissible behavior might suggest that some women were isolated from healthy role models.

Acceptance of the abusive situation within this study referred to either a resignation to the situation or an ignorance that the abuse was a problem. The behavior of learned helplessness can result in such resignation. The perceived powerlessness an abused woman might feel could result in doing little or nothing about the situation as Walker (1981) suggests. Low self-esteem may underlie a woman's acceptance of the abuse as either her problem alone, or her belief that the abuse is not a problem. This belief might indicate that she perceives that she is of little value and perhaps deserving of abuse. Low self-esteem may

also contribute to the shame an abused woman experiences. Thus, the concepts in the conceptual framework were found in many of the responses of the women in this study.

Incidental Findings

The majority of the women and their partners were unemployed. This may be significant as Straus (1980) postulates that the stress of unemployment is often the cause of conflict that leads to abuse. However, because of the small sample, this assumption cannot be made.

Four of the 25 women approached for this study were ineligible for inclusion because they had not had health care due to a lack of money. It is of particular concern that women who are at risk for medical complications as a result of abuse may find it difficult to obtain health care.

Four of the women spontaneously mentioned that their partner's alcohol use played an important role in initiating the abuse. Three of the women voluntarily mentioned that they were abused while pregnant. In one case, the abuse began during pregnancy. This adds to the existing data which suggests that abuse increases or begins during pregnancy (Gelles, 1975; Rounsaville, 1978; Stark, et al., 1979).

As there were only four health care providers who were aware of the abuse in this sample, no conclusions can be made regarding how the majority of health care providers treat abused women. Further, only three of these providers actually asked about the abuse. It is not possible to determine whether the other 13 providers exhibited an avoidance

of the issue or did not recognize the problem. It is also likely that some of these women did not present to the health care setting with injuries suggestive of abuse. The fact that one physician prescribed drugs that "mellowed out" the woman so that she would not get uptight about the situation can be viewed as compounding the problem of abuse by encouraging submissive and passive behavior as Stark, et al., (1979) contend, although there is not sufficient evidence to support this argument. In general, the health care providers were viewed as responding favorably; three out of the four talked with the women and were supportive. Only one physician suggested a referral which is supported in the literature as one of the most constructive responses (Walker, 1981). Walker contends that the cornerstone of treatment for those who have been repeatedly beaten is safety and shelter. She believes that only after women feel protected from another assault can they begin to deal with the reality of the battering situation.

The results of this study suggest that health care providers can be a potential resource for abused women. Their effectiveness can be enhanced by a knowledge of the dynamics of the abuse of women, a knowledge of the resources available, and a non-judgmental caring attitude.

CHAPTER IV

SUMMARY AND CONCLUSIONS

This chapter includes a summary of the study, limitations, and implications for practice. Suggestions for further research conclude the chapter.

Summary

The major purpose of this descriptive study was to identify factors which influenced whether or not abused women chose to disclose their abusive situation to their health care providers. The possibility that health care providers are potential resources for help with abused women was explored. It has been suggested in previous studies that abused women who do not seek help are at risk for further abuse as well as related symptoms of abuse such as chronic illness, depression, and suicide.

A review of the literature suggested that the incidence of abuse among women is an underestimation. This is due in part to the nondetection by society and the non-disclosure of the women themselves. Studies have isolated factors which influence the help-seeking behavior of abused women. The primary factors that inhibit help-seeking include the emotional and economical dependence of women on their partners, limited resources, fear of reprisal, and shame or guilt because of the abusive situation. Health care

providers have been suggested as contributing to the non-detection of abused women by an avoidance of the issue or non-recognition that the woman is being abused. The literature suggests that some abused women would like to be identified by their health care providers but hesitate to initiate the disclosure.

The conceptual framework for this study consisted of the theory that socialization of women into traditional sex roles with the resulting behaviors of dependency, passivity, and low self-esteem contributes toward determining whether abused women will disclose the abusive situation to a health care provider.

An exploratory factor-isolating study was conducted to identify which factors influenced whether women disclosed their abuse. The sample consisted of 16 residents of a shelter for abused women. Using a questionnaire developed for this study, a semi-structured interview was conducted with each woman. Four of the interview items gathered the demographic data regarding age, employment of both partners, length of the abusive relationship, and type of health care provider utilized. Four items gathered information about the interaction of the women with their health care providers during the abusive relationship. These items included information concerning whether the women had been asked about the abuse, whether they acknowledged the abuse, whether they spontaneously mentioned the situation, and whether they would have liked to have been asked about the abuse if they

were not. The responses of the health care providers to the acknowledged abuse was described. A final item asked what the women felt doctors or nurses could do to help abused women. Content analysis was used as a means to examine the responses for recurrent themes that influenced their behavior.

Study data suggested three major themes which influenced whether or not women disclosed their abuse. These were: a fear of the consequences of telling about the abuse; the shame of being identified as an abused woman; and an acceptance of the abusive problem. These findings are similar to the findings of other studies of abused women within the health care system (Drake, 1982; Pahl, 1975). It is reasonable that the themes of fear, shame, and acceptance of abuse relate to the concepts of low self-esteem and learned helplessness which were described in the conceptual framework.

Of the 16 women interviewed, two had spontaneously mentioned their abuse to their health care providers. Three women were asked about the abuse by a provider, and of these, two acknowledged that they were abused and one denied the abuse. Of the 13 women who were not asked, 8 said they would have liked to have been asked and 5 said they would not. Suggestions that the women had for health care providers included: ask about the situation, give appropriate referrals, and have a non-judgmental and compassionate attitude.

Limitations of the Study

A major limitation of this study was the small sample size. This limits the strengths of inferences. Further, data were collected from a sample of shelter women which prevents generalizing the results to any other population of abused women.

It is likely that the retrospective nature of the study influenced the responses. The women's interpretations of events of help-seeking in their past could have been influenced by the recent experience of seeking help at the shelter. It is possible that those women who stated they would have liked to have been asked about the abuse might not have had the same opinion at the time of the health care. It is also possible that it was difficult for the women to accurately remember motivations for past behavior.

Another major limitation was that the questionnaire had not been used before nor tested for face validity. There were no questions which determined the severity or frequency of the abuse; factors which have been found to influence help-seeking behavior (Gelles, 1976; Rounsaville, 1978). How often health care was sought, what type of private physician was involved, and the sex of the provider were not determined, all of which might have influenced disclosure. The income of the woman and her partner were not determined, nor employment throughout the abusive relationship, both of which limit conclusions such as the significance of the factors of economic dependency or socioeconomic class. The

questions that were used could be improved by wording in ways to elicit more sensitive information. For example, simply asking women the questions "why?" or "why not?" did not always elicit the motivations behind their responses. Writing rather than taping the responses probably contributed to missing some of the information.

Implications for Practice

There was evidence that some abused women felt that doctors and nurses could be supportive of their situations. The implications for practice are applicable to all providers in the health care setting, although for this discussion the implications for nurses will be stressed. These implications pertain primarily to nurses working in emergency care, adult ambulatory care, and maternal-child care settings.

The findings that some abused women desire identification by health care providers suggest that routine screening of all women for abuse may give some the opportunity to disclose their situations. Women who present with injuries suggestive of abuse should be asked about the cause of injuries. However, limiting screening to these women would be overlooking those who are being sexually and emotionally abused, or who are currently without injury. Women with alcohol abusing partners should be asked if any violence is taking place at home. Nurses within the maternal-child setting have the opportunity of screening pregnant women who are potentially at risk for abuse.

Questions about potential abuse can be included in the

routine health history. A self-administered questionnaire eliciting information about abuse as well as other social information would provide privacy for women who are ashamed to initiate a discussion about the abusive situation. Direct questioning can also be used in a non-intrusive way. For example, the nurse could express her concern about all aspects of the patient's health and emphasize that problems at home can affect one's emotional as well as physical health. The nurse could say, "tell me about your home situation" and give the woman an opportunity to talk if she desired. If abuse is suspected, a more direct question would possibly be more effective.

Fear of consequences of telling, shame, and acceptance of abuse appeared to prevent disclosure in this study. These findings can guide the way in which nurses approach women whom they suspect are being abused. An important step is understanding the woman's fragile sense of self-worth. An abused woman may respond to the nurse who shows an interest and conveys that the woman is of value. A private setting should be used and confidentiality assured due to the possibility that the woman might be ashamed to discuss the situation.

When an abusive situation is made known, supportive listening by the nurse or other health care provider should be the first intervention. Interaction with a woman who is being abused should be non-judgmental and the woman's strengths should be encouraged. Blame should not be conveyed,

nor unnecessary drugs prescribed which further encourage dependent and passive behavior. For those women who are isolated from healthy role models and may have come to accept their abuse, health care providers can reinforce the fact that violence is not an acceptable behavior. The consequences of chronic abuse should be discussed with the woman. An abused woman's resources should be assessed, including her social support network as well as her financial situation. Practical alternatives to the abusive situation should be explored and appropriate referrals given for shelters, counseling, support groups, or legal aid. Adequate charting should be done to allow for the recognition of the repeatedly battered woman as well as provide legal record in the case of assault charges or custody cases.

As one of the women in the present sample mentioned, the final decision of what to do about the abuse is up to the woman. It is possible that an abused woman will not respond immediately to suggestions by the nurse or physician, and it is possible that she may not respond at all. Many of the factors which keep women from disclosing their abuse, such as economic dependency or fear, may also keep them from leaving their situation. Although women may not immediately respond to situations, the support of the health care provider might be an initial step in helping an abused woman gain the strength and determination she needs to change an abusive situation.

Recommendations for Further Research

This study should be repeated with a larger sample in a similar population of abused women residing in a shelter. The same methods could be used to verify the themes which emerged. A larger sample would also help clarify whether or not abused women desire identification by health care providers.

The same methodology could be employed with modifications of the questionnaire. For example, the interview items should be worded in ways to probe for greater specificity in the responses. More complete demographic data should be obtained, including income, frequency of abuse, and severity of abuse; and these factors should be examined for their influence upon the disclosure of abuse.

A survey of health care providers should be conducted to determine the extent to which they intervene with abused women in ways suggested by women within this study. The following questions should be asked: Which types of and how many health care providers routinely screen for abuse? How is screening for abuse accomplished? What interventions are employed once the abuse is made known? What is the level of knowledge individual providers have about the problem of the abuse of women?

It has been difficult to document the prevalence of women who are abused. Further studies should attempt to improve documentation. One such study could be done utilizing a health care setting. Health care providers within

different agencies with similar populations could be surveyed. One group could be instructed to screen all women for abuse and the other group would not be instructed. The two agencies would be compared for the incidence (number of new cases) of women identified as abused to determine whether there is a higher incidence of reported abuse in the agencies where the providers routinely screen.

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APPENDICES

APPENDIX A

INTERVIEW FORMAT

APPENDIX A

INTERVIEW FORMAT

1. Where do you usually go for your routine health care?

   a. Private doctor

   b. Private nurse practitioner

   c. Public health clinic-------------physician

   d. Public health clinic-------------nurse practitioner

   e. Prepaid health clinic------------physician

   f. Prepaid health clinic------------nurse practitioner

   g. Other____

2a. Have you ever been asked by this person if you were being hit or physically abused in any way by your partner?

   Yes   No   (If no, skip to question 3)

b. If yes, did you agree with or acknowledge that you were being abused?

   Yes   No   (If yes, skip to question 3c)

c. If you did not acknowledge your abuse, why not?

   1.___ I didn't want anyone to know

   2.___ I was afraid my husband might find out

   3.___ I didn't really care

   4.___ It wouldn't have made any difference

   5.___ I didn't think the doctor or nurse would care

   6.___ Other (specify)

3a. Have you ever told of your situation to your health care provider without being asked specifically?

   Yes   No

b. If no, why not?

1.___ I didn't want anyone to know

2.___ I was afraid my husband might find out

3.___ I didn't really care

4.___ It wouldn't have made any difference

5.___ I didn't think the doctor or nurse would care

6.___ Other (specify)

c. If yes, why?

1.___ I thought he/she could help me

2.___ He/she seemed concerned about me

3.___ Other (specify)

4. If your health care provider learned of your abuse, what was his/her response?

1.___ Ignored my comments

2.___ Made me feel like it was my fault

3.___ Gave me a prescription for medication

4.___ Talked with me at length about my situation

5.___ Suggested a referral

6.___ Other (specify)

5a. If your doctor or nurse didn't ask of your abuse, would you have liked them to?

Yes No

b. If yes, why?

1.___ Afraid to tell on my husband, but I wanted to be asked.

2.___ Other (specify)

c. If no, why not?

1.___ I didn't want anyone to know

2.___ I was afraid my husband might find out

3.___ I didn't really care

4.___ It wouldn't have made any difference

5.___ I didn't think the doctor or nurse would care

6.___ Other (specify)

6. Is there anything a doctor or nurse can do to help women who are being battered by their partners?

7. Age ______

8. Employed? Yes No

Partner Employed? Yes No

9. Length of Abusive Relationship __________

APPENDIX B

CONSENT LETTER FROM SHELTER DIRECTOR

16 December 1982

To Whom It May Concern:

As Executive Director and representative of
I hereby provide Claudia Brewer with my permission to conduct her study with the residents of . This permission is granted on the condition that each individual resident interviewed be informed of the rationale of the study and further, that their consent be obtained before Ms. Brewer proceeds with her interview. Furthermore, the anonmymity of all participants must be fully insured.

Sincerely.

Linda Golaszewski
Executive Director

APPENDIX C

PARTICIPANT CONSENT FORM

APPENDIX C

THE OREGON HEALTH SCIENCES UNIVERSITY

Post Office Box 573 Portland, Oregon 97207 Area Code 503 Administration 225-8601
Public Services 225-8026
Technical Services 225-8031
Dental Library 225-8822

I ______________________________ agree to serve as a subject in the investigation named "Identification of Factors That Influence the Detection of Abused Women by Health Care Providers" conducted by Claudia Brewer, R.N., B.S.N., under the supervision of Mary Ann Curry, R.N., D. N. Sc.

The aim of this study is to identify reasons why women who are being emotionally and physically abused may or may not choose to talk about their situation with their health care providers. The procedure expected of me during this investigation is to participate in a private interview conducted by the investigator consisting of six questions that deal with how I have been treated within the health care system.

I understand that my name will not be used on the interview, and anonymity will be insured by the use of code numbers. All of the information will be kept confidential. Neither my name nor my identity will be used for publication or publicity purposes. The results of all of the interviews will be analyzed as a group.

I also understand that there is a slight risk that the questions may make me uncomfortable and that I have the right to withdraw from the interview at any time and this will not affect my care at the [redacted] [redacted] Claudia Brewer has offered to answer any questions I might have about this study.

Although I may not benefit directly from this investigation, my participation will help nurses and doctors learn how to give better care to women who have been victims of abuse.

I have read the foregoing and agree to participate in this study.

______________________ ______________________

Date Subject's Signature

______________________ Witness

AN ABSTRACT OF THE THESIS OF

CLAUDIA BREWER

For the MASTER OF NURSING

Date of Receiving this Degree: June 10, 1983

Title: IDENTIFICATION OF FACTORS THAT INFLUENCE THE DET[redacted]H CARE PROVIDERS

Approved: [redacted]

Mary Ann Curry, D.N.Sc., Thesis Advisor

The purpose of this study was to identify factors which influence whether or not abused women choose to disclose their abusive situations to their health care providers. The conceptual framework for the study holds to the proposition that socialization into a traditional feminine role with the possible behaviors of dependency, passivity, and low self-esteem may contribute towards determining whether or not abused women disclose their abusive situations.

Semi-structured interviews were conducted with 16 residents of a shelter for abused women. These women were asked questions pertaining to the reasons why they had or had not disclosed their abusive situations to their health care providers. In addition, they were asked whether they would have liked to have been asked about their abuse if they were not asked. Content analysis was used to examine women's

responses for recurrent themes that might have influenced their behavior.

Of the 16 women interviewed, 13 had not been asked about the abuse by their providers. Of these, 8 said they would have liked to have been asked; and 5 said they would not. Of the 13 women who were not asked, one spontaneously mentioned her situation to her physician. A total of 4 women disclosed their abuse; 12 women did not.

Three major themes were found that influenced the disclosure of abuse. These were: a fear of the consequences of telling; the shame of being identified as abused; and an acceptance of the abusive situation. Suggestions that women had for health care providers included: ask about the abusive situation; refer to shelters or crisis lines; and be non-judgmental and compassionate.

The results of this study indicate that health care providers can be supportive help for women who are abused by their partners. It is possible that screening for abuse may promote the disclosure of some abused women. The findings that fear, shame and acceptance of abuse may prevent disclosure can guide the interventions of health care providers towards women who are suspected abuse victims.