Boston College

William F. Connell Graduate School of Nursing

SI ME PREGUNTAS, TE LO CONTARÉ TODO:

IF YOU ASK ME, I’LL TELL YOU EVERYTHING:

BATTERED LATINA WOMEN’S EXPERIENCES OF HEALTH CARE

a dissertation

by

URSULA A. KELLY

submitted in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

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Abstract

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BATTERED LATINA WOMEN’S EXPERIENCES OF HEALTH CARE

Ursula A. Kelly

Joellen W. Hawkins, RNC, Ph.D., FAAN, Dissertation Chair

Intimate partner abuse (IPA) is a significant health problem for women around the globe, and a challenge for health care providers (HCPs). Identifying and appropriately responding to victims of IPA is the standard of care for HCPs. There is a lack of understanding of this problem, as well as the needs of victims of IPA, from patients’ perspectives, particularly Latina women. The purpose of this interpretive phenomenology was to improve health care providers’ understanding of the health care experiences of battered Latina women. Feminism was the orienting philosophical framework of the study. Hermeneutic interviews were conducted with 17 Latina women in Spanish and English. Data were analyzed using van Manen’s approach. The women were alone and afraid, living beneath the radar, attempting to avoid harm to their children and themselves. Fear, worry and uncertainty permeated their lives. Their fear of the abusers and the abuse was matched by fear of detection and disclosure of the IPA to HCPs. The women’s fears were based on the unknown and uncontrollable consequences of the IPA becoming known, and included fears of children’s protective services (DSS), Immigration and Naturalization Services, the police, and the abusers. Despite their fears, the women wanted to be asked about IPA and to receive help. Health care providers were experienced as uncaring, untrustworthy, and unhelpful, “just there to do their job.” Several parallels in the women’s relationships with the abusers and with their HCPs were identified. Requisites of safety for disclosure included knowing that HCPs cared about them personally, trusting their HCPs, receiving concrete information about the consequences of disclosure prior to disclosure, and needing to be asked specifically about IPA. The implications for nursing practice, education, and research, as well as health care policy are discussed.
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CHAPTER 1

Introduction

Domestic abuse is recognized as a growing public health problem in the United States. Reduction in the incidence of domestic abuse is one of the 28 focus areas of Healthy People 2010 (US Department of Health and Human Services, 2000). Health care providers are faced with the challenges of appropriately identifying and responding to victims of domestic abuse in every health care setting. In fact, professional standards dictate that providers screen for and intervene in cases of domestic violence (American Academy of Family Physicians, 1994; American Academy of Pediatrics, 1998; American College of Obstetricians and Gynecologists, 1999; American Medical Association, 1992; American Nurses Association, 1991; JCAHO, 1995). This challenge is compounded by the social complexity of the problem of domestic abuse and the increasing diversity of the general population. Extant literature in the area of intimate partner abuse (IPA) has focused on the perspectives and practices of providers. Those studies of patients experiencing domestic abuse have been done with largely Caucasian populations.

This study was designed to address this health care challenge and the lack of the perspective of victims of intimate partner abuse in the literature. The purpose of this study was to explore the health care experiences of Latina women who have been victims of intimate partner abuse. The study question was, “What are battered Latina women’s experiences of receiving health care?”
Background and Significance

Intimate partner abuse is a significant health problem for women around the globe. In Latin America and the Caribbean, 30-50% of adult women with partners experience psychological abuse and 10-35% experience physical abuse (Buvinic, Morrison, & Shifter, 1999). Estimates of the prevalence of intimate partner abuse in the United States range from 960,000 to more than two million incidents per year (Bachman & Saltzman, 1996; U.S. Dept. of Justice, 1998), with 22% of surveyed women reporting a lifetime incidence of intimate partner abuse (Tjaden & Thoennes, 2000). Data from the National Crime Victimization Survey (NCVS) revealed equal rates of intimate partner victimization between Hispanic and non-Hispanic women in the United States (Rennison & Welchans, 2000), while prevalence rates in the clinical literature are inconsistent.

The population of the United States is becoming increasingly ethnically diverse. Ethnic minorities are projected to represent 45% of the U.S. population by the year 2045 (US Bureau of the Census, 2000). The Hispanic population in the United States is estimated to reach 90.3 million, or more than 23% of the general population, by the year 2045 (U.S. Bureau of the Census, 2000). The term Hispanic is a label of convenience used by governmental and other organizations to refer to individuals residing in the United States who trace their ancestry to one of the Spanish-speaking Latin American countries or to Spain (Marin & Marin, 1991). Hispanics originate from 32 different countries, and represent a wide variety of backgrounds, ethnicities, and languages. Shared traditions, culture, religion, and values create Hispanic identity, rather than race or nationality, and must be considered when conducting research with Hispanic populations.
Violence against women across cultures has been identified as a research priority both nationally and internationally (Fischbach & Herbert, 1997; Heise, Pitanguy, & Germain, 1994). The need for further research with minority populations in the United States was identified in a report from the National Institutes of Health (1994), “An area of prime concern is the paucity of information on Hispanic, Native American, African American, and Asian involvement in aggressive and violent behaviors, either as victims or as agents” (p. 21). Further, the need to better understand the perspectives of women who are being battered has been identified as important to guide improvements in screening, prevention, and service provision (Campbell, Moracco, & Saltzman, 2000; Spitz & Marks, 2000).

_Battered Hispanic Women_

*Prevalence.* There is recognition in the literature that intimate partner abuse occurs across all ethnic, racial, and socioeconomic groups (Bachman & Saltzman, 1995; Strauss, Gelles, & Steinmetz, 1980; Walker, 1984). Many health care providers perceive that Hispanic women are more likely to be abused than non-Hispanic women, based on a cultural stereotype. Published reports of the prevalence of interpersonal violence in the past year range from 10.5% to 17.3% for Hispanics, and 3.4% to 11.6% for Whites (Lown & Vega, 2001). Debate continues about whether Hispanic women are more at risk for domestic abuse than other groups.

Cross-cultural studies comparing rates of marital violence among Hispanics and non-Hispanic Whites have produced different findings. In the United States, minority women are often reported to be at higher risk for IPA, though the role of culture in the
complex problem of IPA is not understood (Castro, Peek-Asa, Garcia, Ruiz, & Kraus, 2003). Hispanics have been reported to be at higher (Sorenson & Telles, 1991; Straus & Smith, 1990), similar (Gorton & Van Hightower, 1999; Van Hightower & Gorton, 1998; Torres, 1991), and lower (Sorenson et al., 1996) risk than non-Hispanic Whites for marital violence. Gaffney et al. (1997), in a study of stressful events among pregnant Salvadoran women with cross-cultural comparison, reported a greater percentage of violent episodes among non-Hispanics (43%) than among Salvadorans and non-Salvadoran Hispanic groups (16%, 12%). Kaufman-Kantor et al. (1994) reported equal rates of wife assault among Hispanic-American and Anglo-American groups when norms of violence approval, age, and economic stressors were held constant. Anglo-American women rated 24 of 26 domestic violence indicators as more severe than did Mexican counterparts (Peek-Asa, Garcia, McArthur, & Castro, 2002).

**Predictors of intimate partner abuse.** Several researchers have investigated the characteristics and predictors of intimate partner abuse of Hispanic women. In a study of pregnant women in Mexico, one quarter of the women experienced violence; predictors of IPA during the pregnancy were violence prior to the pregnancy, low socioeconomic status, parental violence witnessed by women in childhood, and violence in the abusive partner’s childhood (Castro, Peek-Asa, & Ruiz, 2003). Level of acculturation, alcohol and drug use, norms of violence approval, stress, and mutuality in the relationship have emerged as factors associated with intimate partner abuse of Hispanic women in the United States (Champion, 1996; Gaffney et al., 1997; Gorton & Van Hightower, 1999; Van Hightower & Gorton, 1998; Jasinski, 1998; Kaufman-Kantor et al., 1994; Krishnan
et al., 1997; Lown & Vega, 2001; Perilla, Bakeman, & Norris, 1994; Torres, 1991; Torres & Han, 2000).

Acculturation has been shown to be positively correlated (Jasinski, 1998; Lown & Vega, 2001) and negatively correlated (Champion, 1996) with intimate partner abuse. Perilla et al. (1994) reported no direct or mediating effect of acculturation on abuse of their study sample of 60 immigrant Latinas. Discrepancies in results may be attributable to the use of different measures of the concept of acculturation. Variables typically used to measure acculturation include English language preference (Kaufman-Kantor et al., 1994), use (Champion, 1996), comfort (Perilla et al., 1994), and use in interviews (Sorenson & Telles, 1991), as well as years living in the United States and ascribed values and traditions.

Jasinski (1998) explored the role of acculturation in wife assault in four Hispanic groups: Puerto Rican, Mexican, Mexican-American, and Cuban. She found that two indicators of acculturation significantly predicted wife assaults. Third generation Hispanic American husbands were nearly three times more likely to assault their wives than non-United States born husbands. The husband’s age at arrival in the United States (younger) was also predictive of wife assault. Ethnic group differences in rates of wife assault did persist, however, when level of acculturation was controlled.

Champion (1996) found that abused Mexican-American women had higher levels of Spanish use and were less assimilated and more traditional than non-abused women. These differences may be attributable to measurement issues. Champion used the Spanish and English versions of the San Antonio Heart Study Acculturation and Assimilation
Scales (SAAS), which measure seven dimensions of assimilation. Abused women in this study were “not sure” or “disagreed” with attitudes toward traditional family structure and sex-roles, but showed lower assimilation on other scales.

Alcohol and drug use by the partner is also associated with intimate partner abuse of Hispanic women (Perilla et al., 1994; Torres, 1991). In two separate analyses of the Migrant Clinicians Network data from Latina farm workers, Gorton and Van Hightower (1999; Van Hightower & Gorton, 1998) reported that women with a partner who used alcohol and drugs were as much as six times more likely to be abused than women whose partners did not use alcohol or drugs. Alcohol and drug use by battered women is also associated with intimate partner abuse. However, this association is stronger for Anglo-American battered women than for Hispanic battered women (Gaffney et al., 1997; Krishnan et al., 1997).

Studies of intimate partner violence in which researchers have examined the role of cultural norms in Hispanic populations have yielded inconclusive results (Champion, 1996; Torres, 1991; West, 1998). Traditional gender roles and machismo have been theoretically linked to sanctioned intimate partner abuse among Hispanics (Kaufman Kantor et al., 1994; Perilla et al., 1994). These investigators demonstrated that the acceptance of violence as a norm doubles the odds of intimate partner abuse, regardless of ethnicity. However, Hispanic couples were not more male-dominated and did not endorse violence more than Anglo-American couples (Kaufman Kantor et al., 1994). Torres (1991) found that Anglo-American women perceived more behaviors as abusive than did their Mexican-American counterparts.
The problem of intimate partner abuse is multi-dimensional. Most studies identify the need to apply a multi-factorial analysis to accurately determine true predictors of intimate partner abuse, particularly in minority populations. Perilla et al. (1994) stressed the need to use an ecological approach for the study of abuse in specific populations. They developed a predictive model of abuse of Latina women that included stress, the man’s drinking habits, and mutuality in the relationship. However, even this model did not and could not account for the multitude of differences (economic, ethnic, personal values, attitudes and beliefs) that influence family relationships. Aldarondo, Kaufman Kantor and Jasinski (2002) used national survey data to assess commonly recognized risk factors for IPA across cultural groups. They concluded that further research is needed to understand both generic and culture-specific risk factors for IPA.

**Battered Women in Health Care Settings**

*Prevalence.* Most researchers have examined intimate partner abuse and battered women from the health care provider’s perspective. Several investigators have examined the rates of disclosure of abuse with different screening strategies in a variety of health care settings (Feldhaus et al., 1997; Freund, Bak, & Blackhall, 1996; Hayden, Barton, & Hayden, 1997). In a survey of four community-based internal medicine practices, McCauley et al. (1995) reported a 5.5% prevalence of intimate partner abuse within the previous year, and a 32.7% lifetime prevalence among female patients. The implementation of a single screening question increased detection of intimate partner abuse from 0% to 11.6% in one urban primary care practice (Freund et al., 1996).

Prevalence reports of intimate partner abuse during pregnancy range from 0.9% - 20.1%.
Health problems. Intimate partner abuse is associated with a multitude of health problems, both physical and psychological. The physical health effects of intimate partner abuse include injuries, headache, chronic abdominal, pelvic or chest pain, gastrointestinal disorders, including irritable bowel syndrome, chronic gynecologic symptoms, sexually transmitted infections, exacerbation of symptoms of chronic diseases such as asthma, and multiple somatic symptoms (McCauley et al., 1995, Walling et al., 1994). Victims of intimate partner abuse also experience psychological effects, including depression and suicidal ideation, anxiety symptoms and panic disorder, eating disorders, substance abuse, and post-traumatic stress disorder (El-Bassel et al., 2003; McNutt, Carlson, Persaud, & Postmus, 2002; Stark & Flitcraft, 1996; Strauss & Gelles, 1990). Often, the abuse is so severe as to be fatal. In the US, 40-50% of women who are murdered are killed by an intimate partner (Campbell et al., 2003).

Screening. Protocols have been developed for both screening and intervention in cases of intimate partner abuse. Barriers to health care providers’ screening and intervening effectively have been identified (D’Avolio et al., 2001; Parsons et al., 1995; Shea, Mahoney, & Lacey, 1997). Commonly cited barriers include personal bias, lack of comfort with the topic, lack of time, fear of offending patients, fear of opening Pandora’s box, lack of training and education, and lack of resources (Parsons et al., 1995; Rodríguez, Quiroga, & Bauer, 1996; Sugg & Inui, 1992). However, Chamberlain and Perham-Hester (2002) found only two variables associated with screening: physicians’ perceptions about the prevalence of abuse among their patients and physicians’ belief that
they have a responsibility to address abuse. Warshaw (1989) described the medical model of care itself as an inherent barrier to the care of battered women, exacerbated by institutional constraints.

The health care research on intimate partner abuse conducted to date has focused primarily on the prevalence of abuse, in general and in health care settings, barriers to and the effect of screening, and the health effects of abuse. A small number of qualitative studies have been done to explore women’s experiences of the abuse, and their responses to the abuse. The extant literature is lacking a sufficient reporting of the perspectives of battered women themselves, particularly relative to their health care needs and experiences. This is particularly true for minority women, who are under-represented in existing research on this topic. There is a tremendous need for an understanding of the perspective and experiences of minority women who have been battered.

Impetus for the Study

My interest in the experiences of Latina women grew out of my seven years of full-time practice as an adult nurse practitioner in an urban neighborhood health center. My patients were predominantly Latina women, most between the ages of 18-60 years. The majority of my patients were undocumented immigrants, monolingual in Spanish, undereducated, and had at least one child. Many were alone in the US, but for their partners and children. Having studied Spanish years previously in college, I developed Spanish skills gradually over the years at the clinic. Screening for intimate partner abuse was a routine component of my clinical practice. I wondered how my questions were received, coming from an Anglo-American woman from a middle-class background.
Many of my patients disclosed past and current abuse, either spontaneously or in response to screening questions. Many others said, “No, we just have our problems like everyone else.” Some simply said, “No.” Some patients talked about the abuse after knowing me for four or five years. Some never did. Often I suspected abuse, either from clues that I saw, or from word of mouth from others in this close-knit community; often intimate partner abuse was denied.

Over time, I became identified by both my health care organization and its patient population as a specialist in the area of IPA. I provided training to all levels of staff about domestic abuse. In preparation for these trainings, I reviewed the clinical literature and discovered that there was a fairly universal approach to screening and intervention for domestic abuse. There were ways to ask the questions and labels to avoid; judgments to withhold and affirming messages to offer; risk assessment to conduct and safety planning to implement; hotline numbers on wallet sized cards and support group referrals to give; posters and flyers to display, defining and describing domestic abuse and offering help.

The literature made it sound so simple, so straight forward, providing a recipe for success. At the same time, there was also ample literature describing the abysmally low rates of routine screening for domestic abuse in health care settings, and the barriers health care providers faced in implementing such screening. Very little of the research at the time addressed the particulars of implementing screening and intervention with the population I was serving, with its unique needs and concerns. All of the literature on appropriate screening seemed to be based on anecdotes and common sense, i.e. of course it makes sense to offer hotline phone numbers.
My heart would break to see the trap in which the women saw themselves, caged in, left with no option but to endure the abuse. The burning questions became for me, “Does any of this really work? How can we actually help?” I rarely saw any clear or direct connection between how I asked the questions and what I offered for assistance and success for my patients, either in terms of avoiding or escaping the abuse. So, I sought to hear from battered Latina women themselves. What is it like to receive health care when you are abused, whether you are asked about the abuse or not? What helps and what does not? What can health care providers do for you?

_Feminist Approach to the Study_

Feminism was the orienting philosophical framework of this study. Feminist philosophy challenges the gender-based biases that are the result of patriarchal, male-dominated cultures. These biases give rise to social beliefs, values, and practices that devalue women and label their experiences and behaviors as deviant from the norm as defined by male existence. As such, feminism brings a valuable perspective to nursing research and practice, by providing a normative context for women’s experiences and ways of knowing (Belenky at al., 1986) that is not marginal.

The application of feminist theory to nursing research and practice is consistent with the goals of nursing. Feminism provides an answer to Florence Nightingale’s question, posed in 1852, “Why have women passion, intellect, moral activity- these three- and a place in society where no one of the three can be exercised?” (Stark, 1979, p. 25). Among the aims of feminism are embracing human worth and dignity of all, the implementation of social change, remedying health status disparities among groups and
communities in society, and instigating social, political, economic, educational, and health systems changes to create a healthier and safer society (Gary, Sigsby, & Campbell, 1998).

Purpose of the Study

The purpose of this interpretive phenomenology was to improve health care providers’ understanding of the health care experiences of battered Latina women. Specific aims of the study included: 1) To describe the meanings that battered Latina women give to their experiences of receiving health care, and 2) to identify battered Latina women’s expectations of health care providers and health care systems. This research provides an understanding of battered Latina women’s perspectives of health care interactions and the meaning they give to these experiences. The result is patient-centered information that guides the development of improved health care interventions for this population, increased patient satisfaction with health care, and enhanced patient-provider relationships.

Definition of Terms

Hispanic refers to an individual residing in the United States who traces his/her ancestry to one of the Spanish-speaking Latin American countries or to Spain. In this study, all of the women were from Latin American countries. Both Hispanic and Latino/a have become politically laden terms, with ever-shifting and varying meanings and attendant implications. In this study, the term Latina is preferred. The term Hispanic will be used for consistency when citing sources that refer to Hispanic populations.
The term battered is being used to refer to women who have experienced intimate partner abuse. Multiple definitions of these terms exist. In this study, intimate partner abuse was defined as a pattern of physical, psychological, and/or emotional abuse perpetrated by an intimate partner against his or her partner, for the purposes of control or intimidation. Women self-identified as having experienced intimate partner abuse. Domestic abuse is a broader term that encompasses intimate partner abuse, child abuse, elder abuse, abuse of a disabled person, or abuse between people residing in the same domicile.

Health care experience refers to an interaction with a health care professional (nurse, nurse practitioner, physician’s assistant, physician) for the purposes of receiving health care, regardless of the setting (primary care, emergency department, specialty visit). The initial definition in this study excluded visits with mental health providers, including social workers, psychologists, and psychiatrists. However, the definition was revised to include health care providers of any kind. The informants were not always certain of the profession of the health care providers they saw, nor did they draw such clear delineations in experiencing interactions with the providers.

The term informant is used in this study in lieu of participant. Informant has an attendant meaning of active involvement and contribution, without which the study would not be possible. In feminist research, informants are recognized as informing the study and the researcher, as opposed to being studied by the researcher. The term participant will be used for consistency when citing other work as necessary.
CHAPTER 2

Review of the Literature

This study was designed and approved in June, 2001, based on a review of the literature and extant knowledge through that date. This review of the literature is inclusive of published studies through 2003.

Battered Hispanic Women's Experiences of Domestic Abuse

Several researchers have conducted qualitative studies to investigate battered Hispanic women’s experiences of the abuse (Davila & Brackley, 1999; Mattson & Rodriguez, 1999; Pilowsky, 1993; Sorenson, 1996; Wessel & Campbell, 1997), experiences of receiving health care (Bauer & Rodriguez, 1995; Rodriguez et al., 1998), and to develop community interventions to prevent domestic abuse (Fawcett et al., 1999; Maciak et al., 1999; Rodriguez, 1999).

Social inequities as well as cultural norms were identified as contributing to wife abuse and Hispanic women’s perceived options for reacting to or escaping the abuse (Davila & Brackley, 1999; Mattson & Rodriguez, 1999; Pilowsky, 1993; Sorenson, 1996; Wessel & Campbell, 1997). Wessel and Campbell (1997) reported the importance of women’s solidarity groups, community sanctions against domestic violence, and sanctuary for battered women as responses to inequities and misogynistic norms. Pilowsky (1993) conducted a grounded theory study with eight Latina women reporting a history of domestic abuse. She found that women faced a “turning point” in their moral development, in which they moved from immobilization to courage to leave the relationship.
The participatory action research and community intervention projects reported in the literature support the above findings about women’s experiences of domestic abuse. Fawcett et al. (1999) and Maciak et al. (1999) reported male denial of responsibility for the abuse and women’s minimization of the abuse, as well as abused women’s reticence to seek help outside of the family, as significant cultural factors associated with domestic abuse. However, in all three studies reviewed (Fawcett et al., 1999; Maciak et al., 1999; Rodríguez, 1999), the researchers reported significant changes in individual and community understanding and responses to the problem of domestic abuse. Rodríguez cited the “power of the collective” (1999, p. 417) as the development of a power base for battered women to support and take care of one another.

*Battered Women’s Perspectives of Health Care*

Little is known about the experience of intimate partner abuse and the process of screening and intervention by health care providers (HCPs) from battered women’s perspectives, though there is a slowly building body of research in this area. Barriers to patients disclosing domestic abuse include embarrassment and shame; denial; confidentiality concerns; lack of trust in the provider; fear of retribution by the abusers; fear of reaction of friends, family, or HCPs; lack of financial resources for medical care and housing without the abuser’s support; and fear of police involvement (McCauley, Yurk, Jenckes, & Ford, 1998; Plichta, Duncan, & Plichta, 1996; Sleutel, 1998).

The few researchers who have considered battered women’s perspectives on their health care report negative experiences. Providers have been described as uncaring, unhelpful, judgmental, unsupportive, and ineffective (Bacchus, Mezey, & Bewley, 2003;
Gerbert et al., 1996). Campbell et al. (1994) found that 50% of battered women seen in an emergency room reported negative experiences with health care providers, including feeling humiliated, being blamed for the abuse, having the abuse minimized or not detected, and not receiving adequate information.

Factors affecting battered women’s disclosures and discussion of IPA with their HCPs were investigated in two recent studies. Bacchus et al. (2003) found that battered women did not discuss the abuse with their general practitioners on the basis of several factors: perceived lack of time in appointments, lack of continuity of care which created a barrier to trust, the potential loss of control of decision making, and the lack of sensitivity to and understanding of social problems on the part of their health care providers. Women in their study who did discuss the abuse were unhappy with their HCPs’ responses, finding them unhelpful. Hathaway, Willis, and Zimmer (2002) reported similar HCP-related influences on disclosure and satisfaction: perceived knowledge and understanding of IPA, care and interest in helping the patient, taking the necessary time, and attention to confidentiality.

These findings support those of a study by McCauley et al. (1998) in which women identified the following clinician behaviors as barriers to disclosure: uncaring, appearing uncomfortable with the topic, not listening, too busy or rushed, or only interested in money. The women were more likely to discuss the IPA if they perceived their HCP as caring, easy to talk to, and protective, or if the clinician offered a follow-up appointment.
Rodriguez et al. (2001) conducted a telephone survey with a random sample of 375 African-American, Latina, and non-Latina white women with histories of IPA to investigate clinician-patient communication about IPA. Twenty-eight percent of the women reported being asked directly about IPA by their HCP; 85% of those women disclosed the IPA. Only 25% of the women who were not asked directly about IPA disclosed the IPA. Significant barriers to disclosure of IPA included: beliefs that HCPs do not ask directly, concerns about confidentiality, belief that HCPs lack time for and interest in discussing IPA, and fear of involving the police and courts. Among the Latina women (29% of the sample), 34% identified language barriers and 21% had concerns about immigration authorities. The most significant predictor of discussion of IPA was the presence of direct questioning about IPA by the HCP. Among the three ethnic groups, Latinas were the least likely to disclose the IPA. Immigrants born outside of the US were also less likely to disclose the IPA, 32% versus 46% for US-born women. The gender and ethnicity of the HCP had no significant effect on disclosures.

Contrary to health care providers’ perceptions that women would be offended by being asked about abuse, both battered and non-battered women report a strong desire to be asked about their experiences with violence (Bacchus, Mezey, & Bewley, 2002; Bauer & Rodriguez, 1995; Friedman et al., 1992; Richardson et al., 2001; Rodriguez et al., 1998; Stenson, Saarinen, Heimer, & Sidenvall, 2001; Webster, Stratigos, & Grimes, 2001). Protocols for screening for IPA recommend that women be questioned when they are alone, without their children or partners present. Zink and Jacobson (2003) investigated mothers’ attitudes about screening with children present, given the lack of
feasibility of separating mothers and children in busy clinical practices. They found that mothers did not object to general questions, but preferred in-depth discussions in private.

Positive Experiences of Health Care

In one study, the researchers reported positive health care experiences from battered women's perspectives. Gerbert et al. (1999) described two phenomena considered helpful by survivors of abuse: 1) a complicated dance of disclosure and identification of abuse between victims and health care providers, and 2) validation from the health care provider. These authors reported a wide variety of behaviors and styles experienced as helpful by the survivors, involving both explicit and implicit acknowledgement of the abuse, and direct and indirect responses and action plans.

Battered Hispanic Women and Health Care

In general, Hispanics have lower health care utilization rates than non-Hispanics (Estrada, Trevino, & Ray, 1990; Saha, Arbelaez, & Cooper, 2003). In the literature, authors have attributed this underutilization of health care services to several barriers, including lack of access to the health care system (Zambrana, Dorrington, & Hayes-Bautista, 1995), the high cost of services (Zambrana et al., 1994), the lack of bilingual and bicultural care providers (Ginzberg, 1991), socio-demographic variables including low income, low education, and young age (Zambrana, 1988), and discrimination (Cornelius & Altman, 1995; Zambrana et al., 1994). Additional barriers faced by some Hispanic battered women may include lack of understanding of legal rights, fear of deportation, the police, and losing their children.
In only a few studies have the investigators specifically explored battered Hispanic women’s experiences of health care (Bauer & Rodríguez, 1995; Belknap & Sayeed, 2003; Rodríguez et al., 1998). Barriers to medical help seeking by battered women included a code of silence, maintained by both the women and their providers, and misdiagnosis and mistreatment of their abuse and attendant problems. Latina women in one study described _confianza_ (trust, confidentiality, support, comfort, and safety) as critical to a patient-provider relationship in which domestic violence could be discussed (Rodriguez et al., 1998).

Positive health care provider behaviors that enhanced communication and created positive experiences included compassion, respect, kindness, and sincere concern (Bauer & Rodríguez, 1995). The importance of HCPs raising the issue of IPA and encouraging discussion has been reported in several studies of both Hispanic and non-Hispanic women (McCauley et al., 1998; Rodríguez et al., 1998; Rodriguez et al., 2001). Belknap and Sayeed (2003) supported these findings, and extended our understanding of the needs of battered Latina women relative to creating the requisite trust for discussion of IPA with their health care providers. Health care providers must “be sincerely present for the client, ask about her life, listen to her response,” and provide appropriate referrals for services (p. 723).

_Cultural Considerations in Conducting Research_

Conducting research across cultures requires consideration of cultural values, differences, and meaning, and has implications for all aspects of the research process. Marin and Marin (1991) identified several cultural values shared by Hispanics. The
values of allocentrism (collectivism), *simpatia* (positive smooth social relationships),
familialism, and the prescribed gender roles of *machismo* (male dominance) and
*marianism* (female submission) have significant implications for the study of Hispanic
battered women and their health care providers. Culture-specific research on violence
should also include culture-based definitions of domestic abuse, attitudes about domestic

In conducting research across cultures, every step of the research process involves
consideration of cultural values and meaning, from the formulation of the research
question, through instrumentation, data collection, data analysis, and conclusion
formulation. Cultural relativism is the underlying premise of cultural research. The
meanings given by the informants must be understood and respected (Marin & Marin,
1991). However, given the private nature of domestic abuse, cultural norms and values
may be used to minimize, deny, and normalize violence against women (Marcus, 1994).

*Challenges in Conducting Research with Battered Hispanic Women*

There is a dearth of research in the area of battering of Hispanic women,
particularly in the area of provision and receipt of health care. Most of the published
literature concerns prevalence estimates, and a few researchers have explored predictors
of abuse. The most significant gap in the literature is an investigation of battered
Hispanic women’s perspectives, perceptions, and experiences of their abuse and receipt
of health care.

The investigators for existing research studies faced many of the usual limitations
of research (problems of measurement, generalizability, researcher and participant
biases), as well as some challenges unique to the study of Hispanics and of domestic abuse. Hispanic is a term of convenience, and does not refer to a homogenous ethnic or racial group. Shared cultural values of Hispanics have been identified (Marin & Marin, 1991), but these are not universally accepted, as is the case in any culture. Variations exist both within and between cultures. The problem of generalizing findings, therefore, is exacerbated in studies of Hispanics.

Feminists have deconstructed the concept of culture as homogenous and equitable within itself. Okin (1999) claimed that most cultures seek the subordination of women by men as a primary aim. Differences within cultures are often ignored in favor of those between cultures. Frye’s (1983) feminist analysis of oppressive systems can be applied to cultures as well. She asked the following questions of such a system: 1) Who constructs and maintains it? 2) Whose interests are served? 3) Who benefits? and 4) Who suffers? Authors of only a few published studies have sought to understand the problem of battering of Hispanic women in the context of a critical analysis of culture and cultural norms (Fawcett et al., 1999; Perilla et al., 1994; Rodriguez, 1999; Sorenson, 1996; Wessel & Campbell, 1997). The ethical challenge in conducting research about battered Hispanic women lies in reconciling cultural relativism and the recognition of systems of oppression in their lives.

Researchers in the area of battered Hispanic women are faced with practical challenges in addition to philosophical issues. Problems of disclosure are paramount, as both Hispanic women and battered women may not discuss their experiences openly. Concerns about confidentiality, safety, loyalty to family, privacy, discrimination, and
judgmental attitudes are inhibitive to disclosure. Several researchers have acknowledged this limitation and surmise that prevalence rates may be higher than actually reported.

Language barriers are the most obvious limitation to studies of Hispanics. By limiting studies to English speaking participants important ethnic differences may be obscured. Kaufman Kantor et al. (1994) avoided this problem by conducting bilingual (Spanish/English) face-to-face interviews. Language barriers make qualitative studies particularly difficult to conduct without adequate resources for interpreters. Cross-cultural research (disparate cultural background of the researchers and the study population) is also difficult to conduct without cultural brokers or bicultural research assistants.

Sherraden and Barrera (1995) identified from the literature several challenges to qualitative research with understudied (Hispanic) populations: 1) difficulty identifying and sampling the appropriate population, 2) incompleteness and inaccuracy of background information, i.e. public health and census data, 3) challenges in designing valid interview procedures, 4) problems specifying culturally appropriate concepts and instrumentation, and 5) complexities in recruiting and interviewing undocumented immigrants. All of these challenges apply to research with battered Hispanic women, and have likely contributed to the lack of a substantive knowledge base about their experiences.

*Feminism, Culture, and Domestic Abuse*

Early researchers about domestic abuse used a feminist perspective (Dutton, 1992; Eisikovits & Buchbinder, 1999; Ferraro & Johnson, 1983; McFarlane et al., 1997)
and a feminist methodology (Parker & McFarlane, 1991). Domestic abuse has also been 
studied across cultures (Counts, Brown, & Campbell, 1999; Moss et al., 1997; Phillips, 
1998; Torres, 1991). To date, this research has not translated into a widespread 
understanding of the complexities of the problem of domestic abuse, particularly abuse 
experienced by ethnic minorities in the United States.

Ill-informed beliefs about domestic abuse persist among nurses and other health 
care providers, particularly in regard to Hispanic battered women. They are accused of 
liking the abuse ("Why don’t they just leave?") and/or expecting and accepting the abuse 
("It’s a cultural thing, they think it’s okay."). While these statements are easily refuted, 
continued feminist and culturally appropriate research about Hispanic battered women is 
necessary for knowledge development and improved nursing practice.

The intersection of gender and ethnicity was proposed by Sorenson (1996) as 
central to studying ethnicity and violence against women. Phillips (1998) used the image 
of location (Crenshaw, 1995) to describe a more complex intersection of the social forces 
of gender, race and ethnicity, class, language and citizenship, religion and culture. These 
intersecting systems of oppression and women’s locations within them create varying 
experiences of domestic abuse and the meaning given to those experiences.

The image of location is central to the concept of marginalization. 
Marginalization is defined as the “process through which persons are peripheralized on 
the basis of their identities, associations, experiences, and environments,” (Hall, Stevens, 
& Meleis, 1994, p. 25). This process may involve various forms of oppression: gender,
racial, political, cultural, or economic. Consequently, marginalization encompasses the complexity of a battered Hispanic woman’s experience.

Meleis and Im (1999) delineated a strategy for developing knowledge about marginalized populations that is not itself marginalizing. They questioned the trend in nursing toward relativism, and stated that cultural knowledge taken out of the context of political and positional constraints, as well as without some universal humanistic values, is marginalizing. “It is not the culture that shapes the health care experiences of clients. It is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized, and ordered around” (Meleis & Im, 1999, p. 96). Developing knowledge that is not marginalizing requires full attention to all kinds of diversity, as well as analysis of power differentials.

In conducting research with marginalized populations, questions should come from the margins. Marginalized individuals are informants who should be invited to talk at length about their experiences and problems, with this information driving the research questions and process. Hall, Stevens, and Meleis (1994) outlined a relevant research design for studies involving marginalized populations, such as battered Hispanic women. Included are the formation of individual therapeutic alliances, group forums, story telling, participatory research, political action, and any other method that brings forth the voice of the informants. Such research requires the reflexive involvement of the researcher, establishing and maintaining solidarity with informants throughout and ideally beyond the research process.
Summary

The literature on the prevalence of domestic abuse generally supports the claim that rates of battering are roughly equal between Hispanic and non-Hispanic groups in the United States. Equal prevalence or not, domestic abuse represents a significant public health threat and societal problem. Several factors have been identified as associated with battering of Hispanic women: level of acculturation, alcohol and drug use, stress, and norms of acceptance of violence. Battered Hispanic women face many obstacles, both within and outside of their cultural group, to receiving help.

Cultural values regarding family may make Hispanic women reticent to seek help from friends, social service agencies, or health care providers. Researchers have shown the empowering and positive impact of supportive community-based responses to the problem of domestic abuse. Health care providers in particular can have a positive impact in the lives of battered Hispanic women by maintaining a respectful, compassionate stance, listening, forgoing a strictly medical view of the problem, and relinquishing the need to fix it.

Health care providers are faced with the challenge of providing expert care to battered Hispanic women. Insufficient understanding exists about the characteristics and effects of domestic abuse, and the consequent health needs among Hispanic women. There is a dearth of research to guide theory and practice in this area. Additional situation-specific research is needed to illuminate and overcome the particular barriers to health care services and the achievement of health faced by this population. This study is
designed to meet this need by asking the question, "What are battered Latina women's experiences of health care?"
CHAPTER 3

Methods

The purpose of this interpretive phenomenology was to improve health care providers’ understanding of the health care experiences of battered Latina women. Specific aims of the study included: 1) To describe the meanings that battered Latina women gave to their experiences of receiving health care, and 2) to identify battered Latina women’s expectations of health care providers and health care systems.

The orienting feminist framework of this study guided consideration of the research question and of the study design and implementation. Particular research techniques were incorporated, consistent with a feminist approach to research and with the strategies for developing knowledge about marginalized populations described by Meleis and Im (1999). Bernhard (1984) defined feminist methodology as containing interaction between the subject [informant] and the researcher, non-hierarchical relationships within the research, the expression of feelings, and concern for values. Harding (1987) added to this, and asserted that the researcher’s point of view, including biases and background, should be included in the data. The target group is considered part of the research team in feminist methodology. In identifying the focus of feminist research on women’s experiences, Harding was careful to clarify the plural, recognizing that there is no universal “woman” or “woman’s experience,” as these experiences come from different races, classes and cultures. Shulamit Reinharz (1992) extended this conceptualization of plurality to research. She described feminist research practices as a plurality, emphasizing “women’s ways of knowing” (p. 4).
As this study sought to explicate the meaning of human experience, a phenomenological approach was used. Interpretive phenomenology was the method most suited to answer the research question, “What are battered Latina women’s experiences of receiving health care?” In particular, what are these experiences like, given the social, cultural, and political influences on these health care experiences? The application of the phenomenologic method, specifically van Manen’s approach, is designed to elicit and articulate the informants’ own versions of reality and the meanings they give to their experiences.

*Phenomenology*

Phenomenology has been adopted by nursing from philosophy as a research method, resulting in both descriptive and interpretive applications. Both approaches are intended to explicate the lived human experience. Descriptive phenomenology addresses the question, “How do we know?” It is aimed at revealing the essence, the essential structure of a lived experience, and as such it is epistemological in nature. Husserl based his phenomenology on an eidetic (descriptive) approach. Husserl was committed to the ideal of rigor in the human sciences. His method is a process of reduction, involving bracketing presuppositions, and approaching the data from an atheoretical stance (Husserl, 1913).

Interpretive phenomenology (Heidegger, 1962) is ontological, and seeks understanding of the nature of lived experience. It is based on the thesis that the lived experience is itself an interpretive process. As a method, interpretive phenomenology (hermeneutics) requires reflection to uncover the hidden meanings in experiences (Ray,
1994). Interpretive phenomenology rejects the assumptions of logical positivism, and recognizes the multiple influences on the researcher, as well as the researcher's influence on the informants and the data.

In interpretive phenomenology, the assumptions, biases, situatedness, and approach of the researcher are made explicit from the outset. They are acknowledged and challenged throughout the research process in contrast to the bracketing of descriptive phenomenology. This is consistent with the current feminist view of the role of the researcher in the research process. The outdated conception of the feminist researcher as an "all-knowing, unified, distanced, and context-free seeker of objectified knowledge whose very gender guaranteed access to women's lives and knowledges" (Olesen, 2000, p. 226) has given way to a recognition that both the researcher and the informant are situated in history and context.

The goal of interpretive phenomenology is to reveal commonalities and differences. Benner (1994) identified five areas of commonality of interest to phenomenologists: situation, embodiment, temporality, concerns, and common meanings. While all of these areas are grounded historically and culturally, embodiment and temporality have more to do with direct perception, a critical concept in phenomenology. Direct perception has to do with the moment to moment lived experience, in contrast to the context of that experience.

Content analysis and qualitative description have been the most frequently used methods to investigate the topic of abused women and the receipt of health care (Bauer & Rodríguez, 1995; Gerbert et al., 1999; Gerbert et al., 1996; Rodríguez et al., 1998).
However, Drew (1986) used interpretive phenomenology to explore acute care patients' experiences with professional caregivers. She characterized the experiences as ones of exclusion and confirmation. Phenomenological studies in the area of domestic abuse have been done, primarily focusing on the experience of the abuse itself (Farrell, 1996a; Farrell, 1996b; Germain, 1994). In Farrell’s (1996b) study of sense of relationship in women who have been abused, four themes were identified: lack of relational authenticity, immobility, emptiness, and disconnection. It is possible that these same themes may be seen in health care interactions as well.

*Study Design: Van Manen’s Phenomenological Method*

Van Manen’s (1990) phenomenological method draws on both descriptive and interpretive approaches. It provides both an essential description and an explicated meaning of an experience. Van Manen asserted that phenomenological inquiry should be driven by passionate commitment to the subject, and guided by a general “set of guides and recommendations for a principled form of inquiry that neither rejects or ignores tradition, nor slavishly follows or kneels in front of it” (1990, p. 30). I chose this particular method for this study because of its philosophical and methodological resonance with me.

While not providing a specific set of procedures, van Manen described six dynamic research activities that form the essential structure of human science research:

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented pedagogical relation to the phenomenon;
6. balancing the research context by considering parts and whole (van Manen, 1990, pp. 30-31).

_Sample_

A purposive sample was recruited from a population of women using a battered women’s services agency and a legal services program in an urban area on the northeastern coast of the United States. Both agencies agreed to provide access to me for this study. The informants self-identified as Hispanic or Latina, and were Spanish or English speaking, or bilingual. The majority of women who accessed services at both of the recruitment sites were from Central American countries, Colombia, and Puerto Rico. Women from a variety of countries were sought to provide diversity in the sample. The sample size was determined by data analysis. Sample adequacy was determined by redundancy in the statements made by the women about their health care experiences, and the emergence of a deep understanding of their experiences.

Informants were sought who were no longer in an abusive relationship to enhance the safety of participation. While this strategy may have limited the perspectives included in the study by considering health care interactions after the immediacy and crisis have passed, I believe that temporal distance and retrospection enhanced informants’ reflections and insights. The potentially inhibiting influence of familialism (the cultural value of family loyalty) was mitigated by informants’ separation from the abuser. Additional inclusion criteria were: 1) currently in a safe situation and this safety would not be jeopardized by participating in the study; 2) having had one or more interaction
with a health care provider during the time that she was in the abusive relationship; and
3) the health care interaction was within the past 5 years.

The five-year time limit addressed two issues: informant recall and health care
provider practices. The benefits of retrospection may be lost as informants’ recall of rich
detail may fade over several years. Health care providers’ awareness of domestic abuse
and screening practices may have changed in recent years with publicity and changing
practice standards. Therefore, I supposed that positive health care experiences would be
more common in recent years.

Delimitations

This study did not address the experiences of battered women who did not receive
health care during the time they were being abused. While the reasons for the lack of
health care may be relevant to the goals of this research, this phenomenon was beyond
the purview of this study.

The Settings

Two agencies, a battered women’s services agency and a legal services program,
were used to recruit informants. Both agencies operated out of storefront offices on the
main street of an urban area in the northeast. The city was very ethnically diverse, with a
high number of immigrants from Central and South America, the Caribbean, and Asia, as
well as Anglo-American and African-American residents. The agencies were located
within a city block of each other, and had a close affiliation, as well as many shared
clients. Both agencies provided free services, and had primarily low-income clients. The
agencies were both non-profit and had limited financial resources. The battered women’s
services agency offered a variety of services, including individual advocacy, support groups, peer leadership groups for teens, child care, and life skills training, as well as emergency shelter and transitional and long-term housing. The legal services program provided legal representation pursuant to family law, housing, public benefits, employment discrimination, disability and immigration issues. The one family law attorney practicing at this site was my contact. She informed only her clients about the study.

The battered women’s services agency was identifiable only by the street number on the building. It was not a hidden setting, simply not advertised. Access to the office was through a double set of solid doors, the second of which was locked. A video monitor and intercom system were used to control entrance. The legal services program was identified with signage and had unrestricted access. Within each agency’s office, space was limited, but private offices were available for conducting the interviews.

Recruitment

Since the focus of this study was to examine women’s experiences with health care providers, I did not recruit informants from health care settings to avoid potential conflict of interest in their responses. The cultural value of simpatía may lead informants to overly emphasize positive aspects or de-emphasize negative aspects of interactions with health care providers, particularly if the study is conducted in a health care setting.

My professional contacts at the study sites informed their clients about my study, both individually and in support groups at the battered women’s services agency. Women who were interested either chose to take my phone number or release their names and
phone numbers, as well as any specific instructions about calling them, to the staff to forward to me, with the understanding that I would then contact them directly with further information. In cases where the women did not have phones, the staff scheduled appointments at the sites for me to meet potential informants to discuss the study. Recruitment was relatively unproblematic, and was enhanced by using two sites, as well as my participant observation in a 10 week long support group at the battered women’s services agency. This gave potential informants the opportunity to get to know me a little before deciding whether or not to participate. The ease of recruitment was not surprising, given that Hispanics have unusually high response rates in research studies (Marin & Marin, 1991), mitigating potential barriers to recruitment, i.e. the sensitive nature of the research topic, safety concerns, familialism, and the cultural disparity between myself and the informants.

Potential informants were screened for participation via telephone and in person to determine if they met the study’s inclusion criteria. The chief criterion for study participation was being a survivor of intimate partner abuse. Women self-identified as having been in an abusive relationship with an intimate partner in the past. For the purposes of this study, an intimate partner was defined as someone with whom the subject had a sexual or marital relationship, regardless of gender. All of the intimate partners of the women in this study were men.

Pilot interviews were conducted with two women who were recruited from the legal services program. The women were purposefully selected by the family law attorney, based on their health care experiences and perceived willingness to discuss
those experiences. Both interviews were conducted in a private office within the legal services program office. The process of recruitment and conducting the interviews was not problematic, however screening for participation in the study was not done prior to the establishment of the appointments. This resulted in the implementation of a screening procedure for the full study that could be conducted by telephone or in person.

Data Collection

Tape-recorded, open-ended interviews were conducted in the language of the informant’s choice (Spanish or English) in a mutually agreed upon confidential and safe setting. The interviews lasted 60-120 minutes. I conducted two interviews with 10 of the informants, three interviews with two informants, and one interview with five informants. Of the five women who were not available for a second interview, two had moved into emergency shelters for their safety, two had moved to permanent housing without providing contact information, and one abruptly stopped receiving services at the referring agency.

The interviews were transcribed in the language in which they were taped. The transcribed interviews were checked for accuracy with the audiotapes by me, as well as spot checked by a certified interpreter.

Pilot Data Collection

The two pilot interviews were conducted by me in Spanish. Several limitations in the process of data collection were identified, suggesting directions for change. The interviews were conducted without the benefit of a full screening questionnaire. A fair amount of time in the interviews was devoted to clarifying which type of provider
(doctor, nurse, psychiatrist, psychologist) was being referenced by the informant. Since it is often difficult for patients to distinguish among health care personnel, I was concerned that my informants might not know the profession of some of their health care providers. Based on this limitation, the research question was revised to pertain to any and all health care experiences, without the restriction to experiences with primary care providers. Additionally, specific questions about the type of health care received (with whom, what setting, how many times) during the period of abuse were added to the screening process and to the pre-interview, demographic data collection. In instances in which the informants were clear about the type of provider seen, this information was recorded.

Some of the interview questions were revised to a more simple sentence structure in a more active voice. Feedback from two informal consultants, as well as my observations during the pilot interviews, suggested that the interview questions as initially written were too complicated for the study population to fully comprehend and respond to appropriately. Midway through the interviews I realized that it would have been helpful to know the informants' level of education and country of origin prior to the interview. The style of the interview was also changed to be more open-ended and less structured than were the pilot interviews, encouraging spontaneity of responses from informants (Wimpenny & Gass, 2000), and to be more congruent with the dialogic nature of hermeneutic interviews.

The pilot data were limited by the disparate primary language of the informants and me. I spoke English and some Spanish. This resulted in the need to interrupt the flow of the interview for clarification of information at times, as well as neglect and lack of
elaboration of information at others. It is presumed that some richness of data was lost because of this limitation.

*Linguistic Challenges: Interpretation and Translation*

The process of addressing the limitations caused by my linguistic capabilities was one of trial and error, and involved several different actions. Following the pilot interviews, I conducted several interviews directly, with an interpreter present to assist as needed. This facilitated ease in developing rapport, as I was speaking directly to the informants. However, this approach resulted in missed understandings on my part during the interviews, creating lost opportunities for exploration of some ideas and experiences. Transcripts of these interviews were primarily in Spanish, resulting in the need for further translation into English by additional research assistants.

My final approach was to use an interpreter for the entire interview. I stopped speaking Spanish in the interviews, creating audiotapes that included both Spanish and English versions of everything that was said, even that which I understood completely. In all cases where I interviewed Spanish-speaking women more than once, this approach of full interpretation was used at least once, allowing for full clarification of any points missed during incompletely interpreted first interviews.

As a result of the various approaches to interpretation during interviews, the audiotapes contained varying amounts of translation into English of spoken Spanish. Eventually, all audiotapes were transcribed verbatim, with additional English translations added to the transcripts as needed after the fact, resulting in complete Spanish and English versions of all interviews conducted in Spanish. The process of getting the data
from interview audiotapes to data analysis involved several activities: interview interpretation, transcription in English and Spanish, and translation of Spanish transcripts into English. Several research assistants were involved in these multiple processes, each with her unique abilities and style in conducting these activities.

Interviews

Prior to responding to interview questions, each informant was asked to provide basic demographic information, (age, race, country of origin, education, years living in the US, immigration status, number of children, number of children in the US) as well as information about the abuse (relationship to the abuser, length of the relationship and how long since it ended) and her health care history (type of providers seen, frequency of visits, reasons for visits).

Hermeneutic phenomenologic interviews are dialogic and iterative (Benner, 1994). In order to elicit narrative accounts of everyday experiences, researchers must communicate in everyday language. The conversational nature of the interview requires the use of conversational language. This became clear as I began my first interviews with an initial sensitizing probe: “In general, what were your experiences of getting health care like when you were being abused? How were you treated?” This question generally elicited a response of “Bueno,” or “Fine,” and nothing more. Shifting to a more natural tone and language, I started asking “What was it like . . . ?” or some simple variation of that question for every topic of interest: the abuse itself, leaving the relationship, health care experiences.
The interviews evolved as conversations, and the topics of interest evolved concurrently. For example, the role of being a mother was not an initial topic of concern to me, but its importance to the women, and therefore its relevance in this study, became clear very quickly. My questions were designed to uncover commonalities and differences among the women’s experiences. The five sources of commonality explored in phenomenology as described by Benner (1994) include: situation, embodiment, temporality, concerns, and common meanings.

It also became clear very quickly that the research question, focusing on the women’s experiences of health care, was jumping into stories in progress. The women nearly universally began by describing their experiences of IPA prior to seeking health care. I realized that in order to fully understand the phenomenon being investigated, I needed to go back to the beginning, or to at least to step outside of the patient-provider interaction to listen to the women as they told their stories in their own way, including their salient concerns. A detailed portrait of the broader contexts and concerns of their lives was critical to understanding these battered Latina women’s experiences of health care. The interview guide was adapted to achieve this, pursuing data on both earlier life experiences of abuse and immigration experiences.

Specific questions focused on health care experiences that were particularly helpful, supportive or positive, or that made a difference in the woman’s experience of living with the abuse; the informant’s perceptions of screening practices; her expectations of her providers; and absent health care provider behaviors or actions that would have been helpful. Data were sought relative to cultural influences or perspectives, given the
cultural disparity between myself and the informants. According to van Manen (1990),
this can be achieved by encouraging dialogue with the informants, clarifying their views
by contrasting them with mine.

Immediately following each interview, field notes were audio-taped and
transcribed to record information about the context of the interview and my general
impressions and reactions, including my thoughts and emotional responses.

One limitation of this data collection method was that I am Anglo-American,
though I spoke some Spanish. This lack of a shared culture may bias informant responses
(Leininger, 1985; Marin & Marin, 1991). Perceived power imbalances between me and
the informants, fears of negative consequences of authentic responses, and the
informant’s emotional state at the time of the interview were also potential inhibiting
influences on the informants. Feminist approaches to research, as described above, were
utilized to decrease these limitations as much as possible.

I attempted to mitigate perceived power imbalances with the informants by
emphasizing with the staff of the sites, as well as with potential informants, the voluntary
nature of the study. The staff was instructed not to approach anyone about the study who
they thought might participate out of a sense of duty or fear of negative consequences for
declining. I scheduled interviews at the informants’ convenience, and provided a $25
stipend per interview, as well as childcare and transportation as needed. I encouraged
them to articulate their thoughts on how the provision of health care for battered Latina
women could be improved, stressing the expertise they had as a result of their
experiences. I gave informants my cellular phone number, enabling them to reach me

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immediately and directly, as opposed to creating a dedicated phone line with voicemail access only. During the interviews, I attended carefully to interactions between myself and the informants, as well as attending to their emotional states.

Data Analysis

Data analysis began as soon as data collection began, and continued concurrently. Immersion in the data was achieved through the process of conducting the interviews, checking the transcripts for accuracy, and reviewing the translations, providing me with an overall familiarity with the data, “a sense of the whole” (Sandelowski, 1995, p. 373). The data were analyzed with the five sources of commonality described by Benner (1994) in mind. These sources guide the phenomenologic researcher in developing an integrated understanding of the human experience. These sources provided several frames of reference for steps two and three of van Manen’s method: “investigating experience as we live it rather than we conceptualize it, and reflecting on the essential themes which characterize a phenomenon” (1990, p. 30).

The interview data were analyzed using thematic analysis, involving “the search for and identification of common threads that extend throughout an entire interview or set of interviews” (Morse & Field, 1995, p. 139). Van Manen’s third step calls for analysis through reflection and entails three approaches to the data. The wholistic or sentitious approach entailed reading and considering each text as a whole, seeking a phrase that captured the fundamental meaning of the text as a whole. The second step to data analysis was a selective approach, in which the tapes and texts were reviewed several times, searching for essential phrases about the women’s experiences. I wrote narrative
statements capturing each informant’s experiences, each followed by several sentences which provided more detail and explication. Finally, a line-by-line coding approach was used to consider what each line or sentence had to say about the experience being described. When coding was complete, relationships between the codes and the narrative statements were considered, and organized into themes.

As an example, Rita talked about her friends’ reactions to the emotional and sexual abuse she was enduring.

So a lot of my friends would say “Yeah, well, but he’s not hitting you, but you know, so what if he comes home at 3 or 4, at least he’s coming home. At least he’s not coming home to beat on you!” And so it was really hard because I didn’t really feel that they could identify with what I was going through, because here I was being yelled at or being told that if you don’t sleep with me, then I’m going to go out and sleep with someone else, and feeling that it was wrong because it was just not right and I had that feeling and saying it to my girlfriends and then them saying to me, “Well, think about it this way, at least you’re not getting slapped because you don’t want to sleep with him or at least, you know, you’re not getting beat when he comes home drunk.” So it was difficult for me at that time. So even though I did talk to a lot of my friends, they were kind of like, they were worse off than I was, so they couldn’t really identify with what I was going through at that point.

My overall impression of Rita’s first interview was “Invisibility as a Person.” The narrative statements I wrote illustrated her various experiences of invisibility: reactions of friends, indifferent treatment by health care providers, responsibility to her daughter at all costs to herself, previous experiences with abuse, hiding the abuse from her family to protect both herself and the abuser, and protecting her mother from losing custody of her to children’s protective services. These narrative statements, as well as the phrase “Invisibility as a Person,” contributed to the theme of “Parallels in Relationships: Abusers and Health Care Providers.”

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Identified themes become “objects of reflection in follow-up hermeneutical conversations in which both the researcher and interviewee collaborate” (van Manen, 1990, p. 99). The themes were discussed with the informants in second and third interviews, allowing for clarification and co-creation of the interpretive analysis of their experiences. The interview guide was revised as needed, removing concepts that revealed presuppositions and that prematurely directed responses. Following the completion of individual interviews and the identification of themes, I conducted a focus group session with four Latina women from one of the support groups run at the battered women’s services agency (two I had interviewed, two were unknown to me). The purpose of this session was to ensure the validity of the data analysis process via member checking. I presented the major themes, which the women confirmed. Additionally, I conducted a third interview with one of the informants, who was also an advocate for battered Latina women. In this interview, I asked her to draw on both her work and personal experiences, and to consider the themes for validity, looking for a “phenomenological nod.” She confirmed and elaborated on the findings.

My constructivist approach to member checking was intended to determine whether or not the themes as I devised them reflected what the women knew to be critical and core aspects of their experiences. I was not looking for each individual to see her specific experiences in the findings, but to concur with the findings as capturing the essence of her experiences.

The fourth step of van Manen’s method involves writing. Writing and rewriting are critical to the hermeneutical phenomenological research process. Phenomenological
writing is about both speaking and being silent. “To write phenomenologically requires that we be sensitively attentive to the silence around the words by means of which we attempt to disclose the deep meaning of our world” (van Manen, 1990, p. 131). Anecdotes and exemplars are used to provide rich description of the women’s experiences, and to provide distinctions between them.

Rigor

Within the interpretive paradigm, rigor in qualitative research ensures trustworthiness. Rigor has more to do with the process of inquiry and analysis than with the outcome, which is evaluated in terms of validity, the believability of the findings. The challenge for the qualitative researcher is to attend to the complexities of the process to ensure trustworthiness (Sandelowski, 1993) and to describe a plausible human experience with its attendant meanings (van Manen, 1990). The aim is to be true to the data, to convey the essence of a phenomenon, rather than to claim a truth about the data.

Trustworthiness in this study was ensured through the application of the criteria for rigor in feminist research established by Hall and Stevens (1991), with slight revisions reflecting the interpretive paradigm. Dependability and adequacy are used as measures of rigor in feminist research, replacing the empiricist concepts of reliability and validity. Dependability was ascertained through careful examination of the analytic process. Auditability of the analytic process was established by frequent and complete documentation in memos, including my impressions and reactions to the interviews, as well as memos about the analysis itself.
Adequacy concerns the whole process of inquiry and the outcomes, not just issues of measurement within a study. Hall and Stevens (1991) described ten criteria for adequacy: reflexivity, credibility, rapport, coherence, complexity, consensus, relevance, honesty and mutuality, naming, and relationality. Reflexivity is the responsibility of the researcher, and entails deliberation on the processes and decisions involved in the study. In this cross-cultural study, reflexivity was demonstrated in the careful consideration of the influences of culture, of both the informants and myself as researcher, in the research process. This is elaborated on below in the section entitled Reflections.

Credibility, coherence, and consensus pertain to faithfulness to the raw data, and were established through the three approaches to thematic analysis. Additionally, careful attention to the interpretation, transcription, and translation processes was imperative, given the dual languages included in this study. It is possible that the number of research assistants involved in this project as interpreters, transcriptionists, and translators may have negatively influenced the credibility of the raw data. However, thematic analysis pertains to experiences, which were captured, not to the specific words used to convey the experiences. I reviewed the Spanish versions of the transcripts and listened to the audiotapes as part of the data analysis process, to ensure that I understood the experiences as described by the women.

Rapport is a measure of adequacy in accessing the informants’ reality. This was enhanced by conducting interviews in Spanish whenever preferred by the informants, either directly or by using an interpreter, as well as through sensitivity to cultural values and differences, emotional vulnerability, and safety concerns. In one case, I obtained
permission from an informant to discuss information she gave me with her attorney, as she had an immediate safety risk that she had not discussed with her. In another case, the informant was emotionally distraught throughout and following the interview. Together, she and I constructed a plan for mental health follow-up care. These actions also served to promote relationality, honesty and mutuality. Reduction of power imbalances was enhanced by my flexibility in the interviews, following the lead of the informants, and encouraging the creation of meaning by the informants.

Complexity, relevance, and naming concern adequacy in capturing the informants' reality, both in the context of their lives, and in the context of broader political, social, and economic structures. These criteria are particularly important in considering the reality of battered Latina women's interactions with health care providers. A full understanding of the complexity of these interactions, particularly relative to power dynamics, was sought through expanding data collection and analysis beyond the primary content of the research question, as described above.

The challenges to rigor included perceived power imbalances and the influence of cultural values between me and the informants. Battered Latina women are theoretically in positions of feeling disempowered physically, economically, and socially. Feminist research approaches were used to maximize rigor, in terms of dependability and adequacy, in studying this population. The focus on reflexivity, relationality, and complexity directly addressed challenges to rigor inherent in this study. Further, rigor was ensured through the process of challenging my assumptions over and over. The
purpose of acknowledging the researcher’s assumptions and biases is so that they can be challenged throughout the analytic process.

Protection of Human Subjects

Written approval to conduct research at the two participating sites was obtained from the executive directors of each organization prior to the beginning of the study. Institutional review board (IRB) approval was obtained from Boston College in October, 2001, and renewed annually until the completion of the study. Informants were provided with oral and written informed consent forms in their primary language. Informed consent was obtained from each informant following screening for inclusion in the study, but prior to any data collection. IRB approval was also obtained from the Massachusetts General Hospital (MGH) in June, 2003, when it became required because of my status as an MGH employee.

All of the informants were assigned pseudonyms, which are used in all public discussion and writing relative to this study.

Reflections

On the Interview Process

After I had conducted several interviews, I had several reflections about the interview process, from my perspective both as a researcher and as a clinician, particularly in the context of the data I was receiving. The interview process in many ways mirrored the clinical encounter, in its deficits, not its strengths. There are two ways in which I observed this: the first related to how I conducted the interviews, at least
initially; the second was how I thought and felt about the informants, based on their presentations.

I had initially set up the interview process to begin by collecting demographic information, then proceeding with questions from the interview guide. I quickly learned to start the tape when we started talking at all, because the women were not just responding to the questions, but started story telling very quickly. A theme that emerged quickly in the interviews was the problem of providers just jumping in and addressing any medical concerns “What are you here for today?” and not taking the time to talk personally with the women by asking them general questions about themselves, their lives, their families. The women talked about wishing their HCPs would platicar, meaning to talk, to chat, as a means for establishing rapport and connection.

I realized that I was, in fact, doing the same thing! While I was not nearly as directive as in a clinical interview, I nonetheless started out with a few demographic questions, then quickly jumped over their life stories of the abuse itself, and went right to health care experiences! I noticed that most of the informants warmed up after a while, but I thought that warm-up could have occurred earlier! I realized I needed to spend more time conversing socially before I jumped into the content I was specifically seeking. This required continual vigilance on my part, as this did not come naturally, as focused as I was on conducting the interviews proper.

The second parallel had to do with noticing how I was reacting to and forming opinions about the informants. As I was writing memos on general impressions about two particularly engaging women, I realized how much I really liked both of them. I felt like
we developed rapport right away, had easy conversations, and that the interviews went very smoothly. This was in contrast to some of the other interviews, where, initially at least, it was like pulling teeth to get the women to talk, to offer their experiences, opinions, preferences. My “aha” realization was that this was in some way reflective of their personal comfort. The two women talked about regaining their self-esteem. They were proud of themselves for their accomplishments, and they were moving forward in their lives. The abuse was still there as an issue, but they were strong, opinionated, and earnestly wanted to help other women who have been abused. With a 4th and 8th grade education, they were both very articulate about their experiences. This was in contrast to some other women, who were still struggling very much with self-esteem, and in a few cases, safety. They were much more reticent in speaking, seeming not to believe that their thoughts and feelings were worth my time, the interpreter’s time, and tape recording. In all cases, the women warmed up by the middle of the interview, but some did not do very much reflection. I needed to provide encouragement and to stress my view of them as experts by virtue of their experiences to create a comfortable enough space for them to openly speak their truths.

This was a dynamic that I suspected occurs in clinical encounters. It is far easier for a health care provider to respond to a woman who can clearly identify and articulate her needs, and ask for help, than to a woman who stares at the floor or off into the distance, and answers questions monosyllabically. This particular issue has not been addressed in the clinical literature. The path to working with these women may well be this process of engagement, of showing interest in them personally, in their lives, and not
just in their symptoms, or even worse, strictly their diagnosed medical problems. As a clinician, it is sometimes easier to meet distance with distance, rather than to expend energy and time in trying to engage a reticent patient.

Benner (1994) described the strategies interviewers conducting interpretive phenomenologic studies should use to help participants tell their stories in their own words. “Conveying a genuine interest in understanding the participant, along with the use of natural language and communication contexts, increases the participant’s effort and ability to communicate,” (p. 112). These strategies seem to apply to enhanced communication in health care encounters as well!

As a researcher, I had 1-2 hours to establish rapport and engagement, rather than the typical 15 minutes of a clinical encounter. This extended time also allowed me to have a much better understanding of the women in the context of their lives, in direct contrast to clinical encounters. As I conducted the first few interviews, I was embarrassed and pained to realize how little I knew about how my patients thought and felt about their lives, even when I knew the particular circumstances of their lives. This was the beginning of my realization about how much patients want to be recognized as fellow human beings, how relational health care is for them, and how hurt they can be by the coldness of Western medicine and hurried and harried providers.

On Research Assistants

For reasons that require further investigation, many research assistants worked on this project for only short periods, resulting in high turnover. There were weddings and pregnancies, family and personal health problems, changes in employment and education
plans, and people who were overextended and needed to cut back on their commitments. The result was the involvement in this project of many individuals with disparate views and understandings.

Each research assistant brought her unique perspective, experience and skill to this project. As most of the research assistants were bilingual and bicultural, I solicited input from them. Many of the research assistants offered their impressions of the informants’ comprehension of my questions and my intended meanings, of the informants’ educational and class backgrounds, and of my ongoing data analysis. One bicultural, bilingual research assistant, who provided both interpretation and transcription services, the most highly educated of all, critiqued my research design as fatally flawed!

The world of the health care providers falls naturally far apart from the world of the Hispanic women. And your exploratory questions go further into how the professionals need to act to help them in cases of abuse. Your project as it is conceived has some degree or an angle of fatal weakness. At times it seems illogical to ask uneducated people who are suffering long-term consequences of enduring abuse what highly educated people should bring to the medical practice without hesitation. . . . There is an abyss between those Hispanic women with little education and Anglo health care providers. And it is an abyss that no exploratory question can repair. We apparently dissent on how education does affect brains. I don’t believe that uneducated women can bring any light to health care providers.

One research assistant provided advice to an informant throughout the interview. Another described to me the emotional toll of transcribing an interview at which she had not been present. The challenge for me was to remember to put all of the feedback I received and observations I made into the context of the research assistant’s own life and reactions to both the process and the content of data collection! Most of the research
assistants had a personal interest in the study, based on either cultural or experiential resonance with the topic.

On Interpretation Challenges

It is well understood that the processes of linguistic interpretation and translation are imprecise and variable. There are multiple ways to interpret and translate the same text, and all interpretations and translations potentially alter original meanings. The predictable challenges inherent in this study inclusive of two languages were exacerbated by the sheer number and varying perspectives of research assistants involved. The process of checking the translations for accuracy revealed the multiple interpretations that could be made about any individual piece of text.

One phrase was particularly problematic, and is emblematic of the potential for significant linguistic misunderstandings in the clinical realm. One of the women described her partner to her health care providers as having un carácter fuerte and un temperamento fuerte. She was upset that her providers did not react to her statement. In the transcript of the first interview, these phrases were translated literally as strong character. In the second interview, I asked her what she meant by carácter fuerte and temperamento fuerte. Her meaning was that he had a bad temper, that he would treat her badly, insult her and threaten her. When I asked several interpreters how they would interpret carácter fuerte, the responses included in a bad mood, sudden change in personality, getting upset for no reason, verbally aggressive, controlling.

There is clearly a significant difference in meaning in describing someone as having a strong character and a bad temper. If translated literally in a clinical encounter,
rather than expertly, this phrase would be misunderstood, leading to neglect of an important comment requiring follow up conversation. This raises concern for the possibilities of other important misunderstandings.

Advantages and Limitations of the Study Design

There were several advantages to this study design. The primary advantage of this study was the inclusion of Spanish-speaking informants. Their inclusion makes it possible for their voices to be heard in a way they have not yet been. This study elicited and brought forth the experiences and perspectives of battered Latina women, addressing a void in the literature and in health care providers’ understandings. The study design enabled the collection of detailed, salient, and highly personal data unique to the informants’ experiences. The design overcame threats to authenticity derived from my status as a health care provider. The informants’ privacy, confidentiality, and safety were protected. The process of conducting the research resulted in the development of community alliances which could be strengthened over time. At the completion of the study, I initiated conversations with the staff of both agencies about future projects to enhance health care access and services to battered Latina women.

A limitation of the study design was the exclusion of the perspectives of women currently in abusive relationships, particularly those who do not seek or receive health care, legal, or battered women’s services. I presume there is a population of women who are not helped by any system, and they remain out of our reach. Eliciting battered women’s experiences and needs as they are being abused may reveal differences from descriptions about those same experiences and needs provided with hindsight, from a safe
perch. A further limitation in the study design was my lack of fluency in Spanish. This created logistic complexities in data collection and the potential for misunderstandings, both in data collection and data analysis.

In the next chapter, I will describe the informants, as a group and as individuals, and present the findings from this study.
CHAPTER 4

Findings

Introduction

Fear, worry and uncertainty permeated the women’s lives. They were trapped, caught in catch-22s, in which they risked harm and death by staying with or by trying to leave the abusers. Their fear of the abusers and of the abuse was matched by fear of detection or disclosure of the abuse to health care providers (HCPs). Worry about their and their children’s well-being was unremitting. They attempted to manage the abusers to avoid conflict, and to manage health care encounters to avoid detection. They lived their lives beneath the radar, avoiding the attention of anyone they thought could cause themselves or their children harm: the abusers, their HCPs, children’s protective services (DSS), the Immigration and Naturalization Service (INS), and the police. Their uncertainty about the future and of abuse to come was matched by uncertainty of how to get help, and even the consequences of trying to get help. They feared escalating abuse, loss of custody of their children, of deportation, police involvement, and economic ramifications.

Despite these pervasive fears and the risks involved, the women wanted to be asked about abuse and to receive help. They longed for someone else to take control of their out-of-control situations. Dropping hints and giving clues to their health care providers failed to garner the support or help they needed. On the contrary, many found their health care providers to be uncaring, untrustworthy, and unhelpful; they rued these missed opportunities for discussion about the abuse and for help they never received. A
feeling of safety was critical to direct disclosure and had several requisites: knowing that their providers cared about them personally, trusting their providers, receiving concrete information about the consequences of disclosure prior to any disclosure, and needing to be asked about IPA, either directly or indirectly. If any one of these components was missing, in most cases, they did not disclose.

These women’s lives were complex, and rife with conflict and danger. Living in dangerous homes in a world that was not their own, mothering their children was a heartfelt responsibility against which all of their decisions and actions were weighed. For most, fully realizing the harm to their children caused by the abuse was the impetus for leaving the abuser. For others, escalating violence and imminent physical danger that threatened to leave their children motherless motivated them to act to escape their abusers. They struggled to gain strength and move forward in life, long after separating from the abuser.

This chapter begins with a description of the sample, and a brief introduction to each of the women. This is followed by findings about the women themselves, the defining roles and experiences of their lives, which contextualize both their experiences of being abused and their health care experiences. As their experiences of health care cannot be understood without understanding their lives as battered women, findings about living and leaving the abuse are presented next. Finally, the women’s experiences of health care will be described.

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Description of the Sample

The seventeen women had found their way to either a battered women’s services agency or to a legal services program specializing in services for battered women. They ranged in age from 19-53 years old. Spanish was the primary language for 13 of them. They came from six countries: Colombia (n=5), Puerto Rico (n=5), Honduras (n=2), Mexico (n=2), Salvador (n=2), and Guatemala (n=1). They had been living in the United States (US) for a range of 2-23 years. Eight of the women were undocumented, five were US citizens from Puerto Rico, and four were residents. They had been in their most recent abusive relationships for a range of six months to 23 years, and out of the abusive relationships for a range of three months to four years. Their years of education ranged from 4-14. The eight women who had ≤8 years of education all spoke Spanish only. Six of the seven who had graduated from high school spoke English and Spanish, with the exception of one woman who only spoke English. All of the women had at least one child, with a range from 1-4 children.

Introduction to the Women and Their Lives

Sara was 26, from Honduras, Spanish-speaking only, undocumented, and had been living in the US for 2 years. She had 2 children living in Honduras, and was pregnant during the study. She married the abuser less than one year after they met, after she became pregnant. He verbally abused her prior to their marriage, and he hit her for the first time a few weeks after they got married. The second time, he beat her so severely she nearly had a miscarriage. She called her brother and the police, he was arrested, and she was brought to the emergency department (ED). Sara obtained a restraining order,
and the abuser was jailed for several days. She had been separated from him ever since, though in hiding. She had very supportive siblings who had been in the US for years, and who were fluent in English.

Maria was 39, from Colombia, Spanish-speaking only, had been living in the US for 14 years, and was in the process of obtaining legal residency. She had been married to the abuser for 11 years, and had left him 4 years prior. She had 3 children, all living with her. She had no family in the US, knew only the abuser, his family, and mutual friends. Both the abuser and his family had threatened to kill her or her children if she attempted to leave. She endured years of physical abuse, sustaining multiple injuries for which she never sought treatment. She decided to leave after being attacked by the abuser with a knife, nearly being killed. She secretly escaped the next morning, taking her children in a taxi to a neighborhood health center where she knew there was a social worker. The social worker had come to her English class one year prior and had talked about domestic abuse. From there she went directly to a shelter, and after several months, on to a transitional apartment.

Rosa was 36, from Colombia, Spanish-speaking only, and undocumented. She had lived in the US for a total of 15 years, having returned to Colombia several times. She had 3 young children, all living with her. She had been living with her partner for 14 years; they never married. The abuse, both emotional and physical, occurred primarily within the previous 3 years. He would often choke her, causing her days of pain and difficulty swallowing. She stayed in the relationship primarily because of economic concerns. She had a 7th grade education, few job skills, and 3 young children to care for.
She was afraid, both before and for nearly 2 years after their separation, to take any action that would anger the abuser, i.e. requesting child support. Immediately following the second interview with me, Rosa met again with her attorney, and decided to pursue all available options for securing safety and economic security for herself and her children. She went on to speak out about her experience in public forums, both locally and nationally.

Julia was 30, from Mexico, Spanish-speaking only, undocumented, with a 6th grade education. She had lived in the US for 11 years. She had been with the abuser for 6 years, and had been separated for more than 3 years. She had one daughter, age 8, who lived with her. The abuse was primarily psychological, he threatened to kidnap her daughter and get her deported, or kill her if she told anyone about the abuse. They fought often, hitting each other. She left him after he had several affairs, he gave her a sexually-transmitted infection, and their fights became more frequent. She moved to another state where she had a few friends who helped her.

Iliana was 36, from Colombia, Spanish-speaking only, with a 4th grade education. She had suffered a lifetime of abuse, and had started working at age 9. She came to the US in order to provide financially for her 3 children in Colombia. She immigrated illegally, and unknowingly served as a mule. She was arrested at the airport in Miami, and after much difficulty, was allowed to leave the state, on probation. She met the abuser on the day she arrived in a new city, having been abandoned by her travel companion. He took her in, and she felt indebted to him. She became pregnant within a few months of meeting him, and they got married. He started beating her the week after
they got married. She stayed with him for 2 ½ years, leaving after a severe beating during which she called the police. She endured severe emotional and physical abuse from him, beatings and being dragged around the house by her hair. Between the 1st and 2nd interviews, she returned to him for one month because she had no where else to go. He raped her on the day they returned to court about child support, and she became pregnant again, one week before her subsidized apartment became available.

Sylvia was 36, from Colombia, Spanish-speaking only, undocumented, with an 11th grade education. She had been with her partner for 11 years, they had never married. She had 3 daughters, all living with her. She lived in the US for a total of 15 years, having returned to Colombia twice. Her boyfriend brought her to the US and she felt indebted to him. She was alone without her family or any friends. He became emotionally abusive once she was in the US, and began hitting her several months after her first daughter was born. The physical abuse continued for years until she fought back. She hit him in the groin, and he was hospitalized for 7 days. He never hit her again, but the emotional abuse continued. She obtained a restraining order and separated from him completely after an episode in which he took the children out of the house in their pajamas, the police were called, and a children’s protective services case was opened.

Ana was 26, from Mexico, Spanish-speaking only, undocumented, with a 7th grade education. She experienced intimate partner abuse (IPA) with a previous boyfriend, and had been raped as a child in Mexico. She came to Massachusetts with her boyfriend at age 17. He immediately became controlling and emotionally abusive; he isolated her completely. He hit her on one occasion. Ana was with him for 6 years. She left him after
seeing flyers that described domestic abuse, but did not obtain a restraining order until 3
years later, because she did not want to cause him any harm. He then stabbed her current
boyfriend, and she went to a battered women’s shelter. She was forced to leave the
shelter after a rule infraction, and he began stalking her. A few months after the first
interview, she relocated to a battered women’s shelter in another state. Several months
later, she returned to Massachusetts.

Manuela was 52, from El Salvador, Spanish-speaking only, had a 7th grade
education, and had been living in the US for 19 years as a legal resident. She was forced
as a young woman to marry the abuser after he raped her; she was with him for 23 years.
She had 2 sons, both in their 20s. She endured horrific psychological, physical, and
sexual abuse from the beginning of their relationship, and sustained many injuries
requiring hospitalization. Her children also suffered abuse at his hands. She got out of the
relationship more than 2 years prior to the first interview, after an episode in which he
beat her. She called a Latino social service agency, and they called the police. She
obtained a restraining order, went to court to continue it, and in the process met an
advocate from a battered women’s services agency. The abuser persisted in abusing her
emotionally and economically long after the separation, and she continued to suffer
psychologically.

Herminia was 53, from Puerto Rico, Spanish-speaking only, and had a 5th grade
education. She experienced severe childhood physical and sexual abuse. She had been
living in the US for 23 years, and was married to the abuser for 22 years. She had 4
grown children. She endured on-going psychological, physical and sexual abuse by her
husband, resulting in disability, depression, confusion, and other medical problems. She did not seek health care for her injuries because he had threatened to kill her if she did. She escaped the abuse after he inflicted a severe head injury. The police were called, she was admitted to the hospital for surgery, and then moved in with her daughter. He continued to threaten her. Shortly after the first interview, she went to a battered women’s shelter.

Delia was 34, from El Salvador, Spanish-speaking only, had a 10th grade education and had been in the US with legal residency for 11 years. She had been married to the abuser for 14 years, and had 3 children, all living with her. She described the abuse primarily in terms of him having an affair for the previous 2 years, and abusing her emotionally during that time. She left the relationship as a condition of regaining custody of her children from children’s protective services. Her children were removed from her care after the oldest daughter told a teacher that her father had beaten her. He underwent voluntary counseling, and Delia was considering reconciliation with him.

Magdalena was 30, from Puerto Rico, bilingual in Spanish and English, with 13 years of education. She was married to the abuser for 8 years, and had 2 sons, a 9 year old, and a 6 year old with a developmental delay. He abused her emotionally and physically throughout their relationship. She had tried to separate from her husband for the last 5 years of their relationship, but remained with him because he threatened to kill her and any new partner. She escaped the relationship by moving to the US, ostensibly to get better medical care for her son. He visited on several occasions and threatened her.
She accessed support services and legal help through her cousin’s wife, who worked for a battered women’s services agency.

Rita was 28, from Honduras, bilingual in Spanish and English, and immigrated to the US without documents at the age of 6. She subsequently became a legal resident. She had 14 years of education, and was enrolled in college. She had one daughter, 11, living with her. She had been in 2 abusive relationships, the first at age 15, lasting 2 years, and the second at age 21, lasting 3 years. The first involved emotional, physical, and sexual abuse, and the second primarily psychological abuse. She left the first relationship for good after he threatened her with a gun. She left the second relationship after realizing that the abuse was affecting her daughter. At the time of the interview, she was working as a legal advocate for a battered women’s services agency.

Carol was 20, from Puerto Rico, had been living in the US for 15 years, and was fluent in English only. She had a 3 year old son, who was living with her. She was with the abuser, her boyfriend, for 6 years, starting at age 14. Her baby was born 2 months prematurely, as a result of him throwing her against a cement wall, and her water broke. The physical abuse escalated when she moved with him to another state, where she had no family. She never disclosed the abuse, for fear that her child would be taken away. She fought back, both verbally and physically. She left him a few times, and left for good after a terrible fight in which she realized that he might kill her. She called the police, but did not follow up in court. She returned to Massachusetts to get away from him. He was incarcerated.
Serena was 25, and born in the US of parents from Puerto Rico. She was fluent in English and in Spanish, and had an Associate Degree. She was with the abuser, her boyfriend for 6 years, from ages 16-22. She had a daughter at 18, who was living with her. The relationship involved mutual verbal and physical fighting, which she did not see as abuse at the time. She left the relationship when she realized that her daughter was being affected by the violence in the household, shortly after a big fight to which the police were called. She later came to see the relationship as abusive, as a result of conversations with other battered women.

Sheila was 32, from Puerto Rico, had lived in the US for 19 years, was bilingual in Spanish and English, and had 13 years of education. She was in 2 abusive relationships with intimate partners. The first relationship involved emotional and psychological abuse, and the second involved psychological as well as physical abuse. She had 2 daughters. Her first husband had custody of her 10 year old daughter, and she had custody of her 14 month old daughter. She was with her second husband for 2 ½ years. She had lupus, and was diagnosed with major depression. She had one suicide attempt, for which she was hospitalized, and then sent to a group home. She left her second husband when the abuse escalated from pushing and shoving to punching, kicking, and choking. She was in hiding, as he continued to threaten her.

Lilia was 19, from Colombia, spoke Spanish and some English, and was undocumented. She came to the US for a visit with her aunts for her 15th birthday, and her mother would not let her return home. She moved to Massachusetts where she had a cousin. She met the abuser, who was 15 years older than she, on the first day. He gave
her a job, and then asked her out. She was with him for 3 years, during which time he emotionally and physically abused her. Both he and his family threatened her with deportation if she reported the abuse. She called the police on 3 occasions, he was incarcerated twice, and she was placed in the custody of DSS. She returned to him when he was released, leaving foster care with a falsified birth certificate. She had a child at 17, and was forced by DSS to leave the abuser, maintain a restraining order, and participate in battered women’s support services in order to have her son with her, though he remained in the legal custody of DSS.

Cecilia was 35, from Guatemala, lived in the US for 16 years, and was a citizen. She was bilingual in Spanish and English, and had started college. She had been with the abuser for 13 years, and had 2 children, who were living with her. She endured emotional, physical, and sexual abuse from him. The first time he hit her was when she became pregnant, one month after they married. She left him several times, but was convinced to go back by both families. She left him for good after seeing the effect of the abuse on her children, and immediately after a particularly violent encounter where she feared for her safety and that of her children. He continued to violate the restraining order, and to fight her through the court system.

*The Women: Life’s Challenges to a Sense of Self*

The women’s sense of self was both created and challenged by the importance to them of being a mother, their cultural backgrounds, their previous exposures to abuse, their immigration travails, and their immigration status. They found themselves in dangerous abusive situations with their children, trying to reconcile their sense of
responsibility as mothers with their cultural values, including familialism, and for some, machismo. The abuse was reminiscent of previous experiences with abuse for some. Being immigrants, whether documented or undocumented, placed them in an unfamiliar world, often alone and without support. “De no saber el idioma, de estar en un país que no era el mío, de no tener familia, o sea, el mundo nuevo para mí, totalmente nuevo, y estar en esos problemas . . .” “Not knowing the language, being in a country that was not my own, not having any family, you know, and it was a new world for me, completely new, and to be having all those problems . . .” (Sylvia)

Women’s sense of self is primarily relational, according to the relational model evolving from the work of Jean Baker Miller (1976) and Surrey (1985). Women develop their sense of self through their ability “to make and then to maintain affiliation and relationships” (Miller, 1976, p. 83). This view of the development of sense of self is essential to understanding the needs of battered women. The women’s sense of self was constantly at stake, and strongly influenced how they experienced both the abuse and their encounters with health care providers.

*My Children Above All Else: Being a Mother*

Mothering was the most important aspect of these women’s lives. This profound responsibility to and for their children guided their every move. Their primary goals in life were to attend to their children’s needs and to secure their well-being. Many came to the United States seeking a better life for their children. They put their children’s needs before their own, making often difficult decisions and personal sacrifices for the sake of their children. Several of the women stayed with their abusers, believing that their
children needed a father, despite their personal suffering. They hid the abuse from others in order to maintain the family unit. These same women left their abusers when they realized the damage to their children’s well-being the abuse was causing. Iliana initially did not disclose the abuse to anyone, out of fear for her children’s well-being.

_Temor de que si yo digo, que él es violento conmigo. ¿Yo voy a ir a dónde? Yo voy a perder mi trabajo, yo tengo tres hijos en Colombia, por quien yo debo trabajar llueva, truene, o relampaguee, haga lo que haga yo tengo que trabajar para sostener a mis hijos en Colombia. Yo prácticamente el temor era de que, si yo no tenía una vivienda, de qué si yo perdía mi trabajo, ¿qué iba a ser de mis hijos? ¿Qué iba a hacer yo con un nuevo bebé que yo tenía en mi vientre? Yo tenía que sobrellevar la situación, porque no podía echarlo todo a la borda, porque no soy sola, somos cuatro._

Fear that if I say that he is violent with me, where am I going to go? I am going to lose my job. I have three children in Colombia I need to work for, come rain, thunder or lightning. Whatever happens I have to support my children in Colombia. Practically, the fear was that I didn’t have a place to live, that if I lost my job, what was going to become of my children? What was I going to do with a new baby that I had in my womb? I had to rise above the situation, because I couldn’t throw it all away, because I’m not alone, there are four of us. (Iliana)

She left the abuser when she came to understand that she could take care of herself and her children economically without the abuser.

_A Woman’s Lot in Life: “Girls always end up getting hit.”_

The degree to which and the ways in which culture influenced these abused women varied. Most of the women described IPA as a normative behavior within Latino cultures. “Girls always end up getting hit.” Some described IPA as culturally accepted, particularly by older generations and newer immigrants to the US. Cecilia described being raised by her grandmother, who allowed her two brothers to hit her, but she could not hit back. When her mother, who was working in the US, learned this, she put an end
to it. During the time they were being abused, several of the women believed that their friends and family would either condone the abuse or blame them for it if they were aware of the abuse, based on cultural norms, and the idea of machismo. Others considered it normal themselves. “En México existe esa palabra machismo. Los hombres beben, que los hombres pueden hacer, que los hombres pueden todo... Entonces yo tal vez vi el control de Carlos, lo vi normal, porque yo crecí controlada.” “In Mexico, there is the word machismo. That the men can drink, that the men can do, the men can do what they want... I saw Carlos’ control as normal, because I grew up being controlled.” (Ana)

One woman described how the close-knit nature of the Latino community made seeking help very risky, in terms of lack of confidentiality. She was sure that if she was seen going to a group or taking a phone number that the abuser would find out, and she would suffer consequences. Many women described concern with public appearance and reputation as culturally important. “You try to seem like you’re fine, even when you’re not” (Magdalena). Because of this, many of the women never even considered disclosing the abuse to HCPs, friends, or family members.

La pena con que uno está viviendo, esta realidad, entonces también a veces uno tiene pena, vergüenza, decirles si he sentido abusada, o me está golpeando y no puedo hacer nada, quizás también por eso uno no puede decir, y muchas Hispanics somos así que no queremos decir, no queremos decir, ¿por qué? Porque la vergüenza...

The shame of what one is living with, this reality, then at times one is embarrassed to say to them that I have felt abused, or he is hitting me, and I can not do anything, perhaps also for that, one cannot tell. And many Hispanic women are like that, we do not want to tell, we do not want to tell, why? Because of the shame... (Julia)
Several women discussed cultural influence in terms of family values and upbringing. A few of the women were stunned by the abuse when it first occurred, as they had no familial context for it. Sylvia thought she was the only woman being abused, as she had never been exposed to family violence before her marriage. Others had experienced domestic abuse as children, and felt this caused them to view their abuse as adults as normal.

*Previous exposure to abuse.* One-third of these women had been abused as children; a few of these by previous partners as well. They identified their previous experiences with abuse as strongly influencing their self-esteem and expectations in relationships. The combined effects of cultural and familial norms as they knew them and direct experiences of abuse led them to consider the IPA normal and themselves to blame. They described continued difficulty with self-esteem, in trusting people and reticence to discuss their personal problems with anyone.

_Living Beneath the Radar: Undocumented and Undetected_

The tremendous fear of being discovered and deported persisted for the eight women who came to the US unofficially and remained here as undocumented residents. They lived their lives in confined social and geographic circles, trying to remain invisible to official systems and personnel. This need to be invisible permeated their lives, causing them to approach interactions with outsiders, including HCPs, with caution and personal withholding. Language barriers and their avoidance of official agencies left many of them ignorant of their rights and of the laws that would protect them.
Two of these women had extremely difficult and emotionally wrenching experiences of immigrating. The betrayal and disappointment they felt contributed to their lack of trust in individuals and systems within the US. Iliana, who was arrested upon her arrival in Miami, felt mistreated by US laws and officials, and had difficulty finding help. She was jailed for 23 days, and released without clothes, shoes, money, or any of her documents.

_Eso lo aprendí yo aquí en este país. Porque cuando yo salí de la cárcel yo salí tan lastimada. Y yo iba allí buscando ayuda contando lo que me estaba pasando lo que me había pasado. Y yo buscaba hablar con un abogado, buscaba hablar con alguien quien me ayudara a encontrar mis derechos. Y que me escucharan, eso para mí era horrible lo que me había pasado y la injusticia que se había cometido y como que todo el mundo como que se burlaban de mí. Como que “está loca.” Yo llegaba llorando. Y lloraba y yo creo que el primer año que viví en este país fue de lagrimas. Como que yo valía tan poco. Como que lo que me había pasado a mí era como tan insignificante para la gente. Insignificante o sea que no tenía valor. Entonces ya lo empecé a ver así._

I learned that here in this country, because when I got out of jail, I was so hurt and I was looking [for help] and I would go there to tell what had happened to me . . . and I was looking for a lawyer, I was looking for someone that would listen to me, that would help me understand my rights, but whoever I told what was happening to me, it was as if they were laughing at me or saying, “Oh this woman is crazy.” I would come home crying and I used to cry and cry, and I think that the first year that I spent in this country was pure tears. It was like I was worthless, that what had happened to me was so insignificant to others, like it wasn’t important. So I started to see it that way. (Iliana)

From childhoods in which they were abused themselves or witnessed abuse, being raised to believe that women always get hit, to immigrating to a foreign land, and trying to mother and protect their children, these women faced tremendous challenges to their sense of self, layering them in veils of invisibility.
Being Battered

Alone, Abused, Afraid, Nowhere to Turn

Fear dominated the day to day lives of these women, who were abused and isolated and felt they had nowhere to turn for help. They feared their abusers and the abuse to come. They worried about threats made by their abusers that if they disclosed the abuse to anyone, including family and friends, but particularly to anyone with an official role, i.e. police or HCPs, they or their children would suffer more severe abuse or be killed. The women were threatened with deportation of themselves or their abusers, the loss of their children to the abuser, to his family, to DSS, and to immigration, harm to their families, and lack of economic and personal resources to survive. Lack of knowledge about their rights, applicable laws, and available resources and support led the women to believe the threats. These threats held even more power over the undocumented, non-English speaking women, who were more likely to be completely isolated, in some cases not knowing a single person other than the abuser and his family.

Casi siempre, lo que él me decía que si yo le decía a alguien lo que nos estaba pasando, que a él lo iban a arrestar, que lo iban a deportar, que cuando lo deportaran a él, él se iba a mi país, a Colombia y que iba a matar a mi familia . . . me amenazaba y yo tenía mucho miedo. Él me decía que él iba ir preso, pero cuando saliera preso, me iba a venir hacer mucho daño a mí, que él no iba a durar toda la vida preso, que cuando él saliera, iba a tener yo consecuencias y bueno me atemorizaba tanto.

Almost always what he told me was that if I told someone what was happening that he would be arrested, that he would be deported, that when he was deported, he would go to my country, to Colombia, and he was going to kill my family . . . he threatened me and I was very scared. He told me that he would go to jail, but not for life, and when he got out of jail, that I was going to suffer consequences and, well, that terrified me a lot. (Iliana)
For some, the fear of the abuse itself, and the physical dangers involved, kept them silent.

Rita hid the IPA she endured as a teenager from her family and some of her friends who had told her they would beat up her boyfriend if he hurt her.

So I would always try to protect him, because he always used to threaten me with it. If you ever tell your friends, if your friends ever come after me, you’re really going to be sorry . . . and I believed it. I was protecting myself. (Rita)

Despite their fears, many of the women were economically, logistically, and/or emotionally dependent upon their abusers. They were unskilled, under-educated, and each had at least one child to care for. One woman felt both economically and emotionally indebted to the abuser because he had paid her immigration expenses. “He told me, ‘You have to do whatever I say because you cost me a lot of money.’” Others were logistically dependent, alone, Spanish-speaking and in a new country.

_Tuve miedo, tuve miedo de que él me dejara, de no saber el idioma, de estar en un país que no era el mio, de no tener familia, o sea, el mundo nuevo para mí, totalmente nuevo y estar en esos problemas, porque él me decía, “Tú no eres capaz de dejarme. Tú no eres capaz de salir sola adelante, tú no puedes.” O sea, esto lo hace como que, yo decidi estar aquí, no puedo, yo sola, si me entiendes, entonces._

I was afraid, afraid that he would leave me. And not knowing the language or being in a country that was not my own, not having my family, you know, and it was a new world for me, completely new, and to be having those problems. Because he would tell me, “You’re not capable of leaving me. You’re not capable of going on your own and making it in life, you can’t do it.” So, all of that kind of like made me feel like, no, I really cannot do it on my own, if you know what I mean. (Sylvia)

All of the women experienced both psychological and physical abuse, in varying degrees of severity. Some suffered sexual and economic abuse as well. The psychological abuse was consistently described as both harder to endure and to heal from than the
physical abuse. "It [psychological abuse] hurts more because it stays with you forever. A slap will go away. A cut will heal, but mental abuse, it doesn’t go away." (Sheila)

Feelings of desperation and despair were common, as women experienced the loss of their self-esteem and shattered dreams. One woman, who was 17 years old when she met the abuser, described the effect on her of the isolation and control he exerted once they moved to a new area,

_Cuando yo llegué [aquí] yo tenía deseos de superarme. . . . Y yo vine a él a comentarle la alegría que yo sentía que yo iba a comenzar la escuela. El me dijo "No, tú no vas a la escuela. Tú ya no estás para eso. Tú tienes dos hijas y vas a tener otro. Tú estás para la casa y para cuidar los niños. O sea que no va." Así que desde ahí yo empecé a dejar de ser lo que tal vez yo quería ser._

When I arrived [here], I had dreams to become someone, to excel. . . . And I commented to him how happy I was that I was going to start school. He said to me, "No, you’re not going to school. You’re not here for that. You have two daughters and you’re going to have another one. You’re here for the house and to take care of the children. In other words you’re not going." From that point on I began to stop being what I wanted to be. (Ana)

Two women, who had endured horrific abuse for more than 20 years, experienced persistent depression, symptoms of post traumatic stress disorder (PTSD), and feelings of being destroyed by the abuser, both during the abuse and after they had separated. They both had multiple chronic medical problems, which they attributed in large part to the abuse. Other women experienced negative effects on their health, both emotionally and physically, including pain (headaches, back pain, arthralgias), gastrointestinal symptoms (nausea, vomiting, anorexia, weight loss and gain), and psychological symptoms (insomnia, anxiety, poor concentration). Recognizing the effects of the abuse on her health, Cecilia commented,
Even if I wasn’t sick, I was feeling sick. Because I went so many times to this doctor, maybe that’s why he said, “Oh, you’re fine,” because [I would say] “Oh, I have a headache,” or “Oh, I have a pain,” but it was like, maybe I was inventing that. But I felt it. I felt, like pains, and I felt very down, and I was feeling sick because of that.

The combined effects of the abuse, isolation, fear, and despair left many women feeling completely alone with nowhere to turn for help. “You want to talk, but you don’t know who to talk to. I was pregnant and scared.” For some of these women, these feelings were compounded by feelings of shame, embarrassment, and guilt about the abuse. Common responses included, “I was so embarrassed, I should have known better,” (Carol) “Sometimes I feel like I wasn’t good enough for him.” (Cecilia) A few of the women described additional self-imposed isolation in response to these feelings.

_Yo no hablaba mucho con mis suegros si no, me quedaba en casa, cuando estoy con muchas tensiones yo casi no hablo con nadie. Como si fuera muy encerrada en mi misma, lo tomaba más como para mi lo que estaba pasando en la situación. . . . Es una situación, en serio “¿cómo salgo de esto?” Fueron momentos que yo sentía muy mal, como si viviera una mentira._

I didn’t speak with my in-laws, instead I would stay home. When I have a lot of tension I hardly talk with anyone. It’s as if I was trapped within myself. I was taking what was happening as if it was only to me. . . . It’s a serious situation in which I was asking myself “How do I get out of this?” There were moments where I felt very bad, as if I was living a lie. (Rosa)

The women’s and the abusers’ families had powerful influences on these women’s lives, both overt and covert. In most cases, familial influences further isolated these women. In a few cases, the abuser’s family was an extension of the abuser, in terms of controlling behavior and threats.

_El lado de la familia de él estaba contra de mí. Decían que él era el hombre, que él podía hacer lo que quisiera, que podía tomar, que podía salir. ¿Yo no puedo acusarlo porque me van a matar a mis niños, ¿y yo qué hago? Quería escaparme_
de la casa, pero esperaba que no me hiciesen nada porque si él y su familia se enteraran, pues, que yo fui a la policía, me matarían.

His whole side of the family was against me. They said that he was the man, that he could do what he wanted, that he could drink, he could go out. I can’t accuse him because they’ll kill my children and what can I do? I wanted to escape from the house, but hoped they wouldn’t do anything to me because if he and his family found out about it, well, that I went to the police, they would kill me. (Maria)

Families’ complicity with the abuse manifested as blaming the women for the abuse, hiding the abuse from health care providers, and pressure to stay with or return to the abuser. Manuela’s sister, when she heard that the abuser had burned her with a pot of boiling water, commented, “I wonder if it’s you.” When Manuela’s brother-in-law brought her to the hospital several hours later, she lied about the incident at his insistence. He had told her that she would go to jail if she told the truth. Rita’s first boyfriend as a teenager was abusive. She left him for one month, but her mother convinced her to return to him “because he loved me and he was crying.” Only when he threatened her with a gun did her mother support her in leaving the relationship.

For women who believed their families would not condone the violence, the influence of their families was more covert. Most of these women hid the abuse from their own families, for a variety of reasons. Many wanted to spare their families from the suffering they knew knowledge of the abuse would bring, especially to their mothers. Others feared that informing their families would only worsen the situation, because their fathers and brothers would try to retaliate against the abuser. These women predicted that ultimately, this would only cause problems for their family members, escalate the abuse they were experiencing, or cause undesired harm to the abuser.
Staying, Then Leaving, for the Sake of My Children

The fears that had kept the women in the abusive relationships at some point propelled them out. Many of the women stayed in the relationships out of fear for their own and their children’s safety if they tried to leave. Ultimately, the painful realization of the effects the abuse was having on their children motivated them to act to escape the abuse. Witnessing their children behave like the abuser, “He [my son] started yelling at me just like my husband did,” or reacting to the abuser as they did, was for many women the last straw.

So they [children] were like really afraid too. I’m afraid and they are afraid and I saw my daughter crying. That was the day I felt bad because she was crying, the same way I was crying for the same brush. . . . My daughter was crying up and down because she couldn’t find his brush. I saw myself in her, and I said, she’s going to grow up thinking that’s right, and when she gets married, she’s going to be doing the same thing . . . so that’s what I wanted to change, give the children what they deserve. (Cecilia)

Other women left their relationships when their children’s behaviors revealed harmful effects of living with the abuse. Serena, who had tried to protect her daughter from witnessing or hearing the abuse, made the decision to leave when her daughter witnessed an incident in which the police were called.

She was starting to hear it and see stuff and I said oh no, because she knows. She can talk. She knows. She’ll sit there and talk about things, and I’m like, oh my gosh. Hearing him calling me, F-ing this F-ing that, you B. My daughter knows, “Oh, daddy called you bad names,” and she would tell people, and I was like, oh no, no, no. She’s catching up . . . and she still remembers that fight. (Serena)

Sheila, who endured years of abuse before her baby was born, left the relationship once she had a child to protect.
It's always hard, but I kicked him out before a couple of times, but I didn't have my baby yet. I tell [sic] him once I have my baby and you continue this behavior, my baby's not going to see any of it. So he did. So I kicked him out. I'm not going to put my baby through anything.

Two women left their abusers as a specific condition for regaining custody of their children from the Department of Social Services (DSS).

_Fear Kept Me With Him, Fear Got Me Out_

Fear of injury or death for trying to leave became fear of injury or death for staying, in some cases. Episodes of escalating violence and danger propelled some women out the door, fleeing with their children. They took immediate action to escape when they realized for the first time that they might actually be killed, usually following a particularly severe attack with a weapon. Herminia never returned to her abuser of 22 years after she required neurosurgery following a brutal assault in which he inflicted a head injury. Several women left their relationships after incidents in which “He went crazy.” They viewed these incidents as very dangerous for themselves and their children, and as indications that the abuser was out of control, and therefore unpredictable.

Then he was like “Oh, if I'm going to kill you, I'm going to kill the baby and I'm going to kill myself because ain't [sic] nobody going to have that baby either.” I was like oh my God. I was like he really means it this time. He's going to kill me. So I was like oh my God. Then I called the cops. (Carol)

One woman, Sara, left the abuser within a month of the first episode of physical abuse. She nearly had a miscarriage as a result of the assault; the abuser was jailed for six days, and she immediately obtained a restraining order. Unlike the other women in this study, she did not try to keep the abuse a secret, and did not feel responsible for it or ashamed. Her primary concern was her own safety and that of her unborn child.
However, like many other women in this study, her fears and her endangerment increased after she left him.

*Cuando recién me golpeó, sí, tuve mucho trauma, tuve como tres meses que, no podía salir, tenía miedo, perdí el trabajo que tenía porque él ya conocía mi trabajo, tuve que salirme del trabajo, y cada vez que salía a la calle tenía que andar con mi familia, que me acompañara, o sea, me ha costado mucho recuperarme.*

The first time he hit me, yes, I was traumatized, for three months I could not go out, I was afraid, I lost my job because he knew where I worked, I had to leave my job, and every time I went out, I had to have my family accompany me, so, it has been really hard to recover. (Sara)

*Gaining Strength and Moving Forward*

All of these women talked about their lives in terms of gaining strength and moving forward, trying to leave behind the tremendous fear, pain, isolation, and dependence of their lives with their abusers. They described varying degrees of feelings of freedom and independence, as well as continued emotional and financial struggles. The process of leaving the relationship was gradual for some of the women, and sudden for others, painful for some and excruciating for others. The endings of their relationships were preceded for many of the women by a growing awareness that they were being abused. Consciousness-raising occurred through flyers and posters, friends and relatives, health and legal professionals, and public media. Many women described a process of conquering fear and gaining strength prior to leaving the relationship completely.

Taking action of some kind, calling the police for the first time, fighting back, or finding the courage to talk about the abuse, gave some of the women a sense of control, safety, and strength they had not felt before. Iliana, whose abuser tried to force her to
leave the hospital one hour after giving birth, told him that the nurses were now looking out for her and were going to visit her at home, resulting in cessation of the physical abuse. She then felt able to start taking steps to be able to leave, for example, secretly saving money and looking for a room to rent. After she left him, he continued to harass her, but she felt confident in her decision.

_O sea yo ahora en este momento yo me siento segura de que él a mi me puede amenazar, me puede decir muchas cosas. Pero él a mi no me puede tocar. O sea en el momento que yo llamé la policía yo sentí que ya yo no estoy sola._

Now I feel like, now at this moment, I feel secure that he can threaten me, he can say whatever he wants to say, but I know that he can’t touch me. Since the moment that I called the police, since then I feel that I’m not alone. (Iliana)

Sylvia fought back physically during an assault, causing her abuser to be hospitalized for 7 days, effectively bringing an end to the physical abuse.

_Yo fui al hospital y le dije “Eso es para que a ti nunca jamás en la vida se te olvide que tú nunca debiste haberme pegado. Y si tú otra vez en la vida tú tratas de pegarme, yo te voy a dar en la misma lugar. Okay? Eso es para que cada vez que tú toques tu miembro te acuerdes de que a mi no me vuelves a pegar.” Y desde ese día no me volvió a pegar._

I went to the hospital and I told him “This is for you so you’ll never, ever forget that you never should have hit me. And if you ever in my life try to hit me, I will hit you in the same place, okay? That’s so that every time you touch your member, you remember never to hit me again.” And he hasn’t hit me since that day. (Sylvia)

He continued to abuse her verbally for several years, but did not ever hit her again.

For others, the process of gaining strength and moving forward involved smaller changes, painstaking decisions, and continued struggle even after separation from their abusers. Ana described the difficulty she had in ending the relationship. Only after three years of separation did she obtain a restraining order against the abuser, out of a desire to
avoid causing him problems or hurting him. Rosa’s story was one of trying to adapt and adjust to a series of unexpected negative experiences, change in her partner’s personality, the abuse itself, an unplanned pregnancy, and the lack of financial support and options after separating. Despite being very unsure of how to find help and manage on her own, she knew she had to move forward, primarily for the sake of her children.

Decidí, bueno vamos a hacer las cosas para otro lado y a pesar de que me duela tanto pero ya tengo que ponerlo un fin. Si ya no va a cambiar nunca, yo tengo que continuar con mi vida, no puedo quedarme tan poco por una eternidad. Yo sé que tengo que tratar de seguir así, sacar mis niños adelante, de que estudien, de que estén bien, bueno por ellos, porque por mi es como si me hubiera parado ahí.

I decided okay, we’re going to do things a different way, and even though it hurts a lot, I was going to have to put an end to it. So, if he is never going to change I have to continue with my life, I can’t stay here for eternity. I know I have to try to move on and raise my children, for them to attend school, for them be well, anyway, for them, because for me, it is like I stopped there. (Rosa)

The struggles that these women continued to experience after separating from the abusers were both external and internal. For those women who did not go into complete hiding, many of the abusers continued to abuse them economically, and to cause them legal problems by challenging child custody and support agreements, as well as property settlement agreements. Other abusers continued to harass them by telephone, for example by calling 50-100 times a day and hanging up without speaking, thus avoiding violation of restraining orders.

Ambivalence about their decisions to leave plagued some women, particularly as they witnessed their children’s painful reactions to the separation. “Sometimes I feel like I’m worse than I was, because my children, especially my daughter, she’s been very affected, especially now visiting [her father].” (Cecilia) Others struggled with self-blame
and guilt for enduring the abuse as long as they did, and for the lasting affects it had on their children. “Yo digo que él abusa, me destruyó y le dejé destruir a mis hijos. Eso es lo que no me perdono yo mismo. Bestia, es una bestia mi esposo.” “He destroyed me, and I allowed him to destroy my children. I cannot forgive myself for that. A beast, my husband’s a beast.” (Manuela) Many of the women blamed themselves for loving their abusers and thinking that they could change them. “Uno se deja de querer a uno mismo y se hecha la culpa de las cosas.” “One stops loving oneself and starts blaming oneself.”

(Ana) Others expressed regret for staying in the relationship as long as they did. Sylvia, who was so afraid that she had “gotten into trouble” when her HCPs suspected abuse, looked back and wished she had told the truth.

S: Porque si yo hubiera actuado, si yo lo hubiera demandado, o sea si lo hubiera mandado a la cárcel por haberme pegado . . . no me hubiera pasado lo que me pasó tantas veces.

UK: ¿Qué quieres decir con eso?

S: Si yo hubiera hablado en ese momento que él me pegaba, se hubiera parado de pronto tantos años de abuso.

S: Because if I had acted, reported him, sent him into jail for having hit me . . . all the things that happened to me so many times, wouldn’t have happened.

UK: What do you mean by that?

S: If I had said something at that moment that my husband was hitting me, I would have stopped so many years of abuse. (Sylvia)

Faith in God was a strong source of comfort and support for many. For Magdalena, faith was critical to her processes of surviving in the abusive relationship and of moving forward in life with her children after she left the relationship.
Sometimes I feel like I’m not going to make it. But then, I just think of my kids, they are my goal. And I said, if I don’t keep going just to the front, to the future, who’s going to take care of my kids? . . . So, every single day, I just say, when I wake up, “God help me, thank you for another day, thank you for my life, thank you for my children, take care of me, take care of them. Just show me the way that I have to go.” Because it’s not easy, I’m Mom, I’m Dad, my children are growing up only with me. (Magdalena)

Finding meaning in their experiences, both for themselves and others, was an important part of moving forward. Many of the women articulated a strong desire to use their experiences to help others. They informally counseled friends and acquaintances in abusive relationships, encouraged others in support groups, and viewed their participation in this study as a means to prevent other women from experiencing the difficulties they had, both in intimate relationships and in seeking health care. Sylvia had studied psychology in Colombia, and was hoping to continue her education some day.

Quizás un día puedo hacer mucho para otras mujeres lo que hicieron por mi, eso a mí me encantaría, definitivamente. Que me gusta, me gusta mucho, como sacar a esa gente de la depresión para ellas, y que tengan auto estima propio, y pues que se den cuenta que si pueden, eso es lo que me gustaría hacer, definitivamente.

Maybe one day I can do a lot for other women what was done for me, that’s what I would love, definitely. I would love that, I would really love that. To get these people out of depression and to give them self esteem and for them to realize that they can do it. That’s what I would like to do, definitely. (Sylvia)

*Experiences of Interactions with Health Care Providers*

Fear was the women’s constant companion. Isolated from loved ones, not knowing whom to trust, the only certainty in the lives of the women was fear. There was a high price to pay for living in fear. Some women paid with hearts that raced, stomachs that bled, hands that trembled, weight they could not control; fear always extracted a cost. Some women withdrew into themselves, the one place they knew was safe. Some
women’s fears were compounded by the fact that they were undocumented immigrants. Many of the women’s abusers had used this information as an additional club with which to beat them. The women, limited in their ability to speak English, were unaware of their legal rights.

Sara sought health care when she first arrived in the US, but left immediately when she was asked for her social security number. Later, her sister brought her to the emergency department (ED) following an assault by the abuser during her pregnancy. “I thought they were not going to help me,” because she was Latina, did not speak English, was not paying for her health care, and was undocumented.

What will become of my children, what will become of me, if I seek help for this terrible problem of mine? Will he finally kill me? Will they take my children? Will I get deported? The stakes were so high; the women could not have been in a more vulnerable position. The word vulnerable can be defined as “can be wounded, open to attack” (Webster’s New World Dictionary and Thesaurus, 2002, p. 711). These women were already so deeply wounded that to discuss the abuse with a health care provider would be to lay themselves open to being wounded again, even with the hope for help. Many of the women feared DSS and INS more than they feared the abuser.

Many of the women came to their health care encounters looking for help, for comfort, for human compassion. Unfortunately, they left without finding those things. Some health care providers were viewed as cold, uncaring, untrustworthy and not at all helpful. Despite their overwhelming fear, many of the women wanted to be asked about the abuse, but could not bring themselves to disclose it unless they were specifically
asked. “If you ask me, I will tell you.” Some encountered significant cultural and linguistic barriers, but found more pain and frustration in the interpersonal barriers, the coldness and aloofness that stunned them, coming from someone “who is supposed to care.” These women identified several requisites for feeling safe enough to disclose the abuse to a health care provider, as well as recommendations for improving HCPs’ identification of and response to battered Latina women.

“What will happen if I tell you?”: Fear of Disclosure and Detection of IPA

Tremendous fear of talking about the abuse and of “being found out” pervaded the women’s health care experiences. Uncertainty and misperceptions about the consequences of the IPA becoming known furthered their fear and worry. Fears revolved around reactions by the abusers and by the various official systems, i.e. DSS, the judicial system, and INS, that they believed would become involved. These fears were fueled by the abusers and paralleled and overlapped their fears of the abusers. The women feared the abusers themselves, feared the consequences the abusers threatened from various systems, and feared HCPs as the conduit for unwanted systems’ involvement. They could not discuss the abuse with their HCPs until they knew the answer to their critical and burning question, “What will happen if I tell you?” (Figure 1).

Many of the women believed that disclosure of the abuse to their HCP would set in motion a series of steps beyond their control, all with significantly negative consequences for themselves and their children. Some believed that their HCP would contact the abuser to confront him or to offer to help him. Others believed that the police would be called, either to arrest the abuser or to arrest them. Police involvement was
Figure 1: Parallel and Circular Fears of Abusers and HCPs

Disclosure/detection leading to HCP contact with abuser; DSS, INS, and police involvement

Abuse (Emotional, Psychological, Physical, Sexual, Economic); Threats of DSS, INS, and police involvement

Fear of Abuser

Fear of HCPs
believed to lead directly to the loss of custody of their children to DSS or to deportation of themselves or the abuser by INS. They worried that arrest or deportation of the abuser would lead to economic hardship, and that arrest or deportation of themselves would result in their children becoming motherless.

These fears of the abusers and of official systems kept the women from disclosing the abuse. Cecilia saw her HCP two or three times a month for management of depression and a variety of physical complaints. Her provider never asked her why she felt depressed, or screened her for IPA, though posted on the office wall was a flyer about domestic abuse. This flyer made her realize she needed help, but she did not tell her provider about the abuse.

It was always in his room . . . and it was in Spanish. I wanted to say something, but I didn’t, because I didn’t know what would happen, or what he would say. Because I couldn’t take it any more, I was pregnant again . . . I didn’t know what would happen to me because they say they have shelters or something and I said maybe they’re going to take me out of the house and they’re going to take my kids . . . oh! (Cecilia)

Other women hid bruises and injuries with clothing or makeup, or avoided health care all together in order to prevent detection of the IPA they were enduring. Julia did not seek health care when she was bruised because of the threats the abuser had made.

Yo no fui porque sabía que me iban a preguntar y yo no quería decir que había sido, pues, abusada. . . . él me decía que si yo decía algo o si lo mandaba a la cárcel o lo reportaba, o más que si le hacía algún daño que él me iba a quitar a mi hija, que él me iba a quitar a mi hija . . . que me iba a mandar a México y él se iba a quedar . . . por eso a veces no fui, no decía nada.

I didn’t go because I knew that they [HCPs] were going to ask me and I did not want to say that I had been, well, abused. . . . He [abuser] told me that if I told, or that if I sent him to jail or reported him, or better yet, that if I caused him any
harm, that he was going to take my daughter from me, that he was going to take my daughter from me . . . that he was going to send me to Mexico, and that he was going to stay here . . . because of that, at times I did not go, I did not say anything. (Julia)

Some women lied about what had caused their injuries or symptoms, particularly in emergency settings, often leading to misdiagnosis of their physical problems, as well as missed diagnosis of the IPA that caused them. Maria went to the ED after being thrown against a wall and being “out of it for two days.” She told her providers that she had fallen, and they diagnosed her with migraines.

Fear of DSS involvement overrode fear of the abusers, and was widely shared by both the Spanish and English-speaking women. DSS involvement was viewed as punitive, as “getting in trouble.” Even the English-speaking women, who had no particular fears of the justice system, worried that any information about abuse within their homes would result in the loss of custody of their children to DSS. Sheila, who lost custody of her older daughter to her first husband who was emotionally and psychologically abusive, felt penalized for being abused.

They [HCPs] get you in trouble. . . . As soon as a woman is in domestic violence, they all assume the kid is in danger, but I think that out of a hundred women that are being abused, I’m only one of them that will not let my kid see the abuse or get abused. . . . So you get scared sometimes and you don’t talk. That’s why I come to the groups. I talk in the groups. (Sheila)

Sylvia thought that DSS would take her children away with very little cause. In one incident, she believed that if the police thought that she knew her abuser was taking the antidepressant Prozac®, and she had left her daughters in his care for even a few hours, that her children would be taken away and put in foster care. When her HCP
suspected abuse when she arrived for an appointment with facial bruises, she was worried and frightened.

Me puse muy nerviosa cuando él me preguntó que me había pasado. Él me decía, “No tengas miedo, cuéntame qué pasa? Tu esposo te pegó?” Yo le dije, “No, no, no, él no me pegó, él no me pega.” Y él lo que hacía, era que hacía así, aahhh [frustrada] . . . Entonces me dijo que esperara un momento y salió y llamó a la trabajadora social y entonces yo dije “Ay, Dios mio,” Yo me metí en un problema yo pensaba, yo tenía miedo yo dije, “Oh my God, yo me metí en un problema.”

I became very nervous when he asked me what had happened. He said, “Don’t be afraid, tell me what’s going on. Did your husband hit you?” And I said, “No, no, he didn’t hit me, he doesn’t hit me.” And he was like, you know . . . aahhh [frustrated] . . . And, he said for me to wait a moment and he left and called the social worker and then and I said “Oh, my God.” I thought, “I’ve gotten myself into trouble.” That was what I thought, I was afraid. I said, “Oh, my God, I’m in trouble.” (Sylvia)

Two of the women were minors and pregnant during the time they were being abused. They feared double jeopardy when it came to DSS: being placed in DSS custody themselves, and losing custody of their children to DSS. Carol’s many health care providers in two states strongly suspected IPA. She knew that as a 16 year old with a child, she was being scrutinized as a parent. She repeatedly denied that she was being abused, even when asked multiple times. She felt she could protect her son better than DSS could, and always placed her son in a different room when there were physical fights.

Very few of the women were asked specifically about IPA. One woman disclosed the abuse to her health care provider, though did not tell her everything that had happened. None of the others explicitly disclosed the IPA spontaneously or in response to screening. The HCPs of two women who were seen emergently for serious injuries
caused by IPA were aware of the abuse. In Sara’s case, her English-speaking sister told the HCPs what had happened. Herminia’s head injury was witnessed, and she was unconscious when she was brought to the ED. The cause of her injuries was reported to the emergency department staff by others. She had previously avoided both routine and emergent health care when she had visible injuries, because her husband had threatened to kill her if she went. She believed him and felt afraid.

"If you ask me, I will tell you.": Despite Fear, Wanting to Be Asked

*Relinquishing control.* Though living in great fear of having the abuse publicly known, the women harbored the wish that someone, like their HCP, would ask them about abuse, or better yet, figure it out without them. Their fears did not preclude desires for help, or for a listening ear. However, they would not disclose the abuse unless asked.

“They didn’t ask, so I didn’t say anything.” A code of silence prevailed, maintained by both the women and their HCPs, with many of the women left feeling a continued sense of isolation and resignation. The women had a sense of waiting to see what would happen, what their providers would say and do. They relinquished control to their providers by maintaining a posture of “If you ask me, I will tell you.”

Lilia was receiving prenatal care when she was 16, and did not disclose the abuse.

“Actually if they asked me, I would tell them, but I was afraid. But if they don’t ask, that’s fine.” Her subsequent provider also did not ask her about abuse. “The only thing she’d say [was], ‘Why did you get involved with an older guy?’ Because he’s 34 and I’m 19. That was the only thing that she said.”
Many of the women went to appointments with HCPs hoping to or waiting to be asked about abuse. When the questions did not come, they remained silent. Sheila saw the same primary care provider (PCP) for years, often monthly, and knew this person longer than anyone else in the US. She wanted her PCP to ask her about abuse, but she never did, and Sheila remained hurt by that for years.

When you are still with the person (abuser), you don’t . . . sometimes you want to talk because you don’t know who to talk to. The person that I wanted to tell didn’t ask me, basically, which was the person that I knew for so long. (Sheila)

They didn’t ask, so I didn’t tell . . . . They never asked me why I was crying every day, they just wrote [sic] down . . . Sometimes you’re afraid to tell. But when someone asks you, and you feel that you can trust them, you could be able to talk. (Magdalena)

Sheila’s prenatal care provider did ask her directly about abuse, and she denied it, “I was pregnant and scared and I didn’t really know her that well.”

Some went to health care appointments intending to disclose, but remained silent based on the providers’ behavior. Cecilia went to see her PCP at least once a month, complaining of physical and psychological symptoms, and worried that she was “going crazy.” While she felt some relief in talking with her provider, she also felt minimized, and therefore did not disclose the abuse.

He spoke Spanish and sometimes I went with the idea of telling him what was happening. Because one day I remember, [MD asked] “Are you okay?” And I started crying, but I didn’t say and I remember the question in front of me, that sign and I said what if I tell him, because I wanted to tell him . . . . He was very nice. And I went like, twice a month maybe to talk with him. Because it was when I was having a lot of problems. So I feel release when I went. So he always said, “No don’t worry, you’re not getting crazy.” Because I went to talk to him many times, saying that I feel . . . that I was getting crazy because sometimes I didn’t even know what I was doing, like, I was very distracted, like always thinking, I didn’t want to go back home sometimes, because I was afraid something would
happen every time. And he said, “No, don’t worry, you’re not getting crazy.” He suggested to me to go and lose weight, because my husband was saying that I was out of shape or things like that. (Cecilia)

*Giving clues, “But no one understood what I was trying to say.”* In the absence of direct questioning by providers, dropping hints and giving clues was one way the women tried to prompt further questioning that would enable them to disclose the abuse. They attempted to initiate discussions about the abuse by raising the topic of their relationships or partners, but failed in these efforts. Several of the Spanish-speaking women described their partners as having a “caracter fuerte,” meaning bad temper, usually in a dismissive voice, or while at the same time defending the abuser. To Iliana, this was an obvious clue that “Something bad was happening to me. But no one understood what I was trying to say!” Others used more subtle clues, hoping to open the conversation about their relationships and their lives. Two women commented that their partners “tell me I’m fat.” They were both told by their HCPs to diet and exercise to lose weight. When Cecilia cancelled her surgery for a tubal ligation at her husband’s insistence, her provider, who was Latino, laughed, and responded, “Oh, you have a macho man!” but did not further discuss or explore her relationship with her husband.

These behaviors of hoping for questions about abuse, and giving clues but not discussing the abuse directly, represented a relinquishing of control by the women to their HCPs. The women wanted their HCPs to take control of the abusive situations in a way that they themselves could not. They wanted their HCPs to take the very actions that they feared. Maria avoided health care and disclosure for fear of providers calling the police. On the other hand, she wanted providers to notice and see how her husband was treating

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her, and to call the police on her behalf. “De esa forma, no lo hubiera hecho yo . . . que algún día lo pudieran coger pero sin yo decir nada, porque a mí me daba miedo.” “That way I wouldn’t have done it . . . some day they would be able to get him without me saying anything, because I was afraid.”

Iliana told her HCPs that her husband “treated her badly” and that he had a “carácter fuerte” or bad temper, and requested psychological help for him. In reality, she hoped her providers would take action to protect her.

No lo hacia porque quería encontrar una solución, de encontrar ayuda. Como un ayudante antes de tener que llamar a la policía. Yo no quería llegar a esa situación. Yo quería mejor dicho que le dijera otra persona, que yo no fuera. Que como otra persona se diera cuenta de lo que yo estaba viviendo y otra persona le diera aviso a la policía que yo no fuera la persona haciéndolo.

No, I was doing it because I wanted to find a solution, to try to find help. Like help before having to call the police. I did not want it to have to go that far. I wanted somebody else to do it. I didn’t want to be the one. I didn’t want to be the one calling the police. I wanted somebody else to see the situation that I was living and for them to call the police. I didn’t want to be the one having to do it.

(Iliana)

In one incident that Carol endured, the abuser was screaming at her in front of emergency department personnel. He pounded on the window, demanding that she leave the ED with her son, who was ill.

Carol: He was like “Come out here!” He was swearing, swearing and they were all looking at me, like, should I call the cops? I was like, “No, no, don’t call the cops. Don’t call the cops.” They were like, “Are you sure?” I was like, “Yes, he just needs time. He just needs time to calm down. Don’t call the cops.” But he was really banging on the window like he was going to break it.

UK: Was there a part of you that wanted to tell them . . .
Carol: I really did. I really did. I wanted them to just call the cops and tell him to get away from me.

However, in a few cases, fear prevailed, and some women avoided health care interactions completely when they felt that the abuse might be discovered, and they could not afford the risk.

*Looking for Help and Coming Up Empty*

Individual women's experiences with their HCPs were influenced in part by their expectations and hopes for health care encounters. As a group, their expectations of relationships with their providers spanned a spectrum from a distant professional relationship to one with a deep personal connection. Some women viewed their HCPs as basic providers of health services, while others were seeking a feeling of caring and compassion. Regardless of their hopes and expectations, most of the women were unhappy with their health care. Most of the women left their health care experiences feeling like they had been treated like a number and not like a person. Where they sought help, they found none. They looked for a person in whom they could share their deepest, saddest secret and they found untrustworthy people, who treated them in sometimes disrespectful and uncaring ways. They experienced their HCPs as mechanistic in their approach to their jobs, treating them like parts on an assembly line.

"We're all human beings!": *Looking for connection.* Most of the women were seeking some sense of connection with their HCPs, ranging from basic human decency to a friendship of sorts. For many, this became clear to them only by its absence. They were surprised and dismayed to be on the receiving end of cold and distant treatment by their
providers. “For many many years, it felt like I was just a number, not even a patient.”

(Rita)

Carol had multiple HCPs, but felt connected to and trusted only one, her midwife. She saw her as “a friend more than a doctor.” While she never disclosed the extent of the abuse to her midwife, even when her water broke prematurely as the direct result of the abuser slamming her against a cement wall, she felt supported and cared about by her midwife. Specifically, she did not feel pressured by her. Carol appreciated that this provider talked with her on a personal level, in an open and honest manner. The midwife would share stories from her own life, about her pets or her child. Carol experienced this as connecting personally, and as being nice. This was the only provider with whom Carol felt she could talk about personal problems, though even then, not specifically about the abuse, for fear of her baby being taken away from her by DSS. In sharp contrast to her midwife, she felt that providers in general “try to break you down.” Carol experienced questioning by HCPs about abuse as pressure to admit that she was being abused. She was asked repeatedly within visits, on multiple occasions about abuse. Her “no” responses would be met with “Are you sure? Are you sure?” She did not see their efforts as a sign of caring about her, but more as concern for her child’s safety, which she felt capable of ensuring herself.

Julia wanted to feel like she was going to see a friend when she saw her provider. She was looking for a feeling of concern and attention that would have made open communication possible.
Más como amigos . . . Quizás no a lo mejor no sea muy personal pero por ejemplo preguntas sobre la escuela. No tiene que ser tan privado, pero cosas para tener confianza.

More like friends . . . it doesn’t have to be very personal, but for example, questions about school. It doesn’t have to be really private, but things to build a little more trust. (Julia)

She had a different provider every year for several years, contributing to the lack of relationship building. She was taken aback by the apparent lack of genuine concern, as she believed, “We are all united [one].” She mimicked the typical behavior of HCPs she had seen: rushing in to the room, speaking rapidly without eye contact, “Sit down. How are you? What do you need? Here you go. Goodbye.”

Sheila, who had known her PCP longer than anyone else in the US, was looking for an emotional connection and for support because she had no one else. She felt extremely hurt by her provider, who she felt let her down, causing her additional harm.

[Doctors] know you for so long and they know everything about you. You think that they’re like related to you and you expect something, I don’t know, maybe I’m not supposed to expect nothing. I don’t know. I really don’t know how a doctor is supposed to be. (Sheila)

No expectation. Several of the women were looking for nothing more than “straight medical care” from their providers. This group of women was generally satisfied to very pleased with the health care they received, for themselves and their children. They did not expect or hope for personal conversations as part of their health care, did not want the abuse to become known, and were not looking to their HCPs for solutions.
Just There To Do Their Job

The women largely experienced HCPs as uncaring on a human level. They felt their providers were “just there to do their job,” going through the motions of providing medical care, without seeming to truly care. Many of the women mimicked the behaviors of their HCPs to demonstrate these feelings. They described and demonstrated several examples that to them indicated that their providers were not connecting with them on a personal level, including physically rushing, speaking rapidly, failing to make eye contact, focusing on writing while talking, failing to respond to questions, and ignoring the women’s expressions of emotions.

Lack of time, manifested as rushed behavior on the part of the HCPs, was interpreted by the women as disinterest in them, or an indication that they simply did not have the time to attend to them beyond the bare necessity of the visit. There was no time for conversation, and the rushed behaviors made them unwilling to risk opening up. “My doctor is a good person, but she is too busy.” (Ana) “She does my check up, but she doesn’t give me time.” (Manuela) “Your five minutes are up.” “They do what they have to do.”

Attitudes of indifference and lack of follow up questioning were representative to the women of HCPs’ uncaring approach to their patients. Ana’s primary care provider referred her to a psychologist without ever asking her why she felt depressed, or any questions about her personal life. “If I needed a physical, she did the physical, but she never asked me anything, just ‘How’s your health?’” Ana’s pediatrician scolded her for losing weight, but did not inquire about why she was so stressed. Sheila was diagnosed
with lupus, and she felt her provider never considered any other explanation for her multiple pains and injuries beyond the lupus. “Doctors just give you pills. . . . When I complained about something, they just give you pills for the pain, but don’t really go into details. Sometimes I wish they would ask ‘Why?’ a little more.” At one point, Sheila was hospitalized for a lupus flare the day after her abuser had slammed her head against a cement wall. When she complained about pain in her neck, she was told to expect that with lupus.

It’s not like in the movies. In the movies you see a psychiatrist answering the questions and trying to help the patient by giving them answers. When you go to a psychiatrist in real life, you’re just spilling your guts out to a complete stranger. I mean you’re just talking to the wall, I might as well not go at all sometimes, you know? (Sheila)

Iliana was frustrated and angered by her HCPs’ lack of interest and follow-up. She felt that she specifically tried to get help for the abuser, whom she saw as mentally ill, but no one seemed to care. Julia felt that the HCPs she had seen were focused on their jobs and not their patients. She contrasted the care she received in the US from that in her country.

_Yo sé que es un trabajo verdad, ser doctora, enfermera, es un trabajo, pero a veces lo ocupan mucho no más en su trabajo y no se preocupan por la persona. Si una no más hace su trabajo, no preguntan, no preguntan, “¿Cómo está?” “¿Cómo está en su trabajo?” Van no más directamente a su trabajo, “¿Cómo te sientes?” “¿Qué es lo que te duele?” “¿Qué problema tú tienes?” No hay como una comunicación que se sienta una confianza, o más que todo, con ayuda, una ayuda no siento. No sé si hay doctores que puedan ayudar a la gente, no sé, porque nunca lo pregunté. Si hubiera preguntado quizás ellos me hubieran mandado a otro lado, o algo, no, nunca pregunté. . . . en nuestros países, o sea, es una diferencia, ¿no? Que en nuestros países, cuando uno tiene doctor, que dice de cabecera, y preguntan a veces, ¿dónde trabaja, cómo trabaja, su pareja? A veces conocen a la gente y dicen ¿cómo estas? ¿como te ha ido? A veces sienten los problemas, ¿qué te preocupa, qué tienes? Entonces a veces ellos pueden_
ayudarnos. O sea, en mi país realmente no hay mucha ayuda como aquí, pero siento que los doctores a veces se preocupan un poco más que aquí.

I know it is a real job, to be a doctor, a nurse, it is a job, but at times, they are not focused on anything other than the job and they are not worried about the person. If one is just doing their job, they don’t ask, not asking questions, like “How are you?” “How is your job?” They just go straight to the point, “How do you feel?” “What hurts?” “What’s your problem?” There is no communication that makes you feel trust, or more than anything, helped, I don’t feel helped. I don’t know if there are doctors who can help people, I don’t know, because I never asked. If I had asked maybe they would have sent me someplace else or something, no I never asked. . . In our countries, there is a difference, right? In our countries, when one has a doctor, your primary doctor, sometimes they ask, “Where do you work? How is your work, your partner?” At times they know people, and they ask, “How are you? How have you been?” At times they feel our problems, “What is worrying you? What’s going on?” So then, sometimes they can help us. In other words, in my country, really there is not as much help as here, but I feel like sometimes the doctors are a little more concerned about us than here. (Julia)

A few of the women reflected on HCPs’ behavior in terms of failing to demonstrate an understanding of the universality of human experience and existence. The women felt that HCPs need to recognize and appreciate the humanness of both their patients and themselves. “We are united [one]” (Julia). “Antes de ser profesional, tienen que ser un ser humano. . . Y si es ser humano, va a dar entrada a esas personas que tienen miedo.” “Before being professionals, they should be human beings. . . And if they act like human beings, then they will open the door to those people who are afraid. (Sylvia)

Poner las cosas que yo pienso a cargo, no solamente hacerlo, como por su profesión, no, si no saber lo que la otra persona lo que esta sintiendo, no verla solamente, como lo voy a ser por mi trabajo si no con ese sentimiento de hacer las cosas con la otra persona, saber que si la va a ayudar, que va a tratar de ayudarla de muchas formas porque somos humanos.

Taking what I think seriously, not just doing it like, because it is their profession, no, instead to know what the other person is feeling, not looking at her as if I am
going to do it for my job, but with a feeling of doing things with another person, knowing that if you’re going to help her, that you’re going to try to help her in many ways because we’re all humans. (Rosa)

These same women reported positive interactions with their HCPs. They felt cared about, even if rushed. None of them, however, discussed the abuse with their HCPs.

*Coming Up Empty*

Taking the risk to find help was a gamble with poor odds. One woman’s savior was another’s disappointing failure, particularly among the police and courts. Several of the women felt that their efforts to find help from their HCPs were fruitless. Vulnerable to begin with, they took risks and came up empty. This group felt betrayed by their HCPs in their failure to give help to them. Two of the women, Herminia and Manuela, both saw their same primary care provider (PCP) for years for management of multiple chronic illnesses, including depression. Each also went to her PCP frequently with physical and psychological complaints. Herminia felt abandoned and neglected by those to whom she turned for help. When she tried to tell her PCP a little of what was happening, her provider responded, “You need Disability.” Herminia interpreted this as disdain, and felt ignored. “She made it clear to me that she didn’t care about the situation that I was in.” Once she felt hurt and not helped, Herminia gave up on her relationship with her primary care provider in terms of connection and hope for help. She continued to see her for her medical problems and to get medications, but left her true needs at the door.

Manuela told her PCP of 15 years about the abuse, providing some examples, but not all. Her provider told her, “Just leave him.” She also disclosed the abuse during
multiple ED visits she had for hemorrhaging, which was the result of an assault by the abuser. No one ever discussed the abuse with her. Complicating Manuela’s situation, her PCP was also her abuser’s doctor for many years. Manuela continued to struggle to understand her PCP’s response to her over the years, and blamed her for failing to help.

Many of the women experienced great difficulty in finding help from other systems. While legal services were readily available to this population, their legal options were often limited. Many faced significant barriers in seeking help from the police and courts, as well as difficulties and challenges with ensuring their on-going safety.

Cecilia described seeking help, but facing multiple barriers, “It’s hard to get help.” She went to the clinic frequently, “feeling bad.” “Nobody helped me, they sent me to the court.” She did not feel helped by clinic staff, court personnel, or the police. She regretted getting the restraining order because it was handled so badly, and she was afraid of the abuser. The system did not work for her: the abuser lived right around the corner from the court house, so she was afraid to go. The court personnel said they couldn’t help her unless he had hit her or had been arrested. When she did obtain the restraining order, the police taped it to the door of their house rather than serving him personally, making it invalid. When she delayed 2 days in reporting a violation, so that the children would not witness the police arresting their father, the police called her “hypocritical”. When she did leave the abuser, and applied for food stamps, welfare, and educational programs, she received nothing, and had to depend upon her family for food. There was no shelter available, so she went to her uncle’s house for several days. “Women have a reason to be afraid [to disclose], because you don’t always receive the help you expect.”
The way it should work: "I thought they were not going to help me, but they always treated me very well." One woman, Sara, sought help and received multiple forms of assistance. She did not expect to receive health care or legal assistance because she was undocumented, uninsured, and Spanish-speaking. When she arrived at the ED, pregnant and hemorrhaging from an assault by the abuser, she received prompt medical care. Sara experienced the nurses and doctors as very caring and concerned about her. She was given free medical care and information about applying for Medicaid. She was referred to an advocate who assisted her in obtaining a restraining order. She was referred for prenatal care. When she told the prenatal nurse about the abuse,

Ella me supo comprender y a veces parece que [ella] como yo le he contado todo mi problema y todo lo que he pasado. Tengo un trato bien especial con ella, yo me siento bien a gusto con ella. Me gusta como se preocupa ella.

She knew how to understand me and sometimes it seems like I’ve told [her] all my problems and everything that has happened. I have a special relationship with her, I feel very comfortable with her. I like the way she shows me a lot of concern. (Sara)

Her prenatal nurse referred Sara to a social worker. She left the abuser immediately after that assault, and he was jailed for several days.

Several circumstances made Sara’s situation unique from the other women’s. She presented for health care with acute, visible injuries from the abuse, as opposed to living with chronic abuse that may not show physically. She was pregnant and bleeding, so there would have been heightened concern and attention. Her sister, fluent in English, communicated for her, and disclosed the abuse. Some communication occurred only between Sara’s sister and the MDs in the ER, without Sara’s knowledge (that the baby’s
heart had stopped beating). She also had been in this relationship for six to eight months, and had not been living with abuse chronically. She did not feel responsible for the abuse, or ashamed by it. She called the police immediately when he hit her for the second time, and actively sought help from legal and mental health service providers. She felt supported by her HCPs, psychologist, attorney, the police, and the judge.

When nothing would work. Carol endured abuse as a teenage mother. Several of her providers strongly suspected IPA, and asked her about it repeatedly. She kept the abuse from her HCPs, as well as from her family, particularly her mother. She had a midwife with whom she felt a close personal connection. She had a PCP whom she liked and saw for many years. She never disclosed to any of her HCPs because she was sure they would take her child away. She did not tell her PCP, because she believed that her mother would find out. She avoided telling her mother because “I didn’t want to hear ‘I told you so.’” When asked what could have helped her, she described how the combination of her fear of the abuser, her embarrassment and shame about the abuse, and the emotional force of being in love kept her from disclosing. She saw herself as responsible for both getting into the situation and getting herself out.

C: They [HCPs] knew. They knew. It was obvious. It was so obvious. . . . I was like, “No, it’s not true, no!”

UK: Can you tell me again why you kept saying it wasn’t true?

C: I don’t know. I was embarrassed. I really was. It was embarrassing. I don’t know. I never got hit. My mother and my parents never hit me. So I’m like, I don’t know, I thought I was okay because I thought it was my fault. You know, I was doing something bad. I don’t know. I thought it was my fault. So I don’t know, I was embarrassed, I really was. Then to tell someone he hit me, I was like, oh my God, I couldn’t.
UK: Mostly out of embarrassment?

C: It really is embarrassing telling somebody. Now it’s not, but back then, when it was really happening, like, I thought I would look like I’m crazy or something.

UK: You thought they would think you were crazy?

C: Yes for staying with him, for staying with him. It was hard, it was really hard. I had gone to [a battered women’s services agency] so I knew what abuse was, but it was so hard because I loved him so much. I don’t know, like the way I see it, he had me wrapped around his finger. . . . I was in love. I really was in love. Well, I love him, that’s okay. It’s okay. Like, it reminds me of a poem that I read in here, it said, “He brought me flowers.” I don’t know if you ever read that poem?

UK: No. What does it say?

C: I don’t remember the words but I know the whole concept was he would hit her and then he will buy her flowers and then he will hit her again and buy her flowers and at the end, he was sending flowers to her grave. I said oh my God! Every time I think about that, I’m like oh my God, this poem! I don’t know, he would just be nice. He would tell me sweet things, and he was like, he was eating my brain all the time, you know. Now I know that. But back then I didn’t know that. I thought, oh my God, he loves me, telling me he’s never going to leave me. He’s never going to hit me again and all this stuff. I’m like, oh my God, he’s sorry. Yeah right. . . . It was because of my son. Like if I was to tell that he was hitting me, I thought they would take the baby away. That’s what I thought. I was like, I can’t have that, not in Philly, not in Philly, not in Philly. Because I have nobody in Philly who’s going to take him. I didn’t want his family to have him either. I was like, no, I can’t, they can’t know. That’s what I thought, DSS would have came in and everything.

UK: I kept asking you last time if there was anything that anyone could have done to help you, and you basically said no. You know, you basically said no, that you just loved him so much that . . .

C: Like I didn’t want to believe it. I didn’t want to believe it. “Is he hitting you?” “No, he’s not hitting me.” How could he hit me if he loves me, why is he gonna hit me? While I knew he was hitting me. It’s hard, it’s hard to hide it. I don’t know, I think it’s obvious, not in every person, but it’s obvious.
UK: Do you think that there's anything that anyone could have done to help you get out sooner?

C: I had to do it by myself. I had to do it all on my own.

UK: Why did you have to do it all on your own?

C: Because I got into it and I have to get out myself.

"¿Habla español?": Linguistic barriers. The first question for the Spanish-speaking women of their HCPs was “¿Habla español?” They wondered “Will you understand me? Will I understand you? How will I get the care that I need?” Potential language barriers existed for 12 of the women. Ten of the women spoke Spanish-only. Two women identified Spanish as their first language, but were able to speak and understand some English. Several were studying or had studied English at various times, and several were learning some English as they remained in the US. The women’s health care experiences varied in terms of their use of interpreters, the availability of Spanish-speaking providers, and the availability of English-speaking family members to accompany them. Several of the women did not encounter problems with linguistic barriers, but a number of them did.

Only Sara had an English-speaking family member available to accompany her to appointments. She found great relief in this, and worried about what would happen if her sister was not available when she went into labor. She believed that she had to accept limited communication between herself and her HCPs because she did not speak English.
On a few occasions, she went for tests and appointments without her sister, and no interpreter was available.

Pero el último vez, la muchacha que me atiende en el ultrasonido, ella habla un poquito de español, pero a veces me queda algo como que yo le quiero preguntar sobre como está el bebé, o cualquier cosa, y ella no me entiende. Entonces quedo con la duda que es lo que está pasando. Y en ese aspecto que me afectara que fuera un poquito mejor que me dieran que le facilitaran un traductor a uno. Entonces uno a veces se siente mal porque como uno es Hispano y no sabe inglés, necesita aceptar lo que pase.

So the last time, the young woman who does the ultrasound, she speaks a little bit of Spanish, but sometimes I’m left wanting to ask how is my baby doing or anything else that I would like to know about my baby and she doesn’t understand me. Then I am left with doubts of what may be happening. In that aspect it affects me because it would be a bit better if they would arrange for a translator. Sometimes you feel bad because you’re Hispanic and don’t know English, so you need to accept whatever happens. (Sara)

Sara distinguished this problem from the manner in which she was treated, which she thought was very good.

Some of the women experienced language barriers with providers who spoke some Spanish, as well as with interpreters who they felt were inadequate. Two of the women continued to see providers with whom they knew communication was incomplete because they liked them personally, and felt they were kind. Iliana described how her provider’s Spanish improved over the years, to the point where she eventually spoke well. She was quite frustrated in the early years of seeing her, but decided to remain with her and to see what the future would bring.

I: Ella habla ahora muy bien el español. Primero a los años atrás, digamos casi tres años ella no hablaba mucho español. Antes yo le hablaba y ella casi no me entendia. Pero ahora ella me entiende y me ha ayudado mucho.
¿Cómo era esa experiencia para usted saber que iba a verla y que ella no la entendía?

Bueno yo salía frustrada. Y más frustrada aun cuando las personas que hablaban español que yo les contaba con lágrimas en los ojos que me estaba pasando no actuaban. Siempre quedaba, vamos a ver que pasa más adelante como esperar en el futuro.

Now she speaks Spanish really well. At first, years ago, let’s say almost three years ago, she didn’t speak much Spanish. Before, I would talk to her and she hardly understood me. But now she understands me and she has helped me a lot.

What was that like for you when you were going to see her and you knew you weren’t being understood?

Well, I used to leave very frustrated, and more frustrated still when, with tears in my eyes, I would tell people who spoke Spanish what was happening to me and they did nothing. I would always wait and say let’s see what happens next, like having hope for the future.

A few of the women felt that it was their responsibility to learn English, and if they did not, they needed to settle for the barriers created by only being able to speak Spanish. Many of the women spoke apologetically about their limited English skills.

However, one woman, Julia, felt that she was treated badly because she did not speak English, that there was a bias against non-English speakers within the health care system. For not speaking English, she was made to wait for hours, and had rushed visits with reticent and uncaring interpreters. “Entonces no hay mucha confianza como cuando uno se habla por ejemplo con un hispano a hispano, o que la doctora aunque sea Americana nos pueda atender.” “So there is not much trust, like when one talks, for example, Hispanic to Hispanic, or that the doctor, even though she is American, could attend to us.” Julia saw language as a significant barrier to relationships between patients.
and providers, more than culture. For her, lack of fluency between provider and patient inhibited open, natural communication, and the opportunity for help.

* Cultural bias. * Very few of the women identified cultural bias by non-Latino providers as an influence on their experiences of health care. Language barriers were more important, and more of an obstacle to understanding and communication. However, more important than cultural or linguistic congruency was a sense of connection with their HCPs, and a feeling that their providers were compassionate and caring.

* Parallels in Relationships: Abusers and Health Care Providers*

Several parallels emerged between these women’s experiences of being in relationships with their abusers and with their HCPs. These related to the women’s emotional responses and their behaviors within the relationships, as well as the behaviors they experienced from the abusers and from HCPs. These parallel emotional responses included fear, lack of control and powerlessness, feeling controlled, and feeling invisible. Behaviorally, the women relinquished control to their HCPs and remained passive about their own needs. In the research process, a few of the women strove to protect their HCPs, just as they had protected the abusers from detection.

* Fear*

The women feared contact with their HCPs for many of the same reasons they feared their abusers. The uncertainty they had about the consequences of disclosure or detection of IPA by their HCPs left them afraid. They anticipated more severe abuse, the loss of their children, deportation, or other legal problems as a result of contact with their HCPs. In many cases, these were the consequences they were threatened with by the
abusers.

Lack of Control and Powerlessness

These fears were based largely on the lack of control they felt in their relationships with the abusers, as well as with their HCPs. Disclosure or detection of IPA would result in a series of events and consequences at the hands of the abusers, as well as their HCPs, that were beyond the control of the women. These women, particularly those who were Spanish-speaking only, undocumented, and uninsured, felt vulnerable and powerless in their interactions with HCPs and health care systems. The feelings of powerlessness and lack of control the women felt with their HCPs paralleled their feelings of powerlessness in their abusive intimate relationships.

Feeling Controlled

A few of the women experienced their HCPs, as well as other helping systems, i.e. battered women’s shelters, DSS, and legal services, as controlling, paralleling their experiences with the abusers. Carol experienced repeated questioning by her HCPs about IPA as a kind of badgering. “They kept like, not pressuring me, but like asking me and asking me and asking me, and so they thought I would break down and say, ‘Oh yes he is,’ but I didn’t. I didn’t break down.” Others experienced their HCPs as controlling in their provision of health care, particularly with respect to controlling the appointment agenda and duration, medications, treatments, and instructions.

Invisibility

The abuse itself, in some cases the reactions of family and friends, and indifferent treatment by HCPs, left many of the women feeling invisible as persons. The women felt
a lack of voice and presence in their relationships with the abusers. Many had lost self-esteem and self-efficacy as a result of the IPA. They were scolded, minimized, and at times ignored by the abusers. They placed their needs last, always attending to those of the abusers and of their children. The women often experienced treatment by their HCPs in a similar way, i.e. feeling scolded for not following instructions, feeling minimized for their concerns and worries, and feeling ignored by rushing HCPs who did not seem to really see them.

I found a lot of the doctors that I had been seen by were doctors that I felt were just there to do their job and not there because they cared. . . . For many many years it felt like I was just a number, not even a patient. (Rita)

The secrecy that the women maintained about the IPA, often to protect the abusers as well as their children, reinforced this feeling of invisibility, as their true life experiences remained unacknowledged.

Relinquishing Control

The women often relinquished control within their health care encounters, remaining passive in terms of disclosure or identification of the IPA. Many of them hoped, despite their tremendous fear, that their HCPs would ask them about their lives in general, and about IPA specifically. Some wanted their HCPs to take control of the out-of-control situations in which they found themselves relative to their abusers. Manuela wished her PCP had called the police, and “made them make me talk.” They gave clues to encourage their providers to seek more information, but did not disclose the IPA unless specifically asked. Unfortunately, very few of them were asked. Their attitude of “If you ask me, I will tell you,” reflected their ambivalence about disclosure of the IPA. This
ambivalence reflected the ambivalence experienced in their relationships with the abusers.

These women also maintained, in many cases, passivity about their own needs. They did not insist that their HCPs listen to them or provide them with what they were looking for. They went to health care appointments with hopes for positive outcomes, but did not often ask specifically for what they needed. Iliana's experiences of seeing a HCP who did not understand her fully for several years exemplifies this point. When asked how she handled her frustration with not being understood, she replied, "I would always wait and say 'Let's see what happens next,' or try to wait and see what happens, what the future was going to bring."

The women also used passivity and conflict avoidance to survive health care encounters safely. By maintaining secrecy about the IPA, they were attempting to protect themselves and their children from physical harm at the hands of the abuser, as well as to avoid terrible consequences from DSS and INS. They employed similar behaviors or passivity and conflict avoidance in their relationships with the abusers to avoid emotional and physical harm.

Protecting the Other

During the interview process for this study, a few of the women expressed a concern with "getting them [HCPs] in trouble." The women worried about disclosing negative information or mistreatment by a HCP in the same way they had worried in the past about disclosing the IPA. They withheld information in an attempt to protect their HCPs from professional harm in the same way they had tried to protect their abusers in
the past. They rationalized their HCPs’ behavior, minimizing and excusing the negative. When reassured that no harm would come to their HCPs as a result of this study, they felt free to talk openly about their experiences. This process mirrored their interactions with HCPs in which they were uncertain about the consequences of disclosure of IPA, and the protection and justifications they had given the abusers.

The most extreme example of this was Sheila, who felt betrayed and hurt by her HCPs’ behaviors. She was hurt and frustrated that they immediately prescribed medications or referred her to someone else whenever she tried to talk about her feelings or being in pain. “I think my doctors made things worse just by not listening well enough, made things worse, until I was being abused by my husband and my doctor.” At the same time, she was quite concerned about speaking honestly about her experiences.

S: It’s kind of hard because you don’t want to talk bad about the physicians.

UK: Are you holding back?

S: No, I’m not really. I basically said everything I have to say. But it’s hard. I may look like it’s easy but it’s not. Because they do, like I said, they do so much for you, but they miss sometimes a couple of things, that’s all. I don’t want to say they’re bad, you know. Because I have a great doctor but for that, for prescribing and for referring.... I know you guys have a hard job. [nervous laughter] That’s one of the hardest jobs in this world.

Creating Safety for Disclosure: What Women Need, What HCPs Can Do

None of the women felt that they had a direct and fully honest and open conversation with a HCP about the IPA they were enduring. With rare exception, there was a universal lack of feeling of safety to reveal the IPA to HCPs. There were a few very limited disclosures, as well as more frequent proffering of clues. The risks involved
in trying to get help to leave the abusers outweighed the risks of staying with them. One set of fears overrode another.

However, the fears and risks of talking about the abuse with a HCP could be addressed. The women identified several requisites of safety for disclosure, derived from their experiences with HCPs. There were four needs: knowing that their providers cared about them as people; trusting their providers; receiving concrete information about the consequences of disclosure prior to any disclosure; and being asked about IPA, either directly or indirectly. If any one of these components was missing, in most cases, they did not disclose. The women had several recommendations for improving HCPs’ identification and response to battered Latina women. They drew on their own and others’ health care experiences, their hindsight, as well as their fervent hopes that other women could be helped in ways in which they themselves had not.

"Where’s the love?": Needing to Know That HCPs Care

Many of the women felt that their HCPs did not care about them and were “just there to do their job,” as described above. Some women described knowing within a few minutes of meeting a new HCP if that person was caring, sometimes based on a gestalt feeling, supported by specific observations. They observed body language, mannerisms, eye contact, as well as verbal communication, as part of their assessments of their HCPs. Magdalena described the process:

Right now I’m talking with you, and I’m looking at you, and I trust you, and I don’t even know you, but I’m looking at your face, I’m looking at your eyes . . . and I could see through your eyes, and I could see if you could help me, or if you cannot. So sometimes, in the way people talk to you, you can say, this is a good
person, or this is not a so good person: This could be a nice person, or this could be a rude person. That’s exactly what I feel when I’m with my primary doctors.

These women needed to be recognized as human beings, and to interact on a human level with their HCPs. Many felt depersonalized in their health care interactions, “I was just a number, not even a patient.” (Rita) Being treated “like a patient” meant not being treated like another person, like a sentient being. Some of the women wanted to feel like they were going to see a friend when they saw their HCP. Others were looking simply for a basic human connection. These women viewed questions from HCPs about their personal lives, i.e. children, partners, work, families, as an indication that they were being seen as people. They interpreted HCPs’ failure to ask questions of a personal nature as an indication that those HCPs were uncaring, rude, and disinterested in them. On the other hand, these women were vulnerable, and needed to benefit in some way in order to be willing to expose themselves. “Why should I be telling you my whole life if you’re not going to do anything for me?” Sheila maintained a happy public persona, based on her past experiences with providers. She no longer expected to get help from health care providers, so chose not to reveal her pain.

Many women identified rushed behavior on the part of the provider as an indication of lack of caring and concern. A few HCPs did screen the women for IPA, but did so in a rushed or insincere manner, rendering the screening ineffective.

They don’t really actually go into it either, they just ask you a couple of questions real fast. “Have you been in a relationship, blah, blah, blah?” Like just a regular conversation, they just don’t really go into it. So you say, “No, it’s fine. I’m okay.” Like just saying hi and bye. (Sheila)
Showing the Love: Demonstrating Caring and Concern

Showing caring and concern requires an affective manner that is kind, friendly, and not brusque. The most commonly described means of demonstrating caring and concern was to talk with women on a personal level. The very act of asking a woman questions about herself, her personal life, and her family would convey caring and build trust between the HCP and the woman. Restricting questions to medical issues was seen as rude, impersonal, and failing to create a sense of safety. The women urged HCPs to talk with their patients, “platicar,” to have conversations that are personal and social in nature, before asking medical questions.

Yo pienso que debe haber más, más comunicación, más comunicación. Aparte de que es el doctor, o que es la doctora o la enfermera y la paciente, somos seres humanos, o sea hay dos seres humanos, por ejemplo dos mujeres, y más aun si hemos tenido hijos, como que y yo me pongo en tu lugar y tú te pones en el mio es, sabe, como más, más confianza y más diálogo. Más diálogo, me encantaría eso.

I think that there should be more, more communication, more communication. Aside from being the doctor or the nurse or the patient, we are human beings, I mean, there are two human beings, for example, two women and even more if we have had children. Like, okay, I put myself in your shoes and you put yourself in mine. So there is like more, more trust and more dialogue. More dialogue, I would love that. (Sylvia)

Some of the women in the study did report positive experiences with health care providers, but these experiences did not involve discussion of the abuse. With IPA taken into account, feeling cared about was not enough, and the women reverted to fear, worry, and uncertainty.

Muy bien, espectacular. Muy lindos todos . . . muy lindos todos, muy, muy se preocupaban mucho, muy pendientes o sea estaba chequeando siempre, bien, muy bien. Solamente que no le dije al doctor lo que me había pasado. Incluso cuando
una trabajadora social . . . yo dije “No, es que me cai. Yo me cai, a mí no me pasó nada, yo me cai.”

Terrific, spectacular, they’re very nice, all of them . . . very nice, they were very, very attentive, always on top of things, you know, always checking up on things, good, really good. The only thing is that I never told the doctor what had happened to me. Even when a social worker . . . I said, “No, I fell, I fell. Nothing happened to me, I fell.” (Sylvia)

“Can I trust you with my life?”: Needing to Trust HCPs

The need for trust emerged as a major theme in these women’s experiences of health care, and as an absolute prerequisite for honest communication about the IPA. The women needed to trust their HCPs in a variety of ways, interpersonally, professionally, and practically. Interpersonal trust needed to be built over time. For some women, trust was established over a few visits, while others trusted their HCPs only after a few years of frequent contact. The women saw their HCPs as responsible for creating trust between them. Interpersonal trust emerged in relationships in which HCPs demonstrated sincere caring behaviors over time. Consistently talking with patients about their families and their lives before beginning medical questions was identified by many of the women as an imperative interpersonal trust-promoting behavior.

The women placed less emphasis on their HCPs’ professional trustworthiness in their provision of health care. Most of the women experienced their HCPs as competent providers of strictly medical care. This was important only in its absence. Professional trustworthiness alone was insufficient to create a safe environment for discussion of IPA. Practical trust related to trusting HCPs with information about the IPA, and believing that no harm would come to the women or their children as a result.
"They didn’t ask, so I didn’t tell."; Needing to be Asked About IPA

The women did not volunteer information about the IPA they were enduring to their HCPs, even when they were being seen for injuries or health problems that were directly related to being abused. They told their HCPs about “stress,” “tension,” and “depression,” but did not put these feelings in context for their HCPs. The women’s passivity and their HCPs’ failure to ask about IPA, directly or indirectly, together created a code of silence about the IPA. Many of the women described the act of asking questions about their lives and about IPA specifically as an indication of caring, and a critical step in building the requisite trust for disclosure.

If he asked me, I will explain, and I know I’m going to start crying, but I will tell him. But when they don’t ask you, you don’t want to talk, like you feel, no. But if they ask you, “What’s really going on?” and I could see you, and I could feel if I could trust in you . . . (Magdalena)

Delia, who was one of very few women who were not physically afraid of their abusers, did not disclose the abuse to her HCPs, primarily because they did not ask about it. The act of being asked the question would have helped her overcome her embarrassment and lack of trust.

Está bien que hubieran preguntado. Me gustaría que a todas las personas, a todas las mujeres que cuando llegan al hospital, tienen que preguntar, “¿Cómo va usted en su matrimonio?” No, porque si no me preguntan . . . a veces no tenemos la confianza, quizás es lo que nos falta. La confianza para poderle exponer este caso. No es que a uno no quiera decir. Si no que a veces, nosotros los Latinos, no tenemos el carácter para poder hablar, pero no es que no queremos. Tenemos, como nosotros decimos, tenemos pena de hablar.

It would be good for them to have asked me [about the abuse]. I would like that everyone, all women who go to the hospital, be asked, “How’s your marriage?” Because if they don’t ask me . . . many times we don’t have the trust necessary to expose our problems. It’s not that one doesn’t want to speak out, but sometimes,
we Latinos, it isn’t in our nature to be able to talk but it’s not that we don’t want to. We have, as we say, shame to talk. (Delia)

Questions about IPA should be asked universally and consistently over time. The very act of asking specific questions about abuse would convey a sense of trustworthiness and sincere interest. A belief that they would disclose if a HCP asked more than once, over several visits, was commonly shared by the women. Trusting a HCP enough to disclose IPA would require more than one encounter and more than one question.

The first time I think I would not answer. I would not. I would not answer, the first time. When you have to broke [sic] the ice, you feel like, okay, I have to, but you feel afraid of [talking], but if it would be like the second or third time I went there, I would say everything. (Magdalena)

*Asking Questions and Listening to the Answers*

*Talk with me!* The women identified asking personal, conversational questions as important to both the development of a trusting relationship and as a strategy for both the woman and her HCP to share information. Nearly all of the women believed that asking questions about women’s personal lives would yield information about IPA. For some, these questions would be a way of screening for IPA indirectly, which they favored.

*Bueno, me voy a poner por un segundo de doctora o enfermera con la paciente y yo le digo “¿Cómo está?” Y la miro, y le digo, “¿Está bien? ¿Cómo está pasando en la casa? ¿Le están tratando bien en casa? ¿Está todo bien?” Si esta persona, si ella está bien, me va a contestar bien, pero si no está bien, va a empezar a llorar [cayendo]. Y ahí ve uno que está pasando algo.*

If I imagine myself as a doctor or nurse for a moment, and I tell you, “How are you?” I look at you and I ask you, “Are you well? How are things at home? Are you being treated well at home? Is everything okay?” If this person is okay, she will tell me she is okay, but if she is not okay, she will start crying [becomes silent]. And then you see that something is going on. (Delia)
For others, personal questions would create the setting in which a woman would have enough trust to feel safe enough to answer what should be a direct screening question about IPA. They implored HCPs to ask women directly and frequently, recognizing that it takes time to build trust and safety.

_Y que siempre tengan la palabra presente al decirles a ellas que si en algún momento tiene algún problema y eso que recuerde que no está sola, que hay gente para ayudarla. Porque tal vez con la primera vez que uno vaya y le preguntan “¿estás bien?” o algo, uno tal vez la primera vez no dice nada. Pero constantemente si uno mira que la doctora es preocupante y que siempre dice, “mira, no estás sola. Si tú tienes algún problema de los que dicen ahí [en el volante] o que tú sientes que estás siendo abusada, mira, recurre a este o a este o a mí.” O sea, que siempre estén diciéndole a uno constantemente las cosas._

And to always put out there [to patients] that if at any time you have a problem, remember that you are not alone, that there are people to help you. Because perhaps the first time you go and they ask, “Are you okay?” or something, perhaps the first time you wouldn’t say anything. But if you consistently see that the doctor is concerned, and always says, “Look, you are not alone, if you have any problems like the ones here [on this flyer], or if you feel you are being abused, look, go here and go there and seek assistance here or there or from me.” In other words, they should always being saying these things constantly [to patients]. (Ana)

Regardless of whether the screening questions are direct or indirect, women need to be given information prior to being questioned about the confidential nature of the conversation, as well as potential consequences, to allay fears about calls to the abuser, the police, INS, and DSS. Of course, fears of DSS involvement cannot be alleviated completely, as HCPs are mandated reporters for suspected child abuse and neglect.

_Listen! Listening to patients is critical in responding to this vulnerable population._

The women described the importance of listening in the full sense of the word, to responses as well as silences, to verbal and non-verbal reactions. Many felt that attentive
HCPs could detect as much by a woman's silence as by her words. A few of the women described listening as a complete response in itself. "All they have to do is listen!"

Several of the women saw HCPs as having a role in consciousness-raising for women who are being abused. This could be done both through questioning about IPA, as well as responding, and providing resources and information.

_Hacerme conciencia a mí. Quizás ayudándome a que ese miedo se me fuera. Diciéndome el apoyo que una mujer abusada tenía. Abriéndome un poco la vista y los oídos. Yo estaba ciega. Yo pensaba que sin él yo no podía vivir. ¡Yo no sé! ¡Yo no sé!_

Make me conscious of it, perhaps by helping me to lose the fear, telling me about the support that abused women have, opening my eyes and my ears a little more. Because I was blind. I thought that without him I could not live. I don't know! I don't know! (Manuela)

"What's Going to Happen Next?": Knowing the Consequences of Disclosure in Advance

Knowing the specific consequences of disclosure or detection of the IPA prior to such a disclosure was critical to the establishment of a safe environment for disclosure. None of the women were provided with this information. They had many fears and beliefs about the consequences, many of which were inaccurate, i.e. deportation. Many of the women had heard stories from other women about their children being taken away immediately by DSS, and feared this would happen to them.

Cecilia felt cared about by her providers, a physician and a nurse practitioner, trusted them both, and saw each several times a year. There were flyers posted in the offices about domestic abuse that read, "Talk to your doctor, we can help." However, she did not disclose the IPA, because she did not know what would come next. She feared
being forced to go to a shelter, or losing her children. Sylvia did her best to hide the abuse from her providers, as well as her children’s pediatrician, whom she adored.

El primero que me preguntó fue el doctor, el doctor de mi bebé. Lo quiero mucho. Y yo me acuerdo de él, es moreno, alto, pero bello con mi niña, muy tierno, como, bien lindo, no se me olvida el nombre. Él me miró y me dijo, “¿qué te pasó, te pegó tu esposo?” y yo dije “No, no.” Bueno, seguimos hablando, y seguimos hablando. Yo creo que él notó mi cambio, mi cambio de la cara, como de tranquilidad a temor. Entonces, él me dijo “Espérate un momentoito que ya regresó.” Entonces volvió con otra mujer, entonces allí me dejó con ella. Y ella me empezó a preguntarme, a decirme, y yo callada escuchando, yo solamente pasaba por mi mente lo que iba a pasar si yo hablaba. . . . Yo pienso que fue eso lo que, que, esa persona no me hizo sentir, como la suficiente seguridad para, para yo hablar, o sea, de pronto fue muy cortante, muy, si, cortante, yo lo definía así, muy cortante. “Mira, ¿qué te pasó aquí? No hay ningún problema, todo va a estar bien. Cuéntame qué pasa,” y ya y yo no fijaste que yo no voy a decir nada.

The first one who asked me was a doctor, my baby’s doctor. I love him very much. I remember him being black and tall, and beautiful with my daughter, very tender, very nice, I will not forget his name. And he looked at me and he said “What happened to you? Did your husband hit you?” And, I said, “No, no.” Then we kept talking and talking. I think he noticed like, my change in my face, like you know from calm to terror, he said, “Wait a second, I’ll be right back.” And he came with this woman and that’s when he left me with her. And she started to ask me and to talk to me and I kept quiet and listened. All that was going through my mind was what was going to happen if I talked. . . . I think that what happened was that this person really didn’t make me feel, like, safe enough to talk. And she was very curt, very, yes, curt, that’s the way I would define it, very curt. “Look, what happened to you here? There’s no problem, everything is going to be fine. Tell me what happened.” [Speaking rapidly, mimicking providers, tapping on table.] And that’s it. And I said, no, I’m not going to say anything. (Sylvia)

Providing Information and Support Up Front and After the Fact

Fears of the consequences of disclosure silenced the women in their health care encounters. By providing anticipatory information about what would happen if a woman disclosed IPA, HCPs could calm those fears and eliminate the uncertainty that plagued these women’s lives. Even in my interviews, over and over the women replied, “I didn’t
know, I didn’t know that,” as I responded to their misconceptions about how health care providers can and do respond to disclosures of IPA, for example not calling the police, except in the four states with mandatory reporting.

*Responding to Disclosures: Open the Door and Be There When They Are Ready*

These women saw HCPs as well-positioned to provide support and information to battered women. A few of the women referred to support in emotional terms, as demonstrated by caring and concern. Women should be assured that they are not alone, and that help is available when they are ready. “Just listen, show you care, and offer help!” Most of the women emphasized logistical support and information as most important in helping women to get out of abusive relationships. Sara felt she benefited greatly by the specific information her HCPs gave her, leading her to skilled supportive mental health, legal, and social services. “I don’t want pity. What I want is support.” (Sara) These women had all found help through a battered women’s services agency and/or legal services program. They felt these sources of support and help were invaluable. They urged HCPs to make this information available to women who need it, and who are unaware of the support and help that are available. They encouraged referrals to battered women’s services agencies, as well as the provision of information about their legal rights and services available.

*Recognizing Women’s Autonomy and Relinquishing the Need to “Fix It”*

Health care providers need to understand that they do not have to, nor can they fix the problem. Serena made a strong point about patient autonomy, and the boundaries of providers’ influence. Providers themselves need to recognize these limits, and not think
that they can “make people do things. It’s really up to us, women, to see which way we want to go. Do we want to go or do we want to stay? Because I don’t think a doctor can make you do anything.”

Maria felt strongly that no one can make a woman accept help until she is ready, but it is important to open the door and offer help, and be there when she is ready. She heard a social worker from the clinic talk very briefly about domestic abuse at an English class. No one in the room acknowledged needing help, though Maria knew that several women were being abused. She thought about it for a year, and when she was ready, sought out that social worker, who helped get her and her 3 children into emergency shelter. She felt it is important for HCPs not to badger a woman with questions and make her even more afraid. HCPs can just plant the seed, and know that they cannot fix the problem, they can only offer help and support.

Missed Opportunities for Disclosure, Identification, and Intervention

The women’s experiences with HCPs represent a series of missed opportunities for disclosure, identification, and intervention for IPA. Their health care encounters were ridden with emotional and logistic complexities, as well as contradictory hopes and fears. The women entered health care encounters vulnerable, both fearing and hoping for identification of the IPA. They had fear and doubt about their HCPs, while at the same time hope for a personal connection with them. The women talked in my interviews about their attempts to bridge these contradictory emotions and needs. Giving clues was the primary mechanism they used to open the conversation, but they would then follow the lead of their HCPs. In nearly every case, these attempts were unsuccessful in creating
a conversation that lead to disclosure. This was frustrating and disappointing to the women, who thought that their attempts to give clues were transparent and obvious.

Iliana actively sought psychiatric help for her husband, whom she saw as mentally ill, hoping that help for him would ultimately help end the abuse. There were flyers on the clinic walls about abuse, but when she hinted to her HCPs, saying that he had a “caracter fuerte,” a “short temper,” they did not react, so she thought they thought it was normal. She experienced a mixed message, “I didn’t know who to talk to.” When she told the phlebotomist, she told her that the abuser would change at some point, and never told her HCP. When she spoke with the social worker, she was told they could not force him to come in for help, leaving Iliana feeling more alone than before.

Ana wanted to be asked about abuse, but was not. She had two providers, her pediatrician [she was pregnant as a teenager], and her gynecologist. She wanted both to ask her about her life, to understand her emotionally, but neither did. Her gynecologist referred her to a psychologist at her request, after learning that she had been in therapy in another state and at times felt depressed, but never asked her if there was a reason she felt depressed, as Ana wished she had. Her pediatrician scolded her for losing weight, but never asked her why she was losing weight.

Magdalena went to her ophthalmologist with progressive visual changes.

And they thought that I have a disease, but they made all the test, and they said they are normal. But what’s going on with you? So then the doctor just asked me, he just make the exam, and he asked me, “Are you under stress or something like that? Because really you know that stress could kill you? Did you even notice?” And I told him, “Yes, it could be because my personal life is stressful [stressful]. I’m under a lot of depression.” And he told me, “Well, you have to handle that, you have to take care of that, because if you don’t, you could be dead, or die,
because a stress situation could kill you, okay?” That’s the only thing that he told me, just control yourself, try to get out of the stress. (Magdalena)

_Hindsight is 20/20: “I would have left sooner if they had asked me.”_

Looking back, many of the women considered the process of HCPs asking patients about abuse to be an important intervention. They thought they would have disclosed the IPA if asked, “If you ask me, I will tell you,” and that they would have received help that would have led them out of the relationship. They regretted the near misses of disclosure and their withholding and passivity tremendously. They also wished that their HCPs had been more attentive to their behaviors and the clues they provided, had asked them about their lives and IPA specifically, and had helped them to escape the abuse. They saw their HCPs as missing multiple opportunities to help them, from creating awareness, “opening my eyes” to tangible support, guidance, and referrals.

Ana described how a HCP asking the question would have given her the freedom to talk and the trust to disclose the IPA. Ana thought that if her HCPs had asked her about abuse, she would have received help earlier, and might not be in such a bad way emotionally for years to come. Manuela did disclose the IPA to her HCP, and blamed both herself and her provider for not taking action sooner. “If they would have helped me before, I would have gone through all that I’ve gone through.” Looking back, Serena thinks that learning about abuse would have helped her understand that she needed to leave, as she had not thought about her relationship as abusive. If her HCPs had asked about IPA, “I probably would have left quicker.” Cecilia repeatedly asked herself and me during the interview, “Why didn’t they ask me?” thinking that by having been asked she
would have been spared years of abuse. "I was hoping that he would ask me, why didn’t he ask me or something? [I thought] Maybe I will tell him, but I didn’t know how to tell him."

Summary

These women were heavily burdened. For many the promises of a happy life with their partners had been perverted into betrayal and abuse. The women were strangers in a strange land, trying to overcome the traumas of the past, trying to be good mothers, daughters and partners. They tried to be protectors of their children, even at a time when their own lives were so devoid of protection. The women were trapped, literally and figuratively. Day to day life was risky business. Isolated and afraid, the women played it safe by living below the radar, avoiding the attention of anyone who could do them harm.

When viewed from the vantage point of below the radar where the women lived, their health care providers loomed as large and powerful figures. The women were not always sure what to expect in their encounters with health care providers, but their fears were many. Because their abusers taunted them with lies, some of the women believed that health care providers would have them deported, call the police, or take away their children. Maybe their abusers were wrong, but who was going to trust their provider enough to find out? The risks of disclosure often outweighed the benefits. Despite their overwhelming fear, some of the women desperately wanted to be asked about the abuse and to receive help. Dropping hints and giving clues about the abuse was not enough to garner their health care providers’ full attention, they simply missed the boat. In their

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hour of great need, health care providers failed these women in their quest for comfort, guidance and help.

In the context of their fear, threats from the abusers, misunderstandings or lack of knowledge about their rights and the laws that would protect them, the women remained silent about the abuse. Only in a completely safe context could they disclose. They would need to know that their provider cared about them as a person; they would need to trust their provider; they would need to know the consequences of disclosing beforehand, and they would need to be asked about abuse. With this safety, and with questioning, they would tell. “If you ask me, I will tell you everything.”

My Reflections as a Health Care Provider

These findings were exquisitely painful to explicate. They reflect the women’s experiences of health care encounters, as well as their experiences in life outside of the clinical realm. Fear and uncertainty, unfulfilled hopes and overwhelming disappointment, vulnerability and daily challenges filled their lives as abused women. In a positive light, all of the women had escaped the abusive relationships, and were moving forward in their lives. They still had struggles, now they were single parents, and a few still had problems with their abusers, but all described the newfound freedom and happiness leaving the abuser had brought them and their children. Their faces were lighter and eyes brighter as they described their new lives. They relished the support they had found from the battered women’s services agency and the legal services program, and the friends they had made in support groups, new jobs, and in new housing arrangements. They expressed
a heartfelt desire to help other women who suffer as they had. “If this [participating in this study] helps just one woman, it will be worth it,” they said over and over.

As a health care provider, my heart broke to hear about the fear, hurt, and disappointment in their health care encounters, in their relationships with their providers. It saddened me to hear that of these 17 women, only one identified her health care providers as helpful to her in getting away from the abuser. But I was heartened to talk with women who had escaped intimate partner abuse. That was relatively new for me. When my patients got out of abusive relationships, I rarely knew about it, as they would disappear out of necessity. My skewed view as a clinician was that battered women hardly ever got out, as I had so many patients who endured year after year, and even more who never disclosed to me that they were being abused, but whom I strongly believed were.

As I conducted the interviews, reviewed and transcribed the audiotapes, and conducted data analysis, I had several reactions, as a health care provider, as a researcher, and as a fellow human being. My reflections as a health care provider can provide a glimpse from the other side of the exam table, albeit just one view of many. Consistent with interpretive phenomenology, my perspective becomes part of the research process, and certainly part of the interpretive process in data analysis. My view can add another dimension to the women’s experiences, putting them in yet another context. What it can not do is change those experiences, make them what they were not, or repair them.
Where I See Ambivalence, You Are Living in Fear

The fear the women lived with relative to the abuse placed them in untenable situations. They were caught in a trap, with the fear keeping them in the abusive relationships, while they longed for a safer, better life for themselves and their children. Their fear of the abusers and of the abuse to come created fear of health care interactions, for their inherent uncertainty of the consequences of disclosure or detection of the abuse. With every health care encounter, they had to weigh one set of fears with the other: keep quiet or try to get help? Is it worth the risk? Can I afford to be vulnerable with this person? Will I get help or make matters worse?

As health care providers, we often perceive battered women as caught in a trap, but we label the trap ambivalence, not fear. Corridor and coffee-room conversations among HCPs reinforce the idea that until women are ready to leave, our hands are tied. One person cannot undo another's ambivalence. Health care providers are known to get frustrated and burned out, especially when they have offered a woman help and she has not taken it. It is true that women in abusive relationships have ambivalence about staying with or leaving abusive partners; after all they want the abuse to end, not necessarily the relationship. But perhaps we misinterpret and misunderstand the behaviors that we label ambivalence. If a woman describes walking into a door, when we can clearly see evidence of assault, we [HCPs] think she is not telling us the truth because she is not ready to leave the relationship. More likely it is her fear, and for the moment, she is more afraid of the harm that we can cause than she is of continuing to endure the abuse in silence. If I as a HCP understand these behaviors as fear-based, I can actively
respond to those fears, rather than taking the hands off approach of “I am here when you are ready.” Of course, we need to offer that open door, and to leave it open, but we need to recognize fear, life-and-death fear, for what it is.

“How can I help you today?”

So many of the women described the abrupt way in which their HCPs started their health care visits. “What are you here for today?” “What do you need?” “How is your health?” “How can I help you today?” The women viewed these questions, and the general approach of HCPs to their visits as brusque, impersonal, and sometimes rude. They did not understand if a HCP knew they had children, how could they not ask about them first? “If they [HCPs] know I am working, or going to school, why wouldn’t they ask me about that?” Social custom dictates that we inquire about the other, her family, her life, prior to jumping into our own agenda.

As HCPs, we recognize the need to establish rapport. However, we are educated to establish rapport by introducing ourselves, and making sure the patient is physically comfortable prior to beginning the health history! We open a health history with exactly those questions above or, “What concerns bring you here today?” (Bickley, 2003, p. 26). These questions are designed to elicit what we label the patient’s “chief complaint.” Newer texts label this “chief concern;” this language is less problematic, but the idea is the same. There is a clear agenda for each visit, and our duty as HCPs is to determine the patient’s agenda at the beginning of the encounter. We seem to think that by asking an open-ended question, which is certainly preferable to dictating the agenda of the visit, we will illicit a clear articulation of need. In reality, as these women told me, “No one is
going to walk in to the clinic and say, ‘I’m being abused and I need help.’” For these Latina women, personal conversation, having nothing to do with health concerns, is the starting point for a caring, trusting, relationship, with honest and open communication.

“Your five minutes are up.”

Lack of time, manifesting as 5-10 minute appointments, rushing providers, and hurried, incomplete verbal exchanges, emerged as a tremendous barrier in these women’s health care experiences. Some of the women interpreted lack of time as representing a lack of caring on the part of their providers. Given that meaning, they responded by shutting down emotionally, setting aside any hopes for comfort or discussion of and help with the abuse they were suffering. They adjusted themselves to what they thought the provider could or was willing to do, prescribe medications and make referrals to other providers.

HCPs know the time pressures within which we work. I doubt there is a HCP out there who does not want more time with her/his patients. I found myself wanting to correct the women’s assigned meaning. “It’s not that we don’t care, it’s that we don’t have time! We really don’t!” Time pressures are a tremendous problem, perhaps the biggest, in our health care system. Lack of time influences more than patient-provider communication and interpersonal relationships, it causes medical errors, incomplete care, and more frequent visits, as well as provider fatigue burnout. In fact, I left my full-time clinical practice when I felt the negative influence of time constraints in each of these domains. Not only was it not safe, but I was not even being nice anymore! Had I become “too tired to care”? How do we show that we do truly care when we haven’t stopped
moving for eight hours straight, without food, water, or bathroom breaks? How can I show that I am trustworthy, when everything I do and say is at an accelerated pace?

"I would have left sooner if they had asked me."

*Hindsight is 20/20.* That which is obvious and facile today for the women was murky and complex in the past. The women identified questions about the abuse while they were being abused as the doorway to freedom. They saw a clear causal cascading effect of screening: HCP asks → I tell → I get help → I get out. Of course, it is not that simple, nor was it in the past. The women themselves clearly articulated several requisites to disclosure, being asked about abuse was only one of them.

As HCPs, we can have that same magical thinking, expecting a clear sequence of events to follow our screening for IPA. The frustrations come in for many HCPs when that sequence is interrupted. HCPs often believe, “If I ask you, and you don’t tell me, there is nothing I can do. If I ask you and you do tell me you are being abused, and I offer you help, in the form of hotlines, referral to a shelter or a battered women’s services agency, and you don’t get out, then there is really nothing I can do.” The challenge for us as HCPs is to recognize that intimate partner abuse is not a linear problem with a linear solution: screening does not always lead to disclosure, and disclosure does not always lead to separation from the abuser. We may not be able to fix it, but we can recognize the complexity of the problem, and respond accordingly.

In the next chapter, I will discuss these findings in the context of Heideggerian hermeneutics, the current state of nursing knowledge on the topic, as well as the contributions these findings make to nursing knowledge. I will also discuss the
implications of these findings for nursing practice, education, research, and health care and public policy.
CHAPTER 5

It is not the culture that shapes the health care experiences of clients. It is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized, and ordered around. (Meleis & Im, 1999, p. 96)

Significance of the Findings and Implications for Nursing Knowledge

The purpose of this study was to describe battered Latina women’s experiences of health care. Interpretive phenomenology was the method chosen to achieve this. The goal of interpretive phenomenology is to describe, as richly as possible, a lived experience, uncovering commonalities and differences. These data were analyzed with five sources of commonality in mind: situation, embodiment, temporality, concerns, and common meanings (Benner, 1994). Toward that end, in the first part of this chapter I will shed light on the women’s interior experiences, particularly their senses of self, as they described them to me. Then I will discuss the significance of the findings as they pertain to the current state of knowledge, as well as new and different findings. The limitations of the study will be elucidated. Finally, the implications of these findings for nursing practice, education, research, and health care and public policy will be discussed.

*Being in the World as Battered Latinas: Phenomenologic Commonalities*

The women all found themselves unexpectedly situated in positions of incredible conflict. Nearly universally, the women’s relationships with their abusers had started as positive relationships. Some of the relationships began out of necessity, but nearly all began with love. Several of the women moved across the country or immigrated to this country to be with their abusers. All of these women described the shocking and sudden
change in their partners' personalities once they had relocated to be with them, leaving their families and friends behind. Partners went from being charming and attentive to controlling and violent. Much of the women's energy and focus went to attempting to manage their abusers, trying to predict and avoid violence, protecting themselves and their children.

Some women were situated in additional sources of conflict and tension. All were parenting, and struggled internally with what was best for their children, given the violence at home. Many were undocumented and Spanish-speaking, and therefore lived their lives in a constrained way, limited by geography and language, limiting their public exposure for fear of detection. Their isolation that started in relation to external social contact became an internal emotional state of being. They became isolated within themselves. Encounters with health care providers were smooth for some of the women, particularly those who were not seeking either support or help with the abuse they were enduring. For the women who feared the abuse would be detected, either because of visible injuries or their manner, health care encounters were tension-filled and had the potential for incredible conflict. Walking into a clinic or through a health care provider's (HCP's) office door was rarely straightforward and easy for any of these women. Even those who actively sought out their HCPs as potential sources of support were often disappointed, furthering their feelings of isolation and despair.

Embodiment refers to direct perception, the knowing that comes with perceptual, emotional and bodily responses (Benner, 1994). There is abundant literature describing the embodied knowledge that battered women have relative to the abuse and the abuser,
the ways in which they use their finely attuned senses to predict violence. The profound fear and wrenching despair experienced by these women was physically palpable. Cecilia described it well. She went to see her HCP at least every month, with physical symptoms of one kind or another, “Even if I wasn’t sick, I was feeling sick. . . . I felt it. I felt . . . pains.” Her physical symptoms of pain and low energy resolved once she separated from her husband. Her insomnia persisted, however, occurring every time she had to go to court with him, or any time he contacted her.

The women were also extremely attuned to their children’s embodied responses. While these understandings were by definition indirect, many commented on the physical manifestations of the abuse in their children. One of Sylvia’s daughters lost all of her teeth over a short period of time, a problem that was attributed to stress by her pediatrician. Others described their children’s stomach ulcers, hair loss, insomnia, and anxiety. The women watched their children closely; as they saw their children’s emotional and bodily responses to the abuse, they realized they must leave and take their children with them.

Even as they told their stories, the women’s understandings of the situations were embodied. Some took note of that, and explained, “This is just how I felt back then, my heart racing, my stomach hurting.” Shallow breathing accompanied their stories of assaults; several of the women became tired, yawning as they recalled their years with their abusers. A few developed headaches during their interviews. Nearly all of them cried at some point, recalling their emotional and physical despair of the past.
Temporality is the experience of lived time, how one understands oneself from the past and imagines oneself in the future (Benner, 1994). Time slowed down for these women while they were with their abusers. They found themselves in holding patterns, anticipating the future with equal parts hope and dread. They hoped for changes in their partners for the better, and dreaded the threatened abuse to come. Time slowed down most acutely during physical assaults. Carol described a wait for the police that felt unbearable.

I did call the cops. And you know how long it took them to get there? I forgot to tell you this. It took them a long time. I called three times . . . I was like, "I'm about to die, can you send somebody over here?" I was crying. I said "I'm about to die, can you please send somebody over here?" And the lady was like "Hold on a minute." And I held on and she said there was a cruiser on the way. I was like all right, she's like "Just stay on the line with me," and I said, "I can't, he's going to kill me," so I hung up the phone. I was in the bathroom, waiting in the bathroom and I like, oh my God . . . I had the cordless. He was banging on the door, and I was like oh my God, I'm going to die. I called them again. I said "They're still not here. He's going to kill me. Oh my God, what are you guys waiting for, for him to kill me?" I hung up the phone because I was scared, and then he kept banging and banging and banging the door and I called again! I was like, "He's going to kill me! By the time you guys get here, I'm going to be dead, so hurry up!" And then he pushed the door open. The door opened. I don't know who screamed out, the cops are here. Then he just disappeared.

Looking back, they regretted "wasting" and "losing" so much time, staying with abusers. The future was so uncertain for these women. Many described "shattered dreams" and lost hopes for the future as their relationships became abusive. After escaping their abusers, they were able to create new hopes and dreams for the new life they were creating with their children.

The most salient concern to all of the women was the well-being of their children. Mothering was the most important role in their lives, and guided their decision making.
Everything they did was for the sake of their children. They lived for years enduring abuse, but endured no more when they realized the harmful impact of the abuse on their children. Their fears of disclosure or detection of the abuse by HCPs were based in their concern for their children. All of the feared consequences revolved around their children: loss of custody of their children to children's protective services (DSS), deportation that would leave their children motherless, escalating abuse that could harm their children or again, leave them motherless. This prevailing concern for their children guided their decisions, most of which disregarded their own needs. This disregard was emblematic of their invisibility, not only to others, but to themselves.

Most had more contact with pediatricians and HCPs for their children than for themselves. Many first talked in the interviews about their experiences of health care in the context of their children's health care, rather than their own. "Para el niño, para la bebé, todo bien... ¿Para mí? Yo como que no me veía en mi, o sea, no me interesaba que, que, que se preocuparan por mi. ¿Si me entiendes?" "For my son, for my baby girl, everything was fine... For me? I wasn't really thinking about myself. I was not interested in, in, in anybody worrying about me, you understand?"

Multiple common meanings were found in the women's experiences of health care, ranging from general understandings to very specific meanings, which led to unarticulated discontent between the women and their HCPs. The universal hurt and dismay caused by the rushed behavior of HCPs serves as an example. Even though some of the women understood the time pressures of the United States' health care system, all felt hurt or angered by their HCPs' behavior, interpreting it as showing lack of caring and
concern, disinterest, and disrespect. "I wasn't looking for a three hour conversation, but more than three minutes would have been nice." This attributed meaning caused the women to feel hurt, angry, disappointed and frustrated, all feelings which were likely unintended by their health care providers. Similarly, the initial questions of health care encounters, "What brings you in today?" "How is your health?" were viewed as rude, and again, failed to show caring on a personal level. The women expected norms of social behavior within their health care encounters, inquiring about their children and lives prior to establishing an agenda for the health care encounter.

The clues that the women used to prompt a discussion of their intimate relationships and of the abuse had a common meaning to the women that was presumably not understood by their HCPs. That which was so obvious to the women was lost on their providers. "Caracter fuerte" had an understood meaning to the women that went beyond the surface. It meant, "Something bad is happening to me, please ask me about it." I will discuss common meanings further in the section entitled Contributions to the Current State of Knowledge.

In summary, phenomenologically, being in the world for these battered Latina women was excruciating. They were enduring abuse, alone, afraid, and uncertain whom to trust and where to turn for help. They worried about their children, their well-being, and their futures. They struggled to manage everyone and everything around them, living beneath the radar, avoiding detection and notice. Having been made invisible by their life circumstances and by their abusers, they perpetuated this to avoid further harm, remaining invisible even to themselves. Interactions with health care providers were
threatening, as they represented something “official,” with the power to involve other officials who could do them harm. Nonetheless, they desired the attention of their health care providers for support and guidance, emotional and logistic. This they did not find.

Current State of Knowledge

The findings closely parallel extant knowledge about women’s experiences of intimate partner abuse and of abused women’s experiences of health care. These women described similar experiences of abuse, health care interactions, and barriers to disclosure as those reported in the literature. Their health care experiences were primarily negative, and included feeling uncared for, unhelped, and dismissed by HCPs who were “just there to do their job.” Fear was the primary barrier to disclosure; others included lack of trust in HCPs, lack of caring, and confidentiality concerns. In designing the study, I hoped to elicit positive experiences of health care that had been helpful, hoping to shift our focus and understanding to what does work, rather than what does not.

Regardless of the quality of the experiences in terms of compassion and connection, whether positive or negative, the women did not disclose the abuse because of several barriers. Most significant among these women’s barriers to disclosure to health care providers were concerns about HCP behaviors: uncaring, not listening, too rushed, not trustworthy, and not asking about abuse; and concerns about loss of control in decision making and outcomes of any disclosures, including police, DSS, and Immigration and Naturalization Services (INS) involvement. These findings closely parallel those of several recent studies (Bacchus et al., 2003; Hathaway et al., 2002; Rodríguez et al., 2001).

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The added dimensions of immigration and being of Latin culture made these battered Latina women’s experiences unique. For the Latina women in this study, concerns about HCP behaviors and the involvement of various authorities were much more primary as barriers to disclosure than the more internal barriers experienced by Anglos: shame and embarrassment, denial, and fear of reactions of friends and family. Rodríguez et al. (2001) reported that the Latina women in their sample identified language barriers (34%) and concerns about immigration authorities (21%) as significant barriers to disclosure. The most significant predictor of discussion of IPA as reported by Rodríguez et al. was direct questioning about IPA by the HCP. This finding is reflected in the themes of “If you ask me, I will tell you,” as well as the code of silence that was maintained in the absence of questioning. “They didn’t ask me, so I didn’t tell.”

The requisites for safety for disclosure of IPA identified by the women, knowing that the provider cares and is trustworthy, knowing the consequences of disclosure in advance, and being asked about IPA, are reflective of those reported by several researchers investigating Latinas’ experiences: perceiving HCPs as caring, easy to talk to, protective, and being offered a follow-up appointment by the HCP (McCauley et al., 1998); confianza (trust, confidentiality, support, comfort, and safety) (Rodríguez et al., 1998); and compassion, respect, kindness, and sincere concern (Bauer & Rodríguez, 1995).

Worth particular mention is a study by Belknap and Sayeed (2003), which explored the characteristics in a nurse or HCP necessary to give confianza to abused Spanish-speaking Mexican American women to discuss IPA. They found that the women
welcomed discussion of IPA when HCPs demonstrated certain interpersonal characteristics and behaviors: presence, showing an interest in the patient’s life, and listening to her response. Their study and its findings are extremely similar to this study, with both studies identifying asking battered Latina women questions about abuse, and listening to their responses, as key findings.

In summary, the findings of this study strongly support the growing body of knowledge about battered Latina women and their experiences of health care. There are findings that apply to many populations of battered women, and some that are specific to Latinas. Latinas, particularly immigrant Latinas, share concerns with the interpersonal characteristics and behaviors of HCPs with other groups, and are more concerned with language barriers and the potential involvement of various authorities if they disclose IPA. Their fears of the abusers are complicated by their added vulnerabilities as immigrant women, unable to speak English, and unaware of their rights.

*Contributions to the Current State of Knowledge*

There are two major areas in which these findings further our understanding of the health care experiences of battered Latina women. The first has to do with the parallels that these women experienced in their relationships with their abusers and their HCPs. The second has to do with the various influences of culture on these experiences, beyond identification of language barriers and intensified fears of disclosure and detection.
Parallels in Relationships with Abusers and HCPs

Unexpected findings were the multiple parallels that existed in the women’s relationships with their abusers and with their HCPs. As HCPs, we think of ourselves as the antithesis of perpetrators of abuse. We are there to help, not to harm. But from the women’s viewpoints, the health care system and individual HCPs loomed as potential threats. On an interpersonal level, the context, the content, and the character of the patient-provider relationships had the potential, at least, to mirror the abusive relationships. The specific parallels included fear, lack of control and powerlessness, feeling controlled, invisibility, relinquishing control, and protecting the other.

On reflection, these parallels are not surprising. It is not a new idea that battered women, immigrants in particular, are extremely vulnerable, and that vulnerability permeates their lives. The field of psychology offers several theoretical explanations for these parallels. However, nursing has yet to recognize and understand these parallels, and the reactions they can cause the women to have. This is critical to providing effective health care to this population, including effective identification and intervention for intimate partner abuse.

These parallels can be seen in the themes identified by Farrell (1996b) in a study of the sense of relationship in women who were abused: a lack of relational authenticity, immobility, emptiness, and disconnection. Farrell’s study built on the relational model of Miller (1976) and Surrey (1985). Lack of relational authenticity has to do with the women’s relationships with themselves and their sense of identity. This can be seen in the women’s reticence to trust their HCPs, in their unwillingness to disclose the abuse and
their attempts to hide it, and their living below the radar, remaining invisible to those around them, and possibly to themselves.

Immobility is visible in the women’s enduring the abuse for years, in their passivity in their health care encounters, and in the ways in which they relinquished control to their HCPs, over matters related to IPA and not. Emptiness and disconnection are seen in the experiences of the women in their relationships with their HCPs as lacking caring, trust, personal recognition, and personal connection. Health care encounters often exacerbated the women’s sense of disconnection and isolation that was the direct result of the abuse and their immigration experiences.

The women’s identified preferences for HCP behaviors, and their suggestions for improving HCPs’ responses to victims of IPA address many of these parallels and relational components. HCPs must show women that they care about them as individuals, as people, and not “just a number.” HCPs need to earn women’s trust through continuity of care, through personal engagement, and by consistently demonstrating concern for their well-being. These recommendations for HCP behaviors address the emptiness and disconnection that battered women may feel. The women recommended that HCPs ask women directly about IPA, listen to their responses, and provide information and support, directly addressing the immobility that can accompany living in an abusive relationship. Finally, HCPs were urged by the women to recognize each woman’s autonomy, her uniqueness, her needs, and her personal process and choices in dealing with the abuse. This would speak to the lack of relational authenticity, particularly if HCPs would engage women in conversations about their uniqueness and autonomy.
There is a general assumption among HCPs, nurses in particular, that patients give us the benefit of the doubt, professionally and personally. Barring an egregious mistake, it is assumed that patients understand that we are to be trusted, that we would not harm them intentionally, and that our behaviors are in their best interests and are intended to promote their health and well-being. We position ourselves as “here to help.” These findings inform us that this is not always the case. The extent to which any individual confers trust to a HCP de facto varies according to that individual’s life experiences. Battered Latina women have a multitude of reasons, multiple vulnerabilities, causing them to be cautious. Without attending to the interpersonal and behavioral requisites for confianza, and a fully trusting and safe relationship, HCPs miss opportunities for identifying and assisting battered Latina women.

Understanding the Influences of Culture

The influences of culture in battered Latina women’s experiences of health care are many. The surprising finding was that ethnic disparity per se between the women and their HCPs was not viewed as problematic by the women, though language was. There was an obvious cultural divide in the findings, but it pertained primarily to the women’s fears of the health care system and expectations of individual HCPs. The fears were based in their situational vulnerabilities, as opposed to culture-specific concerns. Their expectations of HCPs were culturally based, of course, but reflected universal human emotions and desires that cross cultures.

Within the United States (US), there is a universal recognition that the health care system is in crisis. Concerns about supply and demand, financing, and quality of care
abound (Walker, 2004). An internet search using the search engine Google in March, 2004, and the term “US health care system crisis” yielded 1.68 million hits. A similar search on Amazon.com yielded over 60,000 books on the subject. Widespread discontent with health care interactions fuels public commentary and frequent references in the media, i.e. jokes about the inhumanness and impersonal nature of managed care abound. Health care consumers have become savvy, learning how the health care system works, and how to work it.

Health care providers have also had to learn how the system works in each of its iterations. We have our own perspectives on the provision of health care, and what is and is not possible to accomplish in the setting of competing demands and productivity pressures. When it comes to addressing IPA within the system, HCPs have a limited repertoire of responses. “You don’t deserve it. Let me get you out. Here are phone numbers for hotlines and shelters.” When these responses are ineffective in getting a battered woman out of the relationship, we shake our heads and wonder why.

_Fears of the health care system._ The findings suggest that battered Latina women lack certain knowledge about the health care system and its functioning. Their fears are based in the belief that there is a direct link, a direct line of communication, between health care providers and government authorities, i.e. the police and INS. Of course, they are correct in terms of DSS, as HCPs are mandated reporters of suspected child abuse or neglect. This complicates women's participation in and receipt of health care tremendously. They lack knowledge about the requirements of confidentiality, believing that HCPs might contact the abuser, call the police, or tell other people about the IPA.
Some of the women were unclear about the relationship between publicly funded health care coverage and free care and official contact with INS, believing that if they applied for Medicaid or free care, they risked deportation.

The manner in which health care is provided was confusing to these women. Many were unfamiliar with the concept of primary care, believing instead that they had to see whomever they were given for each appointment. One woman saw a different HCP for her annual physical exam every year for six or seven years, precluding the development of a trusting relationship. Many of the women did not know they could change HCPs if they were unhappy with the care they were receiving, so they persisted in these disappointing relationships, just as they did with their abusers.

The roles of various HCPs and health care settings were also confusing; whom do I see for what? One woman described going to the emergency department (ED) multiple times when she was upset and crying, having endured another emotional or physical attack at the hands of her abuser. “I thought I was dying, I was so upset.” Eventually she was told she could not go to the ED for these concerns, and she was referred to psychiatry.

*Expectations of health care providers.* The women were shocked and dismayed to be on the receiving end of cold and impersonal treatment by HCPs. Many expected a personal connection; they viewed their HCP as someone with whom they were in relationship, one human being to another. While this may represent the influence of Latin culture on these women’s experiences, it can also be understood in another way. Non-Latina and non-immigrant consumers of US health care may simply be more acculturated
to the limitations of the health care system and of patient-HCP interactions. Satisfaction with health care that is impersonal likely reflects a downgrading of expectations, rather than an Anglo cultural value of distance in relationships!

*The subtle dance of disclosure.* One area in which the influence of culture is clear in the findings is the issue of disclosure of IPA. Very few of these women disclosed the abuse to HCPs. They avoided health care, covered their injuries, and denied IPA in the rare instances that they were asked about it. However, many tried to disclose indirectly, by giving clues to their HCPs about problems in their intimate relationships. None of these clues were recognized by their HCPs for what they were.

Disclosure and identification of IPA were described as a subtle and complicated dance between abused women and their HCPs by Gerbert et al. (1999). These authors described disclosure by women and identification of IPA by HCPs as a complicated dance that included a range of direct and indirect communication and behaviors. The abuse survivors in their study disclosed directly, dropped hints, told poorly constructed lies hoping to be found out, maintained silence for years, and denied IPA. Some of the women disclosed only if they knew the HCP would not act on the information. “I will tell you, but I don’t want you to act,” (Gerbert et al., p. 123). Their reasons for not disclosing were similar to those found in my study. Though the sample was primarily white, the study was conducted in California, one of the four US states in which HCPs are mandated to report IPA to authorities. Consequently, women’s fears of loss of control of the outcome in a health care encounter parallel those of battered Latina women’s.
Health care providers in the Gerbert et al. (1999) study asked about IPA directly and indirectly, and acknowledged it explicitly and tacitly. Some HCPs attached labels like “battered,” while others implied support and understanding of the problem without ever naming it. Some picked up on clues and others did not.

Some of the significance of the findings of this study pertain to this subtle dance. The subtleties and complexities of the dance of disclosure and identification get lost in the cultural divide between HCPs and their battered Latina patients. Disclosure often requires a delicate negotiation and sharing of information between HCPs and their patients that is challenged by linguistic and cultural misunderstandings. The clues the women used to prompt discussion of IPA were lost on their HCPs. The common meanings understood by the women as a group were not shared by their HCPs. The subtle approaches that some HCPs used to inquire about IPA, “How are things at home?” were lost on the women. As separate groups, both Latina women and HCPs had common meanings and understandings within their groups, but these were not shared across groups. For example, HCPs understand a question like, “How are things at home?” as an open-ended question inviting the expression of any concerns about home life, relationships, family. The women perceived this as a polite question, but not an invitation for discussion of their deepest concerns and problems.

The dance of disclosure and identification of IPA occurred as if in the context of a disharmonious symphony. Notes were off key, missing their marks. There were starts and stops in the rhythm of conversations, disrupted by misunderstandings and missed clues.
Toes got stepped on, or each person ended up dancing alone, next to the other. Subtlety did not work in this scenario.

The missed understandings between battered Latinas and their HCPs represent a series of missed opportunities for disclosure and identification of IPA. HCPs need to be more attuned to the subtleties, and to communicate and behave in a more direct manner with their Latina patients, particularly in terms of information sharing. Directly addressing the fears of undesired involvement of authorities up front can eliminate the need for attempts at tacit communication.

Limitations of the Study

This study described the abuse and health care experiences of battered Latina women. Each of the women in the study self-identified as having been in an abusive relationship in the past, which she had left. The women all received some type of health care during the time they were being abused. They all had received services from a legal program and/or a battered women’s services agency. Most had participated in a support group for battered women. Therefore, this study is limited in its scope. It does not address the experiences of battered women as they are still in abusive relationships, or women who do not identify themselves as abused. It also does not consider the experiences of women who did not receive health care during the time they were experiencing IPA, or women who have not benefited from formal support services.

The intimate partner abuse and health care experiences the women described all occurred in urban settings. All of the women had access to a variety of services, including health care, legal, and social services. The neighborhood in which the study was
conducted had a battered women's services agency, a legal services program, a mental
health counseling center, and a Hispanic social services agency literally within two
blocks on the main street. A large health care center was four blocks away from that
cluster. The findings reflect the proximity of services available to the women, and do not
address the abuse and health care experiences of battered Latinas in less populated areas,
with fewer available resources.

Implications for Nursing Knowledge

This study has significant implications for nursing practice, education, research,
and for health care and public policy. Attention to this complex problem is necessary in
each of these domains to ensure improvement in health care, positive health care
experiences, and positive outcomes for battered Latina women.

Nursing Practice

The study findings clearly reinforce the research showing that health care
providers have not had a significant role in assisting battered women. Clinicians need to
develop the knowledge and the skills to screen for, identify, and respond to disclosures
effectively in cases of IPA.

Screening. While identification of domestic violence screening as a standard of
care has raised HCPs' consciousness of the issue, screening techniques need to be
improved. Standard domestic violence screening questions are typically something like,
"In the past year [or in your life], have you ever been hit, hurt, kicked, or made to feel
afraid by someone you love?" With the inclusion of a written screening question on many
health history and hospital intake and admission forms, the question has been reduced to

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one of many, risking questioning that is rote, rendering it meaningless. “Do you smoke? Do you drink? Is anyone hurting you?” A vulnerable battered woman, of any ethnicity, is extremely unlikely to respond honestly to this type of screening.

HCPs need to screen patients in a meaningful way, fully cognizant of the significance of the question in an individual woman’s life. They need to attend to women’s needs for sincere caring and attention, as well as trust and safety issues. Screening needs to be conducted consistently over time, asking patients at each visit about IPA, recognizing that it may take being asked several times for Latina battered women to feel enough trust and safety to honestly respond.

Health care providers need to provide anticipatory information about screening questions and the consequences of disclosures, proactively addressing confidentiality concerns very specifically. For patients who are known to be or suspected of being undocumented immigrants, HCPs must reassure patients that INS will not be notified. With the exception of states with IPA mandatory reporting laws, HCPs should inform patients that neither the police, nor the abuser, will be contacted by them.

Health care providers are mandated reporters of suspected or witnessed child abuse and neglect. Most patients are aware of this. There is no simple way to address women’s fear of DSS involvement as part of screening. HCPs cannot promise that they will not contact DSS. The current reality is that DSS, both by reputation and by behavior, is a major barrier in the patient-HCP relationship, particularly for battered women. DSS is viewed by many health care providers, social services workers, and patients as a punitive bureaucracy. However, health care providers can develop collaborative
relationships with child protection workers to improve communication and the responses of DSS to battered women and their children. Any HCP making a referral to DSS should follow up closely with the case worker assigned to the referral, as well as with the patient to foster an on-going relationship. I will discuss collaborations with DSS in more detail relative to health care policy and nursing research implications.

Identification of IPA. Health care providers must be aware of the clinical indicators of IPA, as well as the interpersonal clues. The women in this study used multiple clues to prompt their HCPs to discuss their relationships with intimate partners and the possibility of IPA. It is important to remember that it is extremely unlikely that patients will clearly and spontaneously identify themselves to HCPs as being abused. Remembering that the subtle dance of disclosure and identification fails across cultural divides, HCPs of Latinas need to take care to be explicit in their communication.

Responding to disclosures. Health care providers need to both ask the questions and more importantly, listen to the answers! No one HCP can fix the problem for a patient, but can provide support and information. Particularly in the context of hectic clinical practices, the important HCP response is to connect women with the right services as quickly as possible. Appropriate referrals to skilled battered women’s services agencies and other appropriate providers are critical, and represent an interdisciplinary approach to this multi-faceted problem. The findings strongly support the idea that the women felt that the best thing that HCPs could do for battered women would be to provide them with information about abuse, as well as battered women’s services agencies, which are equipped to provide a full range of services.
**Interdisciplinary collaboration.** The professions of nursing and social work often overlap in clinical practice. Health care settings often require nurses to perform activities that have historically been the domain of social work. Social workers have education and expertise in areas that nurses do not and that battered women need! As with most complex health care problems, interdisciplinary collaboration provides patients with the best that each involved profession has to offer. Nurses in clinical practice should create collaborative relationships with providers in multiple disciplines as well as community alliances, facilitating access to services for their patients. This need not be as abstract or vague as it may sound. In my clinical role, I developed a collaborative program with a family law attorney who was working with Latina battered women. (Her program was one of the sites for this study.) The collaboration was ideal; we each had what the other needed for the women we were serving! She was available and looking for referrals; my health care setting was overwhelmed with Latina women who were being battered and in need of services. This collaboration created smooth and efficient access to legal services, and led to subsequent collaboration with battered women’s services. With this resource in place, the HCPs in the setting were more willing and able to conduct IPA screening because they felt they had something to offer. However, while working to ensure that appropriate resources for battered Latina women are in place is a function of nursing practice, this also needs to be addressed at the policy level.

**Patient education.** Many clinical practices use flyers and posters in the clinical setting to encourage their patients to discuss IPA with their HCPs. They typically read, “Are you being hurt by your partner? Put down? Made to feel afraid? This is abuse and

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no one deserves to be treated this way. Talk to your doctor [HCP]. We can help.” The findings reveal the inadequacy of these educational materials for battered Latina women. Without knowing what “help” is, they did not feel safe to disclose the abuse they were enduring. Again, the problem of not knowing the consequences of disclosure prohibited discussion of the problem.

Based on the findings of the importance of mothering to these women, and the priority they placed on their children’s well-being, a significant area for patient education pertains to the effects of witnessing IPA on children. Several of the women described their efforts to protect their children from witnessing the abuse by putting them in another room. Of course, this is not enough. Child witness to violence carries severe risk to the child (Groves, 2002). As nearly all of the women were ultimately motivated to leave their abusers by seeing the harmful effects of the IPA on their children, this may be a critical point for patient education and intervention. Raising battered women’s awareness of the harm caused to their children, before it is outwardly visible, may assist women in mobilizing their resources to leave the abuser sooner.

In short, critical elements in nursing practice in caring for Latina women who may or may not be abused include:

- Demonstrate caring and concern on a personal level
- Create trust via continuity, personal connection, honest communication
- Provide information in advance of screening for IPA about confidentiality and consequences of disclosure
- Ask the question at each visit and listen to the answers!
In the event of disclosure or identification of IPA,

- Provide emotional support
- Provide information about available social services and battered women’s programs.
- Discuss the harmful impact of IPA on children in the home
- Collaborate with other disciplines and community resources to get women to the services that they need effectively and efficiently.

*Nursing Education*

On-going education of students in health care programs, as well as continuing education for clinicians in practice, are necessary to improve HCPs’ competence and comfort in addressing IPA. Sessions at clinical conferences on IPA are often filled to capacity, reflecting clinicians’ interest and desire in improving their skills. However, the standard curriculum for educating HCPs about identification and response to IPA falls short and warrants revision. The findings of this study illustrate how standard approaches can fail, at least for battered Latinas, i.e. universal screening that becomes rote and insincere. As elucidated above, the approaches that HCPs take with this population need to account for their particular vulnerabilities and fears.

Continuing education has focused on screening for IPA. However, even those HCPs who feel comfortable conducting screening often feel unsure of how to respond to disclosures. This may be due in part to the necessity of having resources and community alliances in place to respond appropriately. Clinicians need to identify specific resources and create alliances in their health care settings and geographic locations. The specifics

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cannot be taught to a larger group. However, education should address HCPs' need to
know what to do when someone does disclose IPA. Education is crucial for developing
competence and comfort in HCPs. Health care policy is crucial for developing the
environment and resources that would enable HCPs to use their skills routinely in
addressing IPA.

*Health Care and Public Policy*

There are several implications for health care policy that emerged from these
findings.

*Coalition building.* There is a clear imperative for coalition building within
communities. Alliances among all of the community organizations that address IPA and
come in contact with battered women are the basis for a cohesive approach to the
problem. For battered Latina women, the complexity of their situations requires a
combination of approaches.

Communication and collaboration among all of the stakeholders are imperative.
Representatives of multiple organizations need time face-to-face to establish working
relationships and to develop creative, cohesive, user-friendly multi-faceted services for
battered women. These organizations include: health care, particularly neighborhood
health centers and nursing, the Department of Public Health (DPH), DSS, battered
women's service agencies, legal services (attorneys and advocates), police departments,
including probation officers, Head Start, social agencies for immigrants, and school
systems among others. Statewide task forces that are truly community based should be
established.
Children's protective services (DSS). DSS is widely perceived as a hostile monolith, an immediate and direct threat to battered women and their children. DSS involvement is viewed as punitive and pervasive, with DSS operating in a reactive mode in an incompetent manner. DSS looms as an immediate roadblock to battered women and to HCPs who attempt to provide and arrange for the services that they need.

DSS is a government agency that needs to be community-based. Community input should be incorporated through the legislatively mandated creation of a community relations committee or advisory board, which would include the same stakeholders identified as crucial to coalition building above. Committee membership must not be politically appointed, but should reflect recognized community experts in the field.

The creation of this advisory board would assist DSS in making necessary changes in their actual operations as well as in their public image. DSS must undertake a public education campaign to redress their current public image and reputation. A case in point is Sylvia, who feared that her children would be taken away by DSS if the police believed that she knew her husband was taking Prozac® and she left her children in his care for a few hours. This level of fear, based on DSS’s reputation for removing children without cause, was shared by most of the women, creating the most significant barrier to women’s disclosure of IPA to HCPs, and to the receipt of appropriate services to assist them.

Public education campaigns. Domestic violence has become a publicly recognized problem. Several organizations, both public and private, conduct public education campaigns to raise awareness of the problem and of the help that is available to
victims of domestic violence. These campaigns have been widely effective as a
consciousness-raising tool. Several of the women described recognizing themselves in
the descriptions of abused women on flyers, posters, and in public service announcements
(PSAs).

Where these campaigns fall short in helping battered Latina women is in their
failure to identify what “help” means. These educational materials need to be adapted to
include specific information that battered Latinas, and possibly all immigrant women,
need in order to feel safe to disclose their abuse. Information about confidentiality
relative to specific authorities, the police, INS, DSS, as well as information about the
types of help available, battered women’s support groups, advocacy, and emergency
shelter should be included. The voluntary nature of these services needs to be
emphasized. Cecilia did not disclose the abuse to her HCP, who had such a flyer in the
office, because she feared she would be forced to go to an emergency shelter with her
children.

*Universal screening as the standard of care.* Universal screening is the current
recommendation of several national health care organizations (American Academy of
Family Physicians, 1994; American Academy of Pediatrics, 1998; American College of
Obstetricians and Gynecologists, 1999; American Medical Association, 1992; American
Nurses Association, 1991), as well as a JCAHO standard. However, research to date has
shown that screening is conducted infrequently and ineffectively in most health care
settings (D’Avolio et al., 2001). The United States Preventive Services Task Force
(USPSTF) (2004) found insufficient evidence in a systematic evidence review that
screening for IPA leads to reduced disability or death, and as such, did not recommend screening on the basis of available evidence. Given the vulnerability that accompanies IPA and the overwhelmingly lack of effective implementation of the recommendation for universal screening, the utility and limits of universal screening should be reconsidered.

Battered Latina women are unlikely to respond honestly to a screening question asked by a HCP whom they do not expect to see again. This is likely the case for most battered women. Examples of IPA screening that are unlikely to lead to disclosures include screening in hospital day surgery units, out-patient testing units, and possibly specialty units where patients are seen only once. However, HCP questions about IPA were identified by the women in this study as a mechanism for consciousness-raising, and as such, can be understood as interventions in themselves. When understood in this way, universal screening can be justified on clinical grounds, the lack of evidence not withstanding. However, HCPs should be aware of the barriers to disclosure of IPA, as well as strategies for creating safe environments for disclosure.

Screening efforts should be focused on settings with continuity of care, for example primary care, prenatal care, physical therapy, etc., as well as emergency care, given the prevalence of battered women presenting to emergency departments for health care.

Therefore, the specific health care policy changes indicated by the findings include:

- Coalition building within communities, including all stakeholders
➢ Creation of a statewide task force that is community-based rather than politically appointed

➢ Mandated creation of a Community Advisory Board to DSS

➢ DSS public relations efforts to address their punitive reputation

➢ Revised IPA public education campaigns, addressing the consequences of disclosure and help-seeking

➢ Universal screening for IPA by HCPs, with an emphasis on settings that provide continuity of care and emergency care

Nursing Research

Suggestions for future nursing research fall directly out of my recommendations for health care and public policy changes. I recommend shifting the focus of IPA research away from descriptive studies investigating HCP screening techniques and behaviors, despite the lack of evidence cited by the USPSTF (2004). Additional descriptive research considering the barriers to accessing battered women’s services, including the role of fear of official organizations (DSS, INS) by battered immigrant women is warranted.

Quasi-experimental studies observing various interdisciplinary approaches, as well as coalition efforts will guide program development and improve community-wide services for battered Latina women. Each profession and organization within the project could evaluate the project within its individual framework. Examples of possible projects include: collaborations that involve staff exchange, for example, advocates in health care settings and nurses and attorneys in battered women’s services agencies. Several

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innovative programs such as these do exist, but should be more widely implemented and studied.

Participatory research designs are ideal for implementation and evaluation of a variety of interdisciplinary collaborations and community coalitions. Participatory action research approaches are designed to generate knowledge and address social problems both as part of the research process and as an outcome of the findings (Wuest & Merritt-Gray, 1997). Wuest and Merritt-Gray (2002) have been using participatory action research methods in two long-term studies of the health promotion processes of single mothers who had left abusive male partners. The second study involves relevant stakeholders (single mothers, policy makers, service providers). The authors theorized that because of this stakeholder engagement, policy would be influenced both by the research process and the research findings. Particularly relative to the problem of battered women’s pervasive fears of DSS, and the barriers to appropriate battered women’s services posed by those fears, participatory action research approaches would provide a mechanism for both generating knowledge and creating systematic change most effectively. Participatory action research designs address questions and concerns of the stakeholders. The findings of my study included several suggestions from battered Latina women themselves about innovative strategies for addressing this problem.

On the basis of the findings, I recommend a pilot study investigating changes in clinical practice and service provision to battered women based on the creation of a formal alliance between health care providers, battered women’s advocates, and DSS. Rates of screening, disclosure, and referrals to social services and battered women’s

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services would be observed. The alliance itself would be monitored, identifying what does and does not work. In addition, a study examining battered Latina women’s experiences with DSS would guide suggestions for DSS programmatic improvements.

One finding of this study was the recommendation that battered women’s advocates be on site in health care settings, available to battered women by referral from a HCP or directly from the street. Their physical placement within a health care setting should be visible yet secure, so that women could walk-in off the street. Implementation of this suggestion as a pilot project would include a research component of observation and evaluation of effectiveness in improving acquisition of services by battered women.

Further descriptive work is indicated to increase our understanding of the challenges faced by battered women in other immigrant groups, beyond Latinas, in their receipt of health care and in accessing battered women’s services. Their particular concerns and vulnerabilities may necessitate different approaches to this complex problem. However, a shift in approach from descriptive to quasi-experimental research to evaluate creative responses to IPA is suggested by the findings. Several research studies are indicated by these findings:

- Pilot study evaluating the effectiveness of a HCP-battered women’s services-DSS alliance in reducing the barriers posed by the specter of DSS
- Evaluation of pilot projects of interdisciplinary collaboration: advocates in health care settings, nurses in battered women’s services agencies
Utilization of participatory action research designs in order to involve stakeholders in the research process, addressing the questions and concerns they identify

Description of the health care experiences of battered women from other immigrant populations

Methodologic suggestions. Conducting this study, inclusive of two languages, was particularly challenging. I tried a variety of approaches to address the linguistic disparity between myself and the informants. This involved the utilization of research assistants for a number of activities, including interpretation, translation, and transcription, in a variety of combinations. In order to minimize these challenges, I suggest several strategies. Interviews should be conducted only with a trained, certified interpreter if the researcher is not fully bilingual. The interpreter’s skills should be evaluated in advance, regardless of her/his credentials. Regular team meetings should be incorporated into the research project, and be part of the research assistants’ responsibilities, even for dissertation research. This is particularly important for research pertaining to emotionally difficult topics, and allows for processing of content, as well as a formal mechanism for receiving useful input from research assistants. For further information on training and utilizing research assistants, please refer to “Training research assistants for multisite research.” (Kelly, 2003).

Another area of significant and surprising challenge for me in conducting this study was interacting with the data as a researcher, rather than as a clinician. As a nurse, I am passionate about the topic of IPA, and very comfortable being with patients in
incredible emotional pain and conflict. In fact, working with battered women has been a clinical focus of mine. As a researcher, I found myself struggling emotionally with the data in a way I had not previously experienced.

While data collection was personally satisfying to me, particularly for the opportunities for interpersonal connection with the informants, I found myself avoiding data analysis. I attributed this avoidance to the fatigue of doctoral studies, rather than the overwhelming nature of the data. This had to do with the richness and detail of the data, as well as the necessity of immersion required for data analysis. This differs significantly from clinical practice, where the depth of description is missing, contact with the story is brief, and best of all, immediate action to help can be taken. My suggestion is for clinician researchers to be aware of the potential for this dimension in conducting studies of emotionally difficult topics, and to attend to one’s needs as a researcher, just as one would as a clinician.

Summary

The purpose of this interpretive phenomenology was to improve health care providers’ understanding of the health care experiences of battered Latina women. As this study sought to explicate the meaning of human experience, interpretive phenomenology was used, specifically van Manen’s (1990) methodologic approach. Feminism was the orienting philosophical framework of this study. The sample included 17 Latina women who were survivors of intimate partner abuse, and who received health care during the time they were being abused. Hermeneutic interviews were conducted with concurrent data analysis.
The findings included several themes related to the women's experiences of health care, of intimate partner abuse, and their salient concerns. Abject fear permeated the lives of the women. Identified themes pertaining to their experiences of IPA included: Alone, Abused, Afraid, Nowhere to Turn; "Staying, then leaving, for the sake of my children;" "Fear kept me with him, fear got me out;" and Gaining Strength and Moving Forward. Experiences of health care were frightening and disappointing. Specific themes included: "What will happen if I tell you?"; Fear of Disclosure and Detection of IPA; "If you ask me, I will tell you."; Despite Fear, Wanting to be Asked; and Looking for Help and Coming Up Empty.

Parallels in the women's relationships with the abusers and HCPs emerged, with inherent implications for patient-HCP relationships. Several requisites for safety for disclosure of IPA to HCPs were identified by the women: knowing that their providers cared about them as people; trusting their providers; receiving concrete information about the consequences of disclosure prior to any disclosure; and being asked about IPA, either directly or indirectly. If any one of these components was missing, in most cases, they did not disclose. The women had several recommendations for improving HCPs' identification and response to battered Latina women. Health care experiences represented a series of missed opportunities for disclosure and identification of IPA in the lives of battered Latina women.

This research provides an understanding of battered Latina women's perspectives of health care interactions and the meaning they give to these experiences. The result is patient-centered information that guides the development of improved health care
interventions for this population, increased patient satisfaction with health care, and enhanced patient-provider relationships. The specific contributions to nursing knowledge, as well as implications of the findings for nursing practice and education, health care and public policy were discussed, and suggestions for future research presented.
References


Fischbach, R., & Herbert, B. (1997). Domestic violence and mental health: Correlates and conundrums within and across cultures. Social Science and Medicine, 45, 1161-1176.


APPENDIX A

Informed Consent English Version

Research Participant Consent and Documentation

Purpose: This research study is being conducted by Ursula Kelly, a doctoral student at the Boston College School of Nursing. This study is being funded by the National Institute of Nursing Research within the National Institutes of Health. The purpose of the study is to improve health care providers’ understanding of battered Hispanic women’s experiences of health care.

Procedures: The researcher will conduct interviews with women who have been abused by an intimate partner. Women are being recruited through the Greater Boston Legal Services and HarborCov, Inc. Interviews will focus on what your experiences of receiving health care were like during the time that you were being abused. Interviews will be conducted up to two times, with each interview lasting 1-2 hours, over the next 3-4 months. The interviews will be audio-taped and the researcher will take notes of the interview. An assistant will help the researcher with the typing and translating of the audio-tapes. It is also possible that an assistant will assist in interpreting for either the participant or researcher if that is necessary. The results of the research study will be published in nursing and health care-related journals and presented at nursing conferences.

Risks: There are no direct risks to your participation in this study. It is possible that you will feel distressed by talking about your experiences. If you need assistance with these feelings, you will be immediately referred either to a battered women’s hotline, service agency, or health care provider. Your participation in this study is completely voluntary. If you choose to participate, you may withdraw your consent at any time. You do not have to answer any questions you do not want to answer. Your refusal to participate or discontinuation of participation will not have any effect on your receipt of legal services, social services, your legal rights, immigration status, or your health care.

Benefits: There are no direct benefits to participation in this study. However, the information obtained in this study will help health care providers better understand the health care needs of women who are being abused.
Compensation: There is $25 compensation per interview for participation in this study.

Confidentiality: Your identity and responses will be kept completely confidential. Your name will not appear on the interview transcripts or in any reports about the study. The researcher will code the interview with an alias name. You will not be contacted at home without your specific permission. Your responses will not be shared with the referral agency staff without your specific permission. Your health care providers will not be contacted as part of this study. All study tapes and transcripts will be locked in the researcher’s home office for a period of seven years, then destroyed.

However, your confidentiality may be broken if you disclose information about plans to harm yourself or others, or child abuse. The researcher is legally required to report this information to the appropriate authorities.

Further information: If you have any questions about this study, please contact Ursula Kelly at [phone number], or Professor Joellen Hawkins at [phone number]. If you have any questions about your rights as a participant in a research study, please contact the Boston College Office of Research Administration at [phone number].

Participant Name: ____________________________
Signature: ____________________________ Date: _________
Researcher Name: ____________________________
Signature: ____________________________ Date: _________

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APPENDIX B

Informed Consent Spanish Version

[Boston College Letterhead]

PROPOSITO: Este estudio de investigación es conducido por Ursula Kelly, estudiante de La Escuela de Enfermería del Colegio de Boston (Boston College School of Nursing). Este estudio es financiado por el Instituto Nacional de Investigación /Estudio de Enfermería (National Institute of Nursing Research), dentro del Instituto Nacional de Salud. El propósito de este estudio es para mejorar el entendimiento a los proveedores de cuidado médico acerca de las experiencias de la mujer Hispana en cuanto al cuidado de salud.

PROCEDIMIENTO: El investigador va a conducir entrevistas con mujeres quienes han sido abusadas por un compañero/a entrañable. Mujeres que están siendo reclutadas por Los Servicios Legales de Boston y HarborCov. Las entrevistas serán enfocadas en sus experiencias de recibir cuidado médico durante el tiempo que fueron abusadas. Las entrevistas van a ser conducidas en dos partes, cada entrevista dura de 1 a 2 horas por un curso de 3 a 4 meses. Las entrevistas van a ser grabadas y la investigadora va a tomar notas de la entrevista. Quizás una asistente va a asistir a la investigadora con la mecanografía y traduciendo las cintas de grabación. También, la investigadora o la participante tendrán un/a asistente para interpretar si es necesario. El resultado de la investigación será publicado en los diarios de enfermería y cuidado de salud, y presentado en conferencias de enfermería.

RIESGOS: No hay riesgos directos cuando usted participa en este estudio. Es posible que usted va a sentirse afligida al hablar acerca de sus experiencias. Si usted necesita asistencia con estos sentimientos, usted inmediatamente será referida a una agencia de servicios, línea de emergencia para mujeres abusadas o a un proveedor de cuidado médico. Su participación en estos estudios son completamente voluntarios. Si usted escoge participar, usted puede retirarse en cualquier momento. Usted no tiene que contestar ninguna pregunta que usted no quiera contestar. El que usted no quiera participar o que usted descontinúe su participación no va a afectar su deseo de obtener servicios legales, sus derechos, estado de inmigración, o cuidado médico.

BENEFICIOS: No hay beneficios directos para los participantes de este estudio. Sin embargo, la información obtenida en este estudio ayudara a los proveedores de cuidado médico a entender mejor la necesidad para el cuidado médico de mujeres que están siendo abusadas.
COMPENSACIÓN: La compensación por cada entrevista es de $25.

CONFIDENCIALIDAD: Su identidad y respuestas serán mantenidas en completa confidencialidad. Su nombre no aparecerá en ninguna transcripción de entrevista, o reportes acerca de este estudio. La investigadora va a codificar la entrevista con nombres ficticios o alias. Nadie le va a llamar a su casa sin su permiso específico. Las respuestas suyas no van a ser compartidas con miembros de la clínica de servicios legales sin el permiso específico suyo. No vamos a compartir con el proveedor de servicios médicos suyo como parte de estos estudios. Todas las cintas de grabación y transcripción van a ser almacenadas en el hogar de la investigadora por un periodo de siete años, luego serán destruidas.

Sin embargo, su confidencialidad quizás sera rota si usted declara información acerca de planes para lastimarse a usted misma a otros, o sobre abuso de niños. La investigadora está obligada por la ley a reportar esta información a las autoridades apropiadas.

MAS INFORMACIÓN: Si usted tiene alguna pregunta acerca de estos estudio, por favor comuníquese con Ursula Kelly al [phone number], o a la Profesora Joellen Hawkins al [phone number]. Si usted tiene algunas preguntas acerca de sus derechos como participante de un investigación /estudio, por favor comuníquese con el Colegio de Boston, Oficina de Administración de Investigación /Estudios al [phone number].

Nombre del Participante: ____________________________________________
Firma: __________________________________________________________
Fecha: ______________

Nombre de la Investigadora: ________________________________________
Firma: __________________________________________________________
Fecha: ______________
APPENDIX C
Demographic Form
Battered Latina Women’s Experiences of Health Care

Interview#: ___________________ Date: ________________
Name: _____________________ Phone #: ________________
Age: ______________________ Okay to call at home? ______
Race: ______________________ Best time to call: __________
Country of Origin: __________
Years Living in US: __________
Immigration Status: __________
Number of children: __________
Children living in US: __________
Years of education: __________

Domestic Abuse: Current: Y/N Past: Y/N
Rel. to abuser: ______________
Length of rel.: ______________
How long ago rel. ended: __________
Abuser’s ethnicity: __________

Health Care During the Abuse:
________________________________________________________________________
________________________________________________________________________

Type of Providers Seen: ______________________________________________________
Freq of Visits: ______________________________________________________________
Reason for Visits: ____________________________________________________________
________________________________________________________________________
APPENDIX D

Interview Guide

1. In general, what were your experiences of getting health care like when you were being abused? How were you treated? What was it like for you?

2. Can you think back to particular health care visit that was especially helpful or supportive to you? What was that visit like?

3. What were your relationships with your HCPs like? Did you have a health care provider that you had a positive or supported relationship with? What was that like? Were you able to talk openly with that HCP? (Probes about disclosures, communication)

4. How did your thoughts or feelings about your relationship or the abuse change as a result of health care visits?

5. Is there anything that your HCPs didn’t do that would have been helpful?

6. Did any HCPs ask you if you were being abused? What was that like? How did you react, and how did you respond?

7. Thinking about the abuse, what were you looking for from your health care providers?

8. What would you like to tell health care providers about how to take care of women who are being abused?

9. Is there anything else you would like to tell me?

10. What was it like for you to immigrate to the United States?

11. What do you think about domestic abuse and culture? Do you think domestic abuse is culturally accepted in Latino culture? How has your culture influenced you in terms of the abuse?