The Role of Public Health and Medicine in Addressing Wife Abuse:
A Qualitative Multi-Ethnic Study of Abused Women's Perspectives

by

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B.A. (Pomona College) 1987
M.P.H. (University of California at Berkeley) 1992

A thesis submitted in partial satisfaction of the
requirements for the degree of
Masters in Science
in
Health and Medical Sciences
in the
GRADUATE DIVISION
of the
UNIVERSITY of CALIFORNIA at BERKELEY

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1995
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University of California at Berkeley

1995
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Abstract

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As wife abuse attains increasing recognition as a public health and medical problem, policy makers, researchers, and practitioners within these fields should develop feminist and culturally sensitive frameworks for understanding this problem. A review of the literature clearly demonstrates the need for greater understanding of the perspectives and needs of diverse groups of abused women patients. The purpose of this research was to qualitatively explore the perspectives of a multi-ethnic population of abused women to identify the factors at the social, structural, patient, and provider levels that affect help-seeking from the medical system. Key features of the research design included an action-orientation, community collaboration, and attention to ethical issues in conducting research. Data collection methods involved focus group interviews with women recruited through community organizations in the San Francisco Bay Area. A total of 51 abused women comprised eight focus groups: two groups each of white women (14),
African American women (9), Latina immigrants (14), and Asian immigrants (14).

Many of the factors that affected these women's abilities and willingness to seek medical care were shared among the different ethnic groups. All the groups identified fear of escalating violence, embarrassment, and low self-esteem. Relationship and family considerations were universal; white and African American women focused on their devotion to their partners; Latina and Asian women focused on their obligation to keeping their families together. Compassion, trust, and understanding were essential elements of patient-provider relationships. Additional recommendations included directly asking patients about marital abuse and offering referrals to community organizations. Structural barriers to seeking medical care differed significantly by ethnicity and immigration status. Except for the white women's groups, all the groups discussed economic and time constraints; Latina and Asian immigrant women identified language barriers, social isolation, and fear of deportation; and African American women were concerned about police involvement. In summary, many abused women experience significant barriers to receiving help from the health care system. Public health and medicine have an important role in addressing these barriers and in the prevention of violence against women.
Dedication

This thesis is dedicated to my mother, Eileen Yvonne,
whose lived experience and unending love and support serve as
the inspiration and guiding force for my work.
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Preface

The genesis and evolution of this thesis over the past three years deserves some reflection and explanation. My interest in wife battering developed from a combination of both personal and professional experiences. The question of the role of public health and medicine in addressing wife abuse seemed like the perfect combination of my interests in women's health issues, the medicalization of social issues, and violence against women. I believed that my background in rape crisis advocacy, feminist political activism, women's health epidemiology research, and public health training could significantly contribute to my work in this area.

Coincident with my entrance into the Health and Medical Sciences program, the fields of public health and medicine were beginning to recognize the important health consequences of violence against women and the potential for health-based intervention approaches. In the summer of 1992, the Journal of the American Medical Association devoted an entire issue to research and commentary on domestic violence. Guidelines for medical screening and intervention were being developed for clinical practice. And national health officials were proclaiming violence as a new public health crisis and receiving a good deal of media attention. The band wagon was off and rolling and I decided to jump on. I believed that my background and beliefs might add something different to the discussion.

My specific concerns and interests evolved as I became more familiar with the literature and availability of research opportunities. Initially I was interested in the question of primary prevention of wife abuse and violence against women using a public health model. But I soon discovered that there
were few opportunities for this type of research in the Bay Area. Later I became interested in epidemiology and definitional problems surrounding marital abuse. But again I found no viable research opportunities. Even though I didn't ultimately pursue these interests through research, I discussed these issues in the first section of this thesis.

As part of exploring this topic further I began establishing connections with domestic violence researchers and organizations in the San Francisco Bay Area. It was through this process that I met Dr. Michael Rodriguez, who was conducting research on abused women's experiences and perspectives in the medical system. The research methods were absolutely perfect -- qualitative methods, patient perspective, multi-ethnic sample, community collaboration. And the data were rich. When I began working on this study, the research design had been established and the data were collected. After working for hours and hours on a paper for publication, Michael generously offered his data and his guidance for my thesis research. Needless to say, I was thrilled.

My plan was to analyze the data from each of the ethnic groups separately and develop some ideas about the interaction of gender, culture, society, and institutional factors in these women's experiences in the medical system. Ultimately my goal was to use these data to contribute to our understanding of the best ways that medical institutions and providers can address the problem of wife abuse. As I began to outline themes and identify quotes, the project became something akin to creating a collage of women's voices: creating a frame, isolating the individual images, and reconstructing the whole picture so that it most accurately represented the abused women in the study. To me, the final product is a careful balance of art and science.
Not only did science and art collide in the process of doing this work, science and politics collided. During my first semester in the medical program, I became involved in curriculum changes within the school of public health and the Joint Medical Program. Along with several public health students and faculty, I participated in developing curriculum for a seminar course called "Violence as a Public Health Issue." As a response to the popularity and success of this course, it was given permanent academic standing. Within the Joint Medical Program, the topic of domestic violence was included in the colloquium series and throughout other clinical courses. Hopefully the current level of awareness and sensitivity on the part of the faculty will ensure the continued inclusion of this material.

The ultimate goal of my research and activism is social change. By increasing awareness among health professionals, advocating for policy change, and setting standards for ethical and inclusive research methods, I hope to improve the health care for abused women patients. Ideally, health-based interventions will empower abused women and reduce the violence in their lives.
Acknowledgements

I extend my deepest gratitude to the following people and organizations:

- Dr. Michael Rodriguez, whose generosity, guidance and support made this thesis work possible. Michael has been a wonderful mentor in his capacities as a researcher, clinician, and violence prevention advocate. The example set by his humility and ethical principles will guide me throughout my research career.
- Selene Szupinski Quiroga for teaching me the science and art of qualitative data analysis, providing translation assistance, and reviewing portions of this thesis.
- The many professional and community research collaborators who participated in research design, recruitment, facilitation of focus groups, and data analysis.
- The abused women study participants who generously gave their stories, insights, and opinions.

- Nancy Krieger for challenging me to critically explore paradigms within the health fields and develop an historical and contextual analysis of wife abuse as a health issue.
- Nancy Chodorow, Denise Herd, and Christina Maslach for extremely valuable discussions, editing, and comments regarding the content of this thesis.
- Henrik L. Blum and Dr. Paul Newacheck for their guidance and encouragement.
• Funding for this research project was provided by the Robert Wood Johnson Clinical Scholars Foundation. Ongoing support and resources were provided by the Pacific Center for Violence Prevention, San Francisco, California.
Introduction

In analyzing the issues surrounding the role of public health and medicine in addressing the problem of wife abuse, the scope of this thesis is quite broad. First, all levels of public health and medical practice were explored, including research, policy development, and patient-oriented medical practice. Second, these issues were explored through an historical overview, discussions of health policy, a review of the research literature, and theoretical and ideologic considerations. One of my objectives throughout this work was to develop a feminist and culturally sensitive analysis and critique of these issues.

In addition to developing an understanding of the current paradigms that shape the public health and medical responses, this thesis includes an analysis of qualitative data from a study of abused women's experiences and perspectives regarding medical care. The goal of this research and analysis was to understand how the health care system can better serve abused women from diverse racial and cultural backgrounds. Ultimately, the aim of this work was to address both the individual needs of the patients as well as the broader social problem of marital violence and abuse.

Organization

This thesis is organized into two sections. The first section, entitled "Policy, Paradigms, and Research," explores the history, research and theoretical issues involved in understanding the role of public health and medicine in addressing the problem of wife abuse. The second section of this
thesis includes the research results from a qualitative multi-ethnic study of abused women's experiences and perspectives regarding health care.

In Chapter 1, I explore the implications for defining wife abuse as a health issue. First, I describe the social construction of wife abuse over the past century in an effort to contextualize the current discussion within the fields of public health and medicine. Second, the commentary and policies within the health fields regarding marital violence are analyzed to gain insight into the currently accepted paradigms. Finally, I discuss the future challenges to this movement, including the potential benefits and dangers of medicalizing wife abuse, difficulties defining and identifying the problem, and the importance of the framing of wife abuse as a form of oppression of women. Although framing wife abuse as a health issue has the potential to broaden the conceptions of wellness, illness, and the determinants of health in the field of medicine, it also has the potential danger of individualizing a complex social problem.

In Chapter 2, I review research both within and outside of the health fields which deals with characterizing the magnitude and health effects of this problem. Research has focused on prevalence, risk factors, health outcomes, and medical responses. After reviewing these data, I describe important limitations of this research. In particular, I argue that greater attention should be paid to issues of gender, race, and class, and that research on patients' perspectives is essential for appropriate policy development.

In Chapter 3, I provide a detailed description of the methods used to collect and analyze the qualitative data from the study on abused women's perspectives. In addition, I discuss feminist research paradigms in relation to the goals and practices of conducting this research. In sum, this study was
multi-ethnic, action-oriented, and community-based; further, we aspired to adhere to important ethical principles.

Section II, entitled "Voices of Abused Women Patients," focuses on the perspectives and experiences of abused women from different ethnic groups. This section is divided into four chapters that separately address the issues relevant to the different ethnic groups that were included in this study: white American, African-American, Latino, and Asian. Each chapter begins with a background section that includes an overview of the data on the prevalence of marital violence within the particular ethnic group. This section also includes a discussion of the cultural and social factors that may be relevant to family life, gender roles, and help-seeking of abused women in that ethnic group. The second section of each of these four chapters includes the analysis of data from focus groups of abused women. In general, the themes drawn from the data are organized into three categories of factors that influenced these women's experiences in the medical system: structural/institutional forces, psychosocial and cultural factors, and issues pertaining to the patient-provider encounter. Each chapter concludes with a discussion of the implications for health policy and medical practice.

Terms for intimate abuse

In general, terms describing abuse between intimates can be understood on a continuum of increasing inclusion of intimate partners or familial relationships. *Wife abuse,* or *wife battering,* is used to describe the abuse of a woman by her husband. This term also has been used to describe abuse by a cohabiting male partner. While *battering* generally implies physical violence or abuse, the term *abuse* is used to encompass all forms of abusive and
controlling behaviors (e.g. psychological, social, economic, sexual and physical abuse). *Woman abuse* includes wife abuse as well as other forms of abuse by males against their intimate female partners (e.g. dating violence). However, the term woman abuse can be confusing as to the relationship between the victim and the perpetrator. *Spouse abuse* does not differentiate the victim by gender, and thus includes both wife abuse and husband abuse. *Partner abuse*, or *intimate violence*, includes spouse abuse as well as abuse occurring between same-sex intimate partners (i.e. lesbians and gay men). Although the term *domestic violence* has been used interchangeably with *wife abuse*, it more accurately includes all forms of intra-familial violence and abuse: child abuse, physical punishment, elder abuse, spouse abuse, and sibling violence. *Family violence* is also used to describe the multiple forms of intra-familial violence.

The issue that I am addressing in this thesis is violence and abuse perpetrated by men against their intimate women partners. Key factors of this phenomenon are: (1) both violence and abuse are included; (2) the perpetrators are men; (3) the victims are women; and (4) the perpetrator and victim are, or were, involved in an intimate relationship. Throughout this thesis, I have chosen primarily to use the term *wife abuse*, however this is not meant to exclude unmarried women. Instead I intend for it to include all forms of abuse that are perpetrated against women by their intimate male partner(s), regardless of legal marriage or cohabitation status. The terms *spouse* and *marital* also should be understood as inclusive of unmarried intimate partners. I chose the term *wife abuse* because it explicitly identifies the problem within a framework of gender. Although this term incorporates
three of the four key factors listed above, I would have preferred a term that didn’t seem exclusive to married couples.

The advantage of gender neutral language (e.g. spouse abuse and partner abuse) is that it includes the less common, but important, occurrence of husband abuse as well as abuse within gay and lesbian relationships. However, by including same-sex partner abuse and husband abuse, the importance of sexism and inequality in society may be overlooked. That is not to say the these other forms of domestic violence are unimportant, but that they should perhaps be considered manifestations of other social and psychological problems (Letellier, 1994). In other words, they are not in the same category or framework, because they are not forms of violence against women by men.

To avoid confusion in this thesis, the term domestic violence is used to describe multiple forms of violence that occur between members of the same family, including marital partners. The term family violence is used only to refer to the sociologic perspective on domestic violence. The term battering is used only to refer to the battered women’s movement and battered women’s shelters and agencies.
Section I.
Policy, Paradigms, and Research
Chapter 1.
The Rise of Wife Abuse as a Health Issue

Although the fields of public health and medicine have only recently recognized wife abuse as within the purview of public health and medical intervention, this is not its the first recognition as an important social problem. In fact, this issue has achieved public notoriety at several points over the past 150 years. Each wave of public concern or professional focus has had a unique social and political context that informed the understanding of the causes of wife abuse and had implications for interventions. It is this ideological legacy that ultimately informs the approaches within the health professions for conducting research and creating policy regarding wife abuse.

This Chapter will briefly explore the social construction of wife abuse over the past century in an effort to contextualize the current discussion within the fields of public health and medicine. The commentary and policy statements within the health fields will be presented to gain insight into the currently accepted paradigms for addressing wife abuse. Finally, future directions and potential consequences of public health and medical involvement will be discussed.

HISTORICAL DEVELOPMENT

Although the first recognition of wife abuse as a social problem developed out of the temperance movement in the mid-1800s, significant social change has occurred only in the last 20 years. The current battered
women's movement, which developed from the feminist movement of the 1970's, has promulgated the philosophy that wife abuse originates from the patriarchal oppression of women. The causes of wife abuse also have been understood through simultaneous work in the fields of sociology and psychology. These feminist and academic ideologies have been both conflicting and mutually informing.

The temperance movement and divorce rights

The first recognition of wife abuse as a social problem developed within the temperance movement of the mid-1800s (Pleck, 1987). The goals of the temperance movement included reducing access to alcohol with the belief that drunkenness was the cause of multiple social problems. One strategy to gain public sympathy for the movement was to portray the innocent victims of drunken husbands and fathers. The public thus became convinced that violence within the family was caused by excessive alcohol use. In the early stages of the movement, there was no criticism of the family or social structure, only the availability of alcohol.

As more women became involved in activism, their goals broadened to include women's rights (Pleck, 1987). Outspoken women temperance activists included Susan B. Anthony and Elizabeth Cady Stanton. They argued that grounds for divorce should include drunkenness and cruelty. In addition, they fought for earning and property rights for women. Much of their arguments for these policy reforms rested on the belief that drunkards' wives deserve protection and legal recourse. In fact women's suffrage was first promoted as a means to pass restrictive alcohol legislation. These women activists were generally viewed as too critical of the family and too
radical by the mainstream movement and government. However, their speeches and writing increased the public awareness of marital violence.

It wasn't until the late 1860s that activists began to demand increased criminal prosecutions and severe sentences for wife batterers (Gordon, 1988). By 1870, the assault of wives was effectively illegal in most states in the U.S. However, only the most severe cases were enforced. The realm of the American home was considered private and state intervention into private family life was vehemently resisted by legislators, law enforcement, and the public.

Although there was virtually no public discussion of wife abuse from the turn of the century until the mid-1970s (Pleck, 1987), social service agencies for child victims of domestic violence were involved in many cases of wife abuse (Gordon, 1988). Until the 1930s, complaints by women to social service organizations consisted primarily of non-support by spouses. Gordon (1988) argued that the transition to wage labor markets and the high unemployment during the Depression 'lessened women's sense of entitlement to support from their husbands, but allowed them to insist on their physical integrity' (p. 260), thereby increasing the level of reporting of wife abuse to public agencies. At the time, the only services available to these women were through child welfare agencies.

Unfortunately, the field of social work took a woman-blaming approach to wife abuse (Gordon, 1988). Because of the increases in women's economic and divorce rights, victimization was seen as a sign of psychological dysfunction. The field of social work in the 1940s and 50s was heavily influenced by the theory of female masochism, developed by Freudian disciple, Helene Deutsch. For example, one book on marital conflict
published in 1949 contains the chapter titles: "The need to suffer", "Excessive dependence", and "Rejection of femininity" (Hollis, 1949). It was assumed that women who had the freedom to escape violence, remained in abusive relationships because they either provoked the abuse or enjoyed it in some way.

Until the women's movement of the 1970s, the problem of wife abuse was understood as isolated personal and family dysfunction, rather than as a problem with the structure of the family or society. The behavior of the batterer was explained by alcohol abuse and victims were seen as masochistic. In fact, it is only recently that activists have challenged the temperance ideology regarding the connection between alcohol and marital violence. Of note, the first U.S. battered women's shelter, opened in 1973, was for wives of alcoholics and funded jointly by Alcoholics Anonymous and the state (Gordon, 1988). Current feminist activists argue that this model allows the abuser to relinquish responsibility for his behavior, and in fact fault his weakness (alcoholism) rather than his power (both physical and societal). The focus on the man's weakness elicits forgiveness more readily from the victim and a more tolerant stance from public institutions. Even though there may be an association between alcohol and marital abuse, activists maintain that alcohol is not the cause of violent behavior (Gordon, 1988).

The battered women's movement

Feminists transformed the issue of wife abuse to an essential political problem of patriarchal domination of women. Erin Pizzey's book Scream Quietly or the Neighbors Will Hear, published in 1974, is often credited as being the first to bring the plight of battered women to public attention. The
book focused on the experiences of women seeking services at the Chiswick Women's Aid Shelter in London in the early 1970s. Within the next five years, the popular literature on wife abuse grew exponentially with the publication of *Battered Wives* by Del Martin (1976), *Conjugal Crime* by Terry Davidson (1978), *Battered Women* by Donna Moore (1979), and *Violence Against Wives* by Emerson and Russell Dobash (1979), among others.

The feminist framework for understanding the occurrence of wife abuse centers around the primacy of gender and gender-based power inequities in society. This gender perspective was originally developed by early feminist researchers (Dobash & Dobash, 1979) and continues to be strongly advocated (Bograd, 1988; Yllo, 1988; Kurz, 1989; Bart, 1993). Advocates of this perspective argue that the problem to be explained is why women are overwhelmingly the targets of violence by men, particularly intimate partners. Feminist researchers argued that the various forms of violence against women by men (rape, incest, wife abuse, pornography, dating violence, and sexual harassment) have more in common than forms of violence among different family members. While the feminist framework supported the idea that wife abuse has multiple causes at the individual level, the social or group level causes are based in the historical and institutional domination of women by men. Activists were particularly critical of male domination within the family (Martin, 1976; Dobash & Dobash, 1979). They argued that the institution of marriage is founded on male domination and female subordination. Further, they argued that marital violence culturally tolerated within certain limits.

In general, feminist activists opposed the idea that the prevalence of marital violence was greater among the poor and/or ethnic minorities. In
part, they were concerned that such claims would serve to stereotype these
groups as more violent and lead to public assumptions about the
"naturalness" of violence within poor and minority populations. Further,
risk factors for abuse beyond gender directly challenge the feminist
framework that gender-based power inequities are the root of male violence
against women. Finally, their claims that wife abuse cuts across all racial and
class lines served important political purposes in attracting national attention
to the issue (Pleck, 1987). While issues of race and class are becoming more
prominent in feminist writing about marital abuse, much of the analysis
continues to focus only on gender.

The development of a gender-based framework to understand marital
violence allowed the movement to focus on ending the violence through
changing social structures that are oppressive to women. For example,
ultimate social change goals included increasing educational and economic
opportunities for women so that they could achieve greater independence.
The feminist concepts of consciousness-raising, self-help, and empowerment
were embedding in organizing strategies and service provisions. More
immediate goals of the movement included providing temporary shelter for
battered women and their children, improving enforcement of existing laws,
passing legislation to further protect victims and prosecute batterers, and
educating the public about the social causes of marital violence. Battered
women's shelters and hotlines were established throughout the country by
grass roots activists. By 1980, over 700 community-based shelters had been
established (Schecter, 1982). Class action suits against police departments in
Oakland, California and New York City were instrumental in improving law
enforcement response to victims of marital violence (Dobash & Dobash, 1987).

Feminist activists also had a powerful impact on the national legislative response (Schecter, 1982). In 1978, the U.S. Commission on Civil Rights held hearings on wife abuse which prompted the formation of the National Coalition Against Domestic Violence (NCADV), which supported shelter legislation and advocacy for battered women nationwide. These hearings were strongly influenced by feminist ideologies: violence against wives was understood as systematic, severe, and related to the status of women in society, and the state has a responsibility to intervene.

With greater public attention to the problem of wife abuse, clinical psychologists and academic social scientists became more involved in the issue. The attention from these institutions legitimized the issue. Further, the research results generally confirmed the severity and pervasiveness of the problem. However, the frameworks developed by clinicians and researchers from these fields were often contrary to feminist ideology.

Psychology and psychiatry

Clinical psychologists working with abused women were interested in understanding the causes and effects of marital violence. In the classic book *The Battered Woman*, psychologist Lenore Walker (1979) identified different types of abuse and control and developed two important theories about wife abuse: the cycle of violence theory¹ and the learned helplessness theory. Walker described the cycle of violence as three phases of abusive behavior (tension-building stage, acute battering incident, and kindness and contrite

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¹ The cycle of violence theory also has been used to describe the theory that children raised in violent homes often become abusers themselves. This theory is discussed below.
loving behavior) which repeat over time and often become shorter and more intense. Walker argues that the underlying motive behind the physical abuse centers around control. In the tension-building stage, the batterer becomes progressively more anxious and frustrated. Typically, he uses non-physical types of abuse (e.g. verbal abuse or threats, economic control, social isolation) to exert power and control over his wife. In the acute battering phase, the tension culminates in physical or sexual abuse and violence. In the contrite loving behavior phase, also known as the honeymoon phase, the batterer may beg forgiveness, promise to stop the violence, or shower his wife with flowers or gifts.

The theory of learned helplessness asserts that repeated abuse diminishes the woman's motivation to respond and she becomes passive and unable to escape. While the theory of learned helplessness is less victim-blaming than masochism theory, it has been criticized on two levels. First, because it focuses on the psychological aspects of the victim, it deflects attention away from the societal constraints on women's response to abuse (e.g. gender-based economic inequities that create dependency). Second, it fails to recognize the strengths and resourcefulness of abused women who continuously negotiate their survival. To this end, this theory has contributed to the portrayal of abused wives as incapable of making decisions in their best interest. This assumption potentially creates an atmosphere of paternalism among professionals seeking to assist abused women. This paternalistic paradigm is contrary to the feminist ideals of empowerment and self-help.

To further investigate psychopathology models, researchers in the early 1970s began studying characteristics of the male abusers. Through research on
male abusers, psychologists identified several personality traits common
among abusers: low self esteem, intolerance of intimacy, insecurity, fear of
abandonment, manipulative behaviors, and low level of self efficacy. In one
study, psychiatrists reviewed 52 case-comparison studies on husband-to-wife
violence covering almost 100 potential risk markers and concluded that a
psychiatric model of the batterer had the most utility (Hotaling & Sugarman,
1986). The diagnosis they proposed to explain the majority of cases was the
borderline or antisocial personality disorder described in the *Diagnostic and
Statistical Manual of Mental Disorders*. The borderline personality disorder
manifests itself in many of the personality characteristics listed above and is
founded on intense fears of abandonment.

Exposure to domestic violence as a child has been explored as a
potential antecedent in both the victimization by, and use of, interpersonal
violence. This idea is based on social learning theory that postulates that the
use of violence is a learned behavior and the tolerance or acceptance of
violence can be developed early in life based on modeled violence among
primary care givers. Social science research has consistently found that
childhood exposure to domestic violence is a risk factor for later abuse
The transgenerational effects of domestic violence are generally accepted with
the caveat that the vast majority of abused and exposed children do not end
up in abusive relationships.

Although feminists did not deny the validity of these research
findings, they argued that a psychological perspective was not sufficient to

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2 Social learning theory also has been invoked to understand the effects of media violence; many researchers believe that exposure to violent images through television increases aggressive behavior (Widom, 1989).
explain the problem (Dobash & Dobash, 1992). First, it did not account for the
pervasiveness of the problem. Generally, explanations utilizing theories of
individual or relationship psychopathology assume that the problem is a
relatively rare occurrence. Second, these perspectives have a greater potential
for victim-blaming. And third, the absence of a more general critique of
social structures, particularly those with patriarchal foundations, negates the
importance of broad social change.

Sociology of the family

Until the late 1960s, the issue of family violence was selectively ignored
by sociologists studying the family. The prominent journal of family studies,
*Journal of Marriage and the Family*, founded in 1939, did not carry a single
article with the word violence in the title until 1969 (Engelinger, 1986).
Because of increasing rates of divorce and family disintegration, sociologists
became more interested in family violence. In 1975, Straus, Gelles, and
Steinmetz conducted the first National Family Violence Survey (NFVS) to
determine rates of violent and abusive behavior among family members. In
their book *Behind Closed Doors: Violence in the American Family*, they
reported that among married and cohabiting couples, rates of intimate
violence were over 10% (1980)³. This discovery of high rates of family
violence challenged the traditional concept of marital relationships as social
units organized to maximize love and support. Sociology researchers were
forced to look more carefully at the family structure to discover ways that it
fosters and perpetuates violent behavior.

³ The detailed results of this research will be discussed in chapter 2.
The family violence model was developed by sociologists to explain the commonalities among the different types of abuse within the family: child abuse, spouse abuse, elder abuse, and sibling violence. The model holds that the family structure is unique in its selective approval of violent behavior that would not be acceptable in other social relationships (Hotaling & Straus, 1980; Finkelhor, 1983). The classic example is corporal punishment. Hotaling and Straus (1980) identified several features of the family unit that increase the risk of violence: time spent together, range of activities and interests, intensity of involvement, age and sex discrepancies, involuntary membership, ascribed roles, high level of stress and conflict, extensive knowledge of social biographies, and family privacy. These researchers theorize that family violence originates in social norms condoning violence as a means to resolve conflict as well as in the unique structure of family life, particularly the nuclear family. According to these researchers, power inequities at the societal level affect family interrelationships, however these influences are not considered a major determinant of violence between family members.

Another line of thinking led to the external stressors theory, which postulated that external stresses have a role in increasing interpersonal conflict and violent behavior. High rates of environmental demands combined with low response capabilities increase an individual’s stress level, which can lead to the use of violence to regain a sense of control and personal power (Allen & Straus, 1980; Farrington, 1980). Positive associations observed between family violence and stressful life events, number of children, and pregnancy supported this theory (Straus et al, 1980).
Although this sociology research served to validate the importance of marital violence by confirming high rates of abuse, many aspects were controversial and even damaging to the battered women's movement. First, the National Family Violence Survey (NFVS) described above found higher rates of female-to-male violent acts than male-to-female. Researchers concluded that there were more battered husbands than battered wives in America. When these results were presented during the 1978 Civil Rights Commission hearings, they were met with confusion and disbelief (Dobash & Dobash, 1987). In spite of the subsequent presentation of evidence that women comprise the overwhelming majority of victims, and the recognition of the methodological shortcomings, these findings had a negative impact on the policy reform movement. For example, in Chicago, local officials withdrew funding from a battered women's shelter under the presumption that women were as violent as men. This episode represented an important clash between researchers and activists over the nature of the problem and who qualifies as legitimate spokespersons (Dobash & Dobash, 1987). The NFVS remains the only national survey on family violence conducted.

The second controversy surrounds the family violence framework for understanding wife abuse, which does not give significant weight to the effects of gender inequities within society and the family. While feminists draw parallels between the different forms of violence against women, the family sociologists draw parallels between the different forms of violence between different family members. Obviously, these competing frameworks have significantly different implications for research and intervention strategies.
In spite of these limitations, this research has significantly contributed to our understanding of family violence. First, it gave validity to research on marital violence in the field of sociology and other academic fields. Second, the design of a random national sample and finding of high rates of violence dispelled the myth that spouse abuse is a rare and unimportant aspect of family life. And third, these researchers were the first to attempt to develop a systematic and reproducible quantitative survey instrument for measuring marital violence.

Over the course of time, explanations for wife abuse have ranged from purely biological to sociopolitical. In general, there are four levels at which the occurrence of marital violence has been explained: (1) the psychopathology of the individuals involved, (2) social and environmental stressors, (3) family structure and dynamics, and (4) gender-based inequality in society. These levels reflect the assumptions about how determinants interact to create violent behavior. Because evidence can be found to support or refute the role of each of these theories, the dominance of an etiological model is determined largely by the politics of the times or within a particular field.

Wife abuse as a public health issue

Violence has been recently defined as a health issue based primarily on the increasing importance of homicide and intentional injury as a cause of mortality and morbidity in the United States. However, because prevention and intervention strategies within the health sector depend on an understanding of causation, the frameworks operating within public health and medicine must be understood. Although these frameworks are rarely
stated explicitly, they can often be inferred from commentary and policy statements made by the major public health and medical institutions.

The reason for the burgeoning interest in wife abuse within the health sector is unclear. Increasing injury and murder rates were primarily attributed to community, or youth, violence; there was no evidence that rates of marital violence were increasing. The battered women’s movement of the 1970s focused almost exclusively on legislative reform and community-based interventions; there was almost no pressure to improve the public health or medical responses to this problem. Furthermore, this interest came at a time when public interest was fading. The 1980s hailed a more conservative political climate. Ideologies of family preservation and decreased government interventions led to cutbacks in funding for domestic violence programs and the elimination of government offices (Pleck, 1987).

Although the earliest research on wife abuse in the fields of public health and medicine was conducted in the early 1980s, these findings were all but ignored by policy makers and medical practitioners. Stark et al. (1981) were among the first to describe rates of abuse among women trauma patients presenting to an emergency department. These researchers described the problems with the medical response, emphasizing the lack of identification in the medical records and the over-prescription of sedatives\(^4\). Several of these researchers have written lucid criticisms of the medical response to wife abuse (Stark et al., 1979; Stark & Flitcraft, 1982, 1983; Kurz & Stark, 1988) and continue to be involved in writing research reviews and commentary (Stark & Flitcraft, 1988, 1991, 1992; Flitcraft, 1992).

\(^4\) The detailed results of this research will be discussed in chapter 2.
In 1985, Surgeon General Koop convened the Workshop on Violence, a national conference to acknowledge the impact that violence has on morbidity and mortality in this country. The goal was to develop ways that health and medical researchers and practitioners can begin to understand and address the problems of violence. Two working groups on wife abuse were assembled, one to address evaluation and treatment and a second to address prevention issues (US DHHS, 1986). Participants included feminist activists and researchers as well as academicians and policy makers. The working group on evaluation and treatment began their recommendations with the statement:

"Spouse abuse is rooted in a sexist social structure that produces profound inequities in roles and relationships and in the way resources and power are shared by men and women in families. All public policies that encourage or support spouse abuse and other forms of interpersonal violence are wrong; they should be revised and changed." (US DHHS, 1986, p. 71)

Both groups recommended sweeping reform in public policy, educational practices, research, and service delivery. The ideology embraced by these groups clearly had its roots in feminist theory. Following this workshop, there was little discussion of the role of public health and medicine until 1989. when leaders of public health agencies and medical associations became involved in marital violence issues5.

Researchers in the Division of Injury Control at the Centers for Disease Control (CDC) have argued for reframing violence as a public health issue.

5 Although the nursing profession has a history of research and activism around wife abuse, this field generally has had little influence on medicine (for review, see Sampselle, 1992; for examples of research, see Bullock et al., 1989; and non-research literature, see Hadley, 1992; King and Ryan, 1989; Moehling, 1988).
(Rosenberg, 1989; Rosenberg et al., 1992). Their arguments included: (1) criminal justice measures alone are not enough; (2) fatal and non-fatal injuries resulting from interpersonal violence have a significant impact on mortality and morbidity; (3) public health introduces a primary prevention focus; and (4) public health brings tools for a systematic approach to measuring and "reducing the burden of illness, suffering, and premature death among human populations" (Rosenberg et al., 1992, p. 3071). Notably, community violence and domestic violence are not discussed separately in terms of the ideological framework. Thus, while recommendations have included broad social interventions like reducing media violence and teaching non-violent attitudes, there was no discussion of working toward greater gender equality.

In the U. S. Public Health Service publication, Healthy People 2000: National Health Promotion and Disease Prevention Objectives (1991), committee members established the goal of achieving a 10% reduction by the year 2000 in the physical abuse of women:

"Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples. (Baseline: 30 per 1,000 in 1985). ... The baseline rate for this objective is an estimate of severe violence, defined as acts that have a relatively high probability of causing an injury. Such acts include kicking, biting, punching, hitting with an object, beating up, threatening with a knife or gun, or using a knife or gun."

(PHS, 1991, p. 233)

In addition, analysts made specific recommendations for: legislation to restrict access to firearms; programs to prevent alcohol and substance abuse; interventions with children to foster nonviolent attitudes and behavior; and
improved mental health care to prevent suicide. The baseline rate of 30 per 1,000 was derived from NFVS data.

In 1989, the American Medical Association (AMA) held a conference on domestic violence and later formed the National Coalition of Physicians Against Domestic Violence which has developed literature and sponsored physician education campaigns. By 1992, diagnostic and treatment guidelines on domestic violence (marital violence), child physical abuse and neglect, and child sexual abuse were published. Although the domestic violence guidelines were prepared by wife abuse researchers, there was no discussion in the published material of the ideological framework for understanding this problem (Flitcraft et al., 1992).

Also in 1989, the American College of Obstetricians and Gynecologists (ACOG) developed guidelines for the identification of domestic violence victims. In a joint project with Surgeon General Koop, they distributed these guidelines through the mail to all of their members. In 1992, ACOG organized a coalition of health provider organizations to work on improving medical education and promoting screening of all patients for marital violence (Randall, 1992).

Leaders in the field of preventive medicine also have focused on the issue of violence and injury prevention (NCIPC, 1989). In a chapter on domestic violence, representatives for the National Committee for Injury Prevention and Control defined abuse as a continuum of violent and controlling behaviors primarily perpetrated by men against women. Further, they emphasize the need to examine women's social position as a component in the phenomenon of wife abuse. Their recommendations focused primarily on secondary interventions (legislative reform, services for abused
women, medical interventions) and individual level prevention (public education).

In response to increasing demands for policy reform, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) updated their 1992 accreditation manual to include requirements that hospital emergency departments develop written policies and procedures for handling adult victims of domestic violence (Salber, 1992). Besides state legislation, these accreditation guidelines provide a means of enforcing changes in hospital procedures.

Leaders in the field of medicine, including George Lundberg, the editor of the Journal of the American Medical Association (JAMA), and Robert McAfee, president of the AMA, recently have become outspoken about the need for a greater focus on violence as a health issue. This commitment was reflected in the June 10 and June 17, 1992 issues of JAMA that were devoted to research, news, and policy statements about community and domestic violence.

In the June 17 issue of JAMA, Surgeon General Novello and officials at the U.S. Public Health Service wrote:

"Domestic violence is an extensive, pervasive, and entrenched problem in the United States. It is an outrage to women and the entire American family. Health providers must take an active, vigorous role in identifying this serious recurrent public health problem." (Novello et al., 1992, p.3132)

In this letter they review the prevalence of marital violence, the effects on the health care system, and medical level interventions. They urge physicians to
take leadership roles in increasing awareness about this problem and creating community-level interventions.

In a separate report, the AMA Council on Scientific Affairs strongly advocated improvements in training of medical personnel; development of protocols to improve identification of abused women patients and intervention procedures; initiation of routine screening for victims; and improvements in record keeping and referral. Further, the Council recommended that the AMA:

"undertake a campaign to alert the health care community to the widespread prevalence of violence against women -- that the effects of such violence are likely seen on a regular basis -- and to sensitize them to the needs of victims of violence." (Council on Scientific Affairs, AMA, 1992, p. 3189)

Although this report advocated a strong role for medical practitioners in dealing with victims of marital violence, it was entirely focused on medical level interventions; questions of ideology and causation were not discussed explicitly.

In their position paper on marital violence, adopted November 1992, the American Public Health Association (APHA, 1993) identified social, economic, psychological and environmental factors as underlying causes of marital violence and strongly advocated a role for public health in education and influencing social change. Although the language is gender neutral (spouse/cohabiting partner abuse), the authors clearly acknowledge gender as an important dimension of marital violence and advocate for "social change to promote greater equality between the sexes and lessen male dominance" (p.
459). This paper also advocated legal and judicial reform, improved service delivery, and greater support for research on marital violence.

Involvement of federal leaders in the Clinton administration has provided significant support to public health and medical leaders. U.S. Department of Health and Human Services Secretary Donna Shalala made wife abuse a top health priority and called for "a national awakening to this unacknowledged epidemic in America." (APHA, 1994) In 1994, for the first time, the federal government allocated $7.5 million for CDC programs to investigate and reduce violence against women. Additional money was available under the Family Preservation and Support Act, the HHS Family Violence Prevention and Services Program, and the Violence Against Women Act passed by the Senate in 1994.

Overall, the commentary on wife abuse and recommendations from the public health and medical fields have varied in scope. Recommendations range from specific quantitative goals in rate reduction to sweeping reform at every level of society. However, it is clear that there are competing and conflicting frameworks being used to understand the origins and solutions to the problem of wife abuse.

CHALLENGES TO HEALTH RESEARCH AND POLICY

As the health fields proclaim wife abuse as a new public health crisis, it is important to understand the underlying frameworks that inform research, policy, prevention, and intervention efforts. The development of frameworks within the health sector is influenced in part by the fields and social movements that have previously defined the issue. In addition, the
health fields bring the traditional public health and biomedical approaches to problems. Thus, proponents of the "violence as a public health issue" campaign have struggled with the balance between defining violence as a disease so that fits within the dominant disease (particularly infectious disease) paradigm and expanding the traditional medical paradigms to include socially determined health problems.

Many of these ideological issues can be understood by examining the potential effects of medicalization on the problem of wife abuse. The term medicalization is used here to describe the process by which the jurisdictional powers of the medical profession are expanded to include behaviors or problems that might otherwise be considered private or personal (Stark, 1982). In this analysis, I will argue that medicalizing wife abuse has four potential negative consequences. First, because of the structure and ideology in medicine, social problems are individualized. In the case of wife abuse, the clinical focus is limited to the proximate cause of the injuries (or somatic and psychiatric manifestations) rather than on the social context of wife abuse. Second, medical frameworks often reduce and objectify experiences of illness. In particular, the deterministic language of medicine essentializes problems so that they become a part of the natural world. Third, socially determined health problems are pathologized, such that victims of adverse circumstances are blamed for their illness. And fourth, through the male-dominated hierarchy and paternalistic models of care, medicine exerts expert control.

Particularly at the micro level of the medical encounter, this domination may undermine abused women's efforts to resolve their problems. Each of these points will be explored in detail.
Individualization of wife abuse

Conrad and Schneider (1992) argued that the medicalization of deviance is a reflection of the prevailing tendency in society to individualize social problems:

"We tend to look for causes and solutions to complex social problems in the individual rather than in the social system." (p. 250).

The biomedical model is intrinsically individualistic in a number of ways. Generally people must remove themselves from their normal social and physical environments in order to enter the medical system. Patients are seen on an individual basis, and the process of diagnosis and treatment often further reduces health problems to physiologic entities. Determination of the cause of a particular problem rarely goes beyond the immediate cause. In this way, illness is not seen as a symptom of larger social problems.

Medicalizing violence has the danger of limiting intervention strategies to the proximate causes rather than the ultimate causes of violence. In her enthusiastic support of violence as a medical problem, Trafford (1992) created an analogy that epitomizes this approach to violence prevention:

"Central to this campaign is the 'medicalization' of violence, taking murder and assaults out of the realm of crime and into the territory of disease. The bullet is a 'pathogen.' Gunshot wounds are 'epidemic.' The riots in Los Angeles are described as an 'extreme outbreak' in the plague of violence." (Trafford, 1992, p. 16)

The solution implied in this analogy is that removing the pathogen (i.e. gun control) will eliminate violence. Although it is true that reducing the lethality of violent behavior would likely lower mortality rates, it does not
address the underlying problems. Another real danger in this framework is that there is no human agent behind the bullet-pathogen.

Specifically in the case of wife abuse, medicalization of the victimization by intimate violence has the potential to ignore the forces in society that allow and perpetuate violence against women. An examination of policy statements in public health and medicine indicates that this may already be happening. Many health policy statements regarding marital violence and abuse do not include a discussion of the broader social factors that lead to violence against women (PHS, 1991; AMA Council, 1992; Noveillo et al., 1992). On the other hand, the policy statements endorsed by Surgeon General Koop, (US DHHS, 1986), developed by the National Committee for Injury Prevention and Control (1989), and advocated by the American Public Health Association (1993) have explicitly discussed gender inequity as a cause and important target for intervention.

Although many of these health policy statements are promising in their focus on the root causes of wife abuse, the majority of public health approaches focus on proximate causes. Further medical approaches tend to be even further downstream, focusing primarily on the identification of victims and individual-targeted intervention and referral.

**Essentialization of wife abuse**

Another consequence of medicalization is the objectification of deviant behavior (Conrad & Schneider, 1992). To fit within the biomedical model, problems are typically objectified and reduced such that their existence is removed from the social and political context. As a result, problems become
part of the natural physical world of medicine and science. Stark (1982) argued that medical care has a tendency to:

"abstract illness and health from the historically specific struggles in which they are constituted and to view them as natural byproducts of some immutable process outside concrete social activity." (p. 422)

Rhodes (1990) argued that one way that social problems are essentialized is through the language of medicine.

"Medicine can describe events in a value-neutral language that makes them appear to be part of the natural world and thus neutralize what are, in reality, social problems." (p. 168)

Warshaw (1989), who conducted research on the treatment of abused women trauma patients, found that medical personnel often use the passive voice in documenting injuries caused by marital violence (e.g. "hit by a fist"). This practice eliminates agency and reduces the problem to the immediate cause of the physical injury. She argued that this reductionism perpetuates the violence and abuse by recreating it.

"By reducing the battered women's lived experience into medical facts and not acknowledging the feelings they [medical providers] avoid by doing so, medical staff inadvertently recreate the abusive dynamic between themselves and their patients." (p. 512)

Pathologization of wife abuse

Medical problems that are not framed within their social context are subsequently reduced to pathological processes that can be attributed to the individual. Individual lifestyle and behavior that are considered responsible
for the medical problem are consequently stigmatized. Examples include alcoholism, obesity, smoking, and psychiatric diseases.

Using research on medical encounters involving abused women patients, Stark et al. (1979) found that medical providers tended to label the abused woman in ways that suggest she is personally responsible for her victimization. These researchers argued that this process of labeling blames the victim and contributes to her oppression.

"Regardless of the personal reasons that lead physicians to abandon scientific logic as they approach health problems that defy classification within their individualist, pathophysiological model, the process of labeling directly contributes to the exploitation and oppression of patients elsewhere because of their race, sex, age, or class." (p. 463)

Several researchers have argued that aspects of the medical encounter perpetuate the cycles of abuse by decontextualizing and negating the woman's experience. Based on their interviews and participant observation in four clinical settings, Kurz and Stark (1988) concluded:

"The current medical response to abuse alternates between a narrow clinical focus on physical injuries outside of the social context that makes them intelligible and an approach that stigmatizes abused women so that they appear responsible for the violence." (p. 249)

Domination of expert control

Another consequence of medicalization is the subsequent domination of expert or professional control. Several aspects of the medical system predispose the creation of a monopoly over anything that is defined as an
illness. Conrad and Schneider (1992) argue that because of the organization of the medical profession and the mandate from society, decisions regarding diagnoses and interventions are almost completely controlled by the medical establishment. This structure ensures that power remains in the hands of the experts (Morgan, 1981, 1985). Furthermore, it sets up the potential for social control at the individual level.

Waitzkin (1989) argued that although medical encounters are microlevel processes that involve individuals, they occur in a social context shaped by macrolevel structures. During these encounters, physicians have the power to convey social and political ideology to the patients. When medical providers are faced with social problems, Waitzkin and Britt (1989) argued that physicians often function as agents of social control.

"By easing the physical or psychological impact of contextual difficulties, or by encouraging patients' conformity to mainstream expectations of desirable behavior, encounters with doctors can help win patients' consent to troubling social conditions." (p. 577).

Waitzkin and Britt (1989) argued further that medical encounters discourage critical analysis and typically do not encourage explicit action by health professionals to change contextual sources of the patients' problems.

Because the majority of physicians are men and the victims of wife abuse are women, this domination of expert control carries the connotation of patriarchal domination of women. Abused women who enter the medical system immediately encounter a gender hierarchy that mimics that of the nuclear family: male physician as father, female nurse as mother, and patient as child. This social structure combined with paternalistic models of care may
function to infantilize the abused woman and perpetuate her dependency, low self esteem, and feelings of helplessness.

In reflecting on her observations of how abused women are treated in the medical system, Warsaw (1993) argued that the learned processes of objectification combined with the hierarchical structure of medicine create ideological barriers to appropriate interventions at the medical level.

"By examining the ways in which medicine is both taught and practiced, we can see how the objectification process intrinsic to its discourse transforms people -- in this case women with lives and agency of their own -- into patients who fit medical or psychiatric diagnostic categories. By showing how this model functions through techniques that institutionalize socially sanctioned hierarchies of domination and control, techniques that mimic the dynamics of abuse and battering, we begin to see why clinicians trained within that framework find it difficult to provide empowering responses that would be most supportive to abused women." (p. 75)

Alternatives to medicalization of wife abuse

In examining the potential dangers of medicalization, it is important to also acknowledge the potential benefits. Conrad and Schneider (1992) argued that:

"Medicalization lends the prestige of the medical profession to deviance designations and treatment." (p. 248).

Medical definitions of deviance are construed to be based in science, and thus beyond challenge. In the case of wife abuse, medicalization has clearly increased public awareness of this issue. In contrast to social science research,
medical and health research is more likely to be publicized by the news media. Activism within the medical field is also more likely to capture the public’s attention. In other words, when the president of the AMA speaks out against wife abuse, the public is likely to believe that it is a significant problem.

One way to counter tendencies toward individualizing wife abuse involves the explicit and continued discussion of the social factors that ultimately cause violence. Health and medical researchers and spokespersons clearly acknowledge the disproportionate effects of violence on the lives of women, minority youth, and impoverished communities. These associations need to be understood as reflections of greater inequity in society: racism, sexism, poverty. Public health and medicine should adopt a contextual, historical approach to understanding violence and abuse and should advocate for broader social reform for the prevention of wife abuse.

In focusing on root causes of wife abuse, it is important to frame the problem within the context of sexual oppression, rather than within the context of family dysfunction. Currently, there appear to be two competing dominant paradigms for understanding the root causes of marital violence: the feminist model and the family violence model. The connections between wife abuse and other forms of violence against women are undeniable given the shared context of a patriarchal society. In contrast, adhering to the family violence model obscures the importance of gender.

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6 This model is also referred to as the Violence Against Women model (Stark & Flitcraft, 1988) and the Gender Politics model (Stark & Flitcraft, 1991).
7 This model was based on sociology research by Straus, Gelles, and Steinmetz (1980). The specifics and distinctions between these two causal models were discussed earlier in this chapter. For an excellent discussion of competing conceptualizations of wife abuse in the field of sociology, see Gelles (1993) and Yllo (1993).
While it is clear that wife abuse and other forms of domestic violence are related, they need to be understood as different entities with different causes and different implications for prevention.

Explicit discussion of these conflicting ideologies and clarification of these issues is critical to the future development of research and intervention strategies. Overall, I would argue that health and medical strategies that attempt to address the ultimate causes of violence and explicitly identify gender-based power inequities as the root of wife abuse are the most useful in guiding public health and medical research and interventions. Approaches that do not acknowledge the role of sexual oppression are simply dealing with the symptoms and not the disease.
Chapter 2.
Health and Medical Research on Wife Abuse

The purpose of this chapter is to review the research that contributes to the understanding of the magnitude and impact of wife abuse. Studies with nationally representative samples have been undertaken to estimate the population prevalence of marital abuse, as well as demographics and risk factors. Clinical studies have been designed to determine the health outcomes of abuse, the prevalence in a variety of medical settings, and the medical response. One objective in reviewing this literature includes providing insight into frameworks used to research wife abuse. To that end, an analysis and critique are included.

LITERATURE REVIEW

Before reviewing the research on marital violence, it is important to understand its limitations. This research is strongly influenced by the framework used by the investigators which determines the definition of the problem, the groups studied, and the methods of analysis. In contrast to most health problems, there is no agreed upon definition of abuse and no standard instrument for measuring abuse. Some researchers define the problem as physical acts of violence, regardless of injurious outcome; others assess only injury or death from violence; and others include psychological and sexual abuse in their definition of abuse. Sources of data and populations studied also vary considerably; some researchers sample only women subjects while
other sample both men and women. The format and setting of the data collection may have an influence on the participants' subjective identification and experience of abuse and violence as well as their willingness to disclose this information. Regardless of these ideological and definitional issues, research on marital violence has illuminated many important aspects of the problem.

Prevalence of marital violence in the U. S.

Research on the prevalence and risk factors of marital violence has been conducted within a number of different academic fields including sociology, criminology, and more recently, public health and medicine. Each discipline approaches the problem according to its own definitions of abuse, framework of relevant factors and methodology. Perhaps the only common conclusion is that the phenomenon of spouse abuse is very difficult to research and consequently estimations of prevalence and risk factors are widely disparate.

The two primary statistical sources of prevalence and demographic data on marital violence are the National Family Violence Surveys (NFVS) carried out by the sociologists Straus and Gelles (Straus et al., 1980; Straus & Gelles, 1989) and crime data from the National Crime Victimization Survey. The NFVS conducted first in 1975 was the first attempt to determine the prevalence of violence in a random sample of family households. The second NFVS conducted in 1985 included a larger sample and greater number of black and Hispanic households (1989). Both studies surveyed nationally representative samples of married or cohabiting men and women with or without children (2,143 in 1975 and 3,520 in 1985).
These surveys used the Conflict Tactics Scale (CTS), a quantitative research instrument composed of 19 methods of conflict resolution, eight of which use force or violence such as throwing, pushing, hitting, kicking, and the use of weapons (see Appendix A). Respondents were asked to specify the frequency with which each of the different methods were used in marital disagreements in the previous year. Other forms of domestic violence (e.g. child abuse, sibling fighting) were similarly assessed. Rates of overall male-to-female violence (items k through s on the CTS) were 12.1% in 1975 and 11.3% in 1985, rates of female-to-male violence were 11.6% in 1975 and 12.1% in 1985. Rates of severe male-to-female violence (items n through s on the CTS, kicking, biting, hitting, or worse), were 3.8% in 1975 and 3.0% in 1985, rates of severe female-to-male violence were 4.6% in 1975 and 4.4% in 1985. These prevalence rates and the finding of greater female-to-male have been replicated in several U. S. and Canadian surveys that used similar methodology to assess domestic violence (for review, Smith, 1989). The framework used by these researchers was that violence occurs as a means to resolve conflict. Thus the occurrence of sexual force or unprovoked violence is not included in this survey instrument. Furthermore, there was no measure of injury outcome, subjective experience, or context (e.g. self defense). These limitations are important to consider in light of the widespread citation of this research and utilization of the CTS in marital violence research.

The U.S. Department of Justice-National Crime Victimization Survey (NCVS) is a general population survey that collects information on assaults not necessarily reported to law enforcement agencies. In addition, data on the use of medical services and characteristics of the victim-offender relationship
are collected. According to 1977-78 NCVS data, the rate of spousal and ex-
spousal assault reported by women was 3.9 per 1,000, while spousal assault
reported by men was 0.3 per 1,000 (Gaquin, 1978). Between 1987 and 1991, the
average annual rate of violent victimization by intimate partners was 5.4 per
1,000 women and 0.5 per 1,000 men (Bachman, 1994). Of the women
victimized by an intimate partner, 59% suffered injury, 27% received medical
care, and 15% received hospital care.

The NCVS prevalence estimates are significantly lower than those
found by Straus and Gelles (approximately 10-fold and 100-fold, respectively).
This may be explained by the NCVS inquiry that requires the victim to
identify the violence as criminal assault. In addition, the NCVS is better
controlled for recall bias by conducting a total of seven interviews with the
same households every six months; data from the first interview are not
included in the analysis, but used to ensure accurate 6-month recall for each
subsequent interview.

Demographics and risk factors

The characterization of the demographics and risk factors for marital
violence has met with many obstacles. First, differences in survey and
sampling methodology have resulted in conflicting data. Second, ideological
barriers to focusing on particular types of risk factors (e.g. race/ethnicity and
socioeconomic status) have resulted in neglect of these issues. Although
female sex and younger age may be the only agreed upon risk factors
throughout the literature, several review articles included other potential
risk factors: marital status, alcohol and drug use, exposure to abuse as a child,
and pregnancy. Each of these will be discussed in some detail.
Both the NFVS (Straus et al., 1980; Straus & Gelles, 1989) and the NCVS (Bachman, 1994) found strong correlations between marital violence and younger age of the victim. According to the NFVS data, women ages 18 to 24 reported the highest rates of marital violence. According to the 1994 NCVS report, the highest rates of victimization were in the younger age groups: 15.5 per 1,000 women age 20-24, 8.8 per 1,000 women age 25-34, 4.0 per 1,000 women age 35-49, and 0.9 per 1,000 women over 50.

According to NCVS data, separated, divorced, and single women had higher rates of abuse by intimate male partners than married women (Gaqun, 1978; Bachman, 1994). In the NCVS instrument the subjects were asked about assault perpetrated by their marital or intimate partners, which may include those not living in the same household. Thus, it is impossible to determine whether separated and divorced women suffer more violence at the hands of their former partners rather than current or new partners. In addition, higher rates among single women may reflect age-related differences. The different risk factors were not analyzed using multivariate analysis, so confounding effects of the different factors are impossible to ascertain.

Correlations of abuse with race, ethnicity, and markers of socioeconomic status have been inconsistent. Although the NFVS and the NCVS have found higher rates of violence among families with the lowest incomes, a household survey of 1,793 women in Kentucky (Schulman, 1979) found only minor differences. It should be emphasized that the data on age, income, and ethnicity are unadjusted for potentially confounding variables. The relationship between marital violence and race or ethnicity is also
controversial\textsuperscript{8}. Essentially, while some studies have demonstrated higher rates for non-white ethnic groups (Hampton et al., 1989; Straus & Smith, 1989), other research demonstrates no difference among different ethnic groups (Gaquin, 1978; Lockhart, 1987; Sorenson & Telles, 1991; Bachman, 1994).

According to a review by Stark and Flitcraft (1991), additional risk factors include alcoholism and drug use, exposure to domestic violence as a child, and pregnancy. Although alcohol and drug use by both the victim and abuser have been associated with violent behavior, most researchers argue that substance abuse facilitates but does not cause violence. Many studies have shown a strong association between exposure to violence or abuse in the family of origin and later involvement in a violent relationship. Pregnancy has been associated with higher rates of abuse and often is associated with the initiation of abuse.

It is likely that only some of these factors are independent risk factors for abuse; others can be explained by their interactions. For example, age, marital status, income, and pregnancy variables are likely to be interrelated\textsuperscript{9}. Age and substance abuse are also likely to be related. Clearly, more research and more thorough data analysis are necessary to understand which of these factors accurately and independently predicts marital abuse.

**Epidemiology within health fields**

In addition to research in the fields of sociology and criminology, health researchers have applied principles of epidemiology research to the

\textsuperscript{8} The details of research on the prevalence among different ethnic groups are discussed in Chapters 5 and 6 for African-American and Latino populations, respectively.

\textsuperscript{9} In fact, much of the obstetric research (reviewed below) has focused on low income single mothers.
SE Asian Studies
- Eric Crayth
- Patty Buan

Stan Sesser - language critic
problem of marital violence. These researchers have used hospital-based data as well as crime data to learn more about the proportion of injuries attributable to marital violence in a given population and the proportion of reported assaults and homicides related to marital violence. Although these studies were innovative in their use of available data sources, these sources were often limited in that the researchers could not control the types of data collected.

Using hospital-based data and vital statistics collected for over one year, Grasso et al. (1991) estimated the prevalence of violence-related injuries among women living in a poor, urban, primarily black community in western Philadelphia. Of women age 15 or older, nearly 10% suffered an injury resulting in an emergency room visit or death during the 1-year study period. The leading causes of injury to women in this population were falls (25.1 per 1,000 women), violence (20.8 per 1,000), and motor vehicle accidents (16.8 per 1,000). In women ages 15-44, violence was the most common cause of injury. Data regarding the perpetrator of violent injury were collected in only 19% of the violence-related injury cases. Of these, 62% were boyfriends or husbands, 21% were friends or family members, 3% were unspecified domestic, and 14% were strangers. The authors comment that the rates of violent injury are probably underestimated because the survey did not include injured women who did not seek medical care or who misrepresented their injuries as falls or unintentional.

CDC researchers Saltzman et al. (1990; CDC, 1990) used police reports in Atlanta, Georgia to determine the proportion of fatal and non-fatal assaults attributable to family members. For their analysis, the researchers defined emotionally intimate relationships as 'nuclear family, other relatives and in-
laws, married and unmarried partnerships, and terminated partnerships.” Current and former partnerships accounted for 74% of fatal assaults and 77% of non-fatal assaults both sexes combined. All types of relationships combined, women were at a 2.4 times greater risk of nonfatal assault and at no greater risk than men of fatal assault. Although victim gender was included in the univariate analysis of overall victimization, these data were not stratified by the gender of the offender. Thus the specific rates of male-female and female-male spouse violence were not reported. Furthermore, intimate partnerships were not stratified by sex separately from other family relationships, thus the specific rates of husband-wife and wife-husband violence were not reported.

Using FBI Uniform Crime Report (UCR) data collected from 1976-85, Mercy and Saltzman (1989) studied the proportion of homicides that occur within spousal relationships. They excluded homicides where the offender and victim were divorced, those with multiple offenders, and those classified as justifiable\(^{10}\). They found that spouse homicides accounted for 8.8% of all homicides and occurred at a rate of 1.6 per 100,000 married persons. The aggregate risk of being murdered by one’s spouse was 1.3 times higher for women than for men, although black husbands were at greater risk than black wives. Demographics examined included sex, race, age, differences in age and race, and changes over time; each analysis was broken down by the sex and race of the victim. To summarize, higher rates of homicide were associated with younger age of the victim, greater age differences between partners, and interracial relationships. The only data on circumstantial factors were the

\(^{10}\) The reasoning behind these exclusions was not clear.
immediate context of having an argument; there were no data regarding the history of abuse or violence in the relationship.

In another analysis of national homicide data by CDC researchers, Kellerman and Mercy (1992) found that between the years 1976 and 1987, women had a higher risk (RR= 1.23) of being murdered by a spouse or intimate acquaintance as compared to men. In addition, although women committed only 14.7% of all murders, in 60% of the cases, an intimate or family member was the victim. Data regarding the circumstances surrounding the murder (e.g. self-defense) and history of violence in the relationship were not collected. Although most studies on homicide show high rates of spousal homicide by both men and women, some research suggests that women are more likely to kill in self-defense (Jurik & Winn, 1990).

In contrast to public health epidemiology research, medical research has focused on specific issues relevant to the practice of medicine: determining the proportion of different patient populations that are at risk for marital abuse, health outcomes related to marital violence, and barriers to care for abused patients. The prevalence of victims of marital abuse has been determined in a variety of health settings, including emergency departments, primary care and internal medicine clinics, and obstetrics and prenatal care clinics. For each of the studies described, the participants were selected at random, although most were limited to women patients and many were conducted in settings that serve low income and minority patients. Methodologies included chart review, in-depth interviews, and quantitative surveys. Definitions of violence and abuse differed significantly as well as the
frameworks for analyzing the data. Thus comparisons between studies are difficult.

Prevalence of marital violence victims in emergency settings

Stark et al. (1981) were among the first to describe rates of abuse among women patients presenting to emergency departments with injuries. They developed a strategy for medical chart review that categorized injuries to women into four groups: positive for abuse, probable, suggestive, and negative. Positive included those with an explicit statement in the record that the patient's injury was inflicted by a male partner, probable included those with evidence of interpersonal violence but no indication of the source, and suggestive included those where the alleged etiology did not account for the location or severity of the injury. Based on a 5-year retrospective chart review of 2,676 women patients, they found 11.0% were classified as positive, 7.5% probable, and 2.5% suggestive of injuries related to marital violence. In all, a total of 21% were considered at risk for abuse. Compared to a random sample of 591 women classified as negative, abused women were more likely to be younger, unmarried, unemployed, black, and Protestant. Of the 435 positive trauma incidents included in the charts, 15% were explicitly identified in the medical record as resulting from marital violence. In a similar medical chart review study of 3,676 women trauma patients, Kurz and Stark (1988) found that 18.7% were identified as abuse victims. Of the 483 positive trauma incidents in this study, 15% were identified as the result of marital violence.

\textsuperscript{11} Statistical interactions between these variables were not reported.
To determine the rate of partner violence in an urban emergency department, Goldberg and Tomlanovich (1984) surveyed a random sample of 492 women and men. The patient population was predominantly black and sample selection was not based on the presenting problem (i.e. the sample included cases of injuries as well as other acute medical problems). Identification of victims was based on an affirmative response to the written statement "at some time my boyfriend/husband or girlfriend/wife has pushed me around, hit me, kicked me, or hurt me." Using this survey instrument, 22% of patients identified themselves as victims of marital violence. Of these, about 10% reported severe abuse (stabbing, whipping, or use of weapons). Risk factors included younger age, unmarried cohabitation, and few years of formal education. Rates of reported abuse did not significantly differ by race, ethnicity, or gender.

In another chart review study of women trauma patients, McLeer and Anwar (1989) found that identification of victims was dependent on the use of a screening protocol by the nursing staff. The majority of patients were from an inner city, low income, black population. Charts were reviewed before and after the staff were trained to use a screening protocol that contained explicit questions about the source of injury. The rates increased from 5.6% (of 359) patients to 30% (of 412) patients with the use of the protocol.

According to these studies the proportion of women patients presenting to emergency departments with injuries who are victims of marital abuse ranged from 18.7% to 30%. Inconsistencies were likely to have resulted from the use of different methodologies and sample populations. Because the rate of identification by medical professionals tended to be low
(15%) in these settings, most authors recommended routine screening of women trauma patients.

Prevalence in primary care settings

Clinicians also have been interested in the proportion of women patients in primary care settings who have experienced marital violence. Presumably, the majority of abuse victims are presenting to primary care physicians with symptoms and problems that are not the result of marital abuse, or at least not obviously related to abuse. Thus this research helps to define the role of the primary care physician in the early identification and intervention with these patients.

Of 218 women patients surveyed at two South Dakota primary care clinics, Rath et al. (1989) found that 48% reported verbal abuse, 44% reported minor physical abuse (defined as "thrown objects or pushing"), and 28% reported severe physical abuse (defined as "hitting with fist or object") by an intimate partner at some time in their relationship. These clinics served primarily low income white women. Risk factors for victimization in this population included substance abuse by the partner and lower socioeconomic status (income and formal education level). Age of the respondent, legal marital status and cohabitation were not significantly related to the level of abuse.

Gin et al., (1991) surveyed 453 English- and Spanish-speaking men and women patients presenting to three ambulatory care internal medicine clinics in southern California. Using a modified CTS instrument, they found that 28% had experienced marital violence in their lifetime and 14% were currently experiencing violence. Rates of reported abuse (in their lifetime)
were higher among women (34% compared to 12% among men), among unmarried persons (35% versus 17%), whites (34% compared to 20% for non-whites). Other risk factors included poverty, alcohol and drug use by either the perpetrator or victim, and the use of controlling and intimidating behaviors by the partner.

In a survey of 394 predominantly (89%) white women patients seeking care from a family practice clinic in a Midwestern community, Hamberger et al. (1992) found that 22.7% reported having been physically assaulted by their partners within the last year; the lifetime rate was 38.8%. Using the CTS, researchers defined assault as having been "pushed or shoved" or worse. The rate of injury (defined as at least a small bruise, not necessarily requiring medical treatment) due to marital assault in the previous year was 13.3%. Victims were younger and more likely to be separated or divorced. Ethnicity and formal education levels were not predictive of abuse.

Using in-depth interviews of 42 women patients presenting to a Midwestern community-based family practice clinic, Elliot and Johnson (1995) found that 45% reported experiencing physical, social, and/or emotional abuse in their intimate relationships; 31% reported moderate physical abuse ("pushing or slapping"); 19% reported sexual abuse ("forced intercourse"); and 21% reported severe battery ("punching, kicking or threatening with a weapon"). Participants were primarily urban working class women. The abused women were more likely to be unmarried, unemployed, and receiving Medicaid.

Based on the results of these studies, the proportion of abused women patients seeking primary care ranges from 23% to 44%. However, direct comparison of the rates is complicated by different patient demographics,
survey instruments, and definitions of abuse. Even comparing rates of physical abuse is difficult since some researchers inquired about abuse within the past year while others were interested in abuse at some time in the current relationship. Regardless of these discrepancies, the majority of these researchers recommended some type of routine screening and intervention for abused women patients in this setting.

Prevalence in obstetric care settings

As discussed earlier, pregnancy is often described as a risk factor for marital abuse. Research in obstetric and prenatal care settings has demonstrated a high prevalence of physical abuse among pregnant women (for review, McFarlane, 1989; Bohn, 1990; Newberger et al., 1992). Part of this interest in abuse during pregnancy has been motivated by concern over the health of the fetus and potential adverse birth outcomes related to injuries. Consequently, many of the studies did not limit the inquiry to acts perpetrated by intimate partners but included any source of intentional trauma.

In a study of 290 pregnant women from public and private prenatal clinics, Helton et al. (1987) found that 5% reported physical abuse by a male partner at some time during the pregnancy; of these, one-third sought medical care for their injuries. Abuse was defined as "hit, slapped, kicked or otherwise physically hurt them." Participants varied in their ethnic make-up: 33.1% Latina, 32.1% white, and 22.4% black. There were no significant differences in age, education level, marital status, and ethnicity between the abused and non-abused women.
In a prospective study of 1,243 predominantly poor, urban, minority pregnant women, Amaro et al. (1990) found that 7% reported physical or sexual violence during their pregnancy. Violence was defined as "fights or beatings" that resulted in some type of injury. Although researchers reported that 94% of victims knew their assailant, the relationship to that assailant was not ascertained. Depression, substance abuse, lack of social support, and "unhappy feelings about the pregnancy" (on the part of the woman, her partner, or her family) were strongly correlated with reported victimization.

Based on a population-based surveillance system involving 12,612 women in four states, 5.6% reported having been "physically hurt by their husband or partner" within the 12 month preceding childbirth (CDC, 1994). Significant risk factors included less formal education, non-white ethnicity, young age, unmarried status, poverty, and having had an unintentional pregnancy.

In a prospective study of 691 pregnant women, McFarlane et al. (1992) found a 17% prevalence of physical abuse (defined as "hit, slapped, kicked, or otherwise physically hurt") or sexual abuse during their pregnancy. Of these, 78% were victimized by a husband, ex-husband, or boyfriend. The sample included black, Hispanic, and white women (percentages not reported); 95% were below poverty level; and 31% were teenagers. White women experienced the greatest number of episodes of abuse and increased severity of abuse. Teenage women reported both their parents and their boyfriends as perpetrators of abuse. Physical abuse was strongly associated with delayed entry into prenatal care.

In another prospective study of 1,203 pregnant women, Parker et al. (1994) found that 20.6% of teens and 14.2% of adult women reported abuse.
during their pregnancy. Of these, 67% of the teens were victimized by their male partner, while 82% of adult women were victimized by their male partner. Methodology and population demographics were almost identical to the McFarlane study. Abuse was a significant risk for low birth weight, as well as low maternal weight gain, infections, anemia, smoking, and substance abuse.

In a comparison of abuse experience among 275 women before, during, and after their pregnancy, Gielen et al. (1994) found that rates of violence were higher postpartum (25%) than in the prenatal period (19%). Rates of violence perpetrated by male partners was 10% prenatally and 19% postpartum. This population was predominantly black (92%), low income (83%), and single (89%). Researchers used the CTS to document physical abuse. Risk factors for abuse included younger age, higher level of education, and substance abuse by the partner. Women who reported having a supportive social environment had lower rates of abuse.

Overall, the prevalence of abused women seeking prenatal care ranged from 5.6% to over 20% depending on the population and definitions of abuse. The reasons that pregnant women had high rates of abuse may be related to concurrent risk factors (e.g. younger age) and/or increased vulnerability related to the pregnancy. Although prevalence studies clearly documented the significance of this problem, more research is needed to understand the underlying causes and context. Researchers and clinicians have long advocated improvements in detection and intervention for this group of patients.
Health and injury outcomes

Not only do abused women comprise a large proportion of a variety of patient populations, research has demonstrated that they present with a variety of traumatic, medical, and psychiatric problems and have increased rates of utilization of medical services (for review, Koss & Heslet, 1992; Plichta, 1992). Several researchers have attempted to characterize the types of injuries, medical problems, and psychiatric needs of abused women patients.

In their review of 564 women trauma patients identified as abused by retrospective medical chart review, Stark et al., (1981) determined the location and types of injuries sustained by abused women. Compared to 591 randomly selected women classified as negative, abused women tended to have multiple injuries that clustered around the head, neck, face, throat, chest and abdomen. More recent research has confirmed these earlier reports. Berrios and Grady (1991) reviewed interviews with 218 self-identified abused women presenting to an emergency room with injuries. A high proportion had suffered severe trauma: 23% required hospital admission and 13% required major surgical treatment. Typically, injuries were multiple and more centrally located (torso, neck and face). Most of these patients had a history of traumatic injury that required medical care. These characterizations of abused women trauma patients have contributed to the creation of a diagnostic profile for women presenting with injuries (Flitcraft et al., 1992).

In addition to trauma, research demonstrates that abused women are more likely to have a variety of other medical and psychiatric problems. In a chart review study of 642 women trauma patients identified as abused, Kurz and Stark (1988) found that 17% had attempted suicide. In another study of 206 women referred for gastrointestinal disorders, 44% reported a history of
sexual or physical abuse (Drossman et al., 1990). Compared to the control group, these abused patients were more likely to report pelvic pain, multiple somatic symptoms, and more lifetime surgeries. In a 5-year prospective study of 117 abused women in Sweden, Bergman and Brismar (1991) found that abused women had a significantly increased use of medical services compared to matched controls. Medical care was provided for a range of problems including trauma, gynecological disorders, induced abortions, and medical disorders. Psychiatric problems included depression, psychoses, substance abuse, and suicide attempts. In a study of 93 "maritally discordant couples", 71% of which experienced at least one act of marital aggression during the past year, Cascardi et al. (1992) found that wives sustained more severe injuries and reported clinical levels of depressive symptomatology. In another study of 394 abused women patients in family practice clinics, depression was the strongest indicator of abuse, while back pain, ulcers, headaches, and anxiety were weaker indicators (Saunder et al., 1993).

These studies demonstrate a strong association between multiple medical and psychiatric problems and a history of abuse. In spite of research demonstrating high prevalence of abused patients and significant health problems, medical providers fail to recognize the majority of wife abuse victims even when signs and symptoms are present (Stark et al., 1981). One approach to improving rates of identification has been through curricular changes and the development of protocols for identification and management of abused women.
Medical system responses

Policy makers in medicine have begun to address the problem of wife abuse by creating guidelines for screening, protocols for intervention, and educational curricula. Consequently, research on the efficacy and utilization of various protocols has been instrumental in driving policy change. In addition, researchers have investigated the use of marital violence training curricula in medical schools and residency programs.

McLeer and Anwar (1989) studied the efficacy of establishing a protocol for the identification of female victims of marital violence in an emergency department. The protocol was administered by a trained triage nurse and contained questions which elicited a trauma history and cause of the trauma. Researchers found that rates of identification increased from 5.6% to 30% following staff training and institution of the standardized protocol. An eight-year follow-up study in the same emergency department demonstrated that without continued training and enforcement of protocol use, rates of identification declined to 7.7%, a rate comparable to the baseline rate before the protocol was established (McLeer et al. 1989). In another study designed to assess the efficacy of a screening protocol in an obstetric care setting, Norton et al. (1995) found that detection of abuse during pregnancy was improved from 1% to 10%. In the screening instrument, abuse was defined as "hit, slapped, kicked, or otherwise physically hurt."

The CDC reported the results of a survey of emergency department marital violence protocols in California (CDC, 1993). The results were complicated and difficult to interpret due to variable response rates to the survey and requests for submission of protocols. Overall, 80% of nurse managers responded to the survey. Of these, 54% reported that their
department had written policies for treating adult victims of abuse, however only 64% submitted written copies, and of the protocols submitted, only 54% included material specific for spouse abuse. Thus, of the 414 departments surveyed, only 14% demonstrated conclusively that specific written protocols exist for treating victims of marital abuse.

In 1989, the CDC reported the results of a survey of all accredited U. S. and Canadian medical schools regarding curricula about adult domestic violence (CDC, 1989). Of the 116 respondents (81%), 53% reported that their students did not receive any instruction on adult domestic violence, 42% reported that students received instruction as part of at least one required course, and 5% reported such curricula offered in an elective course. In 1991, the CDC reported the results of a similar survey of family practice residency programs (CDC, 1991). They found that 59% had none or limited curricula, 36% had some, and 5% had substantial.

This research clearly demonstrates the need to continue to create policy that provides structural changes that will facilitate the identification and intervention for abused women patients. However, some researchers argue that while structural changes are useful, there are greater barriers to improving medical care for abused women, namely resistance on the part of medical providers.

Medical treatment of abused women

Although most health care professionals acknowledge that wife abuse is a significant problem and that they have an important role in identification and intervention, they have difficulty putting this knowledge into practice. Research utilizing physician surveys and interviews indicates that the
reluctance originates from ignorance, discomfort, and lack of time, among other reasons. Other researchers argue that the medical model of care interferes with appropriately addressing this problem.

In their study of women trauma patients, Stark et al. (1981) retrospectively reviewed the medical charts of women identified as potential victims of marital abuse (n=564). These researchers found that the medical response to abused women was more likely to include: (1) treatment focused on the physiological problems (e.g. analgesics and minor tranquilizers); (2) labeling and medical notes that are victim-blaming, which reflects an attitude that is probably perceived by the patient; and (3) punitive interventions. In their analysis, they reconstructed three stages of development of the battering syndrome as it progressed from multiple physical injuries and minor medical complaints to increased injuries, heightened complaints and psychiatric problems to serious psychiatric problems including suicide. Stark et al. (1981) argued that the inadequate and punitive medical response contributed to this syndrome.

Using data collected through a combination of medical chart review of 3,676 women trauma patients (18.7% of which were identified as abuse victims) and participant observation of 98 medical encounters between abused women patients and emergency department personnel, Kurz and Stark (1988) identified several problems with the medical response to victims of abuse: lack of explicit identification in the medical records, lack of referrals to social services, and over-prescription of pain medications and minor tranquilizers. Compared to 689 randomly selected women classified as negative, abused women were more likely to have disparaging labels recorded
medical system is at best ineffective in helping women and at worst
demoralizing and alienating.

In their survey of 505 Canadian family physicians, Ferris and Tudiver
(1992) reported that more than 70% of the respondents believed that they
identified fewer than half of the abused adult women in their practice. The
most common reasons cited for this inadequate identification included
patient unresponsiveness, lack of physician initiative, infrequent visits, lack
of time, and lack of training. In contrast, the vast majority (over 90%)
believed that physicians should be responsible for identification and
management of this problem. A second survey, using the same instrument,
of 963 family physicians confirmed these earlier findings (Ferris, 1994).

In a survey of 27 physicians at private and public primary care sites,
Friedman et al. (1992) found that one third believed that questions regarding
physical and sexual abuse should be asked routinely, however rates of inquiry
were significantly lower: 11-15% "sometimes" asked about sexual abuse and
33-40% "sometimes" asked about physical abuse depending on the type of
visit. The reasons for the discrepancy between their intentions and actual
behavior were not explored in this research.

In an effort to understand the underlying barriers on the part of doctors
to the treatment of adult victims of domestic violence, Sugg and Inui (1992)
conducted semistructured, open-ended interviews with 38 primary care
physicians. Researchers found that along with structural barriers like time
constraints, doctors reported feeling a lack of comfort, fears of offending,
powerlessness, and loss of control when dealing with adult victims of abuse.
The authors recommended that these psychosocial issues on the part of
physicians be addressed in training programs.
Using data from four focus groups of Canadian family physicians, Brown et al. (1993; Brown & Sas, 1994) identified several issues regarding identification and management of abused women patients. The physicians recognized that their attitude and ability to create a comfortable environment contributed to their ability to identify abused patients. Barriers included lack of time, feelings of frustration with the patient’s lack of change, and inadequate training. Barriers to their intervention included feelings of powerlessness and lack of resources. Also, these physicians discussed patient-related issues that included economic and social barriers to help-seeking, psychological issues (e.g., low self-esteem), and tenuous social supports. Overall, they described a willingness and dedication for playing a significant role in addressing this problem.

Although some research (primarily in emergency department settings) has found striking deficiencies in the medical response to abused women patients, more recent interviews and surveys (primarily in primary care settings) demonstrate the complexities that medical providers face in addressing the problem of wife abuse in the health care setting. Although most physicians willingly accept responsibility for identifying and intervening on behalf of abused women, they face important structural (economic, social, policy), psychological (frustration, discomfort), and ideological (biomedical model) barriers.

**Patient perspective and experiences**

Research on medical help-seeking among abused women has focused on three main areas: (1) the perceived helpfulness of the medical system, particularly in comparison to other sources of professional assistance; (2)
patient experiences and preferences regarding direct inquiry about marital abuse; and (3) barriers to disclosure. Although this research has the potential to inform clinical protocol development, only the most quantitative studies were published in the medical literature.

In their study of abused women, Bowker and Maurer (1987) used a combination of quantitative and qualitative methodologies to assess the perceived efficacy of medical interventions for abused women. They used survey data from a national volunteer sample of 1,000 abused women and in-depth interviews with 146 abused women. They found that 39% of the women reported seeking help from physicians or nurses. Of these women, 8% felt that the services were very effective, 23% somewhat effective, 16% slightly effective, 45% not effective, and 9% reported increased violence as a result of seeking medical care. Compared to other professional sources of help (social services, clergy, police, shelters), medical professionals were rated the lowest on effectiveness.

In a similar survey of 270 abused women recruited through Canadian social service agencies, Hamilton and Coates (1993) found that physicians were sought by 43% of women suffering physical abuse, 53% of emotional abuse victims, and 21% of sexual abuse victims. The majority considered medical professionals helpful. Specific responses that were identified as helpful in cases of physical abuse included: listened respectfully, believed my story, helped me understand the effects on the children, asked me directly if I was being physically hurt, helped me to figure out ways to make my present situation safer, gave me advice, helped me to see ways to end the abuse in the future, and directed me to someone who helped me. Unhelpful or damaging responses included: criticized me for staying, suggested my partner and I get
counseling, went along with me when I said it wasn't serious, and questioned the truth of my story.

Research on the utilization and acceptability of screening protocols has involved surveys of patient experiences and preferences. In a survey of 394 women patients presenting to primary care clinics, only six (1.6%) reported ever having been asked by a physician about abuse (Hamberger et al., 1992). In a study to determine patient preferences regarding inquiry about physical and sexual abuse, Friedman et al. (1992) surveyed 164 male and female patients at primary care clinics. Although the majority of patients favored routine inquiry about physical and sexual abuse (78% and 68%, respectively), only 7% were ever asked about physical abuse and 6% about sexual abuse. Ninety percent believed that physicians could help with these problems.

Limandri (1989) conducted research to understand the patients' perspective on barriers to disclosing stigmatizing conditions. Conditions selected included marital violence, AIDS, and herpes. Thirteen abused women were interviewed. Factors that facilitated disclosure included compassion, understanding, trust, and rapport. Among professionals, negative responses included mistreatment, uncaring attitudes, and rejection; neutral responses tended to be noncommittal or nonchalant. The researchers concluded that in a clinical setting, the patient's vulnerability increases the need for a compassionate approach.

In total, health research on wife abuse has focused on the impact of this violence in communities, the prevalence in various medical settings, health and injury outcomes, medical and physician responses, and patient perspectives. Several conclusions can be drawn from the results of this research: (1) wife abuse is a significant problem, both in terms of prevalence
and adverse health outcomes; (2) abused women have high levels of medical utilization; and (3) the medical treatment of abused women patients is inadequate.

LIMITATIONS AND FUTURE DIRECTIONS

In examining the research on spouse abuse used by and created within the health fields, it is important to attempt to understand the driving forces behind the questions that get asked, the populations studied, and the methodology and analytical strategies used. Although sociology and health research on marital abuse has been informative in important ways, the limitations also should be addressed. There are three inter-related problems: (1) the use of data sources that were not created for public health purposes; (2) the acceptance of disagreements in definitions and outcomes; and (3) the inadequate focus on issues of gender. Not only should these limitations be addressed in future health research, there are several topics that merit further inquiry: societal causes of wife abuse, the patients’ perspective, and the efficacy of interventions at the medical level.

Sources of data

In her criticism of public health data collection on socioeconomic status, Krieger (1992) began with the simple statement:

“If you don’t ask, you don’t know, and if you don’t know, you can’t act.” (p. 412)

She made the argument that data is essentially socially constructed and its parameters and sources are a reflection of prevailing theories of disease
causation as well as political climates. There is a misconception that data, especially quantitative data, are objective.

The fact that much of the epidemiologic data on marital violence is derived from crime statistics reflects three main biases: (1) current unavailability of other sources; (2) acceptance of criminal conceptions of domestic violence; and (3) background experience of many of the researchers in criminology\(^\text{12}\). These data sources were not originally intended for health or injury surveillance purposes. Specifically, the use the crime data (Mercy & Saltzman, 1989; Saltzman et al., 1990, 1992a, 1992b) and hospital-based data (Stark et al., 1981; McLeer & Anwar, 1989; McLeer et al., 1989; Grisso et al., 1991) has proven problematic because these data sources inadequately record relevant data like sex of the perpetrator, relationship of the victim to the offender, and history of violence in the relationship. Thus because of limitations in these data sources, researchers are unable to determine prevalence rates of wife abuse or the proportion of injuries and assaults related to wife abuse. Although the use of existing data sources to begin to understand this problem is valuable, the biases and inadequacies should be made explicit. Developing new sources of surveillance data that address these limitations should be a priority.

**Defining the problem**

Unlike most health problems, abuse does not have an agreed upon definition among the different researchers. Most researchers focus exclusively on physical acts of violence; other researchers expand their inquiry to include sexual abuse (McFarlane et al., 1992); others include verbal

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\(^{12}\) In particular, Linda Saltzman of the CDC.
abuse (Rath et al., 1989); and others include social and emotional abuse (Elliot & Johnson, 1995). Data from instruments that assess only physical acts of aggression or violence generally find similar rates of victimization for women and men\(^\text{13}\). While these instruments are extremely reproducible, they are considered by some to be invalid measures of abuse (Brush, 1990). Specifically, the CTS, which was used in the NFVS and is currently in widespread use in health research, does not include an assessment of the injurious outcome, the context of the violent acts (e.g. play, anger, self-defense), changes over time, subjective meaning for the victim (e.g. fear, sense of being controlled), or motivations on the part of the perpetrator (e.g. control), all of which are critical to understanding the nature of violent behavior. It is likely that including an assessment of outcome, context, and the meaning for the people involved would clarify which acts of physical violence should be considered abusive.

Another important consideration in defining abuse is determining which outcomes are of interest to health professionals. For example, if injuries are the only health concern, physical acts of violence that have a high likelihood of resulting in injury or death would be a reasonable definition of abuse. However, if broader health outcomes, including mental health outcomes, are relevant, the definition should include psychological and sexual abuse. Obviously questions about how to define abuse cannot be answered until questions about the importance of different health outcomes is resolved. Although there is some diversity in researchers' perspectives on which outcomes are important, most researchers focus on injurious or criminal outcomes (e.g. injury, reported assault, and death) from the violence

\(^{13}\) An exception is the study by Gin et al. (1991), which found rates of women's victimization to be more than twice those of men.
rather than the broader health effects of abuse (e.g. depression, somatic complaints, general medical problems).\textsuperscript{14}

While focusing on injury prevention may be a reasonable first priority for a health approach to wife abuse, it is important to not lose sight of broader health and social problems caused by wife abuse. In focusing on physical injury, we ignore the other perhaps more subtle effects of wife abuse. Furthermore, we may be precluding public health interventions that potentially reduce all forms of interpersonal abuse and control. In terms of the environment-host-disease model, the "disease" should be defined as the abuse, while injury is merely a symptom.

Based on the literature review, there appears to be significant complacency about the ambiguity and variability in the definitions of abuse and violence that are used to develop survey instruments and determine prevalence rates. Ambiguity over the exact meaning of myocardial infarction or tuberculosis infection would never be tolerated, yet when it comes to interpersonal abuse, there are few attempts to develop sensitive and specific criteria. These differences in definitions and outcomes make comparisons between the different studies very difficult. Developing a systematic definition that can be incorporated into quantitative survey research should be a priority, particularly if the controversy over higher rates of wife-to-husband abuse is to be resolved.

\textsuperscript{14} Noted exceptions included Stark et al. (1981) who studied the complete medical records to understand more about the medical and psychiatric histories and health care utilization patterns of injured women; and Friedman et al. (1992) and Hamberger et al. (1992) who studied primary care settings to demonstrate the potential utility of primary intervention at this level of medical care.
Gender-based frameworks

As discussed in Chapter 1, recognizing the importance of gender in understanding wife abuse is essential. Although the vast majority of health research incorporates issues of gender in the study design (e.g. by sampling only women patients) and in the data analysis (e.g. through statistical analysis of gender and relationship variables), there are a few important exceptions. First, one of the main sources of prevalence data is based on research that used the CTS. As discussed earlier, this research instrument consistently demonstrates equivalent rates of abuse between men and women. Although an interdisciplinary approach to marital abuse is clearly necessary and potentially beneficial, it is important to understand the limitations of the research instruments, the data generated, and the underlying paradigms. Although many researchers and reviewers circumvent a discussion of the methodological problems with the CTS by reporting only the prevalence estimates for husband-to-wife violence, this skirts the discussion of the validity of these data. If the rates of wife-to-husband abuse are inaccurate, how can the rates of husband-to-wife abuse be accepted?

Second, some researchers approach marital violence using a gender neutral framework rooted in the family violence model. Most notable is the research of Goldberg and Tomlanovich (1984) and Saltzman et al. (1990; CDC, 1990). Goldberg and Tomlanovich (1984) argued that because they did not find gender or other demographic differences in rates or risk factors, their study:

"further confirms the futility of using demographics to identify domestic violence victims" (p. 3263).
The possibility that their methods were seriously flawed was not discussed. Saltzman et al. (1990; CDC, 1990) have a similar approach in their study of family and intimate assault which lacks a combined analysis of gender and relationship of the victim to the offender. This research was generated by CDC researchers, has been widely published, and has the potential for influencing future research on wife abuse in public health.

Fortunately, the majority of researchers in public health and medicine view gender as an important dimension of their analysis (Stark et al., 1981; McLeer et al., 1989; Grisso et al., 1991; Friedman et al., 1992; Hamberger et al., 1992). However, only a few have written explicitly about the gender politics framework that operates in their approach to research (Stark et al. 1981; Stark & Flitcraft, 1982, 1983; Kurz & Stark. 1988; Warshaw, 1989). Overall, the framework adopted by public health is critical to shaping the future of research and policy. It is critical that health researchers adopt a paradigm that acknowledges the primacy of gender in the research and development of interventions.

Directions for future research

In addition to addressing these important limitations by improving data sources and survey instruments, there are a few specific topic areas that deserve greater research attention. First, there is little or no research within the health fields that is designed to measure associations between marital violence and social factors (other than demographics). Thus, there seems to be little interest in determining the social and institutional forces that impact wife abuse. This type of research is necessary to explore various etiologic

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15 For example, Kurz (1989) suggested examining the role of the military, sports, campus fraternities, and male bonding rituals in contributing to the abuse of women.
frameworks, better understand the social context, and develop public health prevention programs. As part of future research directions, the historical, economic, legal, and political context of women's social status should be examined in relationship to wife abuse.

Second, greater focus should be placed on the patients' perspectives and needs. While several studies have been conducted on women's experiences in the medical system, only one was published in a medical journal (Limandri, 1989). Survey research on patient preferences regarding screening were published in medical journals (Hamberger et al., 1992; Friedman et al., 1992), however these studies did not assess underlying concerns or issues. Unfortunately, policy decisions regarding screening and management of abused women patients are generally not informed by research on patients' perspectives.

Third, research on medical level interventions is needed to assess their utility and effectiveness. Two studies have been reported in the literature that examined rates of identification before and after training and instituting a screening protocol (McLear & Anwar, 1989; Norton et al., 1995). It was clear from one of the follow up studies that improvements in identification were only temporary (McLear et al., 1989). Another study compared rates of identification and intervention in three emergency department settings with trained personnel to rates in a fourth emergency setting with a battered women's advocate on staff (Kurz, 1990). The program with the advocate was more successful in improving management as well as decreasing the stigma and bias to which many abused women patients are subjected. Based on policy statements discussed in Chapter 1, it is clear that proponents of change are advocating for developing guidelines and improving training. Clearly,
more research on alternative strategies is needed to guide these policy
decisions.

Public health and medical approaches to wife abuse should incorporate
a variety of methods as well as contextual analyses in researching wife abuse.
The public health and medical research on wife abuse contains many
examples of attempts by researchers to describe intimate violence without
considering either the immediate or historical context. It should be obvious
that an understanding of violence that occurs between intimates and
disproportionately affects women must consider women's position in society.
Furthermore, the acceptance of ambiguity, the focus on "measurable"
quantifiable outcomes, and the reliance on inadequate data sources merely
exacerbate the difficulties in creating a useful framework for approaching wife
abuse as a public health issue.

Overall, the involvement of the public health and medical fields has
tremendous potential in the struggle against wife abuse, particularly given
the prestige that these professions carry. However, the temptation to use a
proximate-cause, gender-neutral framework must be avoided. In order to
truly understand and prevent abuse, research must embrace a broad
definition of both the causes and effects of abuse, and pursue a contextual
analysis.
Chapter 3.
Methodological Issues in Researching Wife Abuse

It should be clear from the review of the literature that many questions remain regarding the role of medical interventions for abused women patients. The purpose of this chapter was twofold. First, a detailed description of the methods used to collect and analyze the data presented in Section II of this thesis is provided. Second, the relationship between these methods and feminist research theory will be discussed. As discussed in previous chapters, it is critical that researchers recognize the ideologies and paradigms implicit in their work. This chapter represents my attempt to make these issues explicit.

STUDY METHODS USED

The purpose of this study was to better understand abused women’s experiences and perspectives regarding their interactions with the medical system. The foundations of the research question and methods were developed by Dr. Michael A. Rodriguez (MAR) as part of a Robert Wood Johnson Clinical Scholars Program research project. He believed that the research that informed health policy development around issues of marital

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16 I was not personally involved in the early stages of research design, e.g. designing the research instrument, conducting the focus groups, or developing the code list. I coded transcripts from the African-American, Asian, and white women’s groups, participated in the meetings with African-American and Asian community collaborators, and conducted the data analysis for this thesis.
violence was dominated by the providers' perspective. Thus, he wanted to
design research that would allow abused women to describe what they think
is the role of health care providers in addressing wife abuse.

Not only were the perspectives of patients important, but the diversity
of those perspectives was important. In particular, Dr. Rodriguez wanted to
include women from different ethnic groups and class backgrounds.
Although he was particularly interested in Latina women's experiences, he
expanded the study design to include African-American women, Asian
women, and white women. Because he realized his limitations in terms of
access to abused women and knowledge about different communities, he
sought collaborations with community organizations. As will be discussed in
detail in the following sections, these collaborations were extensive and
varied; different collaborators participated in various aspects of the design,
recruitment, and data analysis.

At first, Dr. Rodriguez wanted to develop a quantitative survey. But he
realized that without preliminary research to identify the issues, questions
and categories developed for a survey instrument may not adequately
represent abused women's experiences and perspectives. Thus qualitative
methods were chosen to best represent the voices of abused women patients.
In the end, Dr. Rodriguez and his many collaborators conducted a multi-
ethnic, community-based, qualitative study exploring abused women's
experiences in the medical care system and their perspectives on the barriers
to identification and management of abuse victims and approaches to

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17 Much of the information regarding Dr. Rodriguez's original conceptions, as well as information regarding data collection, participant recruitment, research instrument development, and the early stages of data analysis were gathered through informal discussions.
improving health care service delivery. This study was approved by the Human Subjects Review Committee at Stanford University.

Recruitment

Women between the ages of 18 and 64 who had experienced marital violence within the past two years were eligible to participate. Although sample selection was not random, the setting was community-based rather than clinic- or shelter-based to include a greater diversity of experiences and perspectives. Although several battered women's shelters participated in recruitment, none of the participants were residing in shelters. Furthermore, many of the women were still living with the men who had abused them.¹⁸

Recruitment strategies were designed to include women from diverse ethnic and racial groups and class backgrounds. Women from diverse backgrounds were sought for several reasons: (1) to better represent the diversity in the Bay Area; (2) to gain a broader range of experiences; and (3) to begin to understand how experiences and perceptions of the medical system are informed by race, culture, class, and immigration status. To reach these different populations, collaboration with community groups that serve ethnic minority and immigrant groups was essential. In addition, variation in class background was achieved by collaboration with both urban and suburban organizations. This approach allowed researchers to reach marginalized populations who are typically overlooked in medical research.

Participants for the study were recruited through a variety of community-based organizations in the San Francisco Bay Area that serve women and their families. Mujeres Unidas y Activas (Women United and

¹⁸ These data were not systematically collected, rather they were derived from informal discussions with participants.
Active), a Latina community advocacy group that develops community education programs, participates in political actions, and serves as a resource center for legal and social services, was actively involved in networking with other agencies to recruit study participants. Latina women were recruited primarily through Mujeres Unidas y Activas, La Casa de Las Madres (The House of Mothers) and House of Ruth, battered women's shelters in San Francisco. White women were recruited through Battered Women's Alternative and Support Network, domestic violence resource centers in Contra Costa County and San Mateo, respectively. Asian women were recruited through Asian Women's Shelter and Cameron House, battered women's shelters in San Francisco that serve the Asian community.

Recruitment of African-American women proved to be more difficult than other ethnic groups. Unlike the shelters and services specifically designed for abused Latina and Asian women, there are no battered women's agencies in San Francisco established specifically to meet the needs of abused African-American women. After one group of four African-American women was recruited through La Casa de Las Madres and St. Anthony's battered women's shelters, a second group was assembled at a transitional housing and drug rehabilitation program in San Francisco.

Recruitment strategies included a combination of public announcements and individual contacts. Collaborators at the different community organizations posted fliers and announcements about the research. In addition, individual women who had maintained contact and interaction with the organizations were contacted by collaborators and invited to participate. All participants were self-identified as abused.

19 However, there is a shelter in Oakland that primarily serves African-American women.
Focus group format

Data were collected using semistructured, open-ended focus group interviews. Focus group interviews are a type of qualitative methodology that is based on small group discussions on a specific topic (Morgan, 1988). This methodology is well-suited for exploring new issues and generating hypotheses for further research. The reliance on group interactions for data generation has the potential for bringing forth material that would not come out of an individual interview.

Participation in the research was made accessible to monolingual Latina and Asian women by conducting groups in their native languages. Both Latina groups were conducted in Spanish and one Asian group was conducted in both Cantonese and Mandarin. All other groups were conducted in English. In addition, the focus group meeting locations were chosen for their safety, familiarity, and accessibility to the participants. One group of Asian women met at the Cameron House; one group of African-American women met at the transitional housing program; white groups met at Battered Women's Alternatives and Support Network offices; all other groups met at the Women's Building in San Francisco. Meetings were held at different times of the day to accommodate diverse work schedules, child care concerns, and family responsibilities. The meeting times varied according to recommendations by community collaborators with experience in scheduling groups.

Focus groups were conducted by two facilitators, at least one of whom matched the ethnic or racial identity of the group. A total of 11 different facilitators participated in the focus groups; 10 women and one man (MAR);
two Latino, two white, three African-American, and four Asian; all volunteered their time and only a few had experience conducting research. No two focus groups were conducted by the same pair of facilitators. This variation was not intentional, rather it was a result of difficulty working around the facilitators' busy schedules. All of the facilitators had extensive experience working with community-based battered women's organizations, counseling individual abused women, and conducting support or therapy groups. Some had professional training in social work, psychology, or psychiatry and others were involved with administrative aspects of community agencies. Although there was some concern about whether the presence of a man in the Latina groups would change the dynamics of the group or the type of data collected, Dr. Rodriguez wanted to participate in these groups to gain first hand knowledge of group process.

Meeting environments were made as comfortable and supportive as possible. As mentioned, locations were selected for their safety, familiarity, and comfort. In addition, refreshments were provided. Before turning on the tape recorder, the facilitators introduced themselves and explained the purpose of the study (see Appendix B-2). A "warm up" period of 5-10 minutes was provided for participants to get to know each other and discuss any concerns or problems with transportation.

Nine focus groups were conducted over a six month period. Group size ranged from four to nine women. Although the original sample size was 59 women, one focus group was excluded from the data analysis because of the poor quality of the audiotape. In the final analysis, a total of 51 women participated in eight focus groups: two groups each of Latina, African-
American, Asian, and white women. All of the Latina and Asian women were immigrants to this country\textsuperscript{20}.

**Research instruments**

The purpose and procedures of the study were explained, and informed consent was obtained in writing (see Appendix B-1). Open-ended questions were drafted by MAR based on a review of the literature. These questions and the format of the focus group interviews were reviewed by community collaborators from Mujeres Unidas y Activas, researchers at the Family Violence Prevention Fund in San Francisco, and researchers in the Robert Wood Johnson Clinical Scholars Program. The final research instrument was a product of these ongoing collaborations.

Questions were divided into three topic areas: (1) perspectives about marital violence, including definitions and sources of help; (2) perspectives about marital violence and the health care system, including positive health care experiences, negative experiences, what makes it difficult to go to a physician, withholding information, and whether doctors should ask direct questions about marital violence; and (3) ways that medical approaches to abused women could be improved, including ways to inquire about marital violence and services that could be provided (see Appendix B-2). Interview questions were designed to elicit experiences with medical providers in a variety of clinical settings (emergency departments, primary care clinics). Approximately 10-15 minutes were allocated for the first topic and 30-40 minutes were allocated for each of the last two topics.

\textsuperscript{20} The specific demographics of each group are tabulated in Appendices D-1 through D-5 and discussed in more detail in Chapters 4 through 7.
In practice, group formats were relatively flexible. For example, not all of the questions were systematically asked by the facilitators. In some cases, questions were not asked because they already had been discussed by group members. For groups conducted later (specifically with white women), questions were added regarding medical providers reporting to the police. This change in the protocol was a response to controversy regarding new legislation in California that requires health professionals to report suspected cases of marital violence to law enforcement agencies.

Each group lasted ninety minutes. At the end of the group session, participants were asked to complete a demographics questionnaire (see Appendix B-3). This questionnaire included age, current marital status, country of origin and length of time in the U.S., number of children, and formal education. All participants were monetarily compensated ($10) for their time and travel expenses.

Data coding and validation

The discussions were audiotaped and transcribed. Discussions from groups conducted in Cantonese, and Mandarin were translated into English before transcription. Before my involvement, the primary investigators were fluent in both English and Spanish. Consequently the Latina transcripts were translated into English (for my benefit) only after they had been transcribed and coded.

The basic code list was derived from the analysis of the first groups conducted, the Latina groups. After an initial reading of these transcripts, codes and subcodes were developed based on topics identified by the primary
research (MAR), three research collaborators22, and two community collaborators22. These codes were constructed to encapsulate concepts such as definitions and types of abuse, sources of help, types of barriers to help, positive experiences within the medical system, recommendations for improvement, and culturally specific issues (see Appendix C-1). Although the code "confianza" was derived from the Latina groups, it was used throughout coding of the other transcripts. Confianza is a Spanish word that encapsulates elements of rapport, such as trust, compassion, and support, that were discussed among members of all ethnic groups.

To ensure that these basic codes could be applied to the transcript data from the other three ethnic groups, the transcripts were evaluated by collaborators matched for the ethnicity of the group. In addition to establishing validity, this collaboration was created under the assumption that these coders would be more likely to identify culturally specific nuances. Without knowledge of the code list, these collaborators read the transcripts and identified general categories of issues. After matching these categories with the code list generated from the Latina data, the coders were given instructions on how to systematically code the transcripts (i.e. transcript excerpts were identified by labeling line numbers with the appropriate codes). Most of the transcripts also were coded by the primary researchers, who did not necessarily match the ethnicity (or gender) of the group. I coded all of the transcripts except those from the Latina groups, which were coded before they were translated to English.

21 Seline Szupinski Quiroga, a medical anthropology doctoral student; Yvette Flores-Ortiz, a Chicano Studies professor at the University of California at Davis and clinical psychologist; Karen Rosen, a social worker with research experience on immigrant and Latino issues and domestic violence counseling experience.

22 Two leaders of Mujeres Unidas y Activas, Clara Luz Navarro and Maria Olea.
After coding was complete, researchers and community collaborators met to evaluate the process, discuss specific cultural issues, and validate the themes identified by the researchers. Transcripts from the Asian groups were evaluated by four different Asian women collaborators, who also had participated in facilitating these groups. Transcripts from the African-American groups were evaluated by two African-American women collaborators, neither of whom were previously involved in facilitating the groups. All of these coders had extensive experience working with abused women. This process of validation served several purposes. First, it increased the validity of themes identified within each ethnic group, particularly culturally specific issues. Second, it fostered flexibility in the code list, since collaborators were encouraged to create codes when issues were not represented in the basic code list. For example, in the meeting with the African-American coders, we decided that some of the subtle barriers to care faced by black women were rooted in the historical exclusion and mistreatment of blacks in this country. In response, we created a special code: barrier to help - historical (BARH-H). Third, it allowed us to explore issues of labeling and cultural representation. For example, in the meeting with the Asian coders, we decided that because the Asian participants were all immigrants, the term Asian was more appropriate than Asian American. In addition, these collaborators discussed the importance of recognizing the diversity within this ethnic category. Fourth, these meetings fostered a sense of shared ownership of the project, which to increased the connections between health care institutions and community organizations.

Transcripts and coded data (line numbers) were organized using Ethnograph 4.0 computer software, which is designed for qualitative data
analysis. Output from this program consisted of transcript excerpts identified by code, focus group number, and participant identity. This software allowed us to separate the data by individual codes, organize the output according to different categories, and determine the frequency of specific coded responses.

Data analysis

Data analysis presented in this thesis was based primarily on five code categories: barriers to help for marital violence, positive health system characteristics, culture-specific information, health system recommendations, and confianza/trust (see Appendix C-1). For each focus group, I organized the coded data by listing each of the individual comments of the participants. The majority of these comments were divided into three categories: positive experiences, barriers to health care, and recommendations for improvement. Each of these categories was further divided into the level at which these factors operated: structural, provider, and patient. Flexible subcodes were developed to further divide the categories. For example, some of the subcodes for barriers to health care at the provider level included: too little time, lack of concern, did not ask, did not give referral. For each of these subcodes, the number of times discussed and the identity of the speaker were recorded. After recording all the individual comments, somewhat broader categories were developed. For example, several subcodes described barriers to health care at the provider level which revolved around the participants' perception of the provider's attitude (e.g. lack of concern, lack of compassion.

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23 Although I was responsible for determining the themes, drawing the conclusions and providing the cultural analyses presented in this thesis, I received guidance and support from Seline Quiroga and Michael Rodriguez.
lack of understanding, judgmental). Every category that was well substantiated by data was considered a theme of that group discussion.

In the final data presentation, I included themes that were discussed by a majority of the participants or had particular salience within a group. Data were presented primarily as excerpts from the transcripts. Quotes were selected that most accurately and concisely represented the theme described. After quotes were identified from computer-generated qualitative data output (i.e. organized by the specific code), the context and meaning were verified by returning to the original transcripts to evaluate the preceding text. Editing of the quotes was minimal and did not change the meaning in any way (see Appendix C-2).

Although it was possible to determine the number of participants who commented on a particular issue (as well as the number of times an issue was discussed), I did not attempt to quantify the different themes. First, I felt that the complexities of group process made quantification invalid. On the one hand, an issue could be overrepresented if groups initiated discussion of an issue that would not have been elicited in individual interviews. On the other hand, an issue could be underrepresented if some of the participants did not contribute comments because they felt that the group had sufficiently represented their point of view. Thus, I felt that it was impossible to draw conclusions about the proportion of participants in a group that agreed or disagreed with a point. Second, there were subtle differences in the ways that individual women commented on the issues. I felt that these subtleties were best represented with qualitative data from the focus groups.
Limitations

There were several limitations that merit discussion. First, it should be obvious that this research is meant to be purely descriptive. The participants were not representative of all abused women, thus the data are not generalizable to other groups. Furthermore, the data probably do not represent the full spectrum of opinions, experiences, and ideas of abused women regarding medical care.

Second, the recruitment and data collection methods probably resulted in a biased sample. Participants included only women who were safe and independent enough to participate in this type of research. The perspective articulated by women who were recruited through battered women’s shelters may have been influenced by their greater awareness and exposure to the ideology of the community organization. In addition, the participants included women who were more comfortable interacting and speaking in a group setting. Clearly, these combined qualities are not shared by all abused women.

Third, the flexibility and unpredictability of the focus group format created non-uniform data collection methods. The moderators for each group were different, thus interview styles varied from group to group. Although all moderators relied on the written research questions, some openly discussed their own opinions at times, and others were more directive in probing for details from the participants. Data that followed questionable facilitator interactions were analyzed in this context (and often disregarded).
FEMINIST RESEARCH PARADIGMS

Feminist research paradigms and methods for researching women's lives have been developed and advocated by feminist social science researchers, women's health researchers, and wife abuse researchers. These researchers have not only developed a critical analysis of traditional scientific research methods, they have created new paradigms for understanding both the process and product of research. Although a comprehensive discussion of this literature is beyond the scope of this chapter, I will present some of the key themes and how they relate to the methods used in this study.

Several common themes have evolved from feminist analysis of methodology: consideration of gender asymmetry, the goal of emancipation of women, attention to ethical issues in conducting research, and validity in representing women's experiences. Because my research deals with women from a variety of cultural and class backgrounds, I also have included a parallel (and embedded) discussion on issues of race, culture, and class in research methodology.

The centrality of gender

The most fundamental aspect of feminist research is the centrality of gender in the analysis of women's experience.

"For us, a radical rebeginning has meant understanding gender as central in constructing all social relations and taking individual women's lives as a problematic." (Acker et al., 1991, p. 135)

This position assumes that women's lives are shaped in large part by their gender. Cook and Fonow (1990) emphasized
"the necessity of continuously and reflexively attending to the significance of gender and gender asymmetry as a basic feature of all social life, including the conduct of research." (p. 72)

Of course, this position does not deny that women's experiences are strongly influenced by their socioeconomic status, culture, race, ethnicity, sexuality, and other socially constructed identities. The position also does not exclude research on men so long as gender is considered as a central organizing influence on their experiences.

Feminist theorists view gender as both a category of difference as well as a category of power asymmetry in society. Because gender socialization and roles are intrinsically intertwined with value judgments and ultimately perpetuate the power imbalance, women's experiences are clearly informed by their social position within patriarchal society. Traditional sociological approaches to understanding human behavior have been limited to male behavior. Not only do feminist researchers have an obligation to question the validity of portraying men's experiences as normative or universal, they must (1) include women as research subjects, (2) reconstruct the sociologic understanding of what is 'the human experience' to include these women's experiences, and (3) question the research paradigms traditionally employed to understand human societies.

In the focus group research on abused women's perspective on medical care, the emphasis on women's experiences is self-evident in the selective inclusion of only women as research subjects. In addition, the centrality of gender and culture in these women's lives is considered throughout the analysis of the data. Not only are their experiences of being abused by male
partners shaped by their gender, but their experiences as women patients in a male-dominated medical system are shaped by their gender.

Intersections of gender, culture, and class

Women's lives are not shaped by gender alone. Harding (1987) argues that there is no universal woman's experience; other socially and individually constructed characteristics must be considered in understanding the lives of women. In particular, race, culture, and class are powerful social determinants that shape an individual woman's experience. In what Collins (1991) referred to as "the interlocking nature of oppression" (p. 41), these elements cannot be dissected and explicited, but instead must be understood in their interrelationships. Rather than prioritizing one form of oppression over another, all forms should be understood as fundamentally dehumanizing.

Cannon et al. (1991) argued that qualitative feminist research is typically biased in that women of color and poor women are not sufficiently represented. In discussing their research on black and white business women, they identified several difficulties in recruitment. First, black women faced greater structural barriers (such as lack of time) to research participation. Second, black women were more apprehensive and distrustful, particularly because the researchers were white and represented predominantly white institutions. Finally, recruitment strategies had to be more labor intensive to reach black women. These researchers argued that inclusion of diverse populations is critical to understanding the spectrum of women's experiences and that recruitment must overcome these barriers.
In our research, addressing issues of race, culture, and class was paramount throughout in the various stages of study design, recruitment, data collection, and data analysis. Explicit sampling goals included recruiting women from a variety of ethnic and class backgrounds. Collaborators made an extra effort to reach abused women who might not otherwise participate in research. Labor intensive strategies included face-to-face and individual contacts. The study was not intended as a class comparison, and achieving class diversity within each ethnic group was not a priority. In addition, the only assessment for socioeconomic status was formal education, which is generally considered an inadequate measure of class. In the final sample, some focus groups were predominantly composed of women with less formal education. These important differences were considered in the data analysis in that salient issues were not ascribed to cultural influences alone.

The importance of race and culture significantly influenced the decision to utilize community members in the design and conduct of the research. It was assumed that these cultural insiders would be more knowledgeable and sensitive to cultural issues. Although the research instrument did not include specific questions about how race, culture, or class affected the abused women's experiences in the medical system, this topic was discussed in many of the groups. Further, the data analysis was framed by the social context of these women's experiences and perspectives. In particular, oppressive social forces and institutional barriers were given priority over issues that individualize these women's experiences or "blame the culture."
The goal of women's emancipation

The action orientation and emancipatory goals of research on women are pervasive themes in the literature on feminist research methods. ‘The goals of a sociology for women, one that is in the interests of women rather than only about women, must be emancipatory. Emancipation, as we use the term, means the eventual end of social and economic conditions that oppress women and the achievement of a free society.” (Acker et al., 1991, p. 134)

“We should not forget that the original impetus for feminist inquiry was to find an educational strategy for eradicating sexism. Our goal after all is women’s liberation, and we assume that creative and scholarly work can contribute to reaching it. ... Both theory and praxis' (the inseparable action component of critical theory) are vital to feminist inquiry.” (Nielsen, 1990, p. 30)

The objective of emancipation in research methodologies takes many forms. First, the research question is framed to examine the root social, political and economic factors that contribute to women’s oppression. Social problems are situated in their historical and social context and the goal of research is to determine the solution to these problems. With regard to research on different cultural groups, situating phenomena within their historical, social and structural framework is also essential (Batalla, 1966).

Second, emancipation may take the form of direct empowerment of research participants. This process may occur simply through participation in the research (e.g. consciousness-raising within the process) or through social
change brought about by the research. Third, research goals include social change and the contribution to greater equality between the sexes. The purpose of research should not simply be to describe existing phenomena, but to provide a critical analysis with the ultimate goal of social justice.

Several feminist sociologists have incorporated this orientation into their research on wife abuse. Dobash and Dobash (1979) combined a historical analysis and in-depth interviews with abused women to attempt to answer the question: why are women abused by their male partners? They researched the political, economic, legal, and religious institutional forces that diminish the status of women and contribute to the acceptance of violence against women. They explicitly reject traditional reductionist, objective research methods in favor of what they call a context-specific approach:

"...we developed a form of contextual analysis that establishes the links between contemporary and historical processes, and combines interactional, institutional, and cultural aspects of the problem."

(Dobash & Dobash, 1988, p. 56)

Dobash and Dobash (1988) also emphasized the link between social research and social action. Their results and conclusions regarding the abuse of women are essentially a detailed and comprehensive indictment of the patriarchy (Dobash & Dobash, 1979).

The focus group study had a clear action orientation. First, the question itself focused on an important source of oppression for many women: male violence in intimate relationships. Second, in focusing on abused women's interactions with the medical system, the research question had implications for improving the responsiveness on the part of medical institutions and providers. Thus ideas of activism and emancipation were
explicit in this research. Another aspect of this project was the involvement of the researchers in disseminating this information to a variety of audiences including medical research communities, health care workers and administrators, medical students, law enforcement agencies and regional and state policy makers. Policy development was a driving force behind this research and continues to be an integral part of the process.

The inclusion of abused women from diverse ethnic and class groups was intended to broaden our understanding of women's experiences. Further, we were interested in how the different perspectives may be informed by culture or class. In efforts to improve the medical response to wife abuse, it is crucial that the voices of poor women and women of color are clearly heard. The attempt to contextualize these women’s experiences within social and structural forces, rather than merely cultural influences, was reflected both in the research instrument and the data analysis. Rather than exclusively focusing on cultural beliefs and practices within a group, research questions were framed to explore the structural factors that affect the experiences of abused women in the medical system. These structural factors played a prominent role in the data analysis as well. Overall, goals of women's emancipation must be inclusive of ethnically and economically diverse groups of women.

Community collaboration

Another means to empowerment and social change is through community collaboration and organizing. Although issues of community collaboration have not been extensively discussed in the literature on feminist methods, they are attaining importance in discussions regarding
public health research and activism (Barnett, 1993). Medical anthropologists have identified several potential benefits to community-based research strategies (Borrero et al., 1982). First, they allow community members, rather than academic researchers and administrators, to identify and frame the issues of importance. Given their membership and close contact within the community, these collaborators are likely to be more knowledgeable about the relevant issues. In addition, these collaborators are better situated to frame the issues in a way that represents community interests. Second, collaboration has the potential for empowering those involved in the research process. Not only is the involvement in important social and institutional change empowering, but often the research experience increases collaborators' capacity to interact more effectively with institutions. Third, the effectiveness of the research in policy change is enhanced, because research results are likely to be more widely disseminated within the community. Each of these potential advantages is particularly important when the research involves communities that are marginalized on the basis of race, culture, or class.

Collaboration with members of a variety of community organizations was an important part of the focus group study. Non-researcher advocates were involved in recruitment, facilitation of the focus groups, and data analysis. Coding of transcripts as well as validation of themes were conducted by professionals and community workers involved with domestic violence. The purpose of this approach was not just to gain access to populations and community resources, but to create linkages between researchers and activists and community members. The collaboration efforts hopefully bridged some of the distance between academia and the community. In addition, this
approach was mutually beneficial. While the researchers were allowed access to an important source of information and unique perspectives on the issues, our collaborators felt a greater sense of involvement and ownership in the project. In meetings with the Asian and African-American collaborators, it seemed to me that they were extremely enthusiastic about the project and excited that their ideas and concerns were important to us.

Qualitative methods: eliciting women's voices

Many feminist researchers have argued that qualitative methods are preferable in research with women subjects (Graham, 1984, 1990; Westkott, 1990). First, these methods more accurately elicit the experiences of the women research subjects, particularly because women's voices have historically been ignored and silenced in social science research. Second, these methods are typically less exploitive. Jayaratne and Stewart (1991) described the value of qualitative methods in women's research:

"Running through much of this enthusiasm for qualitative methods has been an understanding that many aspects of women's experience have not yet been articulated or conceptualized within social science. A deep suspicion of quantitative methods as having concealed women's real experience has motivated much preoccupation with, and advocacy of, qualitative methods as methods which permit women to express their experience fully and in their own terms." (p. 89)

The reliance on quantitative data has been criticized on many levels. The fact that the traditional scientific approach values objective and

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24 This second point is discussed further under ethical considerations.
reproducible observations inevitably leads to quantitative and reductionist methods. This tendency also leads to ahistorical and acontextual descriptions and analysis of "nature", including the social world. Although these positivist approaches have been powerful in understanding the physical and perhaps biological world, they are problematic when it comes to describing human experience. Keat (1979) argued that a strictly positivist approach:

"... systematically excludes any account of the experiences, perceptions, feelings and other subjective states of the participants in the social relationships. But without any grasp of these, it is impossible even to describe the so-called 'data', let alone explain anything." (Keat, 1979, p. 31)

In the focus group study, qualitative methods were employed to elicit the women's experiences and perceptions in their own words. This was particularly appropriate because there is little research on abused women's experiences in the medical system. The use of open-ended questions allowed the participants to create their own context and discuss the issues that were important to them.

But how well do focus groups elicit women's true voices? Unlike one-on-one interviews, focus group methods are more likely to create complicated interpersonal dynamics that may significantly affect the type of data obtained. For example, listening to other group members may have stimulated thoughts and ideas that a given participant may not have otherwise considered. However, it is important to realize that group interactions are often emotionally charged. Thus the data generated are likely to be strongly influenced by interpersonal rapport among the group members. Thus it
seems that to a great extent the process of establishing rapport and trust is essentially beyond the control of the moderator. In fact, it could be argued that group formats may decrease a participant's willingness to discuss sensitive or painful issues (Stillman, 1992). On the other hand, a room full of supportive women may elicit a stronger sense of comfort and safety. Because of the complex interactions, outcomes are somewhat unpredictable and difficult to reproduce.

Another factor in focus group methods relates to differing communication styles that are shaped by gender and culture. It could be argued that women's desire for social acceptance, agreement, and consensus may alter their responses in a group situation. Particular topics may dominate the discussion, while minority opinions remain unexpressed to avoid conflict within the group. Communication styles are also strongly influenced by culture. Although there is no research on the efficacy or validity of focus group methods for different ethnic groups, some researchers have described culturally influenced communication styles that affect other types of qualitative data collection. In particular, Asian women and Latina women tend to have more conciliatory styles (Crites, 1990; Carmen, 1990; Marin & Marin, 1991).

Unfortunately, I cannot provide concrete data from the transcripts to either support or refute these concerns. A comparison of interactional styles is difficult to do with the data collected here because of the diversity of factors within and between the different groups of women (e.g., class, educational background, immigration status) that affect sociocommunication. Furthermore, based on reading the transcripts, it is impossible to clearly differentiate the effects of gender, culture, group dynamics, and individual
styles of communication. However, these potential variations in styles may seriously impact the validity of focus group data. Future research needs to address the efficacy of focus group methods for different cultural groups. Regardless of these important caveats, we believed that the data in the transcripts included important issues and adequately reflected the participants' perspectives.

**Ethical considerations**

Attention to ethical considerations in conducting research has been an important principle of feminist inquiry (Cook & Fonow, 1990). Although these ethical considerations may not be exclusively feminist, an argument can be made that they are gendered in that these issues tend to be more relevant to women's lives and how feminist researchers view their roles and responsibilities. There is little consensus regarding the nature of truly ethical research. Regardless, three main points will be discussed here: (1) methods should be as non-exploitive as possible; (2) distance and power differences between the researcher and researched should be minimized; and (3) the process should be beneficial to the participants.

Although the obligation to avoid exploitation of research subjects is a universal principle in social science, feminist researchers have significantly expanded the concept of oppressive methodology. For example, some researchers argue that quantitative methods are intrinsically oppressive because they negate subjective experience and force research subjects to categorize their experiences within a framework preconceived by the researcher (Jayaratne & Stewart, 1991). This criticism is certainly not universally accepted by feminist researchers. Many researchers merely
emphasized the advantages of qualitative analysis (Oakley, 1981; Westkott, 1990); other researchers have argued that quantitative approaches can be feminist given the appropriate analytic framework and action orientation (Yllo, 1983, 1988).

Research by Hoff (1990) provides an excellent example of the application of this ethical principle. In an attempt to understand how a abused woman's social network of friends and family operates either to facilitate or impair her liberation, Hoff employed collaborative methods to avoid exploitation. She explained:

"For this study the research tools were demystified and developed in active collaboration with the project participants to ensure that the categories and questions were relevant to the women's experiences."
(Hoff, 1990, p. 13)

The use of non-exploitive research methods is particularly important in research with marginalized populations. In what Wolf (1993) referred to as "studying down," which includes researching poor women and women of color in the U.S., avoiding exploitation in the process of gathering and representing data should be an important ethical consideration for feminist researchers.

Exploitation was minimized in the focus group study in a number of ways. First, through collaboration with members of community groups, who may have possessed a greater sensitivity to abused women's needs and cultural issues, the researchers invited closer, more critical evaluation of methods. Second, as discussed earlier, the use of qualitative methods and open-ended questions allowed the participants to express their concerns and
participate in policy development. Third, care was taken to ensure the safety and comfort of all of the participants.

On the other hand, although focus group methods may avoid the ethical pitfalls of interviewing (Oakley, 1981; Patal, 1991; Stacey, 1991), they may be exploitive in other ways. For example, group situations have the capacity to engender an atmosphere of trust and openness that may otherwise be difficult to create in a one-on-one interview. Further, because the researcher is not the focus of attention, participants are not allowed the same opportunity to evaluate their trustworthiness. The researcher may thus gain access to a more intimate conversation among group members who have prioritized group membership over self-protection. Therein lies the potential for exploitation of the participants.

The second ethical principle is that the power differences between researchers and participants should be reduced or eliminated if possible. Cook and Fonow (1990) argued that one principle of feminist methods is the rejection of the subject-object separation that originated from the normative structure of science and the canon of objectivity. They argued that this dichotomy objectifies women research participants. Although it is traditionally held that this separation provides a more valid, objective account, feminist theorists question not only the attainability, but the desirability of objectivity in sociologic research (Jayaratne & Stewart, 1991). In addition, this separation contributes to a power differential between the researcher and researched—particularly when the research subjects have lower social status (e.g. class, race, sexuality) than the researcher (Wolf, 1993). In an excellent discussion of traditional hierarchical interviewing practices, Oakley
(1981) concluded that they are "morally indefensible" and contain irreconcilable contradictions.

A promising aspect of focus group methods is that the social distance between the researcher and researched may be less of a concern. Because the women are interacting with other group members, the position of the facilitator may be less obvious. The facilitator may not be seen as an authority figure, but as a member of the larger group. This of course depends on the particular facilitators and how directive he or she may be at eliciting information from the participants. Also, the groups were facilitated by at least one woman who shared the same the ethnicity as the participants. This strategy may have increased the comfort of the participants, improved rapport between the facilitator and participants, and minimized the sense of being objectified, particularly by an "outsider" researcher.

Beyond the use of non-exploitative, non-hierarchal methods, the goal of accountability includes the concept that research subjects should benefit in some way through their participation in the research. As opposed to the minimalist directive of "do no harm", feminists advocate a maximalist feminist directive (Patai, 1991) that includes goals of social change and participant benefit. These benefits may be direct or indirect, immediate or delayed. In the ideal research design, the process of participation would be empowering and transformational.

Focus group methods have the advantage of offering unique interactional processes that occur only in groups. This format not only affects the data generated in terms of the topics discussed, it affects the women’s experience of participating in this research. It is likely that group members
benefit from hearing about each other's experiences and ideas. Also they are likely to benefit from telling their stories to other women who have had similar experiences and are supportive. Although some feminist researchers have argued that simply having the opportunity to tell one's story does not constitute empowerment (Patai, 1991), these focus groups may have facilitated personal growth and emotional bonds between the women who participated.

In addition to creating a comfortable environment to conduct the groups, the researchers utilized facilitators who were knowledgeable and sympathetic to abused women's issues. When questions arose regarding sources of help, these facilitators were trained to provide information on shelters, support groups, and other service organizations. The research itself thus provided an opportunity for outreach and intervention.

Representation of women's experiences

In addition to obtaining data that accurately reflect women's experiences, feminist researchers consider how those data are analyzed and interpreted, both in terms of the accuracy of representation and the ethics of accountability. Research is not merely a matter of pure representation; critical analysis, hypothesis testing, and inferences are essential parts of the process. Thus a balance must be achieved between representing the voices of women research subjects and providing an analysis that is consistent with other feminist objectives. In discussing "the politics of representation", Scott and Shah (1993) asked the vital question:

"How does one engage in interpretation, yet maintain the voices and knowledge and interpretations of the subjects of research, avoiding the negation of their subjectivity?" (p. 93)
Acker et al. (1991) cautioned,

"As researchers, we must not impose our definitions of reality on those researched, for to do so would undermine our intention to work toward a sociology for women. Our intention is to minimize the tendency in all research to transform those researched into objects of scrutiny and manipulation." (p. 136).

However, in discussing the dilemmas faced in their own research, they went on to argue:

"If we were to fulfill the emancipatory aim for the people we were studying, we had to go beyond the faithful representation of their experience, beyond 'letting them talk for themselves', and put those experiences into the theoretical framework with which we started the study, a framework that links women's oppression to the structure of Western capitalist society." (p. 143).

They concluded that this struggle is inevitable and may be understood as part of the dialectical process of research as questions get redefined and answers get reinterpreted. Some suggested ways to better achieve this balance have included collaborating with the research subjects in the data analysis (Acker et al., 1991), or presenting both the subject's and the researcher's interpretations of the data (Borland, 1991).

In analyzing data from different cultural and class groups, it is particularly important to develop a framework that encompasses the historical and material conditions that impact the participants' experiences (Batalla, 1966; Collins, 1991). Although it may be important to understand cultural influences on individuals' values and behaviors, these influences
must be contextualized within social and structural forces to avoid "blaming the culture."

Another challenge in research on women from diverse cultural and social backgrounds lies in capturing the nuances of meaning and experiences, particularly when researchers do not share membership with the groups being studied (Narayan, 1992; Zavella, 1993). Narayan (1992), a nonwestern feminist, described the concerns of people of color who are represented by white researchers:

"We are suspicious of the motives of our sympathizers or the extent of their sincerity, and we worry, often with good reason, that they may claim that their interest provides a warrant for them to speak for us, as dominant groups throughout history have spoken for the dominated." (p. 263)

She went on to argue that cultural outsiders often fail to fully understand the emotional complexities of living as a member of an oppressed group. Although she did not discourage outsiders from conducting research on women of color, she cautions that they should be aware of their limitations.

Concerns over the accuracy or representation of the content of the focus group discussions were paramount throughout the process of data analysis. I attempted to reduce the influence of my personal biases by conducting the data analysis in a systematic way with clear criteria regarding what constitutes a theme, or salient issue. In addition, independent analyses were conducted by different members of the research team and community collaborators.

Although there was a high level of agreement overall, these comparisons were typically limited to broad categories of issues and selected themes; discussion of the interpretation of individual quotes was less common.
Ideally, the themes would have been verified by the participants themselves. Although this approach may have assured greater accuracy in representing their voices, it would have been impractical. In addition, it may have been an imposition or unwanted intrusion into their lives (Patai, 1991).

The chosen style of data presentation involved taking the quotes out of their conversational context and placing them within text to support a point or theme. One way that I tried to maintain the integrity of the quotes was to include as many quotes as possible in presenting the themes, while reserving the analysis and detailed interpretation for the conclusion section. My intention was to allow the participants an opportunity to "speak for themselves." In addition, the extensive use of quotes exposes readers to the original text of the transcript and allows them to better evaluate the data as well as the interpretation.

The representation of cultural issues was a major concern to me. Although my gender makes me an insider on one dimension, as a well-educated, non-abused, white, middle class American, I am an outsider to most of the groups represented in this research. First and foremost, I was (and am) concerned about misinterpreting or misrepresenting important cultural meaning. Latina, African-American, and Asian ethnic groups have been described as having "high-context" cultures (Lynch, 1992), which means that communication is often non-verbal and that meaning is shared without having to express it. As discussed earlier, the purpose of enlisting community collaborators who shared the same ethnicity as focus group members, to participate in the data analysis, was to capture these potential subtleties of meaning.
We believe that these collaborators provided fresh insight and an insider point of view. For example, one of the African-American coders described her perception from the data that black women called the police as a last resort. She further argued that distrust of law enforcement carried over to other societal institutions, including the medical system. In this meeting, we discussed ways that these women's attitudes toward the medical system could be situated within their broader experiences of oppression and disempowerment from other institutions. In a separate meeting with Asian coders, we discussed the relative lack of negative experiences and lack of strong criticisms for medical encounters. One of the coders pointed out that many Asian women have low expectations of the medical system and that interpreting the participants' perceptions must take their expectations into consideration.

Another important concern in representing cultural issues was the structure of the presentation. On the one hand, I wanted to avoid making cross-cultural comparisons. Instead, each group was discussed separately even though many of the issues were common across the different ethnicities. I felt that a comparison was not appropriate because the sample selection was not designed to control for important factors like class background. Thus, differences between groups could not be attributed solely to cultural factors.

On the other hand, I did not want to combine the data from all the groups and disregard ethnicity. As discussed earlier, consideration of women's race, culture, and class backgrounds is essential for understanding their experiences. The separation of each group allowed me to present an overview of cultural values regarding gender and family relations that may
have an impact on the occurrence or response to marital abuse. Even if these issues were not reflected in the data, they could be used to generate hypotheses about potential cultural differences that can be explored in future research.

In analyzing the data from the different racial and ethnic groups, I took care to consider the cultural issues within the context of social and institutional forces. In conducting a feminist analysis, it can be difficult to find a balance between criticizing cultural features that may be oppressive to women and recognizing that gender is culturally constructed within all societies (Hooks, 1994). Although gender roles, patriarchy, and sexism cross all ethnic groups, they are manifested in different ways. Further, it is not uncommon that values of oppressed groups reflect the values of the dominant culture. Thus, rather than exclusively focusing on cultural beliefs and practices within a group, data analysis was framed to explore the structural factors that affect the experiences of abused women.

A final caveat in this data analysis is that it is limited by the complexities of individuals' experiences. There was great diversity within ethnic groups, particular among women who had immigrated from different Asian and Latin American countries. In addition, most immigrants are bicultural in that they are influenced by both the traditional values of their country of origin and mainstream American values (Bernal and Alvarez, 1983). African-American women also understand and are affected by American cultural values. Overall, it is almost impossible (and undesirable) to attempt to separate culture, immigration issues, and the effects of acculturation and social oppression on an individual's experiences and perceptions.
Overall, many integral aspects of the focus group study reflected feminist and culturally sensitive paradigms in research methodology. First, the salience of gender, race, culture, and class issues was fundamental to the design and conduct of each phase of the research process. Second, community involvement and an explicit action-orientation guided the research questions, goals, and outcomes. Third, qualitative methods were designed to minimize exploitation and maximize benefit to the participants. And finally, the process of data analysis was conducted to accurately represent the abused women’s voices.
SECTION II.
Voices of Abused Women Patients
Chapter 4.
White American women's perspectives

"Just the compassion is going to open up one door. And when we feel safe and are able to trust that makes a hell of a lot of difference as compared with being run through the system."

BACKGROUND

As discussed in Chapter 1, marital violence has recently been reframed as a health issue. Although the feminist movement of the 1970s made the problem more visible, wife abuse was framed as a social problem, the solution for which resided in feminist activism, social services, and the justice system. Recent recognition by government health agencies and national medical and public health associations have expanded both the conception of marital violence and the range of solutions. Many of these leaders have called for a greater role for health care professionals in dealing with this problem.

This chapter focuses on abused white women. Before presenting the data from the focus groups, I will provide an overview of the mainstream American cultural values that may impact the experience of marital violence by white women. The major themes from the focus groups of white women are presented to understand their experiences, perceptions, expectations, and recommendations with regard to their medical care.

Data from the National Family Violence Surveys (NFVS) provide prevalence estimates of violence against wives and unmarried female
intimates. According to the 1985 NFVS, rates of male-to-female violence was 11.3%, rates of severe violence was 3.0%. Demographic factors associated with higher rates of violence include younger age and lower socioeconomic status. In spite of the general acceptance of these figures and risk factors within the health professions, it is likely that these figures do not accurately represent the magnitude of the problem.

American cultural values and norms

With greater emphasis in the public health and medical communities on "cultural competency" in working with persons from different ethnic and racial groups, it has become important to examine the components of mainstream American culture. Lynch (1992) states:

"Culture is akin to being the observer through the one-way mirror; everything we see is from our own perspective. It is only when we join the observed on the other side that it is possible to see ourselves and others clearly -- but getting to the other side of the glass presents many challenges." (Lynch, 1992)

Self-awareness is often considered the first step in improving cross-cultural understanding. Ironically, white Americans who are part of the dominant American culture generally have the least awareness of the ways in which their culture influences their behavior and attitudes. The concept of America as a "melting pot" served to minimize diversity among different European immigrant groups. The diminishing of these cultural roots has resulted in the feeling that white Americans do not have a culture (Lynch, 1992).

Recent efforts by white Americans to reclaim a sense of culture are reflected in the growth of the term European American to distinguish whites
from different cultural groups in this country. Lynch (1992) reviewed some of the literature on values that characterize dominant American culture. Among these are: (1) importance of individualism, with consequent emphasis on independence, competition, stoicism in adversity, and privacy; (2) high regard for achievement, work, and frugality; (3) the belief in the general goodness of humanity, fairness, and the equality of all individuals; (4) emphasis on the future, change, and progress, with consequent de-emphasis on the past; (5) emphasis on the importance of time and punctuality; and (6) materialism, physical attractiveness, and having good taste. In addition, white Americans value interpersonal styles that are direct, assertive, and honest. Further, optimism, cheerfulness, wit and sense of humor are highly valued along with informality.

The value of individualism in white American society has important implications in understanding family life. As part of this individualism, Americans tend to emphasize independence, autonomy, self-sufficiency, competition, and privacy. In contrast to Eastern culture, Western culture promotes the separation of individuals from their families of origin to establish new bonds with a partner to create a new family (Hsu, 1983). This value encourages individuals to find their own roots apart from family bonds. As children develop, they are expected to establish independence. In fact, rebellion in adolescence is considered a normal stage of development.

Some authors have argued that the value of individualism fosters isolation and weakens family bonds. Sue and Morishima (1982) argued that the emphasis on individual achievement and competition interferes with developing strong interpersonal relationships, because a certain level of interdependency is necessary for affective bonding. Further, this value may
significantly weaken the resiliency of the family and lead to increased separation of family members and decreased ability to cope with stress (Hareven, 1989). The fact that marital bonds are considered a voluntary association based on individual fulfillment rather than familial fulfillment leads to increased freedom to marry, divorce and remarry, which may compromise the stability of the family (Brubaker & Kimberly, 1993).

Another influence on family life is the assumption that the ideal family structure is the nuclear family: husband, wife, and children living together. Even with rapidly changing demographics that reflect increasing divorce rates, numbers of single parent households, and remarriage rates, most Americans cling to this ideal (Hareven, 1989). This structure excludes extended family members, particularly elderly grandparents, who could relieve some of the child rearing burden. Thus, not only is greater pressure placed on parents for economic and emotional sufficiency, they are often isolated from other family support.

According to American idealism, marital unions are based on love and romance rather than economic necessity (Murphy, 1990). According to Hareven (1989), the decline in family economic and social interdependence (particularly among the middle class) led to greater emphasis on sentimentality as the dominant base of family relations. Love and affection are assumed to be the primary motivation behind partner selection and the timing of marriage. Not surprisingly, there are often conflicts between the ideals of love and the demands of family life (Murphy, 1990). These conflicts between ideals and reality may lead to dissatisfaction and frustration.

Another potential source of frustration is the idealistic conception of family bliss and harmony. The home has long been glorified in American
culture as a domestic retreat from the harsh world of work (Zinn & Eitzen, 1987; Mintz & Kellogg, 1988; Hareven, 1989). The increased value placed on individualism and the decline in interdependence led to a redefinition of the function of the family. In addition to economic stability, family relationships were expected to provide nurturance and intimacy.

Women and men have traditionally had separate roles in the family. Since the early 19th century, the "ideology of domesticity" glorified the role of women as full time mothers, confined to the domestic sphere (Harever, 1989). In actuality, this was only attainable by middle class women, since rural and immigrant women were increasingly working in factories. Regardless, it became generally accepted that a woman laboring outside the home was demeaning for both the woman and her husband. As a consequence of this role splitting, women are generally regarded as the care-givers in the family, while men are expected to be the providers. Rosenblum (1989) argued that in order to fulfill these roles women are socialized to sacrifice and not exert power, while men are expected to exert dominance in the public sphere and emotional dependence in the private sphere. As another consequence of this arrangement, women are often economically dependent on their spouses, which may lead to further willingness to sacrifice (Thorne, 1982).

Although modern times have brought greater independence and economic opportunity for women, their role in the family has yet to reflect these social changes. Generally, women who work outside the home end up taking on double responsibility because they are expected to continue to fulfill their domestic responsibilities (Brubaker & Kimberly, 1993). Research clearly demonstrates that the majority of men are not taking on a significantly greater responsibility for household work (Huber, 1993). Thus women are left
with the added burdens of maintaining the marriage, providing child care, and completing the housework. In theory, women's greater independence has led to greater self-sufficiency and a decreased need for marriage (Brubaker & Kimberly, 1993). However, because of gender-based inequities in labor market, women continue to be dependent on male wage-earners. This is evident in the fact that single parent woman-headed households are increasingly below the poverty line (Thorne, 1982).

**Marital violence among whites: cultural and social forces**

As discussed in Chapters 2 and 3, marital violence has been researched from a number of different academic and feminist perspectives. Research subjects for the majority of this work were predominantly white women. Although the research was not necessarily aimed at determining the aspects of white American culture that impact the occurrence or experience of marital violence, many of the factors discussed by these researchers are ultimately culturally determined. Specifically, three forces in American culture have been identified as predisposing to marital violence and barriers to social reform: emphasis on the privacy of family life, gender-based power inequities, and the acceptance of domestic violence.

Pleck (1987) argues that the single greatest barrier to reform against domestic violence is what she calls the "family ideal", which includes an emphasis on domestic privacy and autonomy. This ideal impacts social life at many levels including policy making, law enforcement, and individual behavior. The fact that privacy is an essential element of the U.S. Constitution attests to its importance. Research on the barriers to legal reform and improvements in law enforcement against domestic violence
have consistently demonstrated the unwillingness to violate the sanctity and privacy of the family (Martin, 1976; Pleck, 1987). Further, it has been demonstrated that individuals who witness interpersonal violence are less likely to intervene if they believe the victim and perpetrator are related (Straus, Gelles, & Steinmetz, 1980). Overall this cultural emphasis on family privacy may operate to predispose families to violence and to impede intervention at the societal level.

Gender-based power inequities within the family have also been identified as a primary determinant of marital violence. Until fairly recently, the legal system allowed husbands the “right of correction” to physically discipline their wives (Pleck, 1987). The expression “rule of thumb” is derived from 19th century common law dictating that a husband may use a stick no bigger than his thumb to beat his wife. Currently in many states, husbands retain the right to demand sexual intercourse from an unwilling wife. This assumption of male dominance and economic rights is reflected in the expression “A man’s home is his castle” wherein he reigns supreme. Many feminists have argued that given this history of inequality in the marriage contract, marital violence is simply another form of women’s subordination (Martin, 1976).

To exacerbate these institutionalized power differentials, the socialization of women in this culture emphasizes the dependency on men for self-identity. Thorne (1982) argued that the idealization of traditional labor divisions within the family and the romanticized notions of motherhood “deny women individualism, equality, and full access to economic and political resources.” Marriage and childbearing are highly valued and strongly encouraged throughout female socialization. A
woman's identity is often tied to marriage: forms of address differentiate women by marital status, and adoption of the husband's family name is still the norm. As a consequence of these socialization forces many women internalize the belief that "any man is better than no man" (Lloyd & Emery, 1993). Clearly this system of values contributes to women's tolerance of mistreatment by their male partners.

Another social force that strongly impacts the problem of wife abuse is the high level of acceptance of physical violence among married persons. In one survey, researchers found that 31.3% of men and 24.6% of women believed that slapping between a husband and wife is necessary, good, or normal (Straus, Gelles, & Steinmetz, 1980). It is possible that this perception reflects the respondents' attempts to normalize their own violent behavior. On the other hand, this acceptance of domestic violence may be related to the high value placed on domestic privacy. It also may be influenced by the pervasive use of violence for entertainment purposes. Regardless of its origins, this value is likely to predispose partners to violence, allow rationalization and tolerance of violence, and impede intervention.

Barriers to help for abused white women

Women's responses to marital violence take many forms and may occur in stages. First, abused women must identify the violence as a serious problem. This identification may be hindered by denial and attributional processes that excuse their partner's behavior. Abused women have multiple ways to deal with the violence: defending themselves physically, removing themselves from danger, using social networks for temporary shelter, or simply tolerating the abuse. Formal sources of help include police, battered
women's shelters, legal services, psychologists, social workers, clergy, and
health care providers. Ultimately, an abused woman may face the decision to
leave the relationship. Barriers to leaving the relationship may include lack
of economic resources or employment opportunities, emotional dependence,
and lack of protection from further violence.

Abused women face many obstacles to seeking help from medical
institutions and providers. One of these barriers is the victim's
unwillingness to disclose her abuse to the provider (Ferris & Tudiver, 1992).
Some of the reasons behind women's reluctance include fear of further
violence, shame or stigma, and sense of devotion to their partners (Loring &
Smith, 1994). Limandri (1989) found that abused women patients need a
sense of trust and rapport with medical providers in order to feel comfortable
enough to disclose their victimization. Often these elements are missing
within the medical encounter. Researchers have found that providers often
fail to ask a patient about the source of her injuries even when signs and
symptoms of abuse are present (Warshaw, 1989; Hamberger et al., 1992).
Impediments to improved identification and management include lack of
time, feelings of helplessness, and discomfort on the part of the provider
(Sugg & Inui, 1992).

VOICES OF ABUSED WHITE WOMEN

Study participants included 14 white women ages 22-60 years, median
age 35 (see Appendix D-1). All but one graduated from high school and five
had college degrees. The median number of children was two. The majority
of these women were recruited through two battered women's agencies that
serves a high proportion of middle class women. This group of women suffered various forms of abuse and control by their male partners including physical violence, verbal abuse, and economic control. The majority had direct interactions with the medical system.

Unlike other groups in this study, the white women devoted little time to discussing structural barriers to medical care (economic barriers, unwillingness to involve police, immigrant barriers). Instead, these women focused on psychological factors that inhibited their willingness to seek help from medical providers, barriers encountered within the patient-provider interaction, essential elements of rapport, and practical recommendations for improving the identification and management of abused women patients.

The Code of Silence

Several women discussed withholding information about their experience with marital abuse from medical providers. One woman described this as the "code of silence." Even when asked directly about the source of physical injuries, women fabricated stories to avoid disclosing that they were victims of abuse.

In a prior abusive situation I was in, I was kicked and cracked two ribs in that situation. And the doctor asked me how it happened and I told him I fell down a flight of stairs. (1.682.Pt)

She said, "What's going on here?" You know, I could tell she wanted to jump in and do something and [I said], "Oh, nothing. Everything's
"fine." You know, like it's not fine, but, anyways, so I felt like I didn't know how to tell people. (2.661.R)

Some women discussed situations in which they canceled medical appointments altogether to avoid questions and confrontation about their injuries.

... physical abuse can keep you from counseling appointments until the moons [bruises] have gone. At least down to the minimum. ..//.. But the bruises, once they're healed, you'll show up for your appointments, you know. That's all there is to it. I know. (2.886.D)

One time I was so scared I didn't go to the doctor, where I was punched here and my whole face swelled up and blood was dripping inside me on my teeth so I had to stay in the house for two and a half weeks. (1.330.X)

Although the women acknowledged that part of the problem rested with their unwillingness to divulge this information, they explained the powerful psychological and practical restraints on their help-seeking. In addition, they also identified factors within the health care system and attributes of the provider that interfered with disclosure.

**Embarrassment, denial, and self-blame**

Several women identified their vulnerable psychological state as an important factor in help-seeking. The women discussed their shame and
embarrassment over being abused. Some felt responsible at some level for the abuse or at least for choosing to remain in an abusive relationship. Some women discussed being in denial and not identifying themselves as abused women. These factors clearly interfered with their ability to confide in a medical provider or ask for help.

It's really embarrassing to go to someone and say, "My husband's abusing me." To a doctor, to your family... anybody. I don't know what their idea of abuse is. You only know what you're feeling. (1.573.A)

For me it was embarrassing. I'm a mature woman and I'm pretty bright and usually in control of things. And it's very difficult, since I've usually dealt in a man's world, to suddenly be coming up with a woman's problem. (2.477.Jn)

Denial was used as a form of protection for many women. It allowed them to avoid the realization that they had a serious problem in their marriage. Consequently, seeking help or ending the relationship was postponed.

So I felt I really needed to get help and I was asking for it where I could. I had heard about the women's shelter from the first minor attack from the police, but didn't come immediately because I just couldn't think of myself as a battered woman. It just was abhorrent to me. (2.535.Jn)

I think if you want an honest answer about where we go first [for help], we don't go anywhere. We go into absolute and complete denial. We
think there’s a piece of it that’s our responsibility. That somehow we let violence in or we let control in. There’s a line the person stepped over that somehow we feel responsible for that. And I think for me it was over 14 years before I said anything to anyone. (1.146.Pl)

As a result of being abused and controlled by their partners, several women described their sense of low self-esteem and self-blame. Some women felt that they were responsible for and deserved the abusive treatment.

You’re asking me what makes it so difficult to come forward to a doctor? For one, you’re scared. For another you have low self-esteem. You assume it happened for a reason because, you know, I deserved it. (1.487.X)

I was afraid people were going to treat me bad for staying there as long as I did. I took it personal; I thought I deserved it for letting this go on. (1.350.X)

One woman discussed the painful consequence of years of abuse: the loss of trust in other people. This loss of trust was extended to medical providers and consequently interfered with disclosure.

In the beginning I feel we put trust into these men, these abusive people, and then things started happening and we lost trust in them and, basically, trust in other people, including physicians. And it’s very hard to regain that trust in other people. (1.663.Pt)
The value in elaborating these psychological factors lies in understanding the context of these women's lives when they enter the medical encounter. Although providers cannot be expected to fully overcome these barriers, their understanding may facilitate communication, alleviate misunderstanding and judgments, and lead to improved identification and intervention on behalf of abused women patients.

**Fear and control**

For many women in these groups, the influence of their abusive partners extended far beyond the home. These women were reluctant to seek help because of dependency and/or the fear of escalating abuse and violence. Some women were economically dependent on their spouses, while others were manipulated into protecting their partner from exposure as a batterer.

I agree that we put ourselves at jeopardy and in [her] case, her income. Because if her husband loses his job because he has to be arrested 'cause the hospital has reported him, then she's shooting herself in the foot. (1.957.S)

I spent a lot of time and energy covering for my husband. ...//.. But I was constantly trying to protect him at my expense. I was even willing to go so far as to kind of act a little off my rocker to get help without implicating [him]... saying to people... and it was sort of an unspoken agreement, you know. (2.572.R)
Other than being afraid and sheltering these people [batterers], like not calling the police 'cause they may lose their jobs. So what? You know, these men are ruining their families, ruining women. We're so concerned about what might happen to them. (1.1094.X)

One woman discussed constant harassment and manipulation that led to her dependency.

I think I bought into the successful, upper-middle class lifestyle of _____ my husband has aspired to and gained. ../.. And my husband would tell me, ../.. "I'm the best thing that ever happened to you. I picked you up from the gutter and look what I've done for you." (1.703.X)

The fear of retribution was a commonly cited reason for avoiding seeking help, particularly police involvement.

When they're out [of jail], then you know you're dead. You might as well dig your own grave because that's where you're going. (2.1193.D)

If my doctor were to call the police and they went to my husband, my husband would have beat the shit out to me. (1.904.A)

Misdiagnosis and mistreatment

Many women found that their interactions with the medical system were unsatisfactory. The sources of injuries were often not investigated and
these women's medical complaints did not receive adequate attention. At times this was attributed to lack of time in the medical encounter. Other factors included the provider's discomfort, incompetence, and apathy.

A lot of times when I went to my doctor, he was just too busy. He had so many people waiting, he just didn't have time to ask, "How did you get this bruise?" or "Why is your jaw swollen?"... (1.787.A)

... I just don't think they [health care providers] get it unless a person is covered from head to toe with bruises, and even then they don't get it. (1.1341.X)

I think people in general, health care professionals, do not recognize the signs of abuse. ..//.. Even when there are apparent physical bruises, they do not even bother to ask. (1.724.X)

Some women encountered providers who were clearly aware of the problem, but did nothing to intervene. The providers focused on the injury, but did not acknowledge the source of injury or discuss with the patient the seriousness of her problem.

When I was physically hurt I was put into the hospital and the physicians there did absolutely nothing to help me realize I was battered at the time or took time to talk to me. They just took care of what the injury was at the time and that's it. (1.279. Pt)
I had a cast of thousands pull me through that, basically. Most of them in the medical profession. None of them ever said this is an abusive relationship. (2.244.R)

One woman felt that her problems were trivialized by medical providers. When she tried to discuss her marital problems with her doctor, he was more interested in treating her menopause.

I mean, my God. They'll take it for granted that it's hormones or menopause, whatever the case is. I mean, if you look at it, with us being female, it's like society seems to think that... well, actually it doesn't matter what age we are, it's hormones. (2.1327.D)

Other women described providers who knew about the marital abuse, but did not attempt to intervene, make referrals, or follow up on recommendations.

He didn't make any recommendations to follow up with any kind of therapy or treatment, or anything or to talk about how I felt in any way. There was none of that. (2.337.Jn)

The worst thing you can do when someone finally reaches out in crisis and asks for help is to say "Well, I'm sorry, it's not a convenient time right now." That person may take a long time or never to reach out again. (2.1555.R)
To compound the problems of misdiagnosis and mismanagement, some women encountered hostility and judgment from medical providers.

I was told that I was stupid for somebody that's working in legislative... clerical. I should have more common sense to stay out of a relationship like that. (2.188. D)

I can't stand feeling stupid and someone looking down at me, "tsk, tsk." It makes me angry... (2.426.X)

We're going to say we fell down a flight of stairs or whatever. We're not feeling that we're with a person that's going to understand and not take and minimize it and say, "Oh, his job is very stressful." That kind of thing. (1.748.X)

Clearly, medical providers play a large role in maintain the 'code of silence.' By not asking questions, not recognizing the signs of abuse, not acknowledging or discussing the problem, and not intervening, providers implicitly deny that a problem exists. Their silence minimizes the women's experience. Furthermore, the complicity of these providers serves to maintain the mistreatment of these women.

Compassion and understanding

The participants discussed many important factors in the patient-provider relationship that facilitate or impede disclosure and help-seeking. Compassion was identified as an essential element of rapport. In addition,
awareness, understanding, and a nonjudgmental approach facilitated a trusting relationship between these abused women and their providers. Positive experiences in the medical system often included providers who were compassionate and willing to confront the problem directly.

I couldn't breathe and, um, there was a doctor, he was nice, and I was afraid to tell him. Then I told him I was hurt and he said to me, "You realize that's not normal. I want you to know that this is not normal behavior." It made me realize, and I appreciated that from him. (1.507.N)

One woman relayed a story about a medical provider who was profoundly empathic.

Finally there was a health care professional who I started talking with started crying. I realized she's crying. (1.170.P)

Compassion, kindness, and sincere concern for the woman's well-being were important factors in building trust and "opening the door" to disclosing the abuse.

... I think that there has to be a way of building that trust and confidence in the patient that they well, when they're ready, come and talk about it... (1.1425.X)
Just the compassion is going to open up one door. And when we feel
safe and are able to trust that makes a hell of a lot of difference as
compared with being run through the system. (1.1404.P)

So I think that they really need to take more time to be compassionate
and loving and wanting to get to the answer. (1.804.A)

Participants wanted providers to have a better understanding of the context of
wife abuse and the complex forces that influence an abused woman's
behavior.

I think people need to understand violence is a cyclical thing and it's
not normal, it's not rational. .../... A normal person would think of
getting a restraining order... go do this, go do that... be assertive.
Sometimes you can't. And I feel that's what they don't understand.
(1.139.P)

The participants were very sensitive to subtle communication cues,
like tone of voice and avoidance of eye contact, which may convey the
provider's judgmental attitude. Given the psychological vulnerability
discussed above, these women were very sensitive to condescending or
accusatory comments (verbal and nonverbal).

It's very inappropriate to be judgmental or condescending or to act like
you know better. You don't know their life better. There's no way you
could... (2.1387.R)
I think maybe the tone of voice would help a part of it. I know I'm not usually affected by what someone says, but how they say it. And also the [facial] expression. ...//.. I guess it's just important to understand that it does happen and know it's not always the woman's fault when it does happen. (2.733.Jf)

Yeah, I wouldn't want comments like, "Well, what were you doing when this started?" So anything that would allude to the fact that I caused it. (2.1355.Jn)

But looking someone in the eye... you have to feel inside your heart, you have to feel like, okay, this isn't this woman's problem. She's not a messed up person. (2.998.R)

Several women discussed the important of patient autonomy in showing respect and establishing trust. As discussed later in relation to mandatory reporting to law enforcement, these women wanted the final decisions to be left in their hands. The preferred role of providers was to give referrals, make recommendations, and educate patients.

When I went to the hospital, they pretty much took it out of my hands and then put it back in ...//.. I'm glad that somebody's taking it and doing something about it. But they then told me that it would be up to me to make a full report. ...//.. So the control was still in my hands
even though it was good that they did what they did. I felt that was appropriate. (2.1226.Jn)

Improving medical care

The participants discussed several ways that the medical system could improve its response to abused women patients. First, health care providers should improve the identification of abused women by recognizing the signs of abuse and asking about it directly. Second, providers should assist abused women by providing referrals to social service and community agencies. Third, participants discussed the importance of creating policies to improve provider education and protect women’s autonomy.

To facilitate identification of abused women, providers were expected to by knowledgeable about the signs and symptoms of abuse beyond the physical injuries.

But I think, even if you haven’t experienced it yourself, if you have some good ideas of what happens and what it looks like, you can recognize it. ..//... I think once you have some idea about what the telltale signs are, then it’s not as hard as it might seem. Even if it’s not physical. (2.796. R)

In general, the participants favored a direct approach to asking about a history of abuse. However, the attitude of the provider strongly affected whether the woman was willing to disclose. Asking about abuse should be done in an environment that is supportive, trusting, and non-judgmental.
I think it would be a good idea that doctors and other health professionals asked questions. They would have to be quite subtle. I think they would have to ask subtly, but it should be asked. (1.766.I)

Although several women expressed strong support for asking questions about marital violence during a routine office visit, some women were concerned that this approach would be too impersonal.

I don't think there should be routine questions 'cause it can be really intimidating for a doctor to do down a list of questions to you. I think it should be more on a personal level, even if it means him taking time out of his schedule or appointment, and sit down and talk to them. I just don't think it should be routine. (1.1480.A)

Once the diagnosis is made, the participants believed that providers have further responsibility to provide referrals and follow-up support. Referrals include social and legal services and battered women's shelters. In addition to referrals, participants wanted providers to remain involved in the process by providing support, following up on recommendations, and being patient.

They should have a list of phone numbers that they can get a hold of -- battered women house, emergency shelter, and stuff like that. (1.1363.A)
So you need to like don't be afraid, just say, "I'm concerned that you're being abused." And let the person freak out and run away. Give them a little brochure as they're running out the door. And the important thing is women tend to get help when they're ready. (2.1085.R)

Hospitals and institutions have an important role in establishing policy for improving care to abused women patients, educating providers, and providing services. Improving education and awareness among providers was important to many of the participants.

...I would go so far as to say that all medical personnel should go through this two-week stint. .../... Give them insight into what happens. And then it's easier to make supportive statements. It's coming from a base of understanding and getting away from all those stereotypes. (2.1483.R)

It would be great if the health care personnel would say, "This looks a little fishy to me." And have a social worker assigned to the hospital or available or anywhere or somewhere in the hospital system where one could be referred to. (1.963.S)

The women in these groups were asked specifically about the value of laws that require medical personnel to report incidents of marital violence to law enforcement agencies. Although some participants expressed support for these laws, many women were concerned that they may present a barrier to
medical care and interfere with disclosing a history of abuse to a provider. In
general, the participants placed a high value on their autonomy.

I was just going to say I don't think it would be a good idea to ask the
police and doctors to cooperate. It's hard enough to get the doctors to
understand and if you think it's going to go further, you're going to be
even more reluctant to say anything. I think it would make people less
apt to tell the doctor what they need to tell him for their own health.
They're thinking of all the repercussions. (1.1059.K)

If you have a health care professional that is dealing with consenting
adults and this person feels, without having accurate knowledge, they
just feel that your symptoms or that you may be lying or hiding, and
they report you. .../... It's a very scary thought that you're giving
someone else the right to think for you and to make a decision for you.
(1.1005.Y)

Overall, the participants in these groups discussed many important
factors that affected their willingness to seek care and to place their trust in a
medical provider (Table 4.1). Along with psychological factors like
embarrassment and denial, women may be economically and emotionally
dependent on their partners. Participants also discussed the importance of
trust and compassion in the patient-provider relationship in addition to
direct questioning and intervention.
Table 4.1. Summary of key factors identified by the white women which affect seeking and receiving medical care.

| Psychological factors       | • embarrassment  |
|                            | • denial          |
|                            | • self-blame      |
|                            | • loss of trust   |

| Relationship factors       | • economic dependency |
|                            | • protection of partner |
|                            | • control by partner  |
|                            | • fear of escalating abuse |

| Provider barriers          | • too busy        |
|                            | • lack of recognition/misdiagnosis |
|                            | • lack of intervention |
|                            | • lack of compassion |

| Patient-provider relationship issues | • compassion     |
|                                    | • empathy         |
|                                    | • understanding   |
|                                    | • autonomy         |

| Improving medical care          | • direct asking |
|                                | • referral and follow up |
|                                | • education for providers |
|                                | • in-hospital services |
CONCLUSION AND IMPLICATIONS

The white women in this study discussed many issues that affected their experience in the medical care system. In attempting to understand the barriers to identification and management of abused women patients, the various factors have been divided into two broad categories: patient-related barriers and provider-related barriers. Many of the patient-related barriers are derived from culturally constructed gender roles as well as situational factors related to the abuse. The provider-related barriers included external constraints (e.g. lack of time), inadequate attention to the problem, lack of rapport, and inadequate procedures for dealing with abused patients.

Because marital abuse is a stigmatizing condition, abused women feel shame and embarrassment in divulging this information (Limandri, 1989). The results of this study clearly confirm these earlier findings. In addition, the participants discussed their sense of denial and loss of trust. For many women in the study, the fear of judgments from medical providers was well-founded in previous interactions with providers who were not understanding and supportive.

Another patient-related barrier was the women's sense of responsibility for the relationship. Many women blamed themselves for the abuse or they felt compelled to protect their partners. Much of this sense is culturally derived, in that women are socialized to sacrifice their identities to marital unions, be dependent on their male partners, and be responsible for keeping the family together and in harmony (Thorne, 1982). Another aspect of this self-blame is situational to abusive relationships. The participants discussed their fear of escalating violence and the power exerted by their male partner to control them. Thus the psychological barriers to disclosure in the
medical setting are related both to women's socialization and to the effects of being abused.

Participants in this study identified several provider-related factors that interfere with disclosure, including inadequate time and attention to symptoms, lack of acknowledgment, and lack of follow-up. These findings confirm research results from physician surveys, interviews, and observations, which found many of these same barriers (Warshaw, 1989; Hamberger et al., 1992; Sugg & Inui, 1992). The solutions proposed for these inadequacies included direct yet sensitive asking and the provision of referrals to social service agencies and community-based shelters.

A key issue for many of the participants was their need for compassion, understanding, and respect from medical providers. The women in this study expressed a need for trust, sincerity, and empathy from providers. They believed that these elements of rapport could only come from a solid base of understanding and awareness about the difficult problems that abused women face.

In addition, several participants expressed the need for autonomy, particularly regarding decisions about police involvement. Issues of patient autonomy are particularly important for abused women, since the process of responding to the abuse requires a certain level of empowerment. Women who are being abused often have low self-esteem and may believe that they are incapable of responding or undeserving of a better life. Health care providers are in a position where they can facilitate her empowerment by allow her to make the final decisions.

Health care institutions have an important role in alleviating many of these barriers. First, protocols for identification, intervention, and referral
need to be developed and implemented for hospital use. Second, medical schools and hospitals need to develop educational curricula that address these deficiencies so that providers gain knowledge and skills that could help them deal with abused women patients. Curricula should also focus on developing sensitivity, compassion, and understanding of the psychological and social issues around wife abuse. Third, many participants expressed desires for hospital-based services (e.g. medical social workers) for abused women. And finally, laws and policies requiring mandatory reporting to the police of adult victims of domestic violence need to be carefully scrutinized with regard to violations of patient autonomy and potentially damaging effects on the victim. The issue of mandatory reporting remains controversial, however, since it has the potential of enforcing better identification on the part of health professionals and providing women with police intervention that they may not otherwise be able to seek.

As the problem of marital violence gets redefined as a health issue, it is critical that the voices of abused women have a prominent role in the education of providers and development of health policy. Although this research provided many insights into the factors that affect abused women's ability to seek and receive medical care, it is far from definitive. Not only do these findings need to be verified in other groups of abused women, the role of gender and culture in help-seeking behavior requires greater exploration in future research on abused women.
Chapter 5.
African-American women's perspectives

"You walk around in a cage. And it's a real cage you walk around in."

BACKGROUND

Although black feminist scholars have identified wife abuse as a significant contribution to their multiple oppressions, only recently has this problem been considered a health issue. In her essay "Love don't always make it right" in The Black Women's Health Book, Evelyn C. White (1990) discusses the importance of wife abuse, and how the myths and stereotypes of black women make them particularly vulnerable in abusive relationships. In addition, a recent issue of Vital Signs (Spring 1994), the publication of the National Black Women's Health Project, was devoted entirely to violence against black women. The contributing writers praise the movement to put violence on the health agenda and urge readers to become more aware of the problem.

Unfortunately, research on the diversity of ethnic experiences and cultural influences regarding marital violence is limited. In fact, basic prevalence and risk factor data are conflicting and incomplete. In this chapter, I will explore African-American women's experiences with marital violence and the medical system. First, I will review the current epidemiology research and then discuss some of the relevant social and historical context surrounding marital violence in black families. Finally, I
will present data on the major themes from our research with abused African-American women, which address the barriers to seeking and receiving assistance from the medical system.

**Black-white differences in rates of marital violence**

Although most national surveys on marital violence have included measures of race and class, the relationship between ethnicity, socioeconomic status and marital violence is still unresolved. The National Crime Victimization Survey (NCVS) found no significant difference between the rates of victimization of black and white women who have ever married: 6.1 per 1000 and 5.0 per 1000, respectively (Gaquin, 1978). In contrast, analysis of the National Family Violence Survey (NFVS) data (Hampton et al., 1989) revealed significantly higher rates of both husband-to-wife and wife-to-husband violence among the black couples compared to whites (Table 5.1). Not only did these researchers find higher rates of marital violence for black couples, but a significant decrease (43%) in husband-to-wife severe violence in 1985 (p>.05). In both of the NFVS surveys, both groups of black couples had a lower median family income and higher rates of husband unemployment than the groups of white couples. Although these socioeconomic status variables may have been important confounders in the association of race and prevalence of marital violence, they were not controlled for in the statistical analysis.
Table 5.1. Rates of marital violence (per 100) in black and white couples for 1975 and 1985 (Hampton et al., 1989).

<table>
<thead>
<tr>
<th>Current Couples</th>
<th>White</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
<td>1975</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(n=147)</td>
</tr>
<tr>
<td>Black</td>
<td>1975</td>
<td>1985</td>
</tr>
<tr>
<td></td>
<td>16.9</td>
<td>6.9</td>
</tr>
<tr>
<td></td>
<td>11.3</td>
<td>5.4</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>15.3</td>
<td>22.4</td>
</tr>
<tr>
<td>Severe</td>
<td>7.6</td>
<td>12.8</td>
</tr>
</tbody>
</table>

H --> W*
overall 16.9 6.9 11.2 10.7 1.5 1.6
severe 11.3 5.4 3.0 2.8 3.8 2.3

W --> H**
overall 15.3 22.4 10.6 11.6 1.4 1.8
severe 7.6 12.8 4.1 3.9 1.9 2.8


Although most researchers acknowledge the inadequacy of data on the relationship between marital violence, ethnicity and socioeconomic status, few studies have been designed to explicitly address this issue. A noted exception is the work of Lockhart (1987, 1989, 1991), who examined the experiences of marital violence among 307 black and white women across three social classes. Although rates of marital violence differed by class position, when all class groups were combined, rates for black and white women were the same, 35.5% (Table 5.2). Only black middle class women reported more violence than their white counterparts. Lockhart found significantly higher overall rates of violence than those found in the NFVS. This difference may be explained by the different sampling methodology;
Lockhart conducted community-based recruitment rather than random household sampling.

**Table 5.2.** Rates of husband-to-wife violence (per 100) by ethnicity and social class (Lockhart, 1987).

<table>
<thead>
<tr>
<th>Ethnicity of Respondent</th>
<th>Black</th>
<th>White</th>
<th>B:W ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social class</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>44.2</td>
<td>32.2</td>
<td>0.8</td>
</tr>
<tr>
<td>Middle</td>
<td>45.6</td>
<td>27.1</td>
<td>1.7</td>
</tr>
<tr>
<td>Upper</td>
<td>18.2</td>
<td>29.8</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>35.5</td>
<td>35.5</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Although many questions about the prevalence and risk factors for marital violence among black couples are yet unresolved, it is clear that wife abuse is a serious problem affecting many African-American women. Obviously, more research is required to understand the associations between ethnicity, social class, and marital violence. Although rates may differ by race and class, two things are clear. First, marital violence crosses race and class lines. Second, the social and cultural factors that influence both the occurrence of violence and the response by victims need to be ascertained in order to design effective prevention and intervention programs for different population groups.
Historical, cultural and social forces affecting black families in the U. S.

To better understand the social context of marital violence in the black family, it is important to highlight the historical developments and some of the dominant themes within the field of black family sociology. For a more comprehensive review, see Staples and Johnson (1993). Although generalizations about the black community are often used to understand broad social dynamics and to make inter-group comparisons, it should be understood that African-American culture is extremely diverse.

There are three competing dominant paradigms within black family research: (1) the cultural deviant, (2) the cultural equivalent perspective, and (3) the cultural variant perspective (Staples & Mirande, 1989). While the cultural deviant model views black families as pathological, the cultural equivalent model confers legitimacy as long as black family lifestyles conformed to "middle-class family norms" (i.e. mainstream white American values). The cultural variant perspective focuses on the resilient-adaptive features of the black family. These competing perspectives have evolved through research and theory that began with the controversial Moynihan report in 1965. In this report, Moynihan argued that the matriarchal structure of the black family is the root cause of many of the problems that blacks experience in American society. Black activists and researchers immediately responded to the Moynihan report with sharp criticisms. Sociologist researchers began reframing evidence of black family "instability" to include the broader social and historical context of racial oppression. In addition, many researchers focuses on the strengths of black culture in America.

In 1971, Robert Hill's book *The Strengths of Black Families* elucidated the resilient and progressive aspects of black family and community life. Hill
focused on five themes within black family life: strong kinship bonds, strong work orientation, adaptability of family roles, high achievement orientation, and religious orientation. Although the extended family structure and flexibility in family and gender roles may be based in traditional African cultures, they are likely to be perpetuated by oppressive economic and social circumstances that require greater family inter-dependence and cooperation. Hill's work exemplified the movement to acknowledge the survival and achievements of African Americans in the face of astronomical social and political barriers. Recent social science research and theory emphasize both the strengths and weaknesses of the black family within the context of socially oppressive forces.

Another controversy in black family research is the impact of slavery on current conceptions of family ideology and family structure. Until recently, many historians and sociologists believed that slavery emasculated black men, created a matriarchy in the black family, and prevented the maintenance of a strong sense of family. To counter these unsubstantiated inferences, Genovese (1972) provided historical evidence that in spite of the oppression of slavery, blacks maintained strong family bonds and high marital ideals. Furthermore, he argued that researchers should focus on the current social structures that are damaging to black family structure, rather than blaming history. Recent research has demonstrated that both men and women strongly value marriage, family, and parenthood (Taylor et al., 1990).

In spite of having a strong family ideology, national research demonstrates decreasing rates of marriage, increasing divorce rates and an increasing prevalence of single mothers among African Americans (Taylor et al., 1990). This discrepancy between family ideology and the actual family
arrangements may be the result of the social and structural conditions (e.g. employment discrimination) that prevent the fulfillment of family and marital roles by black men (Staples, 1985; Bowman, 1993). One result of these oppressive social conditions has been the 'shortage' of desirable men for marriage (i.e. employed, educated, non-institutionalized). Increasing divisions between black women's and men's levels of education and income may further create instability in traditional family models.

Important sources of support and strength for the black family have included black churches and extended family networks (Taylor, 1990; Hatchett & Jackson, 1993). In the research reviewed by Taylor et al. (1990), primary sources of material and social support were the family and members of the church. Compared to men, women were more reliant upon extended family members, particularly for child care, domestic work, and financial assistance. In the 1960s and 70s, the black church played a key role in the civil rights movement. According to Billingsley et al. (1991), the current national rate of church membership among blacks is 70%. Clearly the church has maintained its role as a significant spiritual, social, and political organization in the black community.

The social and economic forces that significantly impact the black family include higher rates of poverty, unemployment, and racial discrimination. These oppressive forces are likely to play a role in precipitating marital conflict and violence (McAdoo, 1995). In addition, they serve as barriers to seeking and receiving help outside of the black community. Although research on domestic violence within black families is incomplete, it is possible to speculate how social and cultural forces within the black community may impact marital violence.
Marital violence among African Americans: social and cultural forces

In the U. S., black men are faced with many economic and social oppressions that may precipitate their use of violence against their female partners (Staples & Johnson, 1993). Mainstream spouse abuse research suggests that external or environmental stresses lead to increased marital violence (Farrington, 1980; Straus et al., 1980). Economic stresses faced by many African-American families include poverty and unemployment; environmental stresses may include substandard housing and crowding. According to 1991 census data, compared to whites, a higher percentage of blacks live below the poverty line (28% versus 8% for whites) and their median income is significantly lower ($20,209 versus $35,975) (Asbury, 1993). These economic stresses are obviously not exclusive to black families and are more likely to explain the class-related occurrence of marital violence.

However, since a higher proportion of black families live in poverty, these issues are relevant in understanding marital violence among black couples.

Racism and racial discrimination serve as another source of stress. The 1991 National Opinion Research Center's General Social Survey found that 56% of whites thought blacks were more prone to violence (than not), 68% thought that blacks preferred to live on welfare, and 53% thought that blacks were less intelligent than whites (cited in Asbury, 1993). Although this pervasive "everyday" racism and prejudice takes a tremendous psychological toll on its victims, it is the institutional racism that operates to create a social situation where black Americans have the lowest incomes, highest rates of unemployment, and lowest life expectancy compared to other ethnic groups.
Staples and Johnson (1993) argued that the "institutional decimation of black men" has negatively impacted the stability and harmony of black marriages. Previous research suggests that rigidly ascribed gender roles in the family are associated with marital conflict and violence (Walker, 1979). The greater flexibility in roles and more egalitarian division of household labor in the black family should thus ameliorate tendencies toward violence (Asbury, 1987). On the other hand, the construction of gender roles by the dominant culture is likely to impact the expectations of black women and men. Although roles may be more flexible within black marriages, women and men still believe that the man should be the primary economic provider (Taylor et al., 1990; Staples & Johnson, 1993). Because of the difficulties faced by black men in fulfilling the role of provider in the family, their sense of powerlessness may lead them to demand more respect from partners and take out their frustrations through abuse (White, 1985). Franklin (1984) argued that marital conflict also may arise from black women's greater expression of dual gender roles. Black women's greater independence and involvement in the workforce may be perceived as threatening to men's aspirations to be primary providers. Overall, the impact of gender roles on the occurrence of abuse in black partnerships is multi-faceted.

The social support provided by extended family, the church, and the community potentially serves as a buffer from social and economic stresses (Taylor et al., 1990). Social support networks may help relieve the burdens of childrearing and household work. Extended family arrangements also may conserve financial resources. In addition, these institutions serve to support a positive family ideology. For example, research has found that the church has an important role in helping to resolve marital conflict (Taylor et al.,
1990). Cazenave and Straus (1979) found that families with the highest level of physical violence tended to be cut off physically and socially from adult relatives. Black respondents in this study were more embedded in family-kin networks than white respondents, and these networks appeared to be more operative in reducing domestic violence. Although the strengths of black families, flexible gender roles, extended families, and social networks may serve as a buffer against the abuses of society, their power is undoubtedly limited in preventing marital violence.

Obviously, much of the preceding discussion is speculative because there is very little research designed to understand the causal and associated factors of marital abuse among blacks. Furthermore, the assumption that factors that are associated with marital conflict and abuse in white families operate in the same way for African-American relationships is highly questionable.

Barriers to help for abused African-American women

Black women face many important social, psychological, and institutional barriers to seeking help for problems related to wife abuse. As a result of internalized cultural and racial stereotypes, black women face important barriers to identifying the violence as a problem. White (1985) argued that black women who have internalized the "superhuman" images of black women, are more likely to accept the responsibility for keeping the family together and endure the violence stoically. In addition, the stereotype that black women are overbearing and self-reliant may contribute to greater acceptance of violence in their lives (White, 1985). In their analysis of popular black media, Peterson-Lewis et al. (1988) argued that black men and
women have been pitted against each other in terms of social advancement. Media reports tend to blame black women for relationship conflict and portray black women as demanding and controlling. These authors also discussed how black men's violence is often portrayed as a reasonable response to social oppression. This affects the attributional processes of abused black women in that they are more likely to excuse their partner's behavior. This tendency to blame women rather than men for marital conflict creates a significant barrier to women's identification of, and response to, marital violence.

Many black women also face significant barriers to leaving abusive relationships. In spite of their long history of workplace involvement, black women face significant sex and race-based discrimination that limits their earning potential. Thus, there may be important financial incentives to stay in the relationship. The existence of children makes these incentives more salient. Single women with children face housing discrimination, child care problems, and difficulty finding a partner. Women who are considering leaving an abusive relationship may be dissuaded by the shortage of "marriageable" black men. Some have argued that this shortage has caused black women to lower their standards in selecting a partner (Staples & Johnson, 1993).

Based on previous research that demonstrated strong family and social support within the black community (Taylor et al., 1990), one might predict that abused women would find sources of help within their families and communities. Many authors speculate that informal sources of help are more likely to be utilized by abused black women (Jalali, 1988; Coley & Beckett, 1988; Gondolf et al., 1991). The reasons lie in the strength and
effectiveness of these networks as well as the lack of access to formal sources of help. On the other hand, the strong pro-family ideology in the black community may serve as a barrier to ending an abusive relationship. Social networks intent on support may favor retention of the relationship over the woman's well being. Advice from family members and friends also may serve to pressure the woman to stay in the relationship. Clearly, abused women's social support networks may operate as either a source of support, or in some cases, as a barrier to leaving the relationship.

Furthermore, black women may feel more alienated from the institutions established to help abused women. For example, black women face significant obstacles to seeking police assistance. General perceptions of the police in some black communities (particularly low income urban) can be very negative. Many abused women may have had previous experiences where police were either not helpful or outright abusive (Campbell, 1993). In addition, the history of mistreatment of blacks by police may make the woman afraid that her abuser will be treated badly or more likely to be sent to jail unjustly (Peterson-Lewis et al., 1988). Black women also face obstacles to shelters and other battered women's services. Coley and Beckett (1988) argued that some black women believe that because of their origins in the feminist movement, battered women's shelters were established for white women. In addition, negative racial stereotypes on the part of social service and medical professionals may create an important barrier to help (Campbell, 1993). Unfortunately, research on racist, classist, and sexist attitudes of social and medical service providers is lacking.

Overall, black women's response to marital abuse is affected by a multitude of social and cultural factors. These factors operate at all stages of
response including overcoming denial about the abuse, seeking help, and leaving the relationship. Although these factors create individual level barriers as well as institutional barriers, the most significant barriers result from sexist and racist discrimination. Institutional racism affects abused women's attempts to seek help from police, social services, and the health care system. Furthermore, the double oppression of sexism and racism operates to make black women more economically dependent on abusive partners.

Understanding the social and cultural forces that contribute to the problem of marital violence is critical for developing prevention and intervention strategies. Researchers, policy makers, and practitioners need to be sensitive to the complex cultural and societal issues that are salient for different racial and ethnic populations. Some of the barriers to help for abused African-American women are likely to be unique, thus will necessitate broader prevention and intervention strategies. Although the women who participated in our research were not asked specifically to discuss social and cultural factors that influenced their experience with wife abuse, the issues they discussed clearly reflected their social context.

**VOICES OF ABUSED BLACK WOMEN**

Study participants included nine African-American women with histories of physical abuse, in many cases severe. Demographic data were available on only four of the participants (see Appendix D-2); data from the second group were misplaced. These women were young (ages 23-29 years; median 26.5) and most (3/4) had not completed high school. The median
number of children was two. The majority of the women had direct experience with the medical system. The first group was recruited through two battered women's shelters and the second group was recruited through a drug treatment program. Thus many of the women in the second group had personal histories of illicit drug abuse. Clearly, this group of women is not representative of abused black women and the data should be understood in this light. Further, the issues they raised should be understood within the context of their particular social situations.

Police involvement

When the women were asked where they turn for help for problems related to wife abuse, only three of the nine women in our study turned to family or friends in times of desperation. These women discussed living with a relative when they needed a place to stay. Reasons for not seeking family help varied. One woman had moved away from her family to be with her husband, another woman was embarrassed to tell anyone, and another was worried that it would create more conflict. Police and medical care (usually emergency care) were the primary sources of help; they were cited by seven and nine women, respectively.

In terms of barriers to medical care, the women primarily focused on their concerns over police intervention and their interpersonal relationships with medical providers. Although these issues will be presented separately, it should be understood that many of the women's concerns were interrelated in that they revolved around larger issues of safety and trust.

Many women discussed their reluctance to seek help from law enforcement authorities. Three main reasons for this apprehension were
discussed. The majority were afraid of escalating violence by the partner. Others were concerned for the partner's safety or felt loyalty and love for their batterer. Women with criminal or drug histories were afraid of going to jail themselves or losing their children.

One woman feared retribution from her partner if she called the police. In addition, she believed that the police would not protect her.

I'm just not going to take no chance on my life and I'm not going to take no chance on, you know, trusting that the police is going to be here, you know, to save me from him. (1.1197.K)

Other women were more concerned with protecting their abusive partner from prosecution.

Um, you don't want to turn that person in. Like [she] said, because you care about that person, um, it's very hard to do. (1.1023.Ch)

What makes it difficult [to go to the doctor] is because, like, after you've been, like, abused, you kinda scared to tell the doctor 'cause you in love with that person and it ain't like, you really don't want to see that person, you know, see that person get in trouble, but you also have to look out for yourself. (1.968.T)

Many women in this group encountered the additional problem that they may face arrest because of their drug use.
...I was under the influence of drugs at that time and I was going through all trials and tribulations already and I didn't want no more... I mean, police is already involved and it was like, dang, all of a sudden, what am I putting myself through, you know. (1.1110.Ch)

Women discussed times when the abusive partners would use the threat of her arrest to keep her from involving the police.

And I was scared if I called the police, they would take me to jail. .//. .
He said, "You can't call the police 'cause you'll go to jail, too."
(2.446.Cd)

I was just going to say that I recall a time when I called the police on the guy that I was with and he told them that I had warrants and they was going to take me. And I had a houseful of babies. I was the only adult in the house and I was keeping like five kids. (2.503.B)

Another woman told a story about how she went to jail for fighting back.

I remember a time when I did get hit in my mouth before I went to go get high. They took me to jail, too, for fighting back. So it was, like, if I call the police again on this man, then I might as well go to jail, too, 'cause I'm going to keep fighting back, you know. (2.460.C)
Some participants found law enforcement helpful, while others considered it a last resort. Complaints about police services included long waits after calling for assistance, judgmental attitudes of officers, lack of protection for the victim, mistreatment of the batterer, and the hassles of filing a report and dealing with the courts.

And the police they try to con you when you do call them. They, like, they get tired of coming or they take their time about coming if they know what's wrong. By then, I mean, so what if you don't follow through the first couple of times. You're going to get enough and follow through one time or another. And they just like, "All you're going to do is let him come right [back]." (2.484.Cd)

... when the police get here, you already been through so much trauma and stuff that you, I mean, it's like you just going through it all over again. .../... It's really hard to do because, I mean, for myself, you have to go through all kinda, you have to go through the whole system. Everybody wants you to get into, I mean, so, and at that time, you're not looking to go through all that stuff. (1.1019.Ch)

These concerns over police involvement often created a problematic connection between the health care system and law enforcement authorities. It was commonly held among our study participants that seeking help from the health care system meant involving law enforcement authorities. In some cases, women were reluctant to seek medical care because they believed that police intervention would have dangerous consequences for them.
One woman refused to seek medical care because of her fear about retribution from her partner if police were involved.

And I was scared for my life. I never went to the police and I never went to the hospital 'cause I knew that if I go to the hospital I would have to file a report with the police and I was scared. (1.249.K)

Other women discussed their reluctance to divulge information to medical providers.

... what made it difficult for me to confide was the fact that I feared for my life, you know. And I knew that if I was to tell them [medical providers] what actually happened that they would call the police and I would have to file a report and they couldn't guarantee me that they would be there 24 hours to protect me from this maniac. So, therefore, I wasn't taking the chance on my life. (1.1160.K)

I was so scared of my boyfriend that I didn't feel safe telling anybody what he had done. I didn't feel safe at all telling anybody what he had done. So I kept it in and I didn't even stay to get the stitches. I just ran. (1.843.K)

Issues of confidentiality and autonomy in the patient-provider relationship were discussed primarily in relation to concerns over police involvement.
What would make it easier for me would be to, um, preferred to be my choice. Well, "I need help, can you call the police?" Or if, um, this happened to me but I don't want the police involved, "Can you please treat me and keep my confidentiality?" (1.1184.K)

I think the doctor can ask you whether or not you have been involved in domestic violence and ask you do you want to go through the procedures of pressing charges or whatever. And if you say yes they help you out and if you say no they just put it on your chart and leave it alone. (2.1508.Ch)

And he [the doctor] was telling me I didn't have to live like that and he referred me to somewhere so I could get help. And it was up to me whether I wanted to go or not, but at least he tried and he makes sure I got out of that hospital safely. (2.2086.Cd)

Health care system barriers

In addition to concerns over reporting by medical personal, several participants identified other structural barriers to medical care. Specifically, the lack of money or health insurance was an important consideration for some, while other women were frustrated with the long waits they encountered.

Um, but as far as money, most people don’t have money to go to the doctor. Sometimes don’t have no insurance to go to the doctor and if you have to go to [the hospital] for free then you’re not going to want
'Cause a lot of times a person who is a victim doesn't even realize how far or how deep into the problem that they are, you know, 'cause they're in there. And because they're afraid and they're feeling like they're stupid for being in that type of relationship. (1.1481.G)

Several women were devoted to their partners in spite of the abuse.

...he just had this major, he just had, he just had something, I don't know, he just had this trouble. To a point where as I just really, I would do anything for that man. That's the way I feel. (1.593.Ch)

It was just a whole bunch of chaos. I stayed with him as long as I could because... really because I didn't have no where else to go. I stayed with this man thinking that I was in love with this man. Just watchin' him dog me, you know, but after a while I guess I just woke up. (2.552.B)

**Distrust and misunderstanding**

The patient-provider relationship was very important for this group of women. Their experiences and perceptions of medical providers should be understood in light of their social context of being abused and having problems with drug abuse. Many women discussed withholding information from providers. Although part of this decision was based on the same reasons for not involving the police, the quality of their relationship with the provider was important in determining how much to divulge.
Several women discussed withholding the truth about the source of their injuries.

I can remember going to the doctor to get tested for STD and when it came down to it I was all bruised up and the doctor asked me what was wrong. And I would say something like "Oh, I was playing basketball," or "Me and my boyfriend was wrestling" or "playing football." Just makin' excuses. ... I didn't want anybody to know I was being beat up because everybody would tell me get out of the relationship, leave him alone. But I was ignorant, stupid. I thought I was in love, but evidently he didn't love me if he had to do what he did, you know. (2.1002.B)

... I did go to the hospital once 'cause I was so, you know... had to have stitches in my face, but I didn't file a report. I lied and said that I, um, fell and hit my head on the end of a car fender. (1.287.K)

Several women expressed a fundamental distrust of the medical system. These women seemed particularly concerned that they were unfairly judged by medical providers. Although none specifically identified racism as a problem in the medical encounter, they were conscious of their status as abused women.

Um, and just, just, for people not to have the attitude that, well, you know, to show that they pitied me or that they think I'm stupid, you know. 'Cause I've run into that a lot in my experiences, but people just
don't understand. So, they like, "If you want to get out, get out." It's not that easy. You walk around in a cage. And it's a real cage you walk around in. (1.1510.G)

You know, they don't understand. Um, and, again, they judge you, they, you know, they, uh, think that you're in the situation because you want to be or you like getting beat up or, you know, something like that. (1.1807.G)

... I think if they treat you, like, there's something wrong with you, then you're not going to want to come back there. and where you going to go next? You'll have to find someplace else safe to go in and that's hard enough to do. (2.2150.X)

One woman identified drug problems and economic issues around which medical providers are often judgmental.

Also keep in mind that if you're doing drugs or involved in a gang or whatever, we all people, um, we should be treated equally, you know, whether be on welfare or whether you have money or not. (2.2240.S)

Clearly, the women felt as though the medical providers did not understand their situation, and had preconceived ideas about abused women.

Another problem identified by African-American participants was the lack of concern and compassion on the part of health care personnel.
It seems to me that they [medical providers] are not, uh, they don't show enough concern for victims of violence. You know, you're just a number to them. And to me, they need to show some more concern. That makes a world of difference in your healing process. (1.861.G)

I feel like the bad experience with the doctors was when I went to [the hospital]. They didn't really ask me too many questions, they just admitted me. (2.722.B)

Because of the underlying distrust and the sense of being judged, these women emphasized their need for personal privacy in the medical setting. Many women were apprehensive when questioned directly about the source of their injury or history of abuse.

For me, what made it difficult for me to go to the doctor, like I said before, I don't want everybody in our business, I don't want a lot to know this is happening to me. I didn't want to believe it was happening to me because I guess I was, what do you call it, blind about love... (2.924.B)

And then when you get to the abuse part. That's asking something that's real private probably to you, that you don't want nobody to know. (2.1353.G)

Although some of this apprehension comes from concerns over police involvement and fear of the consequences, much of it seems to arise from
shame, embarrassment, and the lack of a trusting relationship with the provider.

**Patient-provider relationship issues**

Participants were asked to discuss their recommendations for improving care to abused women patients. As discussed previously, the abused women wanted medical providers to be educated about marital violence and sensitized to the issues faced by abused women. Specifically, participants wanted providers to express compassion and refrain from judgments.

Um, we should feel like we have support. I mean, you know, that, I mean, you know, at that time you need somebody to care, you just don't need nobody just to run in and just treat you like stuff and just, you know, so I think if he just take time out and communicate with us on a... and be patient. And communicate with us. (1.1677.Ch)

The doctor should take into consideration what we've been through, like [she] said, take time out to listen, to care, to treat us like unique individuals, you know, as in one, don't judge us ..., /.. That's all you got to do is just care, take time out and listen. (2.2255.C)

One woman discussed how she would like to be asked about abuse. She emphasized a caring approach.
...I think it depends how they say it. I think it's one thing for somebody to say, "Hey, you know, I'm seeing a pattern here. [You've] been here several times. What do you want to do about this?" Instead of saying, "Hey, you know, what's up with you? What's the matter with you? Can't you get yourself together? How many times you going to come in here like this?" I mean, I think it's going to make it harder for you to go back the next time. (2.2133.X)

Many participants expressed a strong desire to be listened to, perhaps reflecting their sense that their voices are not heard or their problems were too often trivialized.

You know, when you beat up, that's what you need. You need somebody to listen and you need somebody who understands. Um, just care about me, you know. That's what you need most without criticizing you or judging you. (1.1711.G)

I believe that, um, the nurses and stuff, if they just sit back and they listen to some of these stories and they put themselves in that position then maybe they could really understand... (1.1778.Ch)

...take time out to listen, to care, to treat us like unique individuals...

(2.2258.S)

In response to the question, "how do you think doctors could help you?", one woman stated simply:
Just by being an ear, listening. (1.1405.X)

One woman believed that some encounters with physicians can themselves be threatening. She emphasized her need for a compassionate and gentle approach on the part of physician.

First of all, for me, if I was in that situation, he would have to stay his distance. He would have to be on the other side of the room, you know, talk calmly, nicely. You know, show me that he care, that he's there to help me. That he's just there to help, for one. And then, maybe, as I settle down or whatever, he could come a little closer and examine me, but if I'm all shook up or whatever and there's no other way, then he would have to stay his distance. (2.1869.C)

Several women wanted extra time to collect their thoughts and try to relax.

... you've already been beat up and, it's like, your mind is all just scrambled. And you just need a little time, you know, to get your mind, your thoughts, back in place. (1.1641.T)

Although the majority of women favored the idea that medical providers should ask women directly about abuse, many expressed concerns about the specifics of this inquiry. In general, questions about wife abuse should occur in a context of compassion, understanding, and trust.
One woman expressed her opposition to routine screening.

I think that if a doctor has reasons to suspect that, you know, due to the type of injuries that they're seeing and the frequency that you come in, that they have reason to suspect, yes, they should ask, you know, but just as a routine thing, no. (1.1258.G)

Other women gave specific advice about how providers should approach asking such sensitive questions.

...just ease his way in. I wouldn't feel comfortable if he just asked me straight out. You know, settle me down, make me laugh for a few minutes or something. (2.1699.S)

I think if you're going to the doctor's office and they wanted to ask you about domestic violence, maybe they should just ask you about your relationship. ..//... Don't just, I don't know, I just wouldn't want somebody to come right out and say, "Did you get beat last night?" or "Who hit you in your eye?" or "Who gave you that shiner?" or whatever, you know. Maybe just beat around the bush just a little bit... (2.1658.X)

As discussed earlier, these women were particularly concerned with protecting confidentiality and respecting patient autonomy. One way to accomplish this was to allow the patient to make decisions about whether to
involve the police. Another way was to respect the woman’s wishes if she chooses not to discuss her situation.

I don’t think it’s okay for them to judge a person, tell them what they should do, and what they shouldn’t do. I mean, tell ‘em how to do things. Just like I said before, I think they should just ask do they want help and, if not, leave it at that and just write in on their chart like I said. (2.2046.Cd)

Yeah, if you’re talking to the doctor, but if you don’t want to talk about it they shouldn’t make you talk about it. They should ask you if you want to talk about it and if not, leave it at that. (2.2062.Cd)

The participants discussed the role of the provider in helping them deal with their problem. Not only did women discuss specific interventions, such as referrals and hospital services, but they stressed the importance of understanding and support on the part of the provider.

Referrals were seen as an important way the providers can help abused women.

Doctor could do a good job of helping women by letting women know different resources or programs or places they can go that are available to them. (1.1462.G)
In addition, some participants believed that providers could have an
important role in helping the woman end the relationship through
persistence and support.

I mean, it could sink in, you never know. Um, um, you know, you
just never know, maybe he just, you know, take you a while, but if he
kept on telling me it probably would have sunk in. I wouldn't mind.
(2.2121.S)

That it's, that you, that you have the right not to be beaten up and that
you should, I feel, these doctors or health care workers should, um,
take time out to try and convince these women, 'cause they already
have low self-esteem. They're scared... (1.1745.K)

Participants were asked specifically if the race or sex of the doctor made
a difference in the quality of care. While no one identified race as important,
several stated a preference for a woman doctor.

You know, and race is not important to me but I prefer, in a situation
like that, I would prefer talking to a woman, you know. That would be
ideal to me. The main thing is telling somebody who understands.
And to me only people who have been through it or have been in
situations where they have seen it can understand. Nobody else really
can. (1.1217.G)
The race of the doctor probably wouldn’t matter to me, but I think I would prefer a female than a male because it was a male that caused me to be in the hospital in the first place. (1.1147.K)

The majority of participants believed that training courses would be beneficial for medical staff. They discussed how the training could be an important bridge to better understanding and empathy on the part of providers.

I think a training course would be excellent because then they think it’s more inside on the fear, the trust issues, the actual pain and violence. I mean they could get some insight on what we really go through and they would also see that, you know, a lot of the times we are really the victim and we just, and we did nothing wrong to deserve to be treated like that. (1.1830.K)

Overall, the participants in this study discussed many important variables that affect their ability to seek medical care (Table 5.3). In brief, barriers to medical care fell into five broad categories: unwillingness to involve the police (for a multitude of reasons), economic and time constraints, personal barriers, negative experiences, and patient-provider relationship issues.
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<th>Category</th>
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<td>Psychological/relationship barriers</td>
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<td>Distrust and misunderstanding</td>
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CONCLUSION AND IMPLICATIONS

It is a rare opportunity to hear the voices of the people on the receiving end of medical care, particularly those who require treatment beyond the traditional biomedical approach. Abused African-American women patients are marginalized based on their race, gender, and victimization. Many of the participants in our study were further marginalized through their personal history of drug abuse. It is these voices that are most lacking from the policy debate regarding the role of medical professionals in dealing with marital violence. The women in our focus groups discussed their experiences, perceptions, and expectations of the medical system. It is these insights that should guide future directions for improving access and quality of care.

The women discussed important barriers to seeking help from law enforcement and medical institutions. Of primary importance was the participants' general reluctance to involve the police. Many women believed that police intervention brought great personal danger for both herself and her partner. These women's negative perceptions and experiences regarding law enforcement may be related to the history of poor relationships between police and residents of urban black communities (Peterson-Lewis, 1988; Campbell, 1993). Clearly, these women's stories indicate a need for greater sensitivity on the part of law enforcement, greater efficacy of victim protection, and improved sources of assistance for abused women navigating the legal system.

Because of the implied (and often actual) connection between medical institutions and law enforcement agencies, many women reported a reluctance to seek medical care. Current mandatory reporting laws and proposals that require medical professionals to contact police if they suspect
marital violence may have a profound effect on abused women's access to care. Ironically, policy that was intended to help abused women may in fact lead to further isolation and unwillingness to seek help from the medical system.

The participants faced two structural barriers to seeking medical care: the high costs and long waiting periods. Although several women received government-based health insurance, many were still faced with economic constraints to receiving care. Further, even when care was available at low cost, women paid the price of long waiting periods at county emergency rooms. Because of the unique needs of abused women patients, it may be more appropriate to give them higher priority in receiving acute care.

The participants had many personal motivations for avoiding the medical system or withholding information from providers. These reasons included embarrassment, low self-esteem, and desire to continue the relationship with the abuser. These motivations were tightly linked with the women's perceptions that medical providers are typically judgmental and unconcerned. Because of this well-rounded suspicion and distrust, withholding information from providers was a reasonable means of self-protection. Further, these women may feel alienated from medical institutions that are perceived as white- and male-dominated.

These research results have important implications for improving medical level interventions for abused African-American women. The participants expressed a clear desire for a greater expression of compassion and understanding on the part of the provider. Their explicit requests for the provider to listen better and be gentler may reflect their previous experiences of poor treatment in the medical system. Although there is little research on
sexist and racist attitudes of medical providers and how these attitudes are manifested in patient interactions, it is certain that medical professionals have not escaped the influence of the racist, classist, patriarchal society in which we live. Participants also emphasized the importance of confidentiality and patient autonomy in the patient-provider relationship. Again, it is likely that these needs are particularly salient for this group of highly marginalized women.

While the women in our study did not identify the ethnicity of the provider as an important contribution to quality care, medical institutions should be devoted to training members of the communities that they serve. Several women stated that they preferred talking to a woman about problems related to wife abuse. This desire indicates a need for a sense of connectedness between the patient and provider. This connection may be facilitated by a same-sex or same-ethnicity relationship.

It is critical that policy makers and medical practitioners listen carefully to the voices of abused women, particularly those with complicated needs. The black women in our study elucidated many important issues, however, further research is necessary to better understand the complex social and cultures forces in these women's lives.
Chapter 6.
Latina women's perspectives

"It's that many times, a look is a big support for you -- to know that somebody is paying attention."

BACKGROUND

Although extensive research on marital violence among Latinos has yet to be conducted, many political and health advocates consider wife abuse to be a significant problem in the lives of many Latinas (Zambrano, 1985; Ginorio & Reno, 1986; Torres, 1993). Some advocates have attempted to understand the unique cultural forces that either contribute to marital violence or interfere with an abused woman's ability to seek help. Others have focused on social, economic and acculturation forces. These issues will be discussed in detail in the following sections.

In this chapter, I will briefly review the literature on marital violence among Latinos and provide an overview of Latino cultural norms and values, as well as social and acculturation forces, that may impact marital abuse. Data from focus groups of abused Latina immigrant women will be presented in an effort to understand the experiences, perceptions, and expectations of these women, particularly in relation to seeking medical care.

Prevalence of marital violence among Latinos

Using data from the 1985 National Family Violence Survey (NFVS), which included 711 English-speaking Hispanic households, Straus and Smith
(1990) reported markedly higher rates of marital violence among Hispanic couples compared to non-Hispanic white couples (Table 6.1). One factor that explained some of the increased overall rates of marital violence was the youthfulness of this population, because rates of marital violence were inversely correlated with age. In addition, the sample of Hispanic households differed demographically from the sample of white households in several important ways. The Hispanics tended to live in more urban areas, work in blue collar occupations, and attain lower annual incomes. However, even within matched groups of low income, blue collar, and urban households, the Hispanic sample demonstrated higher rates of marital violence as compared to whites.

Table 6.1. Rates of marital violence (per 100) in Hispanic and non-Hispanic white couples in 1985 (Straus & Smith, 1989).

<table>
<thead>
<tr>
<th>Current Couples</th>
<th>White (n=1,313)</th>
<th>Hispanic (n=711)</th>
<th>Ratio Hispanic:White</th>
</tr>
</thead>
<tbody>
<tr>
<td>H --&gt; W*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>overall</td>
<td>17.3</td>
<td>2.5</td>
<td>7.6</td>
</tr>
<tr>
<td>severe</td>
<td>7.3</td>
<td>5.0</td>
<td>2.4</td>
</tr>
<tr>
<td>W --&gt; H**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>overall</td>
<td>16.8</td>
<td>11.5</td>
<td>1.5</td>
</tr>
<tr>
<td>severe</td>
<td>7.8</td>
<td>4.0</td>
<td>2.0</td>
</tr>
</tbody>
</table>

*H --&gt; W: husband-to-wife violence. **W --&gt; H: wife-to-husband violence.
In a survey of Los Angeles households, which was conducted in both English and Spanish and included 1,243 Mexican American and 1,149 non-Hispanic whites, Sorenson and Telles (1991) reported that lifetime rates of spousal violence were nearly equivalent for Mexican Americans and non-Hispanic whites (20.0% and 21.6%, respectively). Spousal violence was defined in this survey as having ever hit or thrown things at the spouse. The highest rate was found in U.S.-born Hispanics (30.9%), while the lowest rate was among Mexican-born Hispanics (12.8%). Rates were similar for both men and women surveyed.

Although many questions regarding the epidemiology of marital violence within Latino communities remain unanswered, it is clear that wife abuse is a serious problem affecting many Latinas. Obviously, more research is required to understand the relationships between ethnicity, social class, immigration status, acculturation, and marital violence. Regardless, the social and cultural factors that may influence both the occurrence of violence and the response by victims need to be explored in order to improve services for this group of women.

Traditional Latino cultural values and norms

Many labels have been used to refer to Latinos, including Hispanic, Chicano, Raza, and Latin American (Marin & Marin, 1991). Hispanic is an ethnic label used in government census and health data that is meant to include persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race. Chicano and Raza refer to persons who trace their family background to Mexico. Along with Latino, these labels reflect a certain political and social consciousness. Latino, a term
that includes Latin American groups, but not Spanish, is perceived by many social science researchers as more accurately reflecting the political, geographic and historical links present among the various Latin American countries (Marin & Marin, 1991).

Marin and Marin (1991) defined ethnicity as "the collection of group-specific behaviors that are mediated by those shared social values that are characteristic of a given group" (p. 2). However, it also should be recognized that Latinos are a very diverse group. Countries of origin have been differentially influenced by colonization by different European nations. They have different indigenous roots, languages, and traditions. Furthermore, immigrants and U.S.-born Latinos have different levels of acculturation which affect their cultural norms and values.

Despite the diversity among Latino communities, families, and individuals, there appear to be certain common cultural values that have been identified by social science researchers. Marin and Marin (1991) reviewed this literature and describe several key features of Latino culture. Allocentrism and familialism are considered important values that serve to structure the collectivism and interdependency within Latino culture, while interpersonal interactions are guided by norms of simpatia and respeto. Culturally constructed gender roles, particularly within the family, are an important feature of Latino culture and will be discussed below.

Latino culture has been classified as allocentric or collectivist (Marin & Marin, 1991). Allocentric societies emphasize the needs, objectives, and perspectives of an in-group in contrast to individualistic cultures (e.g. Western culture) wherein social behavior is determined primarily in terms of individual objectives and attitudes. Allocentrism is characterized by personal
interdependence, conformity, mutual empathy and trust, and willingness to sacrifice for the welfare of the in-group members (Marin & Marin, 1991). This interdependence is particularly salient for in-group family members.

The value of familialism has been described as one of the most central values among Latinos (Marin & Marin, 1991). This cultural value involves individuals' strong identification with and attachment to their nuclear and extended families, and strong feelings of loyalty, reciprocity, and solidarity among members of the same family. Marin and Marin (1991) discuss three manifestations of familialism: perceived obligations to provide material and psychological support to the family, reliance on relatives for help and support, and perceptions of family members as behavioral and attitudinal referents. In writings on Chicano culture, several authors have argued that the strong emphasis on la familia is the most significant cultural characteristic (Mirande & Enriquez, 1979; Mirande, 1985; Martinez, 1988). Chicano families include nuclear family members, extended kin, and often close friends. Compadrazgo is a system whereby friends are symbolically initiated into the family as godparents, or compadres.

Simpatia is a cultural script that is derived from allocentric values (Martinez, 1988; Marin & Marin, 1991). It emphasizes behavior that promotes smooth and pleasant social interactions through empathy, respect, and a certain amount of conformity. It also describes a general tendency to avoid interpersonal conflict and confrontation in favor of agreement and consensus.

The value of respeto, or power distance, promotes deference and respect toward certain powerful groups or individuals (Marin & Marin, 1991). This power distance generally applies to professionals (e.g. medical providers)
and other authority figures. The value of respect also is an important feature of family dynamics, wherein power differentials are typically based on age and gender. Mirande and Enriquez (1979) described the emphasis on respect in the Chicano culture, where elders and men have the highest social status. Although men may be viewed as having the ultimate authority as husbands and fathers, it is expected that they will not abuse this authority and privilege.

Currently, great controversy surrounds the social science understanding of Latino cultural values regarding the roles of men and women (Staples & Mirande, 1989). Traditionally, Latino families were seen as having rigid patriarchal structures in which *machismo* and female submissiveness were key variables in explaining family dynamics. This pejorative view of Latino families can be traced to research that was based on a pathological perspective. Minority scholars in the 1960s began to question these depictions and construct their own "insider" perspectives that were sensitive, sympathetic, and probably more valid. In general, Latino families are now seen as stable, cooperative, and able to provide emotional security and a sense of belonging to its members (Staples & Mirande, 1989).

The construct of *machismo* has been used to describe the traditional male role in the Latino cultures, particularly among Chicanos. Although popular usage of the term connotes hypermasculinity, physical prowess, or male chauvinism, it was originally used to encompass male attributes of courage, dignity, honor, respect, and authority (Panitz et al., 1983; Mirande, 1985). Although *machismo* has been viewed as a pathological force, particularly in family relations between spouses, many researchers have argued that the understanding of this value should focus on attributes of
cultural pride, integrity, and resistance to cultural oppression and subordination (Mirande, 1985).

Traditionally, Latina women have been stereotyped as quiet, saintly, docile, and submissive, particularly in their relationships to their husbands (Panitz et al., 1983). In more traditional cultural constructions, women were expected to be totally devoted to their families, warm and nurturing, and as a reward, mothers were respected and revered (Mirande & Enriquez, 1979). Some authors have suggested that the teachings of the Catholic church have reinforced women's subordination within the family by emphasizing the value that sacrifice in this world is helpful to salvation. Martinez (1988) described the concept of Marionismo, or the long-suffering mother, in the Chicano culture wherein women are expected to be accepting, silent, and willing to sacrifice. In fact, according to this conception, women should get satisfaction and fulfillment from suffering. Although Latinas are often characterized as strong, enduring, and essential to family functioning and transmission of cultural values, they ultimately carry a significant burden of domestic responsibility (Staples & Mirande, 1989).

Overall, the social science analysis of gender roles in Latino culture is fraught with misperceptions, contradictions, and exceptions. However, most researchers acknowledge the diversity and consider Latino gender roles fundamentally 'benign and flexible' (Martinez, 1988). In fact, research on domestic decision-making supports a more egalitarian model (Mirande, 1979). One study comparing inner city samples of white, black, and Chicano couples, found no inter-ethnic variability in decision-making and conflict resolution (Cromwell & Cromwell, 1978). Although some of these generalizations about Latino culture may by a useful framework for exploring issues related to
marital abuse, these cultural values are likely to be influenced by country of origin, as well as generational and acculturation differences.

Immigration and acculturation issues

The powerful effects of immigration and acculturation on Latinas must be considered in understanding Latino experiences. Ruiz (1977) argued that many Latino immigrants arrive with the expectation of a better life which eventually gives way to the realities of prejudice, language barriers, and poverty. He argued that this disillusion and culture shock cause incredible stress within immigrant communities. Curtis (1990) argued that acculturation can cause important personal and intra-family problems. He discusses how minority groups tend to incorporate the negative value judgments of the dominant culture, which results in lowered self-esteem and the potential for increased conflict. Martínez (1988), on the other hand, argued that the effects of immigration are not necessarily predictable or negative. Immigrants come to this country with different backgrounds and expectations, and their experiences are equally varied.

Cultural transitions may also create significant social stress, personal and intra-family problems which may lead to the use of violence. For example, family conflict may arise because of uneven acculturation of family members, particularly of spouses, which can lead to frustration (Jalali, 1988). Based on her clinical research with abusive Latino families, Florez-Ortiz (1992) developed the idea of "cultural freezing" in which families develop rigid, stereotyped values and behaviors as a result of a difficult acculturation process. Freezing may occur when a woman's desire for greater independence is construed as a failure of family unity, and thus a failure in
her gendered and culturally prescribed duties. The man may feel entitled to punish her in the interest of keeping the family together. Because of the socialization of Latina women, they feel compelled to remain in the abusive relationship and preserve the family unit. Although these forces are not universal for Latino immigrants, they may play a significant role in contributing to marital violence.

Racism and racial discrimination serve as another source of stress for Latinos in this country. The 1991 National Opinion Research Center's General Social Survey found that 50% of whites thought Hispanics were more prone to violence (than not), 74% thought that Hispanics preferred to live on welfare, and 55% thought that Hispanics were less intelligent (Asbury, 1993). Although this pervasive racism takes a tremendous psychological toll on its victims, it is the institutional racism that operates to create a social situation that denies Latinos access to economic and educational opportunities. Clearly these socially oppressive forces affect the experiences of both immigrant and U.S.-born Latinos.

Marital violence among Latinos: social and cultural forces

It is likely that cultural values and social forces play a role in the occurrence of marital violence among Latinos. Although the question of whether machismo and the Latino patriarchy predispose husbands to physical abuse has not been addressed in research, assumptions to this effect are often made (Staples & Mirande, 1989). In response to these assumptions, Mirande (1985) argued that although men may have more authority in families, men who abuse their power and authority through domestic violence lose respect
in the larger Latino community (Mirande, 1985). Thus there are strong cultural values that oppose domestic violence and serve to prevent abuse.

Familialism may operate as a protective factor and source of help for abused Latinas. The social support provided by extended family, the Catholic church, and the collectivism of the Latino community potentially serves as a buffer from social and economic stresses. In addition, the strength and pride of the Latino community may serve to discourage domestic violence. In theory, the amelioration of these stresses and discouragement of abuse and violence may play an important role in decreasing the prevalence of wife abuse.

Although cultural forces may contribute to some of the differences in marital violence, social and economic forces are likely to play a significant role in increased rates of marital violence. It is commonly accepted that economic deprivation can create intra-family conflict and lead to higher rates of violence (Straus & Smith, 1989). The 1988 census data demonstrated that compared to non-Hispanic whites, Hispanics tended to have lower levels of formal education, greater unemployment, and higher rates of poverty (Garcia, 1991). In addition, Latinos face other social stresses including social isolation and ethnic or racial discrimination (Chilman, 1993; Martinez, 1994). It is likely that these stresses impact the rates of marital violence among Latinos.

Barriers to help for abused Latina women

In addition to important social and institutional barriers, several Latino cultural values have been postulated to impede abused women's ability and willingness to seek help or end the relationship. In particular, gender role expectations may significantly impede abused Latinas' efforts to
seek help. In her research with abused Mexican-American and white women, Torres (1991) found very few differences in terms of nature, severity, and frequency of abuse. However, she did find that Latinas were more tolerant of abuse and perceived fewer types of behavior as being abusive. In another study of battered women’s shelter residents, Gondolf et al. (1991) found that compared to white and black women, Latinas expressed greater tolerance of abuse and devotion to keeping their families together. These authors conclude that Latinas appeared to be "bound by a norm of loyal motherhood" that kept them in abusive relationships (p. 112).

The value of simpatia may also may play a role in making confrontation and the expression of emotions uncomfortable. Ginorio and Reno (1986) argue that Latina women’s modesty and indirect styles of communication may discourage abused women from discussing their concerns publicly. The simpatia of women may make them less likely to be assertive or complain about their situation. Further, some authors discuss the role of religion in encouraging women to accept their “destiny” with resignation (Torres, 1993; Ginorio & Reno, 1986).

Zambrano (1985) cites several considerations related to the value of familismo that may present barriers to women seeking outside help: the stigmatization of divorce and remarriage, the expectation that problems are kept within the family, and the willingness to tolerate abuse for the sake of family dignity. Gondolf et al. (1988) found that compared to abused white and black women, Latinas were least likely to have sought help through a friend, minister, or social service agency. These researchers speculate that this finding is related to the strong value of kinship and family dependency among Latinos.
Another impediment to help-seeking may be the lack of economic opportunities for abused Latinas. Gondolf et al. (1988) found that compared to abused white and black women, abused Latinas were married the longest, and had lower formal education, employment, and job status. Rivera (1994) argued that within the Latino community, women’s identities are typically defined by their roles as mothers and wives, which denies them access to individuality and social power. Thus not only are fewer opportunities available to Latina women, but the cultural mandates regarding women’s roles and identities may make them more reluctant to pursue economic self-sufficiency.

Social factors that create barriers to seeking outside help include economic disadvantage, language differences, and institutional impediments (Woodward et al., 1992). Several researchers have examined issues of access to medical care for Latinos. First, Latinos are more likely to be uninsured; over 30% of Latinos lack medical insurance, compared to 13% of whites (Torres, 1993). Second, Latinos face language barriers in seeking medical, social, or legal services (Woodward et al., 1992). Third, lack of consumer knowledge about resources and services contributed to decreased utilization (Giacheilo, 1985). Fourth, inconveniences such as long travel distances, long waiting times, and brief visits with doctors discourage use by many Latinos (Giacheilo, 1985). And finally, the lack of a culturally relevant setting and culturally sensitive providers decreases utilization of health services (Woodward et al., 1992).

Further, in cases where immigrants are undocumented, they often do not seek help because of concerns about deportation (Jang et al., 1990). These concerns may be heightened in abused women who are dependent on their
husbands for their citizenship. In fact, the threat of deportation is a form of abuse in itself. Although local law enforcement authorities have no duty to enforce federal immigration laws, undocumented women face the fear that they will be reported if they seek criminal or civil legal assistance. In addition, these women are typically ineligible for public assistance and face employment barriers that perpetuate their economic dependence on their abusive spouse.

In 1990, Congress amended the marriage fraud provisions of the Immigration and Nationality Act to provide waivers for abused immigrant women who entered into marriage in good faith (Crenshaw, 1993). Although this provision may provide relief for some abused immigrant women, it has several limitations. First, many immigrant women are unaware of this option or are dependent upon their husbands to navigate the legal procedures. Second, obtaining this waiver requires written documentation of the abuse, generally from police, medical, or social service agencies. Because many immigrant women have limited access to these resources, obtaining the documentation may be difficult.

Another important factor is the culturally based expectation regarding the quality of care. Curtis (1990) discusses the Latino value of personalismo, which includes both a sense of personal rapport and an emphasis on trust and reliance on people as opposed to institutions and organizations. Because Latinos have a strong sense of self-respect and dignity, they expect that others will show proper respect. This kind of personal informality may conflict with more formal notions of professionalism and create barriers to services. A related problem relates to the value of respeto, wherein professionals are viewed as the authority. Giachello (1985) argues that this value creates
distance between the patient and provider, lack of rapport, and failures in communication. This distance is exacerbated by the common practice of assigning different doctors to patients for different appointments.

Overall, there are many cultural and social factors to consider in attempting to understand the context in which abused Latinas seek outside help. To date, no research has been undertaken to address their perceptions and experiences regarding medical care. The following data were selected to represent the main themes discussed in groups of abused Latinas.

VOICES OF ABUSED LATINAS

The data presented here were taken from two focus groups with 16 Latina immigrant women from Mexico, El Salvador, Guatemala, and Columbia (see Appendix D-3). These women had been in the U.S. for varying lengths of time (2 months to 15 years; median 6 years). They were recruited through two battered women’s shelters. Their ages ranged from 27 to 50 years; median age was 34.5 years. Although their range of formal education was broad (none to college graduate), the majority of women (11/14) had not completed high school. The median number of children was four. Many were still living with their abusers when the focus groups were conducted.25

The women discussed their experience with marital abuse which ranged from verbal and psychological abuse to severe physical violence. Their experiences with the police, social services and the medical care system varied significantly. The majority of women reported direct contact with the medical care system in seeking both primary care and emergency care. The

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25 These data regarding their relationship status with the abuser were not systematically collected, rather they were derived from informal discussions with participants.
women identified many factors that influenced their willingness to seek medical care and their experiences in the medical care system. These factors were divided into four broad categories: immigrant barriers, health care system barriers, cultural and social barriers, and patient-provider relationship issues.

**Immigrant barriers**

As immigrants to this country, many of the participants faced significant barriers to seeking help for problems related to marital abuse. Although many were bilingual, the majority discussed how the language difference creates barriers. Many discussed the difficulties finding Spanish-speaking social services and adequate translators in medical services. Another problem encountered was the miscommunication and the distance created by having to speak through a translator to a provider who could not speak their language.

Language is a very important factor. It’s very important; not because you don’t trust what they don’t translate but because when a third person is used, you lose that contact which is very much a part of us, and it puts more distance between the physician and the patient. (1.1305.Ez)

For newly arrived immigrants, the social isolation and lack of information about community services presents an important barrier to seeking help for marital abuse. Many women left their families and social support networks behind when they migrated to this country.
When I first came to this country, I felt so depressed, but so depressed, without knowing anyone. I imagine that like the others, I was crying all the time, well, [being] very depressed. (3.430.A)

In my case, I tolerated it for a long time because of fear of getting pregnant quickly, because I didn't know where to go, I didn't have any family, I didn't have. I didn't know about shelters or any of that. (1.164.X)

Yes, that is our problem, when you arrive here, you don't know anyone, so who are you going to tell? You have to keep your problems to yourself. That's why you get depressed because you don't have anyone you trust enough to confide in. There's no way you're going to call home to tell of all the things [problems] you have here. (3.353.M)

The Latinas who were undocumented faced the added fear of being deported. Some were unaware of their right to legal protection. Others feared seeking health services would lead to deportation. Thus they felt trapped in their abusive relationships.

... it's fear, and one of them is the fact that you're here as an immigrant, as an undocumented in this country and you believe that the moment you are going to ask for help, they're going to return you to your country and that's something that perhaps we as Latinas see ourselves obligated to tolerate this type of violence due to the fear of being
deported, or for the fear that they'll take away something which is still our right to keep... (1.183.X)

One woman believed that she did not have a right to receive social services because of her status as an illegal immigrant.

I never knew about a place, a shelter or anything about that, I believed that for being illegal, I didn't have a right [to those services] either. (1.528.S)

Health care system barriers

Entrance into the medical system was hindered by economic concerns as well as frustrations with long waiting times and poor service delivery. Several participants discussed times of economic hardship that precluded seeking medical or social services.

[My friend] told me 'We'll seek professional help.' To seek professional help in this country is very difficult because you need money to maintain the medical services. 'No,' I said, 'I don't have money. I can't.' (3.372.T)

When free or low-cost services were obtained, the women were frustrated by the long waiting periods and the inadequacy of the services provided.
[It was] twelve at night and at two in the afternoon the next day I was still there [in the emergency room] and they hadn't done anything to me.../.. and so I said, "I better go," and I went. I had been there a long time and they did not attend to me or anything so it was better for me to leave. (1.885.G)

If you go to an emergency room, you don’t know if you’ll be in the hospital all day and sometimes it happens that they don’t even attend to you. They leave you there and sometimes if you go and ask, "When are they going to attend to me?", they say, "It’s that there are patients who are grave[ly hurt] and you’re not. It’s better if you wait or if you want, go home and come back tomorrow." That’s what they tell you, and if by chance you come to see a doctor, they are always very busy. They don’t have the time to dedicate to you and so they ask, "Where does it hurt? What’s the problem? You need some tests." They do the tests. "You don't have anything, it’s the stress. You don’t have anything. Look, your tests are fine. You don’t have anything. Go home. Good-bye." (3.1108.M)

Family obligation and tolerance

Many women discussed how the traditional role of women, marriage, and the family in Latino cultures influenced their reaction to their abuse. Particularly in relation to help-seeking and leaving the abusive partner, participants discussed the pressures and desires to keep the family together. Loyalty to the husband, beliefs that children need to live with their father,
and the stigma of divorce lead to a certain level of acceptance and self-sacrifice on the part of Latina women.

Women in both groups cited the welfare of their children or the importance of keeping the family together as a reason for not ending the relationship. For many women, these cultural values led them to be more accepting of the violence and mistreatment in their lives.

Many times in thinking about the children's well-being or because you miss being with that man, or you're going to call him, you put up with a lot of violations. (1.380.X)

Many women felt that marital bonds were sacred and lifelong. They felt a strong loyalty to their husbands. Some of the loyalty was derived from beliefs about traditional gender roles. In other cases the women were economically dependent on their husbands.

No, if I don't have a job I cannot leave him [inaudible] because if I'm going to leave from here, it's to better the situation. because the children always say 'I love my papa, I don't love only you.' (1.225.Ev)

Some women expressed their love and compassion for their abusers. This devotion often prompted them to protect their abusers.

... we are... so much in love with love that for the sake of love, we're capable of covering up for our husband. we don't report him so as to not have problems with him... (3.1478.A)
For many women these cultural values led them to be more accepting of the violence and mistreatment in their lives. Some believed that marital abuse is a "cross to bear" and should be tolerated for the sake of keeping the family together. Some felt that they did not have the right to complain, protest, or seek help.

I didn't know. In my country there exists only sexual violence but violence between a couple doesn't exist because...we're taught that that's a cross we have to bear with our husband. (1.724.N)

...we become wives and the barrier breaks and then one is not a wife, one is there in the home because...it's an obligation that you have...and it's like everything, like everything, one puts up with so many things because...that's how you have it... (3.1902.A)

I did hide something, or rather the problems I had in my house one time because in my country, they don't pay attention to the problems one has with their husband. It wasn't a violence of blows like that, but it was an emotional violence, rather at times they force you to do something you don't want to do, but you know that you don't have the right because of the cultures you have, you don't have the right to say 'I won't do that because I don't want to.' (3.1233.A)

One women eloquently described the role of societal violence in creating greater tolerance among abused women.
We live in such a violent environment that we allow and permit and continue permitting this type of violence to live, I don't know... let's say historically since we live in a violent country in all its expression and so many times we live with violence without realizing that we are dealing with it day to day, minute by minute... (1.820.Ez)

Another element that motivated some of the women to protection their partners was the fear that the violence would escalate. Obviously this fear is based more on the relationship with the abusive partner, than the cultural mandates of loyalty and obligation.

I wanted to say that we live sometimes threatened: they always tell us, even threaten us with death, tried several times even with the children and all but... what I say many times we go back because of the fear... (1.850.X)

We have ...//.. to defend our husband so that they don't put him in jail or if they do put him in [jail], that they don't blame you, because when he gets out, you're afraid that he'll hit you or something... (3.1626.L)

It is important to understand the relationship between these barriers and medical system responses to abused Latinas. First, the barriers to ending the relationship are often the same barriers to seeking help or confiding in a health professional. Second, providers should have a deeper understanding.
of these personal and cultural issues so that communication and intervention can be improved.

Patient-provider relationship issues

Perhaps the most pervasive topic in these focus group discussions was the patient-provider relationship. Many women discussed negative and even abusive encounters with American doctors. For the most part, the participants had high expectations of medical providers. They believed that it is the provider's responsibility to establish rapport and tend to patient's emotional and psychological needs. In relation to wife abuse, most women believed that providers should take the initiative to inquire about abuse and offer advice and referrals.

There were two recurrent themes in discussions of patient-provider interactions: distance and trust. Many women felt that there was great social distance between the doctor and the Latina patient that interfered with open communication and comfort on the part of Latinas. Although they were very sensitive to class and ethnic biases on the part of providers, they also believed that much of this distance was derived from the professional standing of the physician.

... the doctor should be a friend of the patient, but there exists this barrier which is he is the doctor and you're the stranger, the visitor, the inopportune one. All these barriers you feel because that same doctor gives you this impression, you can't exactly say all the symptoms.

(3.1664.T)
One woman believed that doctors' behavior and attitudes contribute to this social distance that Latinas perceive.

The doctors should be a little more human, because when they arrive at the office or at the place of work, it's as if they harden and I don't know whether they have a reason to or not, but from my point of view they should be more human because you run into people who are very hard. (3.1511.M)

I think it's important that the doctor see us as people, not like... we're his patients but... he feels superior to you, I think, I don't know, and so this also bothers you. because sometimes the doctor says, "What is wrong, ma'am?" or "What is going on?" And one feels as if the doctor is talking as if he is superior to you. (1.1486.G)

Some participants cited economic or class differences as important barriers to a balanced relationship. One woman discussed being treated badly because she was poor.

I will never visit a doctor again, better that I cure myself. Because they behave badly, badly, badly, definitely badly. Perhaps because one does not have money, I imagine that with a person who has a higher economic position than you, they are not going to behave like this. (3.1369.T)
Another barrier that some participants encountered was cultural distance between patient and provider. Some women felt misunderstood.

I do not trust doctors. .../... Because unless they give me a Latino .../... they're not going to be interested in my problems really, although for one or another thing, perhaps because we don't belong to the same race, perhaps because they do not speak Spanish well like us, we're Latinos and we have words that they don't know .../... for not knowing anything about me, then I do not trust any doctor to tell them... (3.1067.L)

Other women felt discriminated against on the basis of their ethnicity or immigrant status.

... they're not capable of asking if you have a problem in the house, no, they don't ask you. And I think they should at least try to be more human, because they use a lot of discrimination because you're Latino and you notice the difference when an American arrives, they behave very kindly, "No, go ahead, sit down," and you're so aware of the difference, the brusque change of how they treat you and how they treat the others. (3.1385.M)

If they didn't distinguish races, if they treated us equally because we are all equal. Not because they're born in this country, we're all human beings. (3.1523.C)
Two different women discussed instances in which they felt physically abused by medical providers.

I was eight months pregnant when I went to the hospital. A physician put his hand in me. He brought in another physician who put her hand in me, and then another until five had done this. I think it shouldn’t be this way. It hurts when one is examined too much. (1.1636.Ev)

I became pregnant when I was 17 and went to the hospital for a Pap smear. The doctor put his fingers in me, with gloves, right, then he asked me, “What did you feel? Pain or pleasure because I put my finger in you?” I felt ugly, it hurt, and he said, “Oh, I thought that you had enjoyed it.” (1.1582.G)

The second theme in discussions about patient-provider interactions was trust. The Spanish term *confianza* was used repeatedly to describe the constellation of trust, confidentiality, comfort and safety that was critical for creating rapport. The participants wanted providers to be patient, attentive, compassionate, and trusting.

One of the obstacles I believe, is language. Many times there isn’t a volunteer who can help us and we don’t have trust (*confianza*) because we can’t tell [the doctor] what we feel, what is happening. (1.1220.X)
... it is uncomfortable that they ask you, "How are you?" without even looking at the expression in your eyes. "Ah yes, sit here, change your clothes." It's an attitude that inhibits you from saying what really happened. Sometimes you don't even tell the truth so as to leave the situation because you're already depressed, sad and bored. You feel abused and apart from that, there isn't anything like a support. It's that many times a look is a big support for you... to know that somebody is paying attention. (1.1503.R)

... the doctor is who has to take the initiative so that the patient trusts the doctor, but the doctor beginning little by little... to ask light questions, how do you say [inaudible] small questions first so that you say [to yourself] "Oh, this doctor wants me to trust him." Then you say, "We can trust each other." So that we're going to explain really what you suffered at that time. Because many times, one doesn't have trust (confianza) with the doctor, nor the doctor with you... (1.1172.G)

I think that the doctor, first of all, should take the time to establish a rapport, ask what is happening, be interested in why you feel bad, why you're battered [inaudible] time and trust to interest himself/herself in your problems. (1.1460.I)

Some women felt mistreated by providers who focus only on physiological problems and ignore social and psychological problems. Many participants believed that treating only the physical injuries and illness or prescribing sedative and pain medication undermines the patient-provider
relationship, particularly when patients require compassion and psychological support. Further, this approach to treatment engendered mistrust of the medical system for many Latinas.

I don't tell this to anyone and yes, I miss having someone, a friend, but the doctors don't inspire trust to be able to talk to them, nor the nurses or anyone because they... you go to the clinic or someplace else and the only thing they do is check you well here and there. (3.307.L)

I saw the doctor that night and when he arrived, he examined me: 
"You're fine, only a little bit agitated. So that you can sleep here is a little pill to calm you down and a little pill for the pain so that you feel better."... This is lack of professional ethic. I was disappointed. I will never visit a doctor, I better cure myself." (3.1350.T)

I think that a doctor can really help a woman who comes to ask for help in terms of a physical cure, but the doctor should also pay attention to her emotional malady... 3.1434.A)

Most participants believed that medical providers have an important role in assisting abused women patients. Specifically, they discussed the role of the provider in inquiring about abuse and providing interventions. Some women discussed experiences in the medical system in which they were never asked about the sources of their injuries or whether they were having a problem with marital violence.
I went [to the hospital]... they took x-rays and the doctor told me I only had blows and I said all the places where I had been hit but I didn't say that he had punched me in the head...//... The doctor asked, "Does it hurt here? Does it hurt there?" I had already told him many places, so, so, for that I didn't say... because of shame or what? Or because he didn't ask, "Does it hurt here?" because he only asked me about there... maybe it was because of his embarrassment or my shame of not telling all that I had... (1.895.G)

Yes, I agree that it would be the first they should ask, because the doctors are too curt, too short, yes, like they said to her, if more than one time they've told you, they look at everything and that's it... they open the door and you go, but they're not able to ask if you have any problem in the house... (3.1378.M)

The majority of women agreed that it is appropriate for medical providers to take the initiative in asking patients about marital abuse.

... if he would have asked me I would've answered where it hurt me or where he had hit me, so I say that it's very important what he finished to advise. Yes, it is very important that the doctor takes the initiative, I say that this is very important... (1.1943.G)

If the doctor is willing to ask for an explanation for the symptoms, I think this is very important. I realize that it is not his sole responsibility, but he could give us a referral for a doctor who deals
with our problems - which are own mental and emotional health - I don't know but I think it's partly if he takes the time that I know is limited, he's very busy, but he can. (1.1145.N)

Even if there are no physical injuries or medical complaints related to abuse, participants believed that providers should inquire about abuse.

In the first appointment with a doctor, you are asking if it would be good that the doctor, even though you are physically well, should ask about whether there is domestic violence in the house? I think so. (1.1793.X)

Participants believed that medical providers have a responsibility to provide referrals to community services to help abused women patients. Receiving support and compassionate advice from providers was also seen as beneficial.

I think that it would be good because part of one's physical health is in your mind. If you have problems, you're not going to feel well. Although the doctor is not for that, he can orient you in telling you what you can do to feel better or where to go. (1.1157.I)

I think that [the doctor should] give support to the person and... as I said before, give a reference so that the person can think about therapy, so that a person can feel more comfortable, more [willing] to take the time to express their problem so that person who is going to take the
time with her [inaudible] we know that the doctor isn't going to have all the time for this role but then he should refer us to a place where these people can go for more time. (1.1471.N)

One woman discussed a very positive experience that she had with a doctor who listened to her problems with compassion and offered help and referrals.

I felt comfortable because he [the doctor] saw that the problem wasn't that. "Your blood pressure isn't well, I want to say something... how are you feeling? Have you been having some problems these days?" Then he said, "[If there's] a problem, tell me." And I said that yes I had a problem and this is happening to me. .../... He helped me because he gave me a list of places I could stay, another list of places I could get food, another list about support groups... a lot of things, until I felt very comfortable because I trusted him.../... he listens to me as if he were a brother to me and he gives me... he attends me very well, he advises me and gives me good ideas... (1.932.N)

Overall, the participants in this research discussed many facets of their experience and perspectives on medical care (Table 6.2). The decision to seek medical care was influenced by the same cultural and social forces that operate to maintain their abusive relationships: devotion to their husbands and families. In addition, abused Latinas, particularly immigrants, faced significant structural barriers in seeking care, including language barriers, fear of deportation, and economic barriers. Once these barriers were overcome and medical care was sought, the most important factor for Latinas was their
interaction with physicians and other medical providers. The Latina participants expressed a strong desire for compassionate and supportive assistance by providers.
Table 6.2. Summary of key factors identified by the Latina women which affect seeking and receiving medical care.

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CONCLUSION AND IMPLICATIONS

The goal of this research was to give abused Latinas a voice in the education of medical providers and policy makers regarding the needs of this particular group of women. Many of the concerns raised are clearly not specific to abused Latinas; some are generalizable to abused women of all ethnicities (obligation to family and the need for rapport), but some are generalizable to immigrants and other marginalized populations. The immigrant Latina participants identified structural, social, cultural, and provider barriers to seeking and receiving help from the medical system.

The participants faced many barriers as immigrants including language barriers, social isolation, and lack of information regarding available services. Undocumented immigrants faced the additional fear of deportation. Although current immigration law policy allows abused women to obtain a waiver, many immigrant women are unaware of the recent policy changes. Improvements in services to immigrant women will require better translation services in medical care settings. Medical institutions also have a role in developing community outreach directed toward educating new immigrants about their rights and available services. Finally, it is critical that medical and social service agencies establish non-cooperation policies regarding reporting to the federal immigration authorities.

Many participants found that the high cost and/or poor service delivery within the medical system posed a significant barrier to seeking medical care. Abused Latinas who are dependent on their husbands for financial support are particularly vulnerable to these economic barriers. Improving the economic accessibility and quality of medical services would greatly benefit abused Latinas seeking medical care.
Participants in this study identified several cultural, social, and psychological factors that affect abused Latinas' willingness to seek medical care. Many Latinas believed that the culturally supported role of women in being devoted to their husbands and children fostered greater tolerance of abuse and decreased the willingness of abused women to seek help. Comments made by several of the participants suggest that these cultural values played a role in their willingness to seek medical care. These findings confirm earlier work that identified Latinas' sense of family obligation, economic dependence, and tolerance as important barriers to help-seeking (Gondolf et al., 1988; Torres, 1991). It is important that medical providers are sensitive to these cultural forces when dealing with abused Latina patients.

The abused Latinas in this study were highly conscious of their social status in relation to medical providers. They were very sensitive to provider behavior, class and social status differences, and cultural insensitivity that created distance in the patient-provider relationship. As discussed in the background section, *respeto* in relation to authority is an important cultural value (Marin & Marin, 1991); however it was clear that the women in our study desired mutual respect from medical providers. Their anger and frustration with poor quality care and mistreatment were apparent in much of their discussion of interactions with the medical system. Obviously, this type of treatment (for any patient) is wholly unacceptable and reform must involve the highest structural and ideological levels of health care. Further, medical services to Latino communities may improve through increased training of Latino/a providers and cultural sensitivity training for non-Latino providers.
The sense of trust, or *confianza*, in the patient-provider relationship was very important to the Latinas in this study. This finding confirms previous research on culturally based expectations regarding *personalismo* in the patient-provider interaction (Curtis, 1990). According to the participants in our study, establishing rapport is particularly important for Latina patients who are suffering abuse and feeling vulnerable. Medical providers should be responsive to these cultural issues and expectations by making a concerted effort to provide support and compassion to abused Latinas. In order to elicit full disclosure of abuse, the patient-provider relationship must be built on trust, compassion, support, and confidentiality. It should also be noted that barriers to establishing rapport are exacerbated by the common practice of assigning different doctors to patients for different appointments.

Overall, the participants were able to express and elaborate upon the issues that were most relevant to their lives and experiences in the medical system. Clearly more research is required to confirm the validity and reproducibility of these findings in other groups and to further explore the needs of abused Latina patients.
Chapter 7.
Asian women's perspectives

"Later on when I was more swollen, I told the doctor that I
had fell, but I didn't say anything and no one knew. For
nine years no one knew."

BACKGROUND

Marital violence within Asian families has emerged as an important
issue for Asian women's activism (Lin & Tan, 1994). Within the past several
years, battered women's shelters have been created across the U.S. that
specifically address the needs of abused Asian women. Activists argue that
although marital violence among Asians may not be more common or more
severe, there are important cultural and social conditions unique to this
group that need to be taken into account when addressing wife abuse.

In spite of concern within many Asian communities, there has been
little public awareness and almost no research on marital violence among
Asians living in the U.S. Neither the National Family Violence Survey
(Straus & Gelles, 1980; 1989) nor the National Crime Survey (Gaquin, 1978),
the primary sources of prevalence data on marital violence, contained a large
enough sample of Asian Americans to accurately estimate rates in this ethnic
group.

In this chapter, I will explore Asian women's experiences with wife
abuse and the health care system. First, I will provide a broad overview of
cultural and social forces that may operate within Asian family relationships.
Second, I will discuss how these forces potentially affect the occurrence of wife abuse and Asian women's responses to it. Finally, I will present data on the major themes from our research with abused immigrant Asian women. The focus of this analysis will be on attempting to understand the barriers that these women faced in seeking and receiving assistance from the medical system.

Traditional Asian cultural values and norms

It is very difficult to generalize about the cultural norms and values that influence Asian life in the U.S. According to the 1990 census, Asian Americans make up 2.9% of the total population in the U.S.; however their numbers are rapidly growing (Barringer et al., 1993). An Asian American is defined as someone living in the U.S with their origins in Asian countries east of Pakistan and south of Mongolia, including Southeast Asia and the Philippines. Included are immigrants, native-born Americans of Asian descent, students, and refugees. The groups in this category are very diverse and encompass many distinct cultural groups (Fugita, 1990).

Although it is generally unacceptable to lump together Americans of Asian descent in terms of cultural values, exploring the uniqueness of individual Asian cultures is beyond the scope of this chapter. In the generalizations that are made here, it is assumed that Asian cultures have certain common features and are likely to be more similar to each other than to Western cultures. Many specific examples draw upon Chinese culture, not because it is considered to be representative of all Asian cultures, but merely because of the greater availability of research on Chinese culture.
Generational differences, the level of assimilation into Western society, and diverse immigrant experiences further complicate any generalizations about Asian cultural values. In addition to the cultural values that are brought from their mother countries, Asian immigrants face powerful social forces. As immigrants, they face the stresses of acculturation into a new and divergent society. The effects of racism and classism also must be considered in understanding their experiences of assimilation. Overall, these generalizations may be useful in establishing a broad framework in understanding abused Asian women's experiences, but their limitations must be clearly recognized.

Many researchers have argued that one of the fundamental aspects of Asian culture is the value of the family and the collective quality of life (Sue, 1973; Sue & Morishima, 1982; Wu & Tseng, 1985; Berg & Jaya, 1993). As an indication of this holistic view, Berg and Jaya (1993) noted that there is no word for "privacy" in Chinese, Korean, or Japanese languages. In Chinese culture, Confucian ethics dictate that an individual's life and behavior are collective in nature and each individual's primary obligation is to his or her family. The good of the family is the good of the individual. It is believed that the family is inseparable from the individual's behavior and that the individual's behavior represents the collective qualities of the entire family, including ancestors (Hsu, 1985). An individual achievement is valued because it brings status to the family (gaining face), but failure or deviant behavior bring shame to the family (losing face). The Chinese concept of "face" represents the collective presentation of the family to the outsider.

As a consequence of these collectivist values, social behavior is often informed by the pressure to avoid shame (Sue, 1973; Berg & Jaya, 1993). Social
restraints are internalized according to family values, such that arousing feelings of shame or embarrassment can act as a powerful means of social control (Sue & Morishima, 1982). Traditionally children are socialized against acting independently, or contrary to the parents' wishes, by being told that they are behaving selfishly and not showing gratitude (Sue, 1973). Because failure, delinquency, mental illness, and other dysfunctions are great sources of shame for the family, they are generally kept hidden from the public and managed within the family.

Maintaining harmonious social interactions is highly valued in Asian culture. Berg and Jaya (1993) argued that there is a strong emphasis on form over content in social interactions. For example proper protocols, procedures, ways of addressing others and showing respect are important in maintaining social harmony. This conformity to sociocultural norms of conduct is a prevailing force in shaping attitudes and behaviors of Asian people (Sue, 1973; Wu & Tseng, 1985). Children are trained to adhere to socially desirable and culturally approved behavior. Confucian ethics emphasize order, hierarchy, and obedience to authority in all social relationships, which must be maintained through proscribed behavioral norms.

Because unrestrained emotions are believed to disrupt social situations, Asian children are socialized to control their emotions. Thus, self-restraint is considered an important aspect of Asian character development (Sue, 1973). Quiet stoicism is highly valued as a means of dealing with adversity in life and the capacity to suffer is admirable (Berg & Jaya, 1993). Further, it is believed that having excess negative emotions, particularly aggression and anger, actually endangers physical health. In Chinese culture,
even caring and loving emotions are often not expressed in words, but rather as concern and caring for another person's physical needs (Hsu, 1985).

Family bonds are a vital source of social support and security in the lives of the individual family members. In China, when families are separated because of disaster or immigration, it is not uncommon for individuals to reconstruct a kinship, sometimes with other relatives or friends, and even with total strangers (Xintian, 1985). Traditional Asian families have been characterized as large and extended, often including several siblings and other family members of two or more generations. In the U.S., a significant proportion of Asian families live with at least one relative (cited in Carmen, 1991). Sue and Morishima (1982) argued that extended families and strong family ties "enable the individual to share problems, to have affective needs satisfied, and to have a sense of belonging and continuity." As such, they may serve as a powerful personal resource in combating social stress and mental illness.

For men, blood ties are considered more important than marital bonds. Hsu (1985) relayed a Chinese maxim: "Siblings are hands and feet, while wives are only clothes." Men are expected to have loyalties to parents and elder relatives if conflict should arise with a spouse. In addition, children are highly valued and receive the best care possible, materially and spiritually (Xintian, 1985). Children tend to be indulged, and physical abuse is not tolerated (Sue & Sue, 1973). In spite of what seems like a lesser value placed on vertical ties, marriage is considered to be serious and sacred. Divorce is uncommon and highly stigmatized, especially if children are involved (Xintian, 1985).
Traditionally, the distribution of power in families is based on
generation, age, and gender (Hsu, 1985). These values are dictated by
Confucian role definitions that are hierarchical and patriarchal (Carmen,
1991). In this system, the eldest male of the top generation has the ultimate
power to make final decisions. Women are given low status in this
hierarchy. According to a Confucian saying about the three pathways of a
woman, "in her youth, she must follow her father, in her adulthood, she
must follow her husband, in her later years, she must follow her oldest son."
(Ho, 1990). As a result of this predetermined hierarchy as well as the
emphasis on maintaining social harmony through self-restraint, family
communication patterns tend to be non-confrontational and conciliatory for
those at the bottom of the power structure (Hsu, 1985).

Asian women have traditionally been delegated a lower status than
men (Fujitomi & Wong, 1973; Sue, 1973). Historically, sons have been highly
valued over daughters, and women have faced discrimination in education
and employment. In traditional patriarchal Chinese culture, women were
expected to forfeit their blood ties when they marry. Women were expected
to be submissive, obedient, and carry on domestic duties. After marriage,
women were expected to be devoted to their husbands' parents and family
and to bear children, especially males (Sue, 1973; Sue & Morishima, 1982).
Although many of these gender role expectations are changing with
modernization and with acculturation into Western society, the remnants of
these attitudes still exist.
Immigration and acculturation issues

Immigration and acculturation involves adaptation to a new and alien culture, facing potential changes in family roles and social relationships, and often the interruption in the support of the extended family network (Jalali, 1988). Significant stresses for Asian immigrants also include the migration itself, culture conflict, and discrimination (Carmen, 1990). These stresses brought on by immigration may play a significant role in creating conflict within families and between spouses.

One author argued that the stress of acculturation is related to faulty and inadequate participation in the symbolic meaningful system of the host culture (Jalali, 1988). These cultural symbols include language, nonverbal behavior, concepts, objects, and events that provide a set of criteria against which one's behavior and experiences are evaluated and conceptualized. Although all immigrants face the challenge of learning about and adapting to these cultural symbols, Jalali (1988) argues that Asian immigrants have a more difficult time because Western cultural norms and values are so dissimilar to their own.

Family conflict may arise because of uneven acculturation of family members. Uneven adaptation of spouses may lead to "resistance to change, polarization in their values and norms, and at times dramatic clashes of personalities." (Jalali, 1988). Conflicts regarding sex roles can create significant problems in marriages. Sue and Morishima (1982) speculated that the changing attitudes and behavior of Asian women as they acculturate into White American society, threatens the role of Asian men. Research has shown that in contrast to Asian men, Asian women are more progressive in their view of husband-wife relationships (cited in Carmen, 1990). In addition,
Asian women may be more dissatisfied with the sex roles accorded to them in traditional Asian cultures and seem to acculturate faster than men (Sue & Morishima, 1982). Some have argued that the differential acceptance by Americans of Asian women over Asian men may create jealousy and serve to divide men and women (Fujitomi & Wong, 1973). These issues may contribute to conflict in marital relationships among Asians.

An important aspect of immigration to the U.S. involves encounters with racism and stereotypes. Jones (1972) argued that many forms of culture conflict are actually manifestations of racism, because in many ways assimilation is forced by a more powerful group on a less powerful one. As immigrants, Asians are constantly bombarded with messages about what constitutes superior values, behaviors, and traits by a society that has low tolerance for cultural diversity. By accepting these norms and personal attributes as superior, individuals may develop a kind of racial self-hatred and low self-esteem (Sue, 1973). This transition can cause intense social stress and conflict.

Asian Americans also must contend with powerful stereotypes within American society. In general, Asians are viewed as passive, quiet, deferent, achievement-oriented, thrifty and in some cases ciannish and untrustworthy (Sue & Morishima, 1982). Asian women are seen as domestic, obedient, submissive, sexy and exotic. The accuracy or inaccuracy of these stereotypes is less important than the value judgment assigned to particular characteristics. Stereotypes tend to adversely affect individual self-esteem, limit behavioral options, and influence social interactions. Clearly, stereotypes can be an important source of personal frustration.
More blatant forms of discrimination and racism are also encountered. Asian Americans have a long history of mistreatment, hardship, and discrimination in American society (Takaki, 1989). Many Asian immigrants have formed protective communities to isolate and protect themselves from this oppression. In spite of statistics that show that Asian Americans tend to have lower incomes and higher rates of unemployment compared to white Americans, they continued to be portrayed as successful and well-assimilated (Sue, 1973). The myth of the "model minority" has served as a means for mainstream American society to deny the racial obstacles that Asian Americans continue to face.

Research on violence and abuse in Asian families is limited. Not only are prevalence and incidence data limited, there has been little research on the causes of, circumstances around, or cultural influences on marital violence. In spite of this scarcity of research, activists and professionals have speculated on particular cultural and social issues that may be relevant to abused Asian women, particularly immigrants.

Marital violence among Asians: cultural and social forces

There are several aspects of traditional Asian cultural values that may operate to exacerbate or alleviate the occurrence of wife abuse. Norms that inform gender roles, family and community structures, and individual behaviors are likely to affect marital dynamics. Further, as discussed above, immigration and acculturation forces are likely to bring many economic and social stresses, including discrimination, sex role changes, and loss of family networks. These stresses may increase intra-family and intra-parental conflict and contribute to abuse.
One aspect of Asian culture that may contribute to the abuse of wives is the hierarchical and patriarchal family structure and the devaluation of women. Although American feminists have established theoretical and empirical connections between marital abuse and patriarchal social attitudes and power inequities within families (Martin, 1976; Walker, 1979), few discussions of wife abuse within Asian families have included commentary on these cultural values. Some activists have argued that this lack of criticism stems from the concern that it will confirm negative stereotypes and create gender-based divisions within Asian communities (Lin & Tan, 1994).

Certain cultural values may serve to reduce or discourage marital abuse. Extended families and social support networks may create a buffer for social stress and serve to monitor marital behavior. In addition, the culture values of stoicism and controlling emotion (especially anger and aggression) may make husbands less likely to abuse their wives.

In an attempt to begin to document marital violence against groups of Asian women, Song (1986) conducted a survey of 150 immigrant Korean women in Chicago. She found that 60% reported physical abuse. She found that the incidence of abuse was correlated with having rigid Korean sex-role attitudes that embrace a subordinate status to women and condone violence to enforce this status. The stresses of acculturation, specifically language problems and social isolation, also were correlated with wife abuse. She found no correlation with socioeconomic background nor employment status of the women. This study confirmed the relationship between particular cultural values and the occurrence of marital violence among Koreans. Further research is needed in other Asian groups to explore these correlations.
Barriers to help for abused Asian women

Abused Asian women face many potential barriers to seeking outside help. Some of these barriers may be related to cultural norms, but others are institutional or related to immigration issues. Impediments that may be related to cultural values revolve around issues of saving face and the subordinate status of women. Asian women are likely to hide their victimization to avoid bringing shame upon herself or her family (Crites, 1990). Because family dysfunction and conflict are considered shameful, many problems are expected to be managed within the family. These strong family networks may operate to minimize a problem like marital abuse and impede a woman's attempt to seek outside help. The fear of ostracism, particularly surrounding a divorce, is an important obstacle to taking action against the abuse.

The subordinate status of women in Asian culture may make women more tolerant of marital abuse. Women's desire for harmony and order, particularly within the family, along with the appreciation for stoicism, combine to make them reluctant to seek outside help. In addition, the assertiveness necessary to seek help or file for divorce is contrary to the Asian values of passivity and submission (Crites, 1990). The unacceptability of divorce in the Asian culture also contributes to women's tolerance of abuse. Divorce not only violates several cultural values, including stoicism, submissiveness, and selflessness, it brings shame upon the woman's parents. Further, divorced women are often considered no longer marriageable.

Ho (1990) conducted focus group research with Southeast Asian immigrants to explore culturally based power differentials, attitudes toward
physical violence, and factors that may influence a woman's ability to leave an abusive relationship. Her research confirmed predictions that traditional Asian values of strong family ties, harmony, and order may serve to impede help-seeking rather than to discourage the abuse. Furthermore, she concluded that women's internalized values of perseverance and self-reliance reduce the incentive for abused women to change their situations.

Research on barriers to medical services, although not specific to abused women, has uncovered factors relevant to Asian Americans. It is well-established that many types of social, legal, and medical services are inaccessible to non-English speaking immigrants because of language barriers (Lin & Tan, 1994). In addition, research on access to mental health services has shown that the lack of knowledge about services, economic barriers, and the lack of culturally sympathetic providers were significant barriers to seeking medical and mental health services (Fugita, 1990). It is likely that these factors also play a role in impeding abused Asian women from seeking help.

As discussed in Chapter 6, undocumented immigrant women often do not seek help because of concerns about deportation (Jang et al., 1990). These concerns may be heightened in abused women who are dependent on their husbands for their citizenship. In addition, barriers to employment and public assistance perpetuate their economic dependence on their abusive spouse. Although the 1990 amendment to the marriage fraud provisions of the Immigration and Nationality Act provided waivers for abused immigrant women (Crenshaw, 1993), many women are unaware of this option or are dependent upon their husbands to navigate the legal procedures. Further, obtaining this waiver requires written documentation of the abuse, generally from police, medical, or social service agencies. Because many immigrant
women have limited access to these resources, obtaining the documentation may be difficult.

Clearly, both cultural norms and barriers posed by immigration create important obstacles to help-seeking on the part of abused Asian women. Norms that dictate a woman's behavior and family role, stoic tolerance of adversity, and responsibility to uphold family honor may create internal conflict and fears of ostracism if outside help is sought. Further, their marginalized status as immigrants, language barriers, and lack of knowledge about the services available contribute to their isolation.

VOICES OF ABUSED ASIAN WOMEN

Our study population consisted of 14 Asian immigrant women from China, Korea, Taiwan, Vietnam, and the Philippines who have lived in the U.S. from 1-22 years, median 10 years (see Appendix D-4). These women were recruited through two battered women's shelters. Their ages ranged from 22 to 43 years with a median of 34 years; median number of children was one. Although formal education levels ranged from elementary level to college, the first group consisted primarily of women with elementary level education and the second group consisted primarily of women with college education levels.

These women experienced a range of abuse from psychological and verbal abuse to severe beatings. The health effects discussed included general somatic complaints such as headaches as well as physical injury. Consequently the majority had significant interactions with the medical system. Furthermore, even those who did not have direct contact with
medical providers expressed their attitudes, expectations, and desires about the role of medicine in dealing with issues related to wife abuse.

Immigrant barriers

The most pronounced barriers to health care for the women in our study stemmed from their status as immigrants. Women new to this country were often socially isolated and unaware of the sources of help available to them. The inability to speak English not only added to their isolation but presented obstacles in the health care setting. Fear of deportation was a concern expressed by a few who were undocumented or dependent on their husbands for citizenship. Although some of the data relate to barriers to seeking help from law enforcement, it should be noted that these same barriers often impacted their efforts to seek medical care.

Several women relayed tragic stories of desperately trying to seek refuge from their abusers in an unfamiliar foreign land. These women knew little about law enforcement or their rights, let alone the shelter and social services available to abused women.

When the incident(s) happened I had only been here two and a half months or so. At the time, I didn’t know anything about calling police. After he beat me, I was all alone on the street crying, other people, my friends, helped me call the police. (1.520.G)

Before my husband used to beat me all the time. I would be all bandaged up and was all black and I was scared to call the police. I didn’t know how to call the police. I didn’t know anything. (1.298.Li)
Later she added:

At the time I didn't have any money and I didn't know anything, I didn't know where to go. I didn't know who could help me and I didn't dare to deal with it on my own. I don't have much guts and I'm afraid of things. (1.360.Li)

Another problem faced by many new immigrants was the social isolation of being in a foreign country without family or friends. Some women were completely dependent on their abusive husbands to connect them with the outside world. This isolation not only made them vulnerable to abuse but made seeking outside help difficult.

... after I got here I didn't have too many friends and as a housewife I was always at home. Most of our friends were his friends and from the man's side of the family, so no matter what I said, you know, they usually helped the man. (1.469.E)

For me, I used to have to suffer myself because I don't have relatives here, I don't have many friends because he stopped me to have friends... (2.176.P)

Another woman described the pain and frustration of living with her husband and mother-in-law while suffering abuse.
Especially while I was living with my mother-in-law. You know, I didn't have a job. I just stayed home all day long, almost all day long. It was like going crazy, you know, it was just like hell. Even though my husband abused me, I didn't have any place to go. You know, I just cried in the room and I just prayed, you know? (2.224.J)

As discussed earlier, it is typical in many Asian cultures that women become a part of her husband's family when they get married. And in addition to the isolation of being in a foreign country, many of the participants were dependent on family members that may not be supportive.

Language barriers presented major obstacles for help-seeking for several of the immigrant women in our study. The inability to speak and understand English affected their ability to interact with police as well as their experiences in the medical system.

When I first came I didn't know where to go to and then he beat me and I couldn't bear :: so I fled to the streets to call the police but when the police came I didn't know how to speak [English] and I was scared it was the first time I'd called the police. The first time I was really scared and I didn't know what to say and so I couldn't make a report. (1.245.K)

One woman relayed her difficulty with hospital translator services when she sought medical attention for an injury. She eventually stopped seeking medical care because of this difficulty.
I don't understand Cantonese or English so it was very difficult. They had to find someone who speaks Mandarin and I had to wait for a few hours before... I waited for at least 2 hours... a very long time... (1.760.G)

Later I didn't feel well but I didn't understand English so I told someone at church who referred me to a Chinese doctor in Chinatown and he/she just helped me with some medication. I didn't go to the hospital. It took them a long time to find a translator... it took a long time so I stopped going there. (1.1709.G)

The fear of deportation was discussed by women who were undocumented. Many women believed that if they sought police or medical attention, they would be reported to federal immigration authorities.

If they [the police] came and went I wouldn't know what to do when it happened the next time. At that time I didn't have a green card and I was very scared. It hurt but I tried to endure it. (1.737.Li)

Health care system barriers

Although not a problem specifically related to immigration status, many women were reluctant to seek medical care because of financial concerns. Many women had no money of their own or they did not want to spend their husband's money. In some cases, concerns over medical costs outweighed their pain and suffering.
It used to be that I didn't dare to go to the doctor's or the police. The doctor also cost a lot of money and I didn't want to spend so much money. I just endured it, but then it hurt so much that I could not endure it anymore. (1.720.Li)

I went a few times and they told me that they would need to operate on my nose and I had to pay for it. They said I had to pay first before they could operate. I said I didn't have any money. I was supposed to return on January 17th but I had to pay first up front before they would see me again. But I didn't have any money so I didn't go back. I didn't go back. (1.597.G)

One woman speculated that the high cost of medicine was a significant barrier for many abused Asian women.

I think a lot of people they don't like to tell someone or financially they have no money to go see the doctors or a lot of people, just like she say, a lot of people stay home housewife, that they worry about doctors bills because doctors do charge a lot. (2.738.T)

Shame, tolerance and fear

The second major category of factors affecting access to medical care included those that relate to the women's reluctance to divulge information about the abuse to medical providers. Some of these factors stem from the women's sense of shame and responsibility to tolerate the abuse. Other factors relate more to their reluctance to end the marriage. Because they
believed that any effort taken to seek outside help may adversely affect their marriage, these concerns influenced their interaction with the medical system. Many women in our study held high values about keeping the marriage and the family together, even at high personal costs. In addition, some women felt financially and socially dependent on their spouse, making the prospect of leaving the relationship particularly difficult.

At first when I went to the doctor I said I just bumped myself at home. Later on when I was more swollen I told the doctor that I had fell but I didn't say anything and no one knew. For nine years no one knew... I didn't want a divorce so I didn't tell anyone. I didn't want my family to be separated. (1.1041.K)

Shame and embarrassment motivated many women to hide their abuse. They were ashamed for their husbands' behavior and embarrassed that they were being abused. As discussed earlier, family status and saving face is very important in Asian culture. Marital abuse was viewed not only as shameful, but as a private matter. Furthermore, many women felt some level of responsibility for their own abuse.

... I don't want to tell anybody what's happening. And I feel ashamed to tell anybody what's going on in the house. (2.195.C)

The first time... the first few times he beat me I didn't say anything. I didn't dare to because I didn't want people to say, "Why is your
husband like that." Later on I talked about it after it happened a few times. (1.1031.Li)

If this doctor see the person have a cut or bleeding, they going to ask what happened. You don't tell them they don't know, of course. It's sometimes kind of embarrassing, especially abused by husband. It's kind of embarrassing to tell sometimes. (2.1016.T)

One woman discussed the need for privacy in the medical encounter to help alleviate some of the difficulty in divulging such personal information.

If I had to tell in front of a group then I would be embarrassed. But if each patient has his/her own room then there is nothing to be ashamed about. (1.1316.G)

Another woman stressed the need for empathy in the patient-provider relationship to overcome this barrier.

If you meet a doctor that doesn't start with a concerned approach, you are afraid that he/she is laughing at you and you feel that maybe your situation is not worth attention. That is why I have so seldom gone to the doctor. (1.1612.P)

Interestingly, some women expressed that the sense of shame was more powerful when dealing with a provider from the same ethnic background.
It was so embarrassing I was abusing, you know, from my ex-husband, whatever. I'd rather go to American doctor who doesn't speak Korean. I just feel Korean doctors, this is I think, I feel he's going to look down on me next time. (2.1311.T)

And they [Chinese doctors] look behind you and "Oh, and you come from where? How about that?" Just me. I don't want to want doctor know about where I come from and maybe, they knew some friend they talk about me. (2.1331.M)

Many women discussed stories of treating their own injuries in an attempt to stoically tolerate the abuse. In Asian culture, emotional restraint and stoicism are highly valued. In addition, Asian women are expected to be subservient to their husbands, which may include accepting violence and abuse. Some women used traditional remedies to alleviate their physical suffering.

I didn't go to the doctor because... I only thought of applying some medicinal oil and to endure it because it was like that for so many years. I endured it and went on. (1.654.P)

I was just going to apply some medicinal oil. I didn't want to go. It used to be that I didn't dare to go to the doctor's or the police. (1.718.Li)

The unwillingness to end the marriage or break up the family was a great concern for the women in our study. Some women wanted to continue
the relationship to protect the children. Others feared the stigmatization of divorce and single parenthood. In Asian culture, marital bonds are taken very seriously, particularly when children are involved, and divorce is shunned. In addition, many women were simply afraid of being on their own. In part, this fear is cultivated through cultural mandates about women's proscribed roles in relation to men.

I went to the hospital because I was badly injured and I was carrying a baby. Then I went to the hospital to check because there was a place all black and... I went by myself and they told me that next time it happened I should call the police but I didn't want to cause trouble for my children so I tolerated it. When he beat me I tolerated it for the sake of my children. (1.231.K)

A lot of Asian people they always think this way that even though violent they want to keep the family together because also some people they're thinking if you divorce they look you differently. In the beginning, after I get divorce and I have a friend told me that things like this. She told me she doesn't like her daughter to play with kids of single parents. (2.281.P)

Of course it is better to continue being a family. Besides we even have children. So it was a big decision to come to San Francisco. I was very frightened, very scared. How was I going to find a job with children? (1.482.E)
I didn't know what it would be like if I had to be out on my own. That was the difficulty at the start. I didn't know how to get welfare. I didn't want to make it such a big deal. I didn't know what to do, I didn't know how to find a job, I didn't know anything. I was scared so I stayed on. (1.1077.K)

The fear of further abuse and violence also was a motivating factor in tolerating abuse and withholding information from medical providers.

My husband beat me few times but I did not dare to go to the doctor. I didn't have any money of my own. I was afraid so that the next time he beat me I was afraid to tell anyone because I was afraid that if I told anyone he would beat me again. (1.655.Li)

Patient-provider relationship issues

A third major category of factors affecting medical encounters revolved around the direct interaction with medical providers. The attitude and behavior of the provider were important in making the women feel comfortable enough to discuss their situations. Many women relayed positive experiences in which they believed their doctor to be attentive and caring.

He/she asked me who beat me and I said my husband beat me. The doctor was quite kind-hearted and so I told him/her and she/he gave me a check-up. That doctor was quite good. (1.836.Li)
The doctor never stopped me. He/she would listen to all I have to say and it wouldn't be a problem. He/she would check me here and there and then ask where I was beaten and where it hurt and whatever. Yes, that's what he asked. (1.919.K)

The doctor was quite concerned. My friend spoke for me. Later on he looked at my nose and then asked me if I had been injured in any other places. He was very concerned. (1.1149.G)

Familiarity and a long term relationship with her provider were important elements for one woman. It took her several visits before she was able to trust her physician.

So I said I fell and things like that. That was how it was at first but then we got more familiar and I talked. Every time I went to the doctor it was the same doctor so we became familiar. I saw the same doctor every time, sometimes with a bruise here, or something swollen there. He/she had to ask why I was there all the time. Could it be that I was that clumsy to fall all the time? So the second time I saw the doctor he/she asked me. We knew each other better so I wasn't scared or shy anymore and I didn't know what else to do so I told him. (1.1678.K)

The women in the study were asked generally about the role of medical providers in assessing and intervening on behalf of abused women. The participants were specifically asked about whether physicians should ask
patients directly about abuse. Although most women favored asking, many were concerned that inquiry be sensitive.

It usually happens that you see the same doctor regularly so the next time you go, he/she should ask. Because your expression (literal translation: the color of your face) is different if you are injured from falling down than from being beaten made upset by your husband. So he/she should ask. (1.1212.K)

And I agree with you that it takes some kind of special skill to be able to elicit that kind of information. ..//.. Some way of asking questions that doesn't alienate the victim. (2.987.S)

A few women maintained that responsibility to tell the doctor remains in the hands of the abused woman.

I think when you go to a doctor you talk about abuse by a husband, whatever, and then this time I tell doctor about it. I don't hide anything here. Can I get some help from this kind of problem. I'm hurt. Listen, if I don't tell the doctor he wouldn't know. (2.1174.T)

One woman may have favored direct asking by physicians; however, she was skeptical that it would always be effective. She suffered headaches brought on by emotional stress, but refused to discuss this with her doctor.
I don't want to talk about those problems. I just want them to say, "You have a headache, I'll give you some medicine." (1.1556.La)

When asked why it was difficult for her to tell the doctor that her headaches were caused by abuse, she replied:

I am embarrassed. ... I don't want to talk about this problem. (1.1572.La)

The women generally favored appropriate documentation in the medical records, particularly for legal purposes, as well as referral to shelter services.

It's really hard for people who are victimized to go and prosecute right away so if they have that evidence later on when they feel a little bit better they can do that. (2.999.S)

Our research demonstrates that barriers to help for abused Asian women occur at many levels (Table 7.1). These immigrant women were often unaware of services and socially isolated. Further, economic and language barriers and, for some, the fear of deportation prevented them from seeking or receiving adequate services. The participants also discussed their reluctance to divulge information about the abuse, which stemmed from their sense of shame, responsibility to tolerate the abuse, fear of ending the relationship, and fear of further abuse. The women also identified important aspects of the medical provider's attitude and behavior which influence their ability to divulge sensitive information.
Table 7.1. Summary of key factors identified by the Asian women which affect seeking and receiving medical care.

| Immigrant barriers          | • lack of knowledge       |
|                            | • social isolation        |
|                            | • language barriers       |
|                            | • fear of deportation     |
| Health care system barriers| • economic concerns       |
| Psychological/relationship factors | • shame and embarrassment |
|                              | • tolerance of abuse/stoicism |
|                              | • fear of ending relationship |
|                              |   children/family         |
|                              |   stigma of divorce       |
|                              |   dependency              |
| Patient-provider relationship issues | • fear of further abuse |
|                              | • care and attentiveness  |
|                              | • familiarity/long-term relationship |
|                              | • intervention            |
|                              |   asking                  |
|                              |   documentation and referral |
CONCLUSION AND IMPLICATIONS

Abused Asian immigrant women patients are marginalized based on gender, race, victimization, and immigrant status. To provide appropriate services to these patients, medical professionals must understand the cultural and social forces that influence these women's domestic situations, coping mechanisms, and specific needs. The women in our study discussed personal experiences, perspectives, and recommendations for change. These voices are critical in the effort to reform policy and improve services to this group of women.

By far the most profound barriers to help-seeking revolved around immigrant status. Many of the women in our study were socially isolated, confronted language barriers, and lacked knowledge about available services. In addition, undocumented women believed that they would be deported if they sought formal services. Although current immigration policy allows abused women to obtain a waiver, many immigrant women are either undocumented (and not married to a U.S. citizen) or they are not aware of the recent policy changes. Given these barriers, the medical system has a clear role in improving services to abused Asian immigrants. Clearly, improving translator services is critical. In addition, increasing community awareness of available services and existing policies would likely improve Asian women's ability to seek medical help. Finally, it is critical that medical and social service agencies establish non-cooperation policies regarding reporting to the federal immigration authorities.

Traditional cultural values have a significant impact on Asian women's help-seeking. The participants expressed their shame and embarrassment over the marital conflict, as well as their internalized
pressure to tolerate the abuse. Many women were motivated to tolerate abuse because of their reluctance to end the marital relationship. These concerns are clearly based in cultural values surrounding a woman’s responsibility to her family and saving face, as well as values of perseverance. Although many of these issues are shared by all abused women, Asian women may be more affected by shame and fear of ending the relationship because of their particular cultural influences. Professionals who encounter these patients should have an understanding of these cultural forces and an ability to provide specific services to these patients.

The participants expressed a strong desire for medical providers who were compassionate, respectful, and attentive. Another theme was their preference for a long term relationship with their provider. Because of the cultural influences discussed above, Asian women may require a greater sense of trust and intimacy with their provider in order to discuss issues of marital abuse.

The participants plainly discussed the practical aspects of the role of medical practitioners in dealing with abused women. Many participants stated a preference for provider-initiated questioning about wife abuse. This preference may be based on their own difficulties in initiating such a discussion. Referrals to culturally appropriate social service agencies may require providers and medical institutions to establish stronger connections with the Asian community. Written documentation of abuse-related injuries and problems is essential for this population because their citizenship may depend on qualifying for a waiver to the marriage fraud act. Often medical providers are unaware of these legal implications and uses for medical records.
To develop culturally appropriate prevention strategies, it is necessary to understand more about the causes and circumstances surrounding wife abuse. Although this study was not designed to assess the cultural influences on the occurrence of marital violence, it is evident that the process of immigration and acculturation often creates intense conflict and stress for many Asian families. The exact role of traditional cultural values and these acculturation stresses in contributing to marital violence is unknown. More research is needed to explore these important questions.
Conclusion

As wife abuse gains increasing importance as a public health and medical problem, it is critical to understand the frameworks developed to understand the causes and context of this problem. Throughout this thesis, I have argued that health policy makers, researchers, and medical practitioners should adopt frameworks that recognize the centrality of gender, race, culture, and class in understanding abused women's experiences and needs. In addition, listening to women's voices and eliciting the patient perspective are essential. Even though a detailed review of the health and medical research revealed the need for a deeper understanding of the perspectives of diverse groups of abused women patients, researchers and advocates continue to develop policy and implement screening protocols for interventions that are not informed by the patients' perspectives.

The purpose of the research described in this thesis was to qualitatively explore the experiences and perspectives of a multi-ethnic population of abused women in order to identify the factors that operate at the social, structural, patient, and provider levels to facilitate or impede help-seeking from the medical system. Key features of the research design included an action-orientation, qualitative data collection, community collaboration, and attention to ethical issues in conducting research. Through these research strategies, we were able to identify the barriers to care and approaches for improving interventions at the medical level. In addition, differences in experiences and perceptions among women from different ethnic groups may
serve as a starting point for continued research on the influences of culture and class.

It is a rare opportunity to hear the voices of the people on the receiving end of medical care, particularly those who require care beyond the traditional medical approach. All of the participants in this study were marginalized based on their race, culture, socioeconomic status, immigration status, gender, and/or victimization experience. It is these voices that are most lacking from the policy discussions regarding the role of medical professionals in dealing with marital violence. We believe that the insights gained from this research should have a prominent role in guiding future efforts in improving access to and quality of care for abused women patients.

The role of the medical institutions

The research results from this study have clear implications for policy development, institutional changes, and educational improvements. Participants identified several structural barriers to seeking and receiving quality medical care for problems related to marital abuse. These structural barriers differed significantly by ethnicity and immigration status. With the exception of the white women’s groups, all groups discussed economic and time constraint barriers to seeking medical care. Latina and Asian immigrant women identified language barriers, social isolation, and fears of deportation as barriers to seeking care. African-American women were particularly resistant to police involvement and often postponed medical treatment if they suspected that law enforcement agencies would be notified by the medical providers.
Implications for institutional change to address these barriers include the following:

**Hospital policy**
- enforce guidelines for case identification and management
- triage victims of marital violence to higher priority
- non-cooperation policy with federal immigration authorities
- community collaboration and outreach

**Hospital-based services**
- social workers/counselors/advocates
- translator services

**Education/training curricula**
- patient-provider rapport, special needs of abused women
- sensitivity to marital violence issues
- cultural sensitivity

**Health care legislation**
- oppose mandatory reporting of adult victims of abuse
- oppose barriers to services for undocumented immigrants
- favor increased economic accessibility of health care

Hospitals are in a position to create policy that will significantly improve medical treatment for abused women patients. First, although guidelines for the identification and management of victims of marital abuse have been developed (Flitcraft et al., 1992), they are not widely used in medical practice. These protocols include many of the procedures recommended by the women in our study: directly asking about abuse, recognizing signs and symptoms of abuse, providing referrals to community
agencies, and documenting the abuse in medical records. Hospitals have a responsibility to train their staff to use these guidelines and enforce their use through quality assurance measures (e.g. periodic chart review). Second, emergency departments should triage abused women patients to a higher priority status. Although some of these women do not have injuries severe enough to warrant immediate attention, their "social crisis" puts them at increased risk (Stark et al., 1981). Several women in our study relayed stories of long waits, being told to come back the next day, or simply leaving the emergency room. Both the women's psychological vulnerability and their increased risk of further trauma justify a higher priority status. Third, hospitals should develop non-cooperation policies with federal immigration authorities so that medical care remains accessible to abused undocumented immigrant women. Fourth, hospitals should develop community collaborations with battered women's organizations. Community advocates could provide important insight and guidance for policy development, training, and direct intervention with abused women patients. Feminist organizations, in particular, could provide frameworks for understanding the social basis of wife abuse.

Another role for hospitals is the provision of direct non-medical services to abuse women patients. First, social worker, counselors, and battered women's advocates should be on call 24 hours per day. Although several women in our study discussed the helpfulness of these types of social services, most women had never been provided these services. There are several advantages to a multi-specialty team approach to abused women patients: (1) social service professionals are better trained to handle psychosocial problems; (2) follow up for non-medical problems is improved;
and (3) the responsibility to manage these often complicated cases is shared.

Second, translator services for non-English speaking abused immigrant women are essential. Several Latina and Asian women in our study discussed having to wait for translators or avoiding seeking medical care because of the language barriers. Clearly, this deficiency is unacceptable.

Medical educational institutions have a responsibility to provide instruction on marital violence and abuse to students and residents. Current educational practices are inadequate (CDC, 1989; CDC, 1991). Not only should these training programs address the use of guidelines for the identification and management of victims of marital abuse, these programs should focus on the special needs of abused women. The women in our study discussed their unique social and psychological circumstances that warrant greater sensitivity and compassion in the patient-provider relationship. Of course, these qualities cannot be taught as skills per se, they develop from an understanding of the context of marital violence. For example, providers need to understand that women are not to blame for their abuse, and that they stay in these relationships for many different reasons. Training must also give providers the opportunity to overcome their own discomfort, fears, stereotypes, and frustrations (Sugg & Inui, 1992; Brown et al. 1993).

Sensitivity and understanding about cultural issues is also important. Issues of ethnicity and class were particularly salient for the Latina participants, who perceived intense discrimination in the medical system. Differential treatment based on race, class, or ethnicity is obviously unacceptable and needs to be addressed at the social, institutional, and individual levels. Recent policies to establish cultural competency training at medical institutions will hopefully address some of these issues.
Health policy organizations and advocates must carefully consider the ethical and practical implications of mandatory reporting policies that involve contacting either law enforcement or federal immigration authorities. In 1994, the California legislature passed a law that required health care personnel and other social service professionals to report suspected cases of adult victims of domestic violence. Prior to this law, providers were required only to report felony assaults. It is clear from our research that these policies pose significant barriers to medical care for many abused women patients (see also, Mooney, 1995). Further, they explicitly violate the medical ethics of confidentiality and patient autonomy, both of which were important to the abused women in our study. By mandating that abused adult women be treated like abused children, this type of legislation is paternalistic and insulting. Also in 1994, California voters passed proposition 187 which requires hospitals to report undocumented immigrants to federal authorities. Undocumented Latina and Asian immigrant women in our study discussed their fears of deportation and apprehensions about seeking medical care. The ethic of medical neutrality supports the role of health professionals in providing care regardless of political status. I would argue that given the current political climate, being undocumented is a political category and thus should be protected. Clearly, health care institutions should continue to take an active role in opposition and resistance to this type of legislation. Finally, the health care system should support structural changes that increase economic accessibility of medical care (e.g., national health care reform). Several women in our study lamented the high cost of medicine and some prolonged seeking care. Although this is not a problem specific to abused women, many of the women in our study were financially
dependent on their husbands and could not afford medical care. Overall, there are multiple ways that the medical institutions, including hospitals, schools, and policy institutes, can address the problem of wife abuse.

The role of the provider

Essentially the role of the medical provider revolves around identification and of the victims of wife abuse and intervention on their behalf. Although these functions are relatively straightforward for most medical problems, the case of wife abuse is more complicated. Identification depends on qualities of both the patient and the provider as well as their interaction. Disclosure by the patient is affected by a multitude of psychological, social, culture, and external factors. As discussed in earlier chapters, many women withhold the truth about their victimization because they are afraid of their partners, embarrassed, or want to protect their partner, relationship, or family. For some of these women, even the most supportive medical environments could not overcome these barriers. However, for many others, qualities of the provider and the patient-provider relationship significantly affected their openness.

The importance of establishing a patient-provider rapport which embodies elements of compassion, trust, and understanding was a pervasive theme for all the different ethnic groups. These elements strongly affected their comfort and willingness to disclose information to providers. Although barriers to provider awareness and compassion may include structural constraints (e.g. inadequate time with the patient), stereotypes and preconceptions about wife abuse victims also are likely to play an important role. Simplistic viewpoints and misunderstandings of the abused woman's
circumstances may lead to judgments and frustrations with her unwillingness to leave the relationship. These frustrations may lead to victim-blaming attitudes and behaviors that create distance between provider and patient and impede intervention. According to the participants, one route to creating empathy involves developing understanding and awareness among providers about the powerful psychological and social forces faced by many abused women. As discussed above, this goal of developing rapport through sensitivity and awareness is best achieved through educational curriculum. Another important aspect of identification involves asking the right questions and having a high suspicion for abuse, particularly in cases where the woman’s explanation does not account for the injuries. These "diagnostic" procedures are discussed in detailed in published guidelines (Flitcraft, 1992) and should be taught to all medical providers.

Once a victim of abuse is recognized, it is crucial that medical providers attempt to intervene. First, they should be knowledgeable about available community and hospital services for abused women. The majority of our study participants believed that providers should make referrals and encourage patients to pursue these resources. Second, providers should clearly document cases of abuse in the patient’s medical records. This documentation improves future identification and informs medical treatment and follow up. In addition, this type of documentation can be used for legal purposes (e.g., divorce proceedings, criminal and civil prosecution, immigration waivers). As in the case of improved identification procedures, providers can be trained to use these types of intervention procedures through special training courses.
Effective intervention also requires attitudinal changes on the part of providers. As discussed in Chapter 1, the medicalization of wife abuse carries the danger of reducing the problem to the individual level. In addition, many aspects of medical "culture" pose significant barriers to interventions for wife abuse. First, providers' expectations that problems should be solved quickly and their resulting frustration with delayed results poses some problems. Several women in our study discussed the difficulties of leaving the abusive relationship. Even when medical providers work hard to counsel the patient and make all the appropriate referral, it may still take a long time for the situation to change. Providers need to understand that there is no quick fix for marital abuse. The concept that the success of the intervention should be judged on the basis of the intervention rather than the outcome is very much opposed to mainstream medical thinking (Worcester, 1995). Second, traditional relationships between doctors and patients are based on models of paternalism and dependency (Stark et al., 1979). When treating a victim of wife abuse, these models can perpetuate the woman's victimization by recreating the power dynamics of her abusive relationship (Kurz & Stark, 1988). To counter these prevailing attitudes, models of empowerment and self-help must inform patient-provider relationships. Empowerment means providing advice and referral, but allowing the patient to make her own decisions. Finally, to avoid some of the pitfalls of medicalization, more attention must be paid to the psychological and social context of the patient, rather than simply her physical injuries and physiological manifestations (Beitman et al., 1982). It is clear that medical providers must transcend the traditional biomedical frameworks in approaching abused women patients.
In spite of these ideological barriers, medical providers are in a unique position to assist abused women patients. First, the medical system may be the woman’s only contact with social service organizations that have the capacity to intervene. Second, medical providers hold positions of respect and authority, such that their concern may be taken more seriously by the patient. Clearly, health care professionals have both the responsibility and the opportunity to play an important role in empowering abused women patients.

Intersections of gender, race, culture and class

Although the design of this study did not allow for a valid cross-cultural comparison between the different ethnic groups, several interesting differences emerged from the data. Although manifestations of psychological factors differed according to cultural background, almost all of the groups discussed some aspect of embarrassment and low self-esteem. Relationship and family considerations were universal; however, white and African-American women focused on their continued devotion to their partners, and Latina and Asian women expressed greater tolerance for the abuse and focused on their obligation to their children and keeping the family together. Given the complexities in class backgrounds and individual histories of the participants, these differences may or may not reflect the influences of culture.

Based on these results, there are several hypotheses that relate cultural factors to experiences with marital violence and barriers to help. First, embarrassment, shame, and low self-esteem are psychological consequences of abuse that cross all cultures. These factors may be more related to issues of gender socialization and power differentials that exist in all patriarchal
societies. Second, African-American and white women's sense of devotion and love for their partners (in spite of the abuse) stems from the elements of American culture that socialize women to value love and romance in intimate relationships. These attitudes are derived from cultural values that typically glorify the emotional aspects of marital relationships, while minimizing the functional aspects. Third, Latina and Asian women's sense of responsibility to their families stems from their shared cultural value of familialism.

Initial research strategies to explore these hypotheses should involve qualitative research with abused women from different ethnic groups that includes explicit questions about the role of their social and cultural values in experiences and perceptions of marital abuse. In addition, general associations between ethnic background and these variables could be assessed with surveys of abused women that include structured questions regarding the role of different cultural and social factors. For example, a variety of issues could be listed and respondents could be asked to rank each according to their importance. Research to explore these hypotheses is important for forming the basis of culturally specific prevention and intervention strategies. Once the salient factors are identified through research, intervention strategies can be developed that target different ethnic communities.

Implication for social change

The problem of wife abuse lies in social and institutional forces at every level of society. Thus, while improving the efficacy of interventions by health care institutions and providers is valuable, it is not enough. This problem must also be addressed by improving social and legal services to
abused women. Improvements in legislation to protect abused women, law enforcement, and prosecution processes are essential. In addition, community-based social and shelter services must be actively supported and funded. Without improvements in these other areas, the powerlessness felt by medical providers will be exacerbated, because providers are dependent on these institutions to ultimately intervene on behalf of their patients. Making referrals to shelters that are overflowing and underfunded, or depending on a legal system that does not protect abused women will inevitably lead to frustration and a sense of futility.

The role of medical institutions and professionals in working toward these changes involves active community collaboration with battered women's agencies and political support of legislative and institutional reform. Addressing wife abuse needs to be viewed as a collaborative effort wherein medicine plays a small role. Along with these intervention strategies, public health approaches to primary prevention of marital violence and abuse should be developed that embody values of social justice. Addressing issues of social and material inequities based on gender, race, ethnicity, and class is essential to the effectiveness of primary prevention strategies.

Future research directions

Although there are many possible directions for future research into the role of medicine in addressing wife abuse, I will discuss only two. First, the generalizability of the results of our study should be assessed using a more quantitative instrument that can be distributed to a larger sample of clinic-based or community-based abused women. Each of the different barriers to
medical care, barriers to disclose, and recommendations for improvement could be listed and respondents could be asked to rank or discuss their importance. Additional barriers (e.g., from the research literature and other articles) could be included along with open-ended questions to allow participants to expand the list. For example, additional items could include alternative approaches to intervention in medical settings that involve community advocates.

A second research direction involves assessing the efficacy of a variety of intervention strategies in medical settings. Limited research has addressed the effectiveness of screening protocols in increasing the rates of identification of abused women (McLeer & Anwar, 1989; Norton et al., 1995). An important aspect of this research must include continuous assessment of the intervention, since it has been shown that long term improvements are difficult to attain (McLeer et al., 1989). While the most wide spread and accepted recommendations center around screening, identification, and referral by medical providers, it is important to examine the utility of alternative approaches. For example, research on team-based approaches with social workers, physician assistants, or community advocates needs to be conducted. Although some researchers have argued that these alternative approaches are superior (Kurz & Stark, 1988), more research is needed to support these claims. Study designs that address this question could include retrospective or prospective changes over time, and comparisons of different hospitals or departments. Outcome variables for this research should include the number of abused women patients identified, the number of abused women followed up, the patients' (both abused and non-abused) assessment
of program, and the providers' assessment of program. It is these types of studies that are critical for informing health policy that addresses wife abuse.

As the problem of marital violence gets redefined as a health issue, it is critical that policy makers and medical practitioners listen carefully to the voices of abused women patients. While our research provided many insights into the factors that affect abused women's ability to seek and receive medical care, it is far from definitive. Additional research is needed to confirm the validity and reproducibility of these findings in other groups and to further explore the needs of abused women patients. In short, the communication lines between these patient groups and the medical system must remain open.
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Appendices

A. Conflict Tactics Scale

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C. Data Analysis and Presentation
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Appendix A. Conflict Tactics Scale


No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person or just have snags orights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read some things that you and your partner might do when you have an argument. I would like you to tell me how many times (READ EACH ITEM) in the last 12 months you (READ LIST).

Thinking back over the last 12 months you've been together, was there ever an occasion when your spouse/partner (READ ITEM) (READ ACROSS)

*IF EITHER "NEVER" OR "DON'T KNOW" ON ITEM FOR BOTH Q.35 AND Q.36, ASK Q.37 FOR THAT ITEM, THEN CONTINUE WITH LIST FOR Q.35.*

Has it ever happened?

<table>
<thead>
<tr>
<th>Item</th>
<th>Respondent</th>
<th>More Than</th>
<th>1-5</th>
<th>6-10</th>
<th>11-20</th>
<th>21+</th>
<th>Don't Know</th>
<th>Read</th>
<th>Read</th>
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</thead>
<tbody>
<tr>
<td>READ LIST</td>
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<tr>
<td>1. Discussed an issue calmly</td>
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<td>2. Got information to back up your point of view</td>
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<td>3. Broke in or tried to break in someone to help settle things</td>
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<td>4. Insulted him or swore at him or yelled at him</td>
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<td>5. Sulked or refused to talk about an issue</td>
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<td>6. Stomped out of the room or &quot;bused&quot; or yelled</td>
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<td>7. Cried</td>
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<td>8. Co or said something to spoil or make nervous</td>
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<td>9. Threatened to hit him/her or make them nervous or</td>
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<td>10. Threw or smashed or hit or hit something</td>
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<td>11. Threatened to hit them or hit something</td>
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<td>12. Insulted, grabbed, or shoved</td>
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<td>13. Slapped him/her</td>
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<td>14. Threw, hit him/her with a fist</td>
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<td>15. Hit or tried to hit him/her with a fist</td>
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<td>16. Beat him/her up</td>
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<td>17. Pushed him/her away</td>
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<tr>
<td>18. Threatened him/her with a knife or try to use a weapon</td>
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<tr>
<td>19. Used a knife or tried to use a weapon</td>
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</table>
Appendix B-1. Informed Consent Form

You are invited to participate in a study of domestic violence and the health care system. The purpose of this study is to gain first-hand information from women who have experienced domestic violence like yourself, about the help you obtained with problems related to domestic violence, your experiences with physicians, and how physicians could better meet the needs of women who experience domestic violence. Information gathered in this study will be used to educate physicians and others in the health system about the unique experience and needs of women who suffer from domestic violence.

If you decide to participate, Dr. Rodriguez and his associates will ask you to participate in a group discussion for two hours for the purpose of learning about your experiences with the health system and physicians. In order to compensate you for your time, we will pay you $10.00. WE CANNOT AND DO NOT GUARANTEE OR PROMISE THAT YOU WILL RECEIVE ANY BENEFITS FROM THIS STUDY. There will be no additional cost to you for participation in this study.

If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice to you.

If you have any questions, we expect you to ask us. If you have any additional questions later, Dr. Rodriguez at 725-7997 will be happy to answer them.

For further information, please call (415) 723-5244 or write the Administration Panel on Human Subjects in Medical Research at Medical School Office Building, Room C-051, Stanford, CA 94305. In addition, if you are not satisfied with the manner in which this study is being conducted or if you have any questions concerning your rights as a study participant, please contact the Human Subjects Office at the same address and telephone.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, THAT YOU HAVE DISCUSSED THIS STUDY WITH THE PRINCIPAL INVESTIGATOR AND HIS OR HER STAFF, THAT YOU HAVE DECIDED TO PARTICIPATE BASED ON THE INFORMATION PROVIDED, AND THAT A COPY OF THIS FORM HAS BEEN GIVEN TO YOU.

______________________________
Signature and Date

______________________________
Signature of Investigator or Witness
Appendix B-2. Focus Group Discussion Outline

INTRODUCTION

Self introduction

The purpose of this interview is to get information that will help physicians improve their interactions with women who have experienced domestic violence. As someone who has experienced domestic violence, you are in a unique position to describe what domestic violence is and how it affects people. This interview is about your experiences with the health care system and your thoughts about your experiences. Let me emphasize that your knowledge, experiences, attitudes, and feelings are important.

The answers from all the people we interview will be combined for our report. They will also help us in formulating questions about domestic violence for women. Nothing you say will ever be identified with you personally. All the information will be confidential. As we go through the interview, if you have any questions about why I am asking something, please feel free to ask. Or if there's anything you don't want to answer, just say no. The purpose of the interview is to get your insights about how physicians handle domestic violence and how their behavior affects people.

Any questions before we begin?

Ground Rules
1. There are no right or wrong answers
2. Speak up when you agree or disagree
3. Speak one at a time and say your name before speaking
4. Nothing said here should leave this room

I. WARM UP (5-10 minutes)

Would anyone like some coffee, tea, juice, or water to drink?

Please introduce yourself using your first name (the same name that will be used to identify themselves each time they make a comment).

Any problems getting here today?
Appendix B-2. Focus Group Discussion Outline (continued)

II. PERSPECTIVES ABOUT DOMESTIC VIOLENCE (10-15 minutes)

No matter how well a couple get along, there are times when they disagree, get annoyed with the other person, or just have spats or fights because they’re in a bad mood or tired or for some other reason. Men and women also use many ways of settling their differences.

Based on your experience, at what point is something considered violent?

Where have you or your friends gone for help when experiencing violence in your relationships?

III. PERSPECTIVES ABOUT DOMESTIC VIOLENCE AND THE HEALTH CARE SYSTEM (30-40 minutes)

Many women go to hospitals or clinics for a reason related to the violence they experience in their relationships. Have you ever gone to a doctor for a problem related to abuse in your family?

What kind of experiences have you had? Let’s start with the good ones. Has anybody had a good experience when you went to get help from a doctor for something related to domestic violence?

How about bad experiences? Tell me about those, and tell me about experiences friends or yours have had.

What makes it difficult to go to a physician for problems related to domestic violence?

Have you ever withheld information about violence in your relationship from your doctor? Why?

Do you think that during regular visits, doctors should ask about whether a woman has suffered any violence by her husband or partner?
Appendix B-2. Focus Group Discussion Outline (continued)

IV. WAYS WE CAN IMPROVE OUR APPROACH TO BATTERED WOMEN (30-40 minutes)

- How could physicians do a better job at helping women who are experiencing domestic violence?
- What is the best way for physicians to ask about domestic violence?
- What services would you like to receive from a physician when you have a problem related to domestic violence?
- What do you feel is inappropriate for physicians to do when they are seeing women who are experiencing domestic violence?
- How do you feel about doctors asking your partners about violence in the relationship during a routine visit? (fears/benefits)
- Is there anything else you think doctors or other health workers should do that we have not mentioned?

WRAP-UP

Distribute demographic questionnaire and ask participants to fill it out.
Appendix B-3. Demographic Questionnaire

Questionnaire number  __________

1. What is your age?  __________

2. What is your marital status?
   1. Single
   2. Married/Domestic Partner
   3. Separated
   4. Divorced
   5. Living together
   6. Widowed

3. What country were you born in?  ______________

4. How many children do you have?  ______

5. How many of your children have died?  ______

6. How many years have you been in the U.S.?  ______

7. What is the last year of school that you have completed?
   1. no formal schooling
   2. 1st through 7th grade
   3. 8th grade
   4. some high school
   5. GED
   6. complete high school
   7. completed vocational/technical school
   8. some college
   9. completed college

8. Have drugs or alcohol played an important role in your relationships?

9. If yes to above, please explain below.
Appendix C-1. Codes Used in Data Analysis

**DEFINITION OF DOMESTIC VIOLENCE (DEDV)**

- Psychological  (DEDV-P)
- Physical  (DEDV-PH)
- Sexual  (DEDV-S)
- Economic  (DEDV-E)
- Control/power  (DEDV-C)
- Verbal  (DEDV-V)

**SOURCES OF VIOLENCE (SRCV)**

- Partner  (SRCV-P)
- Health personnel  (SRCV-H)
- Family  (SRCV-F)
- Self  (SRCV-S)
- Societal  (SRCV-SO)
- Institutional  (SRCV-I)

**OUTCOMES OF DOMESTIC VIOLENCE (OUTV)**

- Children  (OUTV-C)
- Symptoms  (OUTV-S)
- Batterer  (OUTV-B)
- Perspectives  (OUTV-P)
- Cycle  (OUTV-CY)
- Interactions  (OUTV-I)

**ASSOCIATED FACTORS OF DOMESTIC VIOLENCE (AFDV)**

- Alcohol  (AFDV-A)
- Environment  (AFDV-E)
- Drugs  (AFDV-D)

**HELP (HELP)**

- Family/friends  (HELP-F)
- Police  (HELP-P)
- Self  (HELP-S)
- Health Personnel  (HELP-H)
- Other external  (HELP-O)

**ASSOCIATED FACTORS OF HELP (AFHE)**

- Support  (AFHE-S)
Appendix D-1. Demographics of the white American participants

Sample size: 14
Demographic data available: 13

Focus groups
Group 1: 9 participants, conducted in English
Group 2: 5 participants, conducted in English

Recruitment venues: Support Network, Battered Women's Alternatives

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Marital</th>
<th>Children</th>
<th>Education Level</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>22</td>
<td>single</td>
<td>1</td>
<td>some college</td>
</tr>
<tr>
<td>2</td>
<td>24</td>
<td>separated</td>
<td>2</td>
<td>completed high school</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>divorced</td>
<td>3</td>
<td>some high school</td>
</tr>
<tr>
<td>4</td>
<td>35</td>
<td>separated</td>
<td>4</td>
<td>completed high school</td>
</tr>
<tr>
<td>5</td>
<td>43</td>
<td>separated</td>
<td>3</td>
<td>some college</td>
</tr>
<tr>
<td>6</td>
<td>48</td>
<td>married</td>
<td>2</td>
<td>completed college</td>
</tr>
<tr>
<td>7</td>
<td>48</td>
<td>separated</td>
<td>2</td>
<td>completed college</td>
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<tr>
<td>8</td>
<td>48</td>
<td>divorced</td>
<td>1</td>
<td>completed college</td>
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<tr>
<td>9</td>
<td>52</td>
<td>separated</td>
<td>0</td>
<td>some college</td>
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<td>Group 2</td>
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<tr>
<td>1</td>
<td>21</td>
<td>single</td>
<td>0</td>
<td>some high school</td>
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<tr>
<td>2</td>
<td>32</td>
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<td>2</td>
<td>completed college</td>
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<td>4</td>
<td>60</td>
<td>widow</td>
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<td>completed college</td>
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<td>5</td>
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Summary
Ages: range 22-60, median 35
Children: range 0-4, median 2
Education level: ranges from some high school to completed college
Appendix D-2. Demographics of the African American participants

Sample size: 9
Demographic data available: 4

Focus groups
Group 1: 4 participants, conducted in English
Group 2: 5 participants, conducted in English*

Recruitment venues: La Casa de Las Madres, St. Anthony's shelter,
 Transitional housing and drug rehabilitation program

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Marital</th>
<th>Children</th>
<th>Education Level</th>
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<tbody>
<tr>
<td>Group 1</td>
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<td>1</td>
<td>23</td>
<td>single</td>
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<tr>
<td>4</td>
<td>30</td>
<td>married</td>
<td>0</td>
<td>completed college</td>
</tr>
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Summary
Ages: range 23-29, median 26.5
Children: range 0-3, median 2
Education level: ranges from some high school to completed college

* Demographic data from group 2 were collected but later misplaced.
<table>
<thead>
<tr>
<th>Education Level</th>
<th>Married</th>
<th>Widowed</th>
<th>Some High School</th>
<th>Group 1</th>
<th>Some College</th>
<th>Group 2</th>
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<tr>
<td>Completed college</td>
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<td>1</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<td>Completed college</td>
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<td>1</td>
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Participating Venue: Support Network, Barred Women's Alternative

Focus Groups:

* 13 demographic data available
* 14 sample size

Appendix D-1: Demographics of the White American participants
Demographic data for Group 2 were collected but later misplaced.

**Education Level: ranges from some high school to completed college**
- Children: range 0-3, median 2
- Ages: range 23-29, median 25.5

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<thead>
<tr>
<th>Education Level</th>
<th>0 marrying</th>
<th>0 single</th>
<th>1 separated</th>
<th>2 single</th>
<th>1 Group 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>some high school</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>some high school</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>completed college</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transition Housing and Drug Rehabilitation Program**
- **Recruitment Venue:** La Casa de Las Madres, St. Anthony's Shelter
- **Group 2:** Participates conducted in English
- **Group 1:** Participates conducted in English

**Focus Groups**
- Sample size: 9

**Appendix D-2: Demographics of the African American participants**

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---
<table>
<thead>
<tr>
<th>Group</th>
<th>Participant Age</th>
<th>Marital Status</th>
<th>Children</th>
<th>Education Level</th>
<th>Years in the US</th>
<th>Country of Origin (number of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30</td>
<td>separated</td>
<td>5</td>
<td>none</td>
<td>6</td>
<td>Colombia (3)</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>single</td>
<td>4</td>
<td>some high school</td>
<td>7</td>
<td>El Salvador (2)</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>separated</td>
<td>6</td>
<td>none</td>
<td>5</td>
<td>Mexico (6)</td>
</tr>
</tbody>
</table>

Summary:
- Ages: range 25-30, median 27.5
- Children: range 3-5, median 4
- Education levels: range from no formal schooling to some college
### Education Level

<table>
<thead>
<tr>
<th>Country</th>
<th>Sample Size</th>
<th>Sample Size</th>
<th>Sample Size</th>
<th>Sample Size</th>
<th>Sample Size</th>
<th>Sample Size</th>
<th>Sample Size</th>
<th>Sample Size</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnam (1)</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
</tr>
<tr>
<td>Taiwan (2)</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
</tr>
<tr>
<td>Philippines (4)</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
</tr>
<tr>
<td>Korea (2)</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
</tr>
<tr>
<td>China (5)</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
<td>Group 2</td>
</tr>
</tbody>
</table>

### Demographics

- **Appendix D-1**: Demographics of the Asian participants

---

**Legend:**
- Divorced
- Married
- Single
- Separated
- Some college
- Completed college
- Elementary level
- Completed high school

**Summary:**
- Ages: Range 22-37, median = 24
- Children: Range 0-6, median = 3
- Education Level: Completed college to some college

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed college</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Completed high school</td>
<td>13</td>
<td>22</td>
</tr>
<tr>
<td>Elementary level</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Completed college</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Completed high school</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Completed college</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Completed high school</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Completed college</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Completed high school</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Some college</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Married</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Years in the U.S.:** Range 1-12 years, median = 6 years

---

**Additional Notes:**
- Research conducted: Asian Women's Shelter, Cameron House
- Focus Groups conducted in Mandarin and Cantonese
- Sample available: 14
<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Age</th>
<th>Educ</th>
<th>Country of origin</th>
<th>Yrs in U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>25+</td>
<td>SC</td>
<td>U.S. (4)</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>25+</td>
<td>SHS</td>
<td>(SHS-CC)</td>
<td></td>
</tr>
<tr>
<td>Latina</td>
<td>25+</td>
<td>E</td>
<td>N-S (3)</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>25+</td>
<td>CHS</td>
<td>(E-CC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>25+</td>
<td>CHS</td>
<td>(N-CC)</td>
<td></td>
</tr>
</tbody>
</table>

*Median age in years; age range in ( ).

**Median level of formal education: range in ( ). N = none, E = elementary, CHS = some high school, CC = completed college.

† Number of participants from country in ( ).

‡ Median years in U.S.; range in ( ).