

University of Windsor

Scholarship at UWindor

Electronic Theses and Dissertations

Theses, Dissertations, and Major Papers

2010

Understanding how healthcare professionals view their role in relation to woman abuse

Courtney Williston
University of Windsor

Follow this and additional works at: <https://scholar.uwindsor.ca/etd>

Recommended Citation

Williston, Courtney, "Understanding how healthcare professionals view their role in relation to woman abuse" (2010). *Electronic Theses and Dissertations*. 45.
<https://scholar.uwindsor.ca/etd/45>

This online database contains the full-text of PhD dissertations and Masters' theses of University of Windsor students from 1954 forward. These documents are made available for personal study and research purposes only, in accordance with the Canadian Copyright Act and the Creative Commons license—CC BY-NC-ND (Attribution, Non-Commercial, No Derivative Works). Under this license, works must always be attributed to the copyright holder (original author), cannot be used for any commercial purposes, and may not be altered. Any other use would require the permission of the copyright holder. Students may inquire about withdrawing their dissertation and/or thesis from this database. For additional inquiries, please contact the repository administrator via email (scholarship@uwindsor.ca) or by telephone at 519-253-3000ext. 3208.

Understanding How Healthcare Professionals View their Role in Relation to
Woman Abuse

by
Courtney J. Williston

A Thesis
Submitted to the Faculty of Graduate Studies
through Psychology
in Partial Fulfillment of the Requirements for
the Degree of Master of Arts at the
University of Windsor

Windsor, Ontario, Canada
2010
© 2010 Courtney J. Williston

Understanding How Healthcare Professionals View their Role in Relation to
Woman Abuse

by
Courtney Williston

APPROVED BY:

Dr. D. Rajacich, Outside Reader
Department of Nursing

Dr. C. Senn
Department of Psychology

Dr. K. Lafreniere, Advisor
Department of Psychology

Dr. G. Chung-Yan, Chair of Defense
Department of Psychology

DECLARATION OF ORIGINALITY

I hereby certify that I am the sole author of this thesis and that no part of this thesis has been published or submitted for publication.

I certify that, to the best of my knowledge, my thesis does not infringe upon anyone's copyright nor violate any proprietary rights and that any ideas, techniques, quotations, or any other material from the work of other people included in my thesis, published or otherwise, are fully acknowledged in accordance with the standard referencing practices. Furthermore, to the extent that I have included copyrighted material that surpasses the bounds of fair dealing within the meaning of the Canada Copyright Act, I certify that I have obtained a written permission from the copyright owner(s) to include such material(s) in my thesis and have included copies of such copyright clearances to my appendix.

I declare that this is a true copy of my thesis, including any final revisions, as approved by my thesis committee and the Graduate Studies office, and that this thesis has not been submitted for a higher degree to any other University or Institution.

ABSTRACT

In Canada, at least one woman in five will be abused by an intimate partner. In order to become free from an abusive man, women often need support from individuals outside of their relationship. Primary care Healthcare Providers (HCPs) are uniquely positioned to identify woman abuse and provide support. Interviews with nine primary care healthcare professionals were conducted and subjected to an interpretative phenomenological analysis. Six themes that related to participants' lived experience emerged from the analysis. These themes included: a) a sense of duty; b) suspicion; c) dealing with role conflict; d) experiencing uncertainty; e) asking as a place, and f) working to guide patients without a roadmap. These findings are discussed in relation to recommendations for how HCPs can overcome their uncertainties, future directions for HCP education, and implications for screening policies.

DEDICATION

This thesis is dedicated to all who have survived abuse as well as those who have provided support along the way.

ACKNOWLEDGEMENTS

I would first like to thank the physicians and nurse practitioners who gave me their time and shared their experiences with me. None of this would have been possible without their participation.

I would also like to thank my supervisor, Dr. Kathryn Lafreniere for lending me her expertise and providing support throughout my Master's degree and this endeavour. I must also convey my sincere gratitude for the advice and suggestions of Dr. Charlene Senn for this and other projects. I would also like to thank my external reviewer Dr. Dala Rajacich for her insights and for providing a window into practice-based concerns of health care professionals.

I would be remiss to not also thank my family, my friends, and my colleagues for the tangible and intangible support they have provided in these past two years. I would especially like to thank Christin Moeller, Stephanie Gee, and of course, Jim Leather.

TABLE OF CONTENTS

DECLARATION OF ORIGINALITY	iii
ABSTRACT.....	iv
DEDICATION	v
ACKNOWLEDGEMENTS	vi
CHAPTER	
I. INTRODUCTION.....	9
Context and Statement of Problem	9
Literature Review	9
Prevalence of Woman Abuse	9
Etiology and Feminist Theory	10
Physical, Mental and Psychosocial Outcomes	11
Help Seeking and Disclosure	13
Healthcare and Screening	15
The Present Study	24
II. METHODOLOGY.....	27
Interpretative Phenomenological Analysis	27
Philosophical Underpinnings and Development	27
Analytic Focus	30
Rigour in Qualitative Research	31
Phenomenological Interviewing	33
Locating Myself	35
III. METHOD.....	37
Sampling and Recruitment	37
Participants	37
Interviews	39
Orienting Questions	40
Transcription	41
Data Analytic Procedure	41
IV. ANALYSIS.....	45
Overview	45
Role and Responsibility	48
Superordinate Theme: A Sense of Duty	48
Superordinate Theme: Suspicion	54
Superordinate Theme: Roles in Conflict	63
Inquiring About Abuse and Handling Disclosure	72
Superordinate Theme: Uncertainty (And Everything Else)	72
Superordinate Theme: Asking and Disclosing as a Place	73
Superordinate Theme: Working Without a Roadmap	78
V. DISCUSSION.....	87
Summary of Emergent Themes	87
Roles and Responsibilities	87
Inquiring About Abuse and Handling Disclosure	90
(Re)contextualizing the Problem	94
Understanding Help Seeking and Disclosure	98

	Womens' Perspectives	101
	Implications for Policy and Education	103
	Strengths and Limitations	107
	Directions for Future Research	110
REFERENCES		111
APPENDICES		126
VITA AUCTORIS		136

CHAPTER I

INTRODUCTION

Context and Statement of the Problem

In a 5-year period, at least 653,000 Canadian women will experience woman abuse (Statistics Canada, 2005). Despite nearly four decades of research examining the scope, distribution, etiology, and prevention of woman abuse and a more thorough understanding of men's violence against women, woman abuse remains widespread. Often, abuse continues for years before a woman is ready or able to leave her abuser and a variety of barriers have been identified that may inhibit leaving. For many women, it is necessary to seek help outside of the relationship with the abusive man in order to make safety plans for leaving and to mobilize any necessary resources (e.g., financial, social, legal, medical). Many women who experience abuse also experience social isolation, and few women access formal services for male violence against women. Because of this isolation and low rates of use of alternative services, due to the nature of their professional role, healthcare professionals are uniquely situated to elicit disclosures of violence and provide supports for battered women (Plichta, 2007). Few studies have investigated how disclosure and suspicion of woman abuse among patients is experienced from a physician's perspective. In this study, I investigate how physicians make meaning of their experiences with women patients who are living with male violence.

Literature Review

Prevalence of Woman Abuse

Intimate Partner Violence (IPV) may be best characterized as violence against women, as the most significant risk factor for intimate victimization is to be a woman

(Walker, 1999). In Canada, male violence against women remains a common social problem. Research indicates that approximately 1 in 5 to 1 in 3 women will experience abuse at the hands of a male partner in their lifetime (Carlson, McNutt, Choi, & Rose, 2002; Statistics Canada, 2005). Women in intimate partnerships with men are the most likely to experience severe physical injury, and are more likely to experience violence over their lifetime (Arias & Corso, 2005; McCloskey & Grigsby, 2005; Saunders, 2002). Further, in Canada, men commit nearly four of every five homicides in which the victim is a current or former intimate partner (Statistics Canada, 2005). It is important, however, to note that violence occurs in every type of intimate partnership, and there is increasing acknowledgement that women do sometimes abuse *male* partners (Saunders, 2002)¹. Scholars agree that prevalence and incidence rates as obtained through population-level surveys underestimate the amount of violence women experience in relationships (Bennice & Resick, 2003; Michalski, 2004, 2005; Murray & Graybeal, 2007; Wofford & Elliott, 1997). Furthermore, the majority of these crimes are not reported to police or other services (Statistics Canada, 2006). Therefore, at this time, the true scope of woman abuse can only be approximated.

Etiology and Feminist Theory

The rise of the feminist movement in the 1970s was instrumental in the recognition of woman abuse as a pervasive and serious social problem by bringing public attention to what was once considered a private matter (Brienes & Gordon, 1983;

¹ While I am sensitive to men's victimization by women and same-sex male partners, and women's victimization by women partners – and do not wish to be exclusionary – throughout this document I will refer primarily to heterosexual and bisexual women's experiences of men's violence. I believe intimate partner violence to be a gendered phenomenon, so I have chosen to emphasize the gender disparity in perpetration and victimization. This will be reflected through use of female pronouns and the term woman abuse.

Pagelow, 1992). Male violence against women is a global phenomenon, affecting the lives of millions of women every year. While research on woman abuse has grown rapidly over the past three decades, the recognition of male violence against women as a healthcare issue is comparatively recent (see Plichta, 2007; Plichta, Duncan, & Plichta, 1996).

As prevalence estimates suggest, intimate violence is a gendered phenomenon. Men overwhelmingly are the perpetrators in cases of physical and psychological violence, and women are the victims. When investigating woman abuse, it is necessary to look beyond individual-level correlates and consequences of violence, and examine the sociocultural environment in which violence occurs. Because woman abuse is gendered – the majority of victims women and the majority of perpetrators, men – male violence against women must be considered in relation to wider social structures and cultural values (Brienes & Gordon, 1983). Violence, from a feminist standpoint, serves an oppressive function and operates as a means of social control (Bograd, 1990; Walker, 1989). Violence perpetrated by men against women, therefore, is considered to be the result of patriarchal social structures that cause and perpetuate systemic power differentials between women and men (Walker, 1999). Men use violence in order to control women, and this use of violence is sanctioned through social and legal structures that permit women’s victimization (Rittmayer & Roux, 1999).

Physical, Mental and Psychosocial Outcomes

Being abused by a male partner engenders a myriad of adverse health effects (both physical and psychological) for women. Psychological sequelae of woman abuse include symptoms of post-traumatic stress, increased levels of anxiety and depression,

and overall lower psychological well-being (Bargai, Ben-Shakhar, & Shalev, 2007; Carlson et al., 2002; Dutton & Painter, 1993; Woods, 2005). Women who experience male violence are also at a higher risk for physical injury than those who do not, including but not limited to bruises, fractures, brain injuries, and pregnancy complications (Plichta, 2007). Given these increased risks for psychological and physical distress, it is not surprising that women experiencing abuse use healthcare services at higher rates than the general population, though the majority of visits are for non-injury complaints (Coker et al., 2002; Dearwater et al., 1998; Naumann, Langford, Torres, & Campbell, 1999). While a significant minority of women who visit emergency departments (EDs) present with abuse-related injuries, the most common reason for healthcare visits to all doctors among women who have experienced abuse are for depression and mental health symptoms (Kothari & Rhodes, 2006; Saunders, Hamberger, & Hovey, 1993).

Beyond specific mental health symptoms and physical injuries, women who currently experience or have recently experienced intimate violence report lower levels of general health and well-being (Campbell & Soeken, 1999; McCaw, Golding, Farley, & Minkoff, 2007). Taken together, these findings indicate that for many women who experience violence, physical sequelae of abuse may not be necessary or sufficient indicators for healthcare providers to identify potential cases of abuse. This is because physical injuries may not be present, or seen by the physician at the time of a medical visit. Instead of presenting with physical injuries, women who are abused are more likely to present with generalized physical and mental health complaints that may or may not be immediately indicative of violence (Kothari & Rhodes, 2006; Saunders et al., 1993). It is

therefore critical that healthcare providers be sensitive to more subtle presentations and/or indicators of abuse. Currently, most healthcare providers raise the topic of violence in the presence of “red flags” – namely, physical injuries (Baig, Shadigian, & Heisler, 2006; Garcia-Moreno, 2002); however, this practice is likely to identify and provide support, treatment, and referral for only a fraction of women who experience partner violence.

Help Seeking and Disclosure of Woman abuse

Once women recognize their partner’s abuse as a problem and decide that they want to seek help or leave their relationship, one of the first steps in this process is disclosure of abuse to a person outside of the relationship. Abusive men often intentionally isolate a woman from her family and/or social networks, prevent her from working, or monitor her activities closely (R. MacMillan & Gartner, 1999). This lack of social interaction limits women’s abilities to disclose abuse to a potential helper. The experience of woman abuse is related to lower levels of social functioning (McCaw et al., 2007). It is reported consistently in the literature that battered women receive less social support than non-battered women do (Barnett, Martinez & Keyson, 1996; Levondosky et al., 2004; Thompson, Saltzman, & Johnson, 2003). Social isolation is also a risk factor of victimization and re-victimization, as social support generally serves as a protective function against woman abuse (Goodman, Dutton, Vankos, & Weinfurt, 2005; Michalski, 2004). The experience of social support has also been found to reduce women’s risk for negative mental health sequelae resulting from abuse (Coker et al., 2002). These findings suggest that social isolation (low levels of social support) both exacerbates victimization and inhibits women’s ability to seek help once violence begins. The availability of social

support is therefore an important factor in keeping women safe from violence; however, it is also important to note that for severe violence, social support does not serve as a protective factor against men's violence (Goodman et al., 2005). While social support serves a protective function for women who experience male violence, social support alone is not sufficient to protect women from violence, particularly for those who experience the most severe abuse.

Disclosure of abuse is a significant event for battered women; it is often the first step towards leaving a partner, which is a perilous time for battered women – the risk of death at the hands of their male partner is highest soon after leaving (e.g., Campbell et al., 2003). Unsurprisingly, women are often reluctant to disclose abuse to others. Not only does the likelihood of violence increase if a woman's partner suspects or knows about the disclosure, but women may also receive unhelpful or victim-blaming responses from their potential helpers (Garcia-Moreno, 2002). Often, a change in the severity of abuse precedes disclosure; however, women who experience more severe violence are also more likely to minimize or omit information when disclosing to potential helpers (Dunham & Senn, 2000; Waldrop & Resick, 2004). Arguably, women who experience the most severe abuse need the support of others the most; however, these women are less likely to reveal the full extent of their partner's violence.

Most women who experience relationship violence do not seek help from police or other legal services (Fleury, Sullivan, Bybee, & Davidson, 1998). Women who do seek help from the police or similar services are likely to experience more severe violence with greater frequency. As a result, women who seek help from the police or shelter services are thought to be non-representative of the larger population of battered women

(Wofford & Elliott, 1997). Furthermore, victims of woman abuse are more likely to seek help from the healthcare system than from any other formal service (Campbell & Lewandowski, 1997). A substantial minority of women who experience male violence may never disclose at all. One study (Coker et al., 2002) found that 31% of the battered women in the sample have never disclosed abuse to anyone. Disclosure of abuse to potentially helpful others is important for many reasons, not least being that helpers may be able to assist in the mobilization of social and tangible resources that can facilitate becoming safe from violence (Saunders, 2002).

Healthcare and Screening

Because many women who experience abuse are reluctant to disclose to friends and family or to formalized services for woman abuse, interactions with their healthcare providers (e.g. family physicians and general practitioners, obstetricians and gynaecologists, and registered nurses or nurse practitioners) are particularly important. Numerous studies in clinical settings indicate that at least one third of women who are seen in primary health care practices have experienced violence (e.g. Burge, Schneider, Ivy & Catala, 2005; Carlson et al., 2002; Naumann et al., 1999; Rodriguez, Sheldon, Bauer, & Pèrez-Stable, 2001). Significantly, the general public views the healthcare setting as a primary source of help for women who are experiencing male violence (McCaw et al., 2007). Moreover, both women who have been victimized and men who have perpetrated violence against their partners believe that abuse-related questions should be asked by physicians (e.g. Burge et al., 2005).

Disclosure and interactions with the healthcare system. Patients often do not present with complaints directly related to relationship violence, though their symptoms

or concerns may be known indicators of woman abuse (Eisenstat & Bancroft, 1999). Given that patients often present with complaints that are not explicitly linked to abuse, physicians may suspect that woman abuse is an issue even when not disclosed. Furthermore, victims are unlikely to disclose abuse unless asked specifically (Rodriguez et al., 2001). Few studies have examined specifically the factors that are conducive to disclosure in healthcare settings. One study; however, found that 85% of women who were experiencing abuse disclosed when asked by their physician, and women report that they are likely to disclose if asked directly (Rodriguez et al., 2001). Most physicians are only likely to ask a patient about violence at home in the presence of physical injury, or if “red flags” are present (Baig et al., 2006; Garcia-Moreno, 2002). Women who experience violence at home generally view the healthcare system as a possible source of assistance.

To date, there is a lack of literature on the conditions that are conducive to disclosure of woman abuse generally, and in healthcare settings specifically. Although Healthcare Professionals (HCPs) may be viewed as potential helpers, women are unlikely to disclose abuse spontaneously for a number of reasons. Hathaway, Willis and Zimmer (2002), and Rodriguez and colleagues (2001) have investigated abused women’s experiences of disclosing to HCPs. The available research suggests that primary reasons why women do not disclose to healthcare professionals are clustered around several main themes, namely; (a) a belief that physicians lack time or are disinterested in discussing woman abuse; (b) shame and/or embarrassment discussing woman abuse; (c) concerns about confidentiality if woman abuse is disclosed; (d) lack of direct questioning about abuse experiences; and (e) a perception that the physician is not knowledgeable about woman abuse (Hathaway et al., 2001; Rodriguez et al., 2002).

Research has found consistently that more than 90% of women who have experienced violence back the implementation of universal screening (the practice of asking each woman about violence or abuse) by HCPs (Burge et al., 2005; Caralis & Musialowski, 1997). Significantly, a recent study found that a larger percentage of battered women support screening than non-battered women (McCaw et al., 2007). Despite the continued recognition that the experience of male violence is common among women from all walks of life, rates of identification of violence in the healthcare system are low. In a recent large American survey, only 7% of women reported that they were ever asked about woman abuse by a healthcare provider (Klap, Tang, Wells, Starks, & Rodriguez, 2007), and other researchers report that less than 10% of physicians engage in routine screening (Janssen, Dascal-Weichhendler, & McGregor, 2006; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999); however a recent survey of Ontario nurses and physicians found that 32% of nurses and 42% of physicians talk to their patients about woman abuse with some frequency (Gutmanis, Beynon, Tutty, Wathen & MacMillan, 2007). Despite the controversies that remain in the medical community over whether or not to implement universal screening for woman abuse in healthcare settings, it is clear that women patients support screening.

Screening efficacy. Although a number of medical and nursing associations in Canada and the United States have recommended that healthcare providers conduct universal woman abuse screening in their practices, no consensus has yet been reached on whether or not to mandate universal screening. In 2003, the Canadian Task Force on Preventive Healthcare concluded that there is insufficient evidence to recommend for or against universal screening (Wathen, MacMillan, & Canadian Task Force on Preventive

Health Care, 2003). This is because, while screening for IPV has not been found to be harmful for women (e.g. screening is not associated with increased violence or injury in the months following a medical visit), screening has not been found consistently to contribute directly to benefits in women's' health and well-being (MacMillan et al., 2009). However, the report does encourage health care professionals to screen when woman abuse is suspected (e.g., in the presence of physical injury).

There is a notable lack of research on the efficacy of screening for woman abuse, and for the various services and interventions to which battered women may be referred. A 2004 review of screening and intervention literature found that no evaluations provided information regarding any negative effects of screening or intervention for women experiencing partner violence, or whether screening and intervention resulted in any harm reductions (Nelson, Ngyren, McInerney, & Klein, 2004). Some recent evidence indicates that screening may be beneficial to women who experience male violence. A study that examined the effects of screening in a U.S. emergency department found that women did not experience any increases in violence as a result of the screening, and that 35% of women who were screened for violence (and were experiencing violence) contacted community services for woman abuse within a 3-month follow-up period (Houry et al., 2008). Other researchers have argued that screening may constitute an intervention in and of itself, and should be investigated as such (Spangaro, Zwi, & Poulos, 2009). The mere act of screening may help to promote subsequent help seeking efforts among battered women, as it demonstrates that other people care, and are interested in providing assistance. If screening for woman abuse does not harm women who experience male

violence, and may increase the likelihood of becoming free from abuse, universal screening should be enacted as a routine feature of medical care.

Institutional and physician barriers to addressing violence. Previous research has identified a number of barriers for routine woman abuse screening among healthcare providers. First, many physicians do not receive formal training about how to screen patients for abuse, and when training is provided, many practitioners view it as inadequate (Baig et al., 2006; Ferris, 1994; Garcia-Moreno, 2002; Minsky-Kelly, Hamberger, Pape, & Wolff, 2005). A second barrier is a concern among physicians that they cannot identify abuse and/or effectively intervene (Chamberlain & Perham-Hester, 2002; Ferris, 1994; Gerbert et al., 2002; Rittmayer & Roux, 1999). Third, institutional barriers (including lack of time and lack of role clarity) preclude effective screening (Ferris, 1994; Gutmanis et al., 2007; Minsky-Kelly, et al., 2005; Sugg & Inui, 1992). Fourth, healthcare providers are concerned with offending the patient by asking them about woman abuse (Elliott, Nerney, Jones, & Friedmann, 2002; Ferris, 1994; Minsky-Kelly et al., 2005; Sugg & Inui, 1992). Fifth, a concern with whether available interventions for women experiencing male violence actually reduces harm for a woman is a barrier to screening patients – specifically, whether referral to services for woman abuse results in harm reduction (Elliott et al., 2002; Minsky-Kelly et al., 2005; Rittmayer & Roux, 1999). Sixth, personal discomfort with screening has been cited as an obstacle for many physicians (Sugg & Inui, 1992). Finally, there is also a widespread general belief among healthcare providers that woman abuse is not common among their patients, making screening less likely (Burge et al., 2005; Chamberlain & Perham-Hester, 2002; Reid & Glasser, 1997).

In an American study, residents were found to believe that male violence against women was more common among low-income and African-American populations; however, no differences were found in actual screening rates based on patient SES or ethnicity (Baig et al., 2006). Limited or absent woman abuse-related education in medical training (Davidson et al., 2001) may also be a major contributor to physicians' discomfort with and reluctance to engage in screening even in the presence of indicators. A combination of these factors may be largely responsible for the low rates of screening by physicians in primary care practices and related specialties. A recent survey of Ontario medical and nursing schools found that 43% of undergraduate medicine programs have woman-abuse in their curriculum, and this content is part of required training at only 66% of these institutions. The same study showed that 83% of undergraduate nursing programs cover woman abuse, and is required for students in 66% of nursing schools (Wathen et al., 2009).

Encouragingly, physicians have indicated that there is a desire for a greater focus on woman abuse-related training in both medical school and as ongoing education (Ferris, 1994). This is particularly important, since physician confidence in their ability to identify cases of male violence against women in their practice is low, with only one third of Canadian physicians believing that they could successfully identify cases of abuse, and 98% believing that they are missing cases among their patients (Ferris, 1994).

In a grounded-theory study conducted with obstetricians/gynaecologists, Rittmayer and Roux (1999) found that physicians struggled with balancing the conflicting medical and psychosocial imperatives made relevant when abuse was suspected in their clients. They cited the medical system's focus on treating symptoms as

acting as a barrier to their dealing with a relational problem that cannot be “fixed” in the manner of a physical symptom. This conflict between a desire to fix a patient’s problem and the knowledge that woman abuse cannot be so easily remedied created a reluctance to engage in screening and discussions surrounding violence with patients. In the modern medical establishment, scientific facility is given precedence above interpersonal skills and sensitivities (Thurston & Eisener, 2006), a focus that becomes problematic when dealing with complex and sensitive social and psychosocial issues. Perhaps because woman abuse, more than many problems physicians confront, sits at the border between social problems and medical issues, HCPs are, overall, ill-equipped to deal with this issue. In sum, low rates of screening among HCPs may be attributable to a handful of contributing factors, namely ongoing controversies within the medical establishment about the appropriateness of screening, lack of physician education about male violence against women, and institutional and personal barriers to screening in the healthcare context.

Factors that promote screening in healthcare settings. While rates of general screening for woman abuse remain distressingly low, a number of factors that increase the likelihood routine screening have been identified. Physicians who believe that screening has value, and is appropriate in the context of the physician-client relationship are more likely to screen for partner violence than those who do not (Allen, Lehmer, Mattison, Miles, & Russell, 2007; Elliott et al., 2002). Women physicians and those in women-centred specialties (e.g. obstetrics and gynaecology) are more likely to report routine and indicated screening during patient visits (Baig et al., 2006; Chamberlain & Perham-Hester, 2002; Elliott et al., 2002). Physicians who belong to ethnic minority

groups, those with more liberal political orientations and egalitarian value systems, and younger physicians are also more likely to engage in screening (Chamberlain & Perham-Hester, 2002; Frank et al., 2006). Unsurprisingly, physicians who report feeling more comfortable with screening, and those who have received recent screening training are more likely to do so (Allen et al., 2007; Chamberlain & Perham-Hester, 2002; Elliott et al., 2002). It has also been found that physicians and other HCPs working in community health centres are more likely to engage in screening (Gerbert et al., 2002; Weeks, Ellis, Lichstein, & Bonds, 2008). This last finding may be due to practice factors rather than a belief that woman abuse is more common in low-income or minority populations. It has been suggested that HCPs who work in low-SES and/or communities with a large proportion of clients who belong to visible minority groups may be more sensitive to the potential for violence in the lives of their patients because these practices may attract physicians who are more sensitive to social and psychosocial issues (Weeks et al., 2008). Despite the belief among physicians that woman abuse is more common in these communities, it is important to note that available research suggests that physicians do not screen low-income or ethnic minority clients preferentially (Baig et al., 2006; Rodriguez et al., 2001).

Differences in screening practice as related to individual differences in the form of beliefs and attitudes held by HCPs appears to be consistent with the victim-blaming literature. It is generally found that younger people, women, and those who endorse less traditional gender roles are less likely to engage in victim-blaming responses and may be more likely to offer helpful assistance to women dealing with violence (e.g. Beeble, Post,

Bybee, & Sullivan, 2008; Bryant & Spencer, 2003; Taylor & Sorenson, 2005; West & Wandrei, 2002; Willis Esqueda & Harrison, 2005; Worthen & Varnado-Sullivan, 2005).

When one considers patients' desires for screening in relation to the practice of screening, there seems to be a marked disconnect between what women say that they want from their interactions with healthcare providers, and what the research suggests occurs in practice. Research indicates that although the general population and battered women support screening, and that many physicians recognize woman abuse as a major health problem, healthcare visits often do not involve discussions of violence and abuse. This disconnect may be associated with differential expectations of and orientations toward healthcare held by patients and physicians, as well as common communication patterns in medical encounters.

Physician and patient communication and relationship dynamics. Medical encounters are a type of social interaction (albeit institutionalized), and patient-physician communication is a developing area of research. Several studies have shown that women physicians are more likely to focus on preventive care and counselling, and are more apt to discuss personal problems with patients, including family issues and social problems (Bertakis, Helms, Callahan, Azari, & Robbins, 1995; Franks & Bertakis, 2003). Patients who are treated by a physician of the same gender report higher levels of satisfaction with both their medical care and the physician-patient relationship itself (Gross et al., 2008). Men physicians have been found to rate the complaints of women patients as "less severe" than the same complaints in men patients, and more frequently report suspicion of a 'hidden agenda' (undisclosed concern) in female patients versus male patients (Gross et al., 2008). Other patient characteristics, including personality characteristics, substance

use, weight and ethnicity have been implicated in the quality of patient-physician relationship and in actual and perceived quality of care (e.g. Bertakis & Rahman, 2005; Ellington & Wiebe, 1999; Peekover & Chidlaw, 2007; van Ryn, Burgess, Malat, & Griffin, 2006); however, it is unknown to what extent these factors influence screening and treatment for woman abuse in primary care visits.

A recent review of the medical interview literature reported that physicians miss many cues and concerns that patients present with during medical encounters (Zimmerman, Del Piccolo, & Finset, 2007). Specifically, physicians are likely to disattend to emotion-focused cues, act in ways that inhibit patient disclosures and gloss over patient-initiated concerns (Zimmerman et al., 2007). This failure to acknowledge or follow-up on patient-initiated concerns (particularly emotional and psychosocial concerns) has important implications for physician identification of woman abuse and treatment of patients experiencing psychological distress – failures to respond to emotional cues may effectively close down potential disclosures of abuse.

The Present Study

The purpose of this study is to ascertain how HCPs view their role in relation to woman abuse as well as how they make meaning from their encounters with patients who they suspect may be experiencing abuse, and patients who disclose victimization. To address the relative lack of psychological research on screening, the present study explores primary care HCPs' experiences of interacting with women who have disclosed, or who are suspected of experiencing violence perpetrated by their male partner.

Initially this study was intended to explore family physicians' perspectives and interpretations of this topic; however, I later elected to include nurse practitioners for

practical and theoretical reasons. Semi-structured qualitative interviews were conducted with nine participants and the interview data were subjected to an interpretative phenomenological analysis. To further our understanding of how HCPs' training on woman abuse-related issues influences their screening practices and interactions with patients, questions explored the educational experiences of HCPs. The way in which HCPs interpret their experiences with patients, and the background knowledge they bring to a situation are likely to shape their interactions with patients. This is also true of their interactions with women patients who disclose abuse at the hands of male partners and patients who physicians may suspect are currently experiencing abuse.

After a review of the relevant literature, four guiding questions were developed. First, how HCPs perceive and make sense of their role in screening for woman abuse and treating women who experience male violence was explored. Second, I explored HCPs' experiences of woman abuse-related education obtained in medical school or through continuing education. Third, HCPs' experiences of treating women who have disclosed violence perpetrated by their male partners during a medical visit were examined. Finally, I explored HCPs' experiences of dealing with patients whom the physician or nurse practitioner suspected may be experiencing woman abuse.

The results of this study provide insights into the subjective experiences of physicians when dealing with women patients who disclose abuse or who are suspected to be experiencing relationship violence and/or abuse. This is important for several reasons. First, this study reveals how HCPs interpret their role in relation to screening for woman abuse and handling any disclosures they may encounter. Second, the findings provide a more nuanced understanding of the effectiveness of woman abuse-related

education that is received by HCPs in medical school, nursing school and beyond, as well as what HCPs feel that they need in order to be more effective in treating women who are abused by men, as related to how they interpret their role. These findings may also assist in identification of strengths and educational practices and content, and thus guide the development of future curriculum components for a wide variety of medical and service personnel. Third, the results help to clarify known barriers to screening and to identify additional barriers that are experienced and/or perceived by HCPs (e.g. personal discomfort, lack of training, lack of institutional support). Fourth, this project extends existing research in the area (which has traditionally relied on survey measures) by exploring the subjective meanings that HCPs attach to their interactions with patients, and how these interactions may affect them professionally and personally. Furthermore, the results of this study provide insights that can guide future research in exploring how HCPs make sense of their experiences in the context of their role as a healthcare provider, and in the exploration of how health care professionals negotiate dealing with sensitive, stigmatizing and potentially contentious issues in practice.

CHAPTER II

METHODOLOGY

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) will be used to guide the interview process and analysis. IPA is an inductive, qualitative approach that is increasingly used in applied psychology generally, and health psychology specifically, in order to understand the experiences and meaning-making activities of both clinicians and patients (Smith, 2004). This is a valuable approach because how individuals interpret and make meaning from their experiences shapes how they respond to events. Relatively little is known about how HCPs interpret their interactions with battered women.

Consequently, obtaining a more nuanced understanding of the meaning physicians attach to their interactions with women who experience abuse at the hands of their male partners may lead to interventions that are more effective.

Philosophical Underpinnings and Development of IPA

IPA was developed in the U.K. in the 1990s by Jonathan Smith. It has since been used mainly in psychological investigations of health and wellness (Smith et al., 1997). Phenomenological inquiry is concerned with how individuals interpret and make meaning from their lived experiences. Interpretative phenomenological analysis is a qualitative, inductive method of analysis that is not hypothesis- or theory-driven. Instead, theorizing and interpretation is developed from (and grounded in) the responses of participants (Smith, 2004). Smith reports that IPA can be described by three central characteristics: idiographic; inductive, and interrogative (Smith, 2004).

Gubrium and Holstein describe interpretative analyses as engaging “both the *hows* and *whats* of social reality; it is centered on how people methodically construct their experiences and their worlds and in the configurations of meanings and institutional life that inform and shape their reality-constructing activity” (2000, p. 448). IPA is grounded in both phenomenology and symbolic interactionism, and is considered a phenomenological method because the focus of the methodology is with a participant’s subjective experience of objects and events.

The phenomenological stance of IPA is that, while there is not a direct relationship between what a participant says and underlying cognitive or affective processes, one’s responses nonetheless provide access to aspects of personally relevant meaning-making activities (Smith, 1995). Furthermore, Smith (2004) posits that IPA is also phenomenological in that it involves a double hermeneutic, specifically, in that the “participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world” (p. 40). Therefore, in using an interpretative phenomenological approach, the role of the analyst is central. This centrality of researcher interpretation further highlights the need to make clear my own positioning such that my analysis is rendered as transparent as is possible.

IPA draws broadly from the theoretical stance of several phenomenological philosophers (most significantly Husserl and Heidegger, and to a lesser degree, Merleau-Ponty and Sartre). From Husserl, IPA borrows the phenomenological attitude, and a focus on the careful examination of subjective lived experience (or lifeworld); Smith interprets this as the examination of “particular experience as experienced by particular

people” (p.12). From Heidegger, IPA incorporates a focus on intersubjective understanding and the examination of the ‘person-in-context’ – that is, a person’s understanding cannot be detached from their understanding of their social and embodied environment. Heidegger also lends IPA the notion that bracketing one’s preconceptions is not a fully practicable activity, but rather that assumptions and preconceptions about the object of interest should be acknowledged and interrogated. Unlike some phenomenologically-based methods, IPA considers these distinct approaches to phenomenological theory as complementary rather than oppositional, so multiple perspectives may be drawn upon in a given interpretation.

Symbolic interactionism has also been a major contributor to the development of IPA. The central idea of symbolic interactionism is that the meanings people give to situations, objects, and action should be of great interest to human science researchers (Smith, et al., 1997). In this perspective, the self is characterized as an agent of both construction and interpretation. Furthermore, symbolic interactionism situates individuals as being intentionally active in the creation of thought and of the meaning that is assigned to objects and events (Denzin, 1969). Meanings attached to objects and events are not static, rather they are malleable and can change over time based on shared cultural symbolic meanings (Denzin, 1969).

Construction and interpretation are both essential elements of the meaning-making process, therefore both standpoints have informed the development of this project, and will inform my analysis. If one adheres to the idea that reality is socially constructed, then symbolic interactionism may be thought of as describing the process by

which individuals incorporate and draw upon social construction in their subjective meaning-making and interpretative processes.

Edley (2001) describes epistemic social constructionism as the “notion that any attempt to describe the nature of the world is subject to the rules of discourse. It points to the fact that as soon as we begin to think or talk about the world, we necessarily begin to represent. Talk involves the creation of construction of particular accounts or stories about what the world is like” (pp. 436-437). While interpretive and constructionist practice are often held as distinct orientations, I believe that one perspective cannot be considered without implicating the other, as a complex reciprocal relationship exists among constructions of reality, perception of experience, meaning, and interpretation. Therefore, constructionist and interpretivist epistemologies, while not commensurate, are compatible, and can be drawn upon concurrently without creating epistemic dilemmas or contradictions.

Analytic Focus

The analytic focus of IPA is flexible, in that data can be analysed at several different levels of abstraction, depending on the goals of the research and the content of the interviews, all the while attempting to adopt an “insider’s perspective” of the object of study (Smith, 1996, 2004) – in this case, HCPs’ experiences of patients who experience violence. Analysis may remain at a level very close to the text, focusing on the deployment and function of various linguistic strategies (e.g. metaphor use, invocation of social comparison) in a manner similar to Discourse Analysis (but without the eschewal of cognition that is characteristic of Discourse Analytic approaches). It is also possible to analyse at a more abstract level, yet remain tied to the specifics of an

individual's data; for example, one may examine data for a participant's construction and interpretation of self, or events, and search for subjective cognitive or emotive meanings for the participant. At an even higher level of abstraction, the analyst may look for connections between participants' meanings and interpretations and wider cultural discourses, or culturally shared knowledge that the participant draws upon to interpret his or her experiences. In a given project, the analyst may choose to interpret at all levels of analysis, or may instead choose to concentrate their efforts at one or two levels. It is not possible to determine a priori what the dominant level of analysis will be for an investigation.

Rigour in Qualitative Research

Traditional conceptions of scientific validity cannot be meaningfully applied to qualitative investigations; therefore the criteria for judging validity in IPA is necessarily different than the criteria for quantitative research (Braun & Clarke, 2006). For the present investigation, I was guided by the recommendations delineated by Lincoln and Guba (1985), Guba and Lincoln (1994) and Denzin and Lincoln (2000). Within this framework, five interrelated criteria (credibility, transferability, dependability, confirmability, and authenticity) are used to ensure rigour, or trustworthiness in qualitative research.

First, credibility was established through an engaging with participants in attempt to capture the essence of their experiences, debriefing with colleagues and my advisor and through the analysis of negative cases (i.e., participant experiences or interpretations of experiences that differed from commonly-shared interpretations).

Second, transferability of the research findings is accomplished through in-depth description of the data and interpretive processes in order to allow readers to translate the findings to a variety of other, related issues or samples, and through sampling of a variety of viewpoints. The reader of this study can determine the extent to which the in-depth description of participant experiences was achieved. I believe that this analysis has tapped into multiple HCP viewpoints (which has also been enhanced the participation of both family physicians and nurse practitioners) and is also relevant to broader aspects of patient care in primary practice.

Third, dependability of the research and findings is supported through maintaining an audit trail and research journal, such that the process of research is made transparent, and biases explicit. Maintaining a reflexive research journal has allowed me to examine more closely my own biases and emotional responses to the interviews and my analytic engagement with the interview transcripts.

The fourth criterion, confirmability, refers to the appropriateness of the research process for the topic of investigation, and that the interpretations made by the researcher are grounded in the participants' data. In this case, IPA was a particularly appropriate method to use to understand HCPs interpretations of their interactions with their patients. Whether my interpretations are grounded in the data can be ascertained to a large degree by whether readers share similar interpretations to my own, given the data and attendant analytic excerpts presented in the analysis section.

Finally, authenticity refers to an assurance that a range of participants' perspectives are demonstrated, and also that the research has the potential to instigate change for participants, or in the phenomenon under investigation. Given that the purpose

of the present study is to produce a nuanced understanding of physicians' experiences of screening for woman abuse and the implications of these experiences for patient care, this framework is well suited to guide and support the validity of this investigation. The ultimate test of this criterion will occur in the future; however, the results of the analysis are used to inform recommendations for HCP education and care of patients, and potential implications for healthcare policy are discussed, as well as future directions for research in this area. Thus, if any of these recommendations are taken up in the future, it is possible that better care for abused women in primary care settings will be achieved.

The aforementioned validity framework is compatible with Smith, Flowers, and Osborn's (1997) conception of the utility of IPA research. They conceive of IPA as being particularly suited to researching psychological issues surrounding health, wellness, and the medical setting. Here, IPA is viewed as being most useful in the production of knowledge that can be used to influence change in medical settings, the development of therapeutic techniques, and to develop intervention strategies. According to both of the aforementioned conceptualizations of research validity – or more accurately, research utility – the most important test of the value of research is in its eventual use.

Phenomenological Interviewing

When interviewing for an IPA study, the researcher is permitted (and sometimes encouraged) to take an active role in co-producing a narrative with the participant. Because the interview format is semi-structured, the researcher plays a central role in the processes of meaning making in which participants engage by tailoring questions to the experience of the participant, and prompting for more detail about situations or interpretations that seem particularly meaningful to the participant (Seidman, 2006). In

this type of interviewing, the interviewer is not “neutral, distant, or emotionally uninvolved”, nor is that the intent of this type of research (Rubin & Rubin, 1995, p. 12). Rather, when conducting an interview of this sort it is imperative that the interviewer be aware of how their own affective states, reactions to participant responses, and prior experiences influence the interview process. In order to accomplish this, I maintained a journal that documented my reactions to interviews and to the data throughout this process. I started the journal when I began the recruitment process, and have regularly maintained it up to and including the write-up. This is accomplished by maintaining a journal to serve as an audit trail that tracks my personal reactions to various components of the research process, including reactions to interviews. This emotional involvement may be heightened due to the potentially sensitive nature of the interview topic, and the reactions of participants to questions posed.

Those who have agreed to participate have also agreed to allow another person access to their personal thoughts, feelings, and experiences, as well as their time. It is important to be sensitive and respectful of any disclosures, thoughts, feelings, and insights into a participant’s experience that they share, as well as to allow participants to speak with their own voices. This requires cognizance of the power dynamics that the interview process creates (Brinkmann & Kvale, 2005). While I believe it unlikely that participants felt disempowered during the interview or by the research relationship, it is necessary to be sensitive to this possibility. I attempted to do so, trying to continually gauge the participant’s level of comfort and our rapport when considering what questions to ask of them and how they were approached. Reflecting on the interviews as a whole, I believe that these goals were largely achieved.

Locating Myself

I identify as a feminist, and locate myself at the nexus of Standpoint and Postmodern Feminism (Campbell & Wasco, 2000; Riger, 1992). These personal and philosophical value positions shape my research to a large degree. While IPA is not an explicitly feminist method, its tenets and application are compatible with several aspects of feminist theory and research process – both IPA and feminist research share a commitment to reflexivity, voice, and an understanding that researcher and participant are collaborators in the construction of data.

In order to conduct this investigation, it is necessary to be explicit about my own perspectives and biases. My perspective is that a researcher is never neutral, and comes to an investigation with a set of experiences, value-standpoints, and biases that inevitably affect the choice of topic, and how that topic is investigated. Necessarily, all of these elements influence research – one can never set aside biases completely. Engaging in an interpretative project requires me to engage in continuous reflexive awareness of my thoughts, feelings, and experiences. Inevitably, my own subjectivities interact with the development of this project, interactions with participants, and interpretations of data.

My interest in the study of violence against women is grounded in personal experience. I had a longstanding interest in sociocultural inequalities; however, it was not until after experiencing abuse from a male partner that I developed a desire to investigate the causes, consequences and effects of partner violence. To me it is apparent then, that my interest in this area of research arose from my experiences of violence, and a subsequent desire to assist those who have experienced abuse – and thereby transform a set of negative personal experiences into knowledge that may have a positive impact on

the lives of others. Specifically, I am now interested in finding ways to help those who have been victimized become free from abuse. As such, my perspective is dual: it is that of a novice academic and that of a person who has been victimized, and it is not possible to separate the two. I have attempted to develop and maintain a reflexive awareness of how these facets of my identity and my value position(s) colour my interactions with participants and conduct of research. My personal experience with violence, however, may allow me greater sensitivity in dealing with this topic as well as further insights into the experiences of battered women more generally. I maintained a research journal throughout this project in an attempt to make explicit how my own feelings and reactions affect the interview and analytic process, and engaging in this process has contributed to the dependability of this research.

CHAPTER III

METHOD

Sampling and Recruitment

Ethics clearance was obtained from the University of Windsor's Research Ethics Board prior to recruitment. In line with IPA recommendations, participants were recruited using purposive sampling (Smith, Flowers, & Larkin, 2009). At the outset of this project, my committee and I recognized that it may be difficult to obtain participation from family physicians for a variety of reasons. This anticipated concern was borne out during the research process. Rates of participation by physicians were low. Out of nearly one hundred potential participants contacted via conventional mail, only two physicians responded to these mailings. Initially, family physicians were chosen as the population of interest as it was assumed that family physicians would have a range of experiences and perspectives on the phenomenon of interest, and furthermore, that the phenomenon would be of some significance to them² (Eatough et al., 2008; Rubin & Rubin, 1995; Smith, et al., 2009). However, in anticipation of low response rates by physicians it was decided that nurse practitioners be included in the sample as well. Nurse practitioners were selected for two main reasons. First, similar to family physicians, nurse practitioners provide primary healthcare to their patients and often have the same continuity of care with patients and their families that is characteristic of family medicine practices. Second, while nurse practitioners share many facets of their role with family physicians, their

² It is of interest to note that during pre-interview contacts with two of the physician participants, they expressed that they had little or no experience with IPV in their practice; however, the subsequent interviews revealed that each participant did in fact have experience treating patients who were experiencing male violence.

training experiences and practice characteristics may differ from those of family physicians' in ways that are meaningful for treating abused women.

Data collection began in January 2010 and was completed in June 2010. Throughout the recruitment process, potential participants were contacted by mail, telephone, and/or by e-mail (see Appendices A for the recruitment script and Appendix B for the letter of information). Potential participants were identified in a variety of ways; first, physicians who were known to the researcher and committee members were contacted, then lists produced by professional organizations were consulted, from which individuals were selected for contact. By May 2010, six interviews with family physicians had been completed, and mail recruitment was proving to be a difficult endeavour, as it was hard to gain entry to a physician's office in the absence of some pre-existing relationship with the office on behalf of the researcher or committee members³. Inclusion criteria for this study required that each physician or nurse practitioner be a primary care provider for adult and/or adolescent women. All physicians contacted had relevant experience working in private or clinic practices, and given the prevalence of woman abuse, it may be reasonably assumed that they are likely to have encountered patients who had experienced woman abuse or had indicated woman abuse.

Participants

Nine HCPs agreed to be interviewed for this study. Six participants were family physicians (two women and four men), and three participants were nurse practitioners (all women). Participants currently (or most recently) practice in one of three mid-to-large sized Ontario cities, and all completed their medical or nursing education in Ontario.

³ Only two of the nine HCPs who took part in this study had no prior association with the researcher, members of the thesis committee or a HCP who was known to the researcher or committee members.

Participants ranged in age from 29 to 79 ($M = 50.3$, $SE = 5.8$), and had been practicing from 2 to 39 years ($M = 18.1$, $SE = 5.54$). To protect participants' identity, pseudonyms were selected by the author. Participants will be referred to by these pseudonyms: family physicians; Anne, Karen, Roger, Carl, Michael, and Glenn; nurse practitioners; Beth, Sarah, and Diane. One participant (Roger) had been retired for 10 years at the time of their interview. Eight participants identified as European-Canadian and one identified as Multiracial. All participants were primary care providers, but there was variability in the populations they served and the nature of their practices. Three of the participants (Michael, Glenn and Sarah) are medical educators as well as clinicians. Four participants work partially or primarily with populations that may be considered marginalized on one or more dimensions; Roger works for a community health centre, Beth works in a highly multicultural setting, Diane works with low income individuals who have insecure housing, and Sarah works with at-risk mothers and children. One participant (Anne) works primarily with young adults⁴.

Interviews

Semi-structured interviews ranged from 52 to 84 minutes in length, averaging 58 minutes. Interviews were conducted at a location agreed-upon by the interviewer and participant. All participants gave informed consent to participate and agreed to be digitally audiotaped (See Appendices C and D for general and audio consent forms). Seven interviews were conducted face-to-face, and two were conducted using a voice and video over internet protocol (Skype). Background and demographic information was collected from all participants (see Appendix E)

⁴ A given HCP may have more than one practice characteristic of note.

At the outset of the project, four orienting questions were developed in order to capture physician experiences of interest (see Appendix F for the interview guide). These open-ended questions were intended to guide the participant to talk about specific topics, while maintaining sufficient flexibility to allow participants to lead the ensuing discussion in directions relevant to their experience. Prompting questions and probes were used when necessary to encourage discussion and elaboration of physician experiences. Due to the flexible and continuous design of qualitative interviewing, it happened that the interview schedule was modified after data collection began as participants raised new issues and introduced unanticipated thoughts, feelings, and meanings that warranted greater exploration in that interview and in subsequent interviews. In line with recommended IPA practice, this allowed participants to speak freely of their experiences. Additionally, this recommendation was in line with many feminist perspectives, allowing for participants to share their lived experience and subjectivities in a way that was relevant to their understanding of the situation, with minimal leading on the part of the researcher.

Orienting Questions

In order to explore how HCPs understand their experience of dealing with patients who have disclosed abuse and those who are suspected of experiencing woman abuse in the home, four research questions were initially developed to guide the interview process.

These guiding questions were:

- 1) How do HCPs view and make sense of their role in screening for and treating patients who experience woman abuse?

- 2) What are HCPs' experiences and interpretations of woman abuse-related professional education during medical school and beyond?
- 3) How do HCPs interpret and make sense of experiences in dealing with patients who disclose woman abuse in the course of their visits?
- 4) How do HCPs' interpret and make sense of experiences in dealing with patients whom they suspect may be currently experiencing abuse at home?

Whereas these questions remained a focus for this investigation, the iterative and flexible approach to interviewing allowed the researcher to explore related areas of interest, based on what physicians and nurse practitioners shared during their interviews. In particular, the experience of suspicion proved to be important for initiating conversations about battering and abuse with patients, and each participant was asked about their experience of suspicion during their interview.

Transcription

The author transcribed all recorded interviews verbatim. The level of detail retained was sufficient to convey potentially significant conversational elements, including (but not limited to) laughter, pauses, false starts, et cetera.

Data Analytic Procedure

All participants were given the opportunity to review their interview transcript in order to make any clarifications or omissions they desired, as recommended by Seidman (2006) to increase the trustworthiness of the analysis and address issues of power and voice. Seven participants chose to review their transcript and three elected to make minor changes (for clarity, transcription error, or to protect their own or their patients' anonymity). The analytic approach used in IPA is not intended to be rigid; rather,

analysis in interpretative phenomenology is undertaken with reference to a set of guidelines designed to be adapted and modified by researchers in order to meet the goals and requirements of an individual project (Smith & Osborn 2008). Therefore, individual researchers are encouraged to apply the principles of IPA flexibly in a way that is most amenable to the nature of the topic of investigation and the data set.

Stages of analysis and reporting for IPA as outlined by Smith and colleagues were followed for this project (Eatough et al., 2008; Smith, 1995; Smith, et al., 2009; Smith et al., 1997). The first stage of data analysis consisted of repeated readings of one participant's complete transcript, while treating that transcript as its own unit of analysis. Notes were made in the margins of paper copies of transcripts on anything that stood out as notable or significant regarding the experience reported by the participant.

The second stage of analysis involved a re-reading of the transcript and the accompanying margin notations. The margin notations from the first stage of analysis were reviewed and these were to assist in the identification of possible themes or overarching ideas that are present in the transcript. This stage involves a higher degree of interpretation, as the organization of ideas and phrases that constitute and/or are representative of particular themes is developed. In this stage, the analytic process vacillates between inductive and deductive stances (Eatough et al., 2008), continually moving between reading the data and interpreting what the data means in the context of a particular participant's experience.

The third stage involved the construction of a list or table of themes that represents the connections among and between them within each transcript. This is done both in an attempt to reduce data and develop an overall picture of the relationships

within and between individuals' experiences. Clusters of themes and overarching, or superordinate, themes are likely to (and did) emerge from this analytic phase. Then, individual transcripts were considered in relation to each other, and not merely as analytic units unto themselves.

Once themes from each interview were identified and coded, interviews were compared for overarching themes. Since IPA is not driven by theory (and because the researcher attempts to set aside their expectations and biases at the outset of the analysis), it was not possible to determine *a priori* what types of themes and sense-making activities would emerge from participants' interviews during the analysis. Due to the iterative nature of interpretive analysis (i.e., the hermeneutic circle), themes emerged and retreated throughout the analytic endeavour as particular individuals and particular themes were considered in relation to the whole of the corpus, and vice versa. Day by day and conversation by conversation these themes and interpretations receded, came into focus, and shifted before me as I struggled to grasp the meaning of each participant's experiences both for participants and for myself.

Throughout the entire research endeavour I was aware of myriad ways in which my own experience of victimization affected my thoughts and interpretations of interactions with participants and later, with their transcripts. While interviewing, I often identified with the victim in our conversations, and struggled at times to remain present and focused on being "in the moment" with participants. I found myself vacillating back and forth between my identities as graduate student/researcher and as survivor. Inevitably this impacted how I viewed my interactions with each participant and also how I have

interpreted the data, presented my analysis, and developed my recommendations based on these.

The final analytic/interpretative stage culminated in the production of a narrative account of both the data and the author's interpretative process. There are various ways to structure this account; however, the two most common methods are: (a) a narrative focused on tracing idiographic accounts and meanings of one or several participants, and (b) a narrative that is structured around the overarching or common themes in participants' responses. Creating a narrative account is a challenging part of the analytic process, since for every turn around the hermeneutic circle, the analyst sees things that were not noticed before, or will consider familiar sights in a new light. It is also therefore difficult to determine when is the appropriate time to exit the hermeneutic circle, because with each engagement with the data and the narrative the previous interpretation seems incomplete and in requirement of revision (or of overhaul). With nine participants, this study has (by IPA standards) a relatively large sample size. For the narrative account of the analysis it made more sense to move away from individualized illustration of participant meanings to a presentation of significant themes that emerged for a majority of participants.

CHAPTER IV

ANALYSIS

Overview

Participants' narratives focused on the cognitive, affective, interactional and existential/reflexive elements of their experience, or, in other words, their narratives revealed how they think about, feel about and make meaning from their experiences with women who have been or may be abused. I entered into this project intent on exploring participants' subjective meanings. However, despite asking many questions related to HCPs' thoughts and feelings surrounding asking about and handling disclosures from abused and battered women, I was left with the sense that, overwhelmingly, HCPs are concerned with what is practical and implementable. That is, they were focused on what their next steps should be in a given situation, and how to provide the best care for the person sitting in front of them, rather than their own subjective experience. They were strongly other-oriented, and whether this is a by-product of their training or a self-protective strategy cannot be concluded with the current data; however, I believe it to be a reflection of both.

The analysis narrative is presented thematically in order to best represent the commonalities among HCP's experiences and the meanings they attribute to their interactions with abused women, and how they interpret their professional role(s) in relation to women abuse. The superordinate and subordinate themes that emerged across participant narratives are outlined in Table 1.

Table 1. Summary of Emergent Themes

Roles and Responsibilities:

Superordinate theme: A sense of duty

Whole person health

Awareness and vigilance

Superordinate theme: Suspicion

A sense

Trusting judgement

Suspicion as a catalyst

Superordinate theme: Roles in conflict

Ill-equipped and overwhelmed

Realities of practice

Inquiring about Abuse and Handling Disclosures: A Journey through Uncertainty

Superordinate theme: Uncertainty (And Everything Else)

Superordinate theme: Asking as a Place

Getting there

What will you find?

Resistance

Superordinate theme: Working without a roadmap (reflexive about role, self, reactions)

Emotional work

Fighting the need to 'fix'

Perspective taking and patient centred practice

To improve clarity of presentation, I have separated the themes into two sections that can each stand on their own conceptually, but these sections are not mutually exclusive and may best be considered in relation to each other. The superordinate themes presented in the first section, Roles and Responsibilities are those pertaining most closely to how HCPs feel about their role in relation to screening and providing care for abused women. All HCPs felt that they were duty-bound to attend to any issues affecting a patient's health and well-being, and that awareness of the potential for violence and abuse in a patient's life is a part of this duty. Further, this responsibility to be aware, or to develop awareness about abuse is what leads to suspicion of abuse in the lives of patients.

Falling under this theme was the experience of suspicion itself, as well as the idea that most physicians trusted their feelings whether or not a person ever disclosed violence or abuse. This sense of suspicion is most often what leads to asking about a woman's safety at home. The last theme in this section encompasses various conflicts HCPs feel between their perceptions of their duties to patients and the structural constraints (or facilitators) to asking about and caring for patients.

The second section is comprised of themes related to the process and experience of asking patients about abuse or safety at home, and how HCPs experience disclosures (or non-disclosures) and their sequelae. Uncertainty pervades HCPs' thoughts about what they have done and would choose to do in the future when faced with a patient who might be experiencing abuse, regardless of the amount of experience and knowledge they have about woman abuse and resources available for patients. Following from the previously identified theme of suspicion (and suspicion as a catalyst to asking questions about relationship quality and personal safety), I inquired what it was like to ask women about whether they felt safe at home, or whether their partner was abusive. Participants frequently used a journey metaphor, likening asking about abuse as "going to a place" with their patients (i.e., that the knowledge of abuse or a disclosure resided within a person, or was somehow removed from the physical immediacy of the HCP-patient encounter). . Another superordinate theme related to asking as a place, was that of being unsure about the next steps. Or, in other words, entering this 'place' of asking about and disclosing abuse is like working without a roadmap, and requires emotional and cognitive work on the part of the HCP in order to provide their patients with what they need most, while at the same time making sense of their own reactions.

Role and Responsibility

Each interview began with asking participants what they considered woman abuse to be, or what their definition of woman abuse is. Each participant presented a definition or understanding of woman abuse that included multiple elements, not consisting solely of physical violence (e.g. verbal abuse, psychological abuse, financial abuse, sexual abuse). Three superordinate themes emerged in relation to role and responsibility: (1) duty and responsibility, (2) suspicion, and (3) role conflict.

Superordinate Theme: A Sense of Duty

At the beginning of each interview, participants were asked about what they think intimate partner violence against woman is, and what they think their professional role is in relation to treating patients who are abused. None of the participants equivocated or presented any indication of uncertainty about what they believe their role to be in relation to treating abused women. The general sentiment was exemplified in Michael's assertion that ... "physicians play a key role..." in identifying and helping abused women.

However, this is not to say that participants felt that this was an easy task, nor that this role is straightforward and uncomplicated. Michael's simple statement embodies the general sentiment in more than one fashion. He highlights the importance of the role itself, but this phrasing also alludes to the specifics of the HCP's role, in that the clinician can act himself or herself as a key to open up the problem to offer potential solutions.

Each participant talked about woman abuse as something that fell under his or her umbrella of care, but also talked about how it relates to his or her personal and professional responsibilities in overt and subtle ways.

Michael blends his personal philosophy about the rights of individuals with the responsibilities he has as a primary care HCP. Participants talked variously about how they viewed their professional and personal responsibilities to deliver comprehensive and appropriate care to the patients in their respective practices. Michael relies on his understanding of his personal stance on the rights of individuals to make sense of and guide how he responds to suspected or disclosed IPV in his professional life:

Ah well um so I've got this sort of basic rule about you know, us as human beings, basically that um really no one has a right to raise a hand to anybody uh ever so and that's at the core and that's actually what kinda um has me quickly organizing my thoughts about how I approach the situation. Um I and I immediately kinda go into the mode of um ensuring that there's a that person knows um about a safe place, knows that we are a safe place. Um, so that's kinda where my energy goes. (Michael, family physician)

For Michael, his personal beliefs about universal human rights intersect with his sense of professional obligation to help his patients. He allows his moral perspective to guide the actions he takes when considering how to engage with his patient and mobilize the resources appropriate to the situation. Furthermore, he views his role largely in terms of being an informational resource for his patient. He reports that he enters a different 'mode' when he encounters this type of situation, and that his 'energy' is channelled into a different place, one that focuses on ensuring that the patient knows her options, and that she feels like she can approach him and his staff members with security. Here Michael's hesitancy and repeated use of fillers (e.g. "um") and repetition highlights the urgency and

weightiness he attaches to his role in trying to ensure his patients are safe from harm (c.f. Holtgraves & Lasky, 1999; Perkins & Milroy, 1997).

For most of the participants, the decision to screen was left up to the individual HCP. While three other HCPs said that they make a concerted effort to ask every woman about safety at home, Sarah's practice was the only one in which every patient was asked as a routinized matter of course:

Um, and so as part of the policy and procedure here at [workplace], every woman is asked about abuse. So it's it's our standard of care. (Sarah, nurse practitioner)

For Sarah then, there is no room for decisions about whether or not to screen; it is built into the nature of her practice. To not ask is not an option, and Sarah believes this policy to be in congruent with her role in supporting health holistically.

Subordinate theme: Whole person health. Participants indicated that they were responsible for diverse aspects of their patient's health. They considered all elements of a person's life to be under their purview, and suggested that they need to be mindful of all of the things that can influence a person's well-being.

Well I think that in a situation of intimate partner violence within ah within a relationship is a health issue. I *know* it's a health issue because it has an impact on people's physical health and mental well-being. (Karen, family physician)

For Karen, looking for and supporting abused women automatically falls under her professional role because she knows it to influence a person's overall health. Karen's view of her role as a family physician encompasses treatment of physical and mental health conditions. She also perceives her role as a HCP to encompass

knowing and investigating any and all other factors that are present in a patient's life, given that these factors have bearing on a patient's health and well-being.

Roger suggests that the unique position he occupies in people's lives by virtue of his occupation gives him both the opportunity and responsibility to inquire about all aspects of people's lives that may affect their health.

Um, well I think it is a pivotal role ah in a lot of cases because often times as as a family physician, you have that um, that trust situation, developed over over a number of years of looking after after individuals that ah would allow you, does allow you to to investigate, to ask questions that many other people might not be given societal or individual ah permission to ask, I think the role is is pivotal. (Roger, family physician)

He feels an imperative to use his socially sanctioned ability to involve himself in diverse areas of patients' lives in order to help improve their quality of life. Because of this unique position, he views his role as 'pivotal' in relation to woman abuse, as he may be granted access into areas of his patient's experience that may otherwise remain hidden.

Finally, Sarah's training and identity as a registered nurse practitioner has a central part in her understanding of her role in woman abuse:

[...] you know ultimately we started out as nurses. To the core we are nurses. And so we for the most part we practice holistically and we look at the social implications. (Sarah, nurse practitioner)

Beth adds to Sarah's understanding of a nurse practitioner's role to encompass any life events or situations, regardless of the valence of their impact on a patient's life. Beth also

believes that she has a role to play in investigating and exploring all areas of a patient's life:

Well I think we have a role in every facet of the patient or the client's life, so whatever area that's troubling them or any kind of area that's kind of affecting them negatively or positively, also. (Beth, nurse practitioner)

Everything that occurs in a patient's life falls under Beth's understanding of her role in the well-being of her patients.

Subordinate theme: Awareness and vigilance. Most participants discussed how a component of taking a wide-angle view of a HCP's role in relation to health and well-being in all life domains was the development and maintenance of awareness of non-medical issues in the lives of patients. Awareness of risk factors for woman abuse and presentational cues that may be indicators of the presence of violence or abuse in a woman's life were cited by all physicians as being important to fulfilling their roles as HCPs. In the absence of this awareness, HCPs recognized that more obvious indicators of violence or abuse (e.g., emergency room records, bruises, broken bones) would be necessary to identify a woman who is being battered by her male partner.

Roger talks about a sense of implicit responsibility to notice indicators that a woman may be experiencing violence:

It really is, I think, um...areas ah that um that a a ah a good family physician, someone who has been looking after people for a period of time, who has some trust on those signs, uh is is in an ideal situation to to begin to ask questions about about um particularly if there are concerns,

particularly if there are ah little red flags or or that sense that something is not right to begin to ask questions. (Roger, family physician)

Roger recognizes that his unique position in the lives of his patients affords him opportunities that he would not have if they had a different relationship, and that he is given the authority or right by virtue of his role to probe into life areas that others may not have social permission to access. Because he believes people will allow him into more private life domains (woman abuse and other sensitive topics) he also feels as though he has a responsibility to act on this.

Closely related to the perceived responsibility to be aware of the potential for violence in patient's lives was the experience of suspicion when obvious physical markers of abuse (and considering that not all abusive men physically abuse their partner) were absent. Instead of clear signs, it was often subtle cues in a patient's presentation, or generalized complaints, that caused a participant to feel that something was not "right" with their patient.

[...] ah but I think that having a high level of suspicion, um under certain circumstances there are certain um presentations um so there could be emotional, psychological, mental health-type presentations, but there could be physical- now, could be physical very specific physical, like bruises and cuts and breaks and stuff like that but it can also be non-specific symptoms. (Michael, family physician)

Implicit in Michael's reflection on his role in maintaining awareness for the potential of abuse in the lives of his patients was the understanding that you need to be aware of constellations of indicators that may point to a woman who has an abusive partner. His

focus on the non-physical indicators of abuse displays his knowledge of the diverse forms that abuse can take and the potential for its consequences to manifest in different ways.

What is particularly informative is that he looks first to the more subtle indicators of violence, acknowledging that they are more likely to be what leads to suspicion of abuse.

The HCPs reported awareness of the potential for violence in the lives of patients and what the subtle indicators of this might be as being antecedents of their suspicion.

The experience of suspicion proved central to physicians' and nurse practitioners' interactions with women in their practice, and was most often what initiated conversations about relationship safety. This awareness of abuse is not referring to sensitivity in the clinical setting per se but rather a knowledge-based awareness, i.e., knowledge of woman abuse as a social or health-related phenomenon. Rather this awareness or lack thereof is significant in that if an HCP does not have the background knowledge of abuse, it removes the possibility that they could ever think it would be happening. If he or she does not have this awareness, then abuse as a possible factor in the lives of patients does not exist, whether or not it is present in the patients'.

Superordinate theme: Suspicion

Overt physical abuse was something that participants reported not seeing often. Because of the relative infrequency with which these cases are seen, our discussions tended to center on more subtle presentations that may indicate abuse, and how the HCPs identify and go about investigating these potential cases. As previously presented, all HCPs talked about having a responsibility to be aware that relationship dysfunction, abuse, and violence may be something that women in their practice are living with. Furthermore, most participants reported that routine screening for abuse is not something

they engage in. Instead, participants reported that they typically ask about relationship dysfunction or whether someone feels safe at home if something in the patient's symptoms or presentation style "makes me suspicious" (Glenn). Thus, for more than half of the HCPs in this study, suspicions resulting from unusual constellations of symptoms or changes in the presentational style of a given woman were necessary and sufficient to initiate questioning in a given medical encounter.

This experience of suspicion was reported by the first participant I interviewed, and thinking it an interesting topic to explore further, I began to ask all participants about their experience of being suspicious, or rather "what suspicion feels like" or "what is suspicion like for you?" as well as how they would respond to their suspicion. This characterization of awareness in and of itself was important, and was closely linked to how HCPs talked about becoming suspicious of potential abuse.

Subordinate theme: A sense. Every HCP in this study talked about one or more occasions in which they had experienced suspicion. While a universal experience, it was difficult for most to articulate what the experience of feeling suspicious is like.

Something's not right. You know, it's just a sixth sense almost, that something isn't right, or that something has changed. (Roger, family physician)

Suspicion could be brought about by a change in 'something', as Roger discussed.

Suspicion, for Roger, is something that he cannot easily define, but knows when something is amiss. He is not equivocal about feeling suspicious. Michael talks about his suspicion using more concrete terms, citing particular cues or signs that, for him, are

indicators that something may be happening in a patient's life that is not attributable to medical causes.

So somebody that has hyperventilation episodes or panic attacks, you know we'll all agree that those things can occur out of the blue. We'll also agree that you know subconsciously there can be causes that aren't clearly understood at the time as a connection. (Michael, family physician)

Michael suggests that he will first look for a medical or psychological source for new symptoms, but will also be aware of the possibility that these new symptoms could be in response to an event or situation that he does not yet know about. He leaves open the unspoken possibility that he does not yet have a complete picture of the woman's situation with her husband or partner, and that abuse could be a precipitator of the medical or psychological complaints of his patient. He goes on to describe:

I think it's about awareness and um you know sort of cueing in to clues that make one suspicious. Like not suspicious in that kind of way, like suspicious like, um triggers a kind of a thought that says, I need to be thinking about this. [...] at the same time I'm left with this little thing in the back of my head. Um where I'm I'll my level of sort of ah my antennae are going to be much more tuned to a higher game and just paying attention to what's going on. (Michael, family physician)

Michael identifies his awareness of the real possibility of violence or abuse as his knowledge of the signs are often associated with abuse. His awareness heightens his sensitivity to potential indicators of abuse, or highlights their relevance in light of other pieces of evidence. The suspicious feeling causes additional vigilance to look for

additional indicators for particular patients in his practice. He is careful to frame his suspicion in a positive light – to ensure that he is understood to be engaging in a suspicious stance characterized by curiosity and concern rather than judgment.

Yeah, I can't say it's a very scientific approach. You know, other than the sort of stuff we talked about earlier, where it would be obvious, people who were always injuring themselves and that kind of thing, but um, it's often just a gut feeling, I don't have... (Karen, family physician)

Similar to the other HCPs in the study, Karen has trouble articulating what her experience of suspicion feels like, though it is clear that she experiences it as a visceral, real response to a given set of indicators of circumstances. She also alludes to the subtlety with which cases of woman abuse would typically present, as opposed to the more obvious instances that would be characterized by evidence of injury. There is a sense that Karen is not at ease with her inability to describe or objectively outline what may be the cause of her suspicion. Karen gives the impression that she would rather be able to come to a more finite assessment, but will pay attention to her intuition and clinical judgement when she experiences a 'gut feeling'.

This sense of suspicion differs from awareness of woman abuse in and of itself, in that awareness as previously conceptualized refers to a knowledge that some women in their practices will eventually or are currently being abused by their male partner. For if an HCP is not aware that abuse occurs in the lives of their patients, it is a foregone conclusion that they will not be able to identify it.

Subordinate theme: Trusting judgement .While the HCPs typically had difficulty describing their experience of suspicion, for the most part, they trusted their

judgement. The majority of participants did not question whether their suspicion was founded once it had been ‘triggered’.

I I use it a lot (laughs) and um, just cause I think it's it's it's really it's something in your mind, it's telling you investigate this further, ask more questions, it's just an uneasy feeling that I haven't covered all of the bases. And so, it just...yeah. [...] Yeah, it's it's obviously difficult to pinpoint but it's just I think you have to go with your gut a lot of the time? And just kind of always keep an eye out for that in the back of your mind, that it's not always just physical, what else is going on mentally that you know might be causing these symptoms. (Beth, nurse practitioner)

Here Beth echoes others’ inability to articulate what exactly suspicion feels like, but she treats it as a genuine indicator – as something that exists, and that indicates the potential for distress in the life of a patient. Her difficulty with defining suspicion is also evident in her hesitant, halting, and imprecise speech surrounding this issue in particular. However, she does consider her suspicion to be important, and it spurs her to maintain vigilance and awareness by “keeping an eye out” and approaching a given case with an investigative stance. This unease spurs her to continue to investigate possible causes for her suspicion or sense of some causal factor for a patient’s symptoms that is not immediately apparent. Other HCPs also acknowledge placing trust in their intuiting in a clinical setting.

Professionally, um, I trust my gut pretty well. (Karen, family physician)

Karen also relies on an indefinable aspect of her clinical judgement to guide her interactions with clients. This reliance on the subjective experience of suspicion is commonly cited by the HCPs in the study. What is also significant is that while they are

not able to quantify or fully explain what may cause their suspicion, they report that they do not doubt its accuracy, and their experience of suspicion is taken seriously and used to guide information gathering with their patients.

While the HCPs trusted their suspicion when it was triggered by cues in their patient's presentation, some also felt that they may be missing signals in some of their patients, and therefore missing opportunities to identify abuse.

[...] early on in my my career I practiced in a in a smaller community than [current city] and I'd have to say, I don't honestly remember a lot of cases that at the time would we would have called woman abuse. Ah, in retrospect, looking back, there probably were more than, than we um, identified at the time, particularly as I think we're seeing an expansion of what abuse is. And I think at that time it was more physical abuse, the black eye, and the bruising and that sort of thing, and and um if we didn't see it it maybe was cause the women didn't come into the office, I don't know. (Roger, family physician)

Here, Roger orients to the possibility that he has missed identifying cases of woman abuse among his the patients he has seen throughout his career, and admits that it has likely occurred. He partially attributes this to changing cultural conceptions of what sorts of behaviours or injuries constitute woman abuse.

Decades ago, both social constructions of woman abuse, and his own personal understanding were substantially narrower than our present definitions, and he attributes this limited conception of abuse as being at least partially responsible for his hypothesized failure to identify some cases. He also suggests that it was

not only his own understanding of the parameters of what constitutes abuse that may have been barriers to identification, but that the women themselves may not have considered their male partner's behaviours as abusive, or that they would not come in to see him when there were obvious physical indicators of their victimization. In sum, he attributes his possible misidentification (or non-identification) of woman abuse to both internal and socio-historical factors.

Subordinate theme: Suspicion as a catalyst. Beyond the experience of suspicion itself, participants reflected that it is typically their sense of something not being 'right' that spurs them to ask about relationship issues or whether a woman feels safe at home. Suspicion as a catalyst for action is particularly meaningful, as participants reported that spontaneous disclosure is something that has never happened, or is very unlikely to happen in their practice. Rather, disclosures of current or former abuse require the HCP inquiring about the quality of a person's relationship. While only one HCP reported screening every patient, others said it is something that they try to do, but are not sure if they have succeeded. In all but two practices, this type of dialogue would typically be initiated based on the HCP's sense that something is "not quite right" in the patient's life, or in their relationship, based on particular presentations or constellations of complaints.

Well if if you're suspicious that there may be some abuse with the individual, like if I've got three emergency room forms or if I've been involved in emergency situation or a situation period where I've had to deal with the individual and finally it triggers in my mind that maybe

there's more to this than meets the eye, I'll just ask outright about it (Carl, family physician)

Here Carl discusses his experience of suspicion in response to a more overt set of circumstances, with reasonably clear evidence of abuse and presentation in which indicators add up in order for his suspicion to be 'triggered'. Carl talks about suspicion being triggered as if it is beyond his control, that eventually pieces of information accumulate until a critical mass of a sort is achieved, at which point, he suddenly recognizes that a woman may be abused by her partner, revealing something that was previously hidden. These discrete pieces of information collect, and all at once they are considered as in relation to each other, and a pattern indicative of abuse is apparent to him, one that he did not see or consider prior to the 'trigger'.

Anne also discusses the accumulation of discrete pieces of information in relation to developing a suspicion about abuse:

Sometimes it would be the persons making little comments about how home situation is not good not great um how their partner might be difficult so sometimes it's the a comment that a person made um sometimes it's um a person comes with a complaint then after a while I start thinking that maybe this seems to be a lot more related maybe to psychological issues than to physical issues then as I explore more then I might you know try to find out more about that specifically (Anne, family physician)

Similarly to Carl, Anne reflects about her suspicion being the result of the accumulation of small pieces of evidence over time that coalesce into a new understanding of what each individual piece means. She leaves the impression that suspicion is achieved when she recognizes that the whole is bigger (or distinct from) than the sum of its constituent parts.

Most of the HCPs reported that their suspicion resulted from a constellation of possible cues or signifiers of abuse, or resulted from a change in the patient's personality or mode of presentation or interaction. However, for one HCP, suspicion took on a different role, as she suspected the presence of abuse or a history of abuse for all of her patients. In Diane's case, working with a population at risk of homelessness, it was more common than not for Diane's patients (both men and women) to disclose that they had experienced one or more forms of victimization in their lifetime. Thus, suspicion was a superordinate theme in all but one participant's interpretation, where instead of suspicion of abuse, there was an assumption that abuse has occurred or is occurring in the lives of all patients in the practice.

Oh yeah, I always suspect I mean I pretty well know, I pretty well know.

Anyone who comes into my clinic has had some horrendous things happen to them, so that's that's just an automatic, an assumption and it's generally a pretty good assumption. And it's just a matter of when they're ready to disclose. (Diane, nurse practitioner)

Therefore, for Diane, suspicion took on a different form, and caused her to always be on the lookout for signifiers of present abuse, or to be ready to receive a disclosure from one of her patients. For her, suspicion is transformed into nearly a certainty, and she is

confident in her assessment that the majority of those who she provides care for will eventually disclose to her if given enough time.

The theme of suspicion was pronounced among all of the participants. Universally, suspicion was difficult to define and articulate beyond a sense that something is different, or is not right in a patient's life. HCPs generally trust their feelings of suspicion and these 'gut' feelings are cited as instigators of opening up discussions with women about their relationships, or whether their partner is making them feel unsafe. Ultimately, when a HCP was suspicious that a woman in their practice may be abused, they felt a responsibility to interrogate this suspicion through probing, or keeping the possibility of violence in the back of their mind, to be called up in future interactions with the patient.

Superordinate Theme: Roles in Conflict

In light of HCP's shared sense of duty and of the importance to be aware of woman abuse, it is interesting that none of them felt as though they are well equipped on at least some level to deal with these situations competently when they arise. The previously discussed idea of a push-pull sort of tension that several participants felt when trying to elicit information or disclosures from their patients is echoed in their feelings about their competing professional priorities. These feelings result from their experience of having unmet needs within the medical establishment. HCPs often expressed the sentiment that they feel as though they are expected to take on so many roles, and to engage in such diverse activities that it is difficult to feel competent in their multifaceted role. In response, some force themselves to recognize that they are just one person with finite resources themselves, and cannot therefore be everything to everyone. They also

get the sense that they feel at times that they are letting themselves or their patients down by having to admit their limitations.

Subordinate theme: Ill-equipped and overwhelmed. When participants were asked about what training they had received in medical or nursing school about woman abuse, results were mixed. Unsurprisingly, the younger HCPs (who had been trained more recently) had more exposure to abuse-related education in medical school. However, the majority knew about and discussed available continuing education opportunities (i.e., workshops, conference presentations), whether or not they had participated. All HCPs who have been educated about woman abuse reported that they appreciated the training they received, and most said that more training would be beneficial. However, two physicians expressed concern that there is too much to learn during medical school as it is, and that additional coverage may not be effective. A common sentiment among HCPs was that, even when abuse is taught, coverage is limited, and there are an overwhelming number of things in which to gain knowledge and competencies.

Carl had the least educational (and cultural experience) with woman abuse, both as the oldest participant and having been trained in the 1950s, before intimate partner violence against women was widely recognized as a social issue (and later as a health issue). All of the other HCPs have received some training in medical or nursing school or in their ongoing voluntary training. Carl's experience exemplifies the limited exposure and training that many HCPs have to work through in relation to how to inquire about and best serve patients who experience woman abuse. When asked about what education, if any, he received on woman abuse while in medical school or beyond, he says:

I mean this this type of thing wasn't brought up at all. And when you interned and went into practice ah again there there wasn't any mention of it either as part of the intern training that you get in the hospitals. Wasn't any of that stuff brought up at all. (Carl, family physician)

While Carl believes it is part of his role to assist women in his practice who are abused by their male partners, he admits that it is not something that he was formally trained in. Instead, it was something he had to learn about on the job, over time, without direct guidance. Carl is referring to a time in the past when talking to patients about more 'intimate' concerns, and he is implying that he was trained under circumstances that were much different than of those today, thereby contextualizing his lack of experience.

Michael also reports not receiving training in medical school, but states that he has taken it upon himself to attend ongoing training sessions on woman abuse. He describes the problem that he and other family physicians face.

Um well you know the additional ongoing training is you know in medicine um you can graduate and never go for anything else in terms of any other education. In family medicine we do have a requirement of like 50 hours a year of additional education which of course as you know in family medicine we've got soup to nuts, pretty much anything and everything so there's a a massive amount of stuff that we're exposed to.

(Michael, family physician)

Michael is troubled by the fact that family physicians do not have to receive ongoing training in particular content areas to keep their knowledge up to date. He looks at the annual 50-hour training requirement favourably, but the dilemma is that there are so

many possible areas to choose to be trained in (“soup to nuts”) that 50 hours seems like very little time to cover all of the topics relevant to primary care. It seems that Michael feels restricted in his ability to access knowledge and gain competencies.

The diversity of experiences and situations faced by primary care HCPs on a regular basis poses a difficulty, in that there may be a sacrifice of breadth for depth, and one may get “exposed” to a great number of topics without the opportunity to gain true expertise. Karen amplifies Michael’s assessment of the situation:

So I don't think it's shocking that a lot of doctors lack knowledge on the topic cause there are so many other topics that are much more in our faces, you know? [...] I mean the stats are always staggering and they are always a good way to preface a talk but there's a lot of, like practically speaking, like what can you do? What, you know, how can you help? And I think really trying to drive home the point that this could happen to anyone (unintelligible). So I mean I think- that it's good, it's like pretty much everything else that we learn, it would be nice if there was more, you know, but there's just often not enough time... (Karen, family physician)

Karen’s interpretation for an assumed general lack of knowledge about woman abuse in the medical community is that physicians (and potentially other HCPs) are inundated with vast amounts of information on diverse topics, necessitating one to become a generalist of sorts in many areas. She feels some frustration regarding her ability to internalize all of the diverse skills and content areas with which they are faced, requiring a divided attention. Therefore it does not surprise her that she and others do not have as much information about woman abuse as she feels they need to care for patients

effectively. Even the cadence and tone of Karen's speech lends a sense of breathlessness and urgency to her assessment of the situation, conveying a sense of urgency related to her assessment of her situation, and need to cover so much ground.

A common sentiment among the HCPs in this study was that, while they have internalized asking about and offering support for abused women as part of their role as primary care providers, their general lack of education on the topic ill equips them to deal with it in practice. Each of the HCPs was aware of continuing education opportunities for woman abuse and related topics and several of the participants have availed themselves of these resources. That education is not consistent across professions or over time within professions indicates that HCPs' knowledge of woman abuse, as well as how to approach and support abused women, exists on a continuum and that individual interest in the topic likely has a strong bearing on awareness and knowledge.

Subordinate theme: Realities of practice. Subsumed under concerns about and expressions of conflicting roles and responsibilities is the necessity of dealing with temporal and resource-based realities that are largely outside of any given practitioner's control. This concern about whether or not one has time to effectively engage with and help an abused woman explore her options was very different for the nurse practitioners in this study versus family physicians working in private practices.

For physicians working in private practices, there is a continual awareness of the time constraints they are under while they are with their patients. When complicated or sensitive issues such as the potential for violence or abuse in a woman's life arise in a medical encounter with a patient, it can disrupt the schedule that is planned for the day. Karen reveals that this is often on her mind:

[..] I don't think there's any denying that lots of days you're also thinking, "15 minutes, 15 minutes, 15 minutes. (Karen, family physician)

As much as her phrasing reveals that she would like to have less concern for time, it nevertheless is a reality that she has to deal with in her practice. Karen feels pressure to maintain the flow of patients through her office and unexpected revelations or having to investigate suspicions about a patient's safety and well-being cause her to worry that she will not meet her schedule and possibly prevent her from meeting other patients' needs.

Michael also shows his orientation to the time limitations he has in his practice, but emphasises that he does not heed these limitations when he feels that there is an issue that he thinks must be addressed within a visit.

Michael: I usually try and well I usually achieve the you know the end point by having enough like giving the patient time. It's not like, okay I've got 10 minutes you know, like this (unintelligible) you know the joke is those kinds issues come out when the physician's got their hand on the handlebar...

Courtney: Yes, the hand on the door phenomenon?

Michael: ...before they are leaving the room and that's when they tell you about it and you're like already you know, already behind. So, that's when I sit them down and say, "okay we're kinda dealing with this" and there's none of this, "oh you know, make another appointment in 2 weeks" because that's a that's an opportunity missed, so yeah. (Michael, family physician)

He recognizes the constraints on his time but actively tries not to let his limitations affect the care that he is able to give his patients. He anticipates that unexpected things will come out in his visits with patients, making an allusion to the ‘hand on the door’ or ‘by the way’ phenomenon that is well-known to clinicians in which a patient will raise a new, often significant concern just as the physician or other HCP is exiting the encounter. Knowing his constraints, he simultaneously recognizes that some emergent issues may be of a more acute nature and are best dealt with in the moment. Consequently, he will at times ensure that the emergent topic (such as an indicator of violence or abuse, or other significant health concern) is dealt with before the woman leaves his office.

In contrast to most family physicians who took part in this study, the nurse practitioners reported having sufficient time with their patients.

So in my practice I'm very fortunate that I can I book my own appointments and I can set my own time. [...] Everybody has a story, um and when they're ready to share it, you wanna be ready to listen to it.

(Sarah, nurse practitioner)

Sarah reflects on the importance of being there for a patient whenever they are ready to disclose something that is difficult to disclose – particularly violence or abuse at the hands of a male partner. She recognizes that her position as a nurse practitioner affords her more time and flexibility with her time than those in other medical specializations. Therefore, she feels able to build time into her day in anticipation that some patients will require more of her time, and that she does not want to inhibit her ability to elicit disclosures and truly be able to take the time to listen to her patients and what they have

to tell her. She recognizes that all people have things that they will need to disclose, and that it is important for her to be able to listen when a person decides to reveal her/his story.

Diane, who is also a nurse practitioner elaborates on the theme:

Yeah yeah, for nurse practitioners, we are paid a salary. Um, there's an expectation of how many patients you see a day, but we're no means- and and then working with this population, I mean the management, the Ministry, everyone knows we're not gonna pump out 20 or 40 patients a day. You know, um, so you know a busy day might mean you see, you have 10-14 patients and I'm saying that's a busy day. (Diane, nurse practitioner)

Here Diane conveys a sense that she feels as though she does not have to live up to expectations that, for her, appear to be unreasonable. Her assessment of her own situation and that of physicians builds a contrast between a less restricted atmosphere in terms of time constraints versus a very restricted atmosphere that is attributed to physicians' practices. She gives the impression of a mechanistic, assembly line approach to patient care, an approach to which she is not tied by virtue of her position as a nurse practitioner. She does not leave the impression that she feels restricted or that she lacks control over her ability to provide the type of care for her patients she desires to deliver.

Time pressures were not the only resource-based challenges encountered by HCPs. Two participants discussed the difficulties they face when trying to provide care for patients who do not speak English and require the services of a translator to communicate with their HCP.

I don't like to use family members or their child, um but because of where I work there's many times that we can, I can um schedule one. [...] You know, I needed an outsider, I needed them separated, I needed an outside source to get both sides of the story, to really help them. [...] We need more more healthcare providers to utilize interpretation services. Even though it's expensive, it's- and to have professional interpreters. It's very important because otherwise you don't get the full story. And even then using one like we said, you have the three person...Even with the professional interpreter who's just a mouthpiece, you're still losing that connection with the patient that that form of communication that is just with two people who are able to communicate together. So yes, a lot of different facets to it. (Beth, nurse practitioner)

Working with a highly multicultural population at times poses additional challenges for HCPs. One of the major barriers that Beth frequently encounters is the inability to communicate in a dyad with her patients. Working with a professional interpreter as a intermediary is still difficult, but she finds building trust and relationships with patients even more difficult if a family member acts as translator. Here the necessity of having an interpreter presents a challenge for Beth because she feels that she is unable to truly gain access to the realities of her patients' lives if she cannot communicate with them directly, and is frustrated by this. She does acknowledge the realities of the situation, and accepts that she has no actual control over the ability to obtain the services of a professional

interpreter, as much as she believes she will be more successful in her role if she has that access.

Inquiring about Abuse and Handling Disclosures: A Journey through Uncertainty

Most of the HCPs who participated in this study have experience treating patients who have experienced intimate partner violence, or whom they strongly suspect have experienced woman abuse but have not disclosed this. As an example of how commonly this comes up in some practices, Sarah and Michael had both talked with patients about possible abuse on the day we met for their interviews. For Karen, who has not been practicing long, the very first person she asked disclosed that they were currently being abused. Diane, who provides care for members of a highly marginalized population assumes (correctly) that nearly all of her patients have experienced abuse, and that it is just a matter of time, and trust before they disclose to her. Each patient in Sarah's practice is regularly screened for abuse. While not all of the HCPs in this study ask patients with such frequency, each has been suspicious of abuse at some point, and has (or has tried to) engage in dialogue to gather information and potentially elicit a disclosure in these situations.

Superordinate Theme: Uncertainty (And Everything Else)

Throughout the analysis, the experience of uncertainty kept cropping up when participants would speak of how to ask about abuse, how to decide on what the next steps for the patient should be, how to deal with their emotions and that of their patients, and what they need to make asking about and dealing with violence easier. That is, uncertainty seems to permeate HCPs experience in dealing with abuse among their patients, and is therefore critical to consider when interpreting all aspects of their

experiences with their patients. Thus, while not manifested or here presented as a typical theme in and of itself, considering the ever-present uncertainty that characterizes HCPs' feelings and thoughts about providing care for patients who experience abuse is important. Moreover, participants' experiences of uncertainty can be witnessed by the reader in the frequency with which participants can be seen to engage in hesitant, halting descriptions of events and their reactions to and interpretations of their experiences with patients who are abused.

Therefore, uncertainty has a place both subordinate to the subsequent themes, and also as a higher-level theme; it cannot be separated from each aspect of the HCPs' narratives without sacrificing understanding of their individual and collective experience. This uncertainty pervades talk about whether and how to seek a disclosure, what to do if a disclosure occurs (or does not occur) and with the outcomes. For lack of a better term or heuristic, uncertainty has been positioned as a superordinate theme, but this is not completely accurate as it should be both conceptually foregrounded or thought about as being positioned as a superordinate theme and also thought of as concurrently being subordinate to all of the themes presented below.

Superordinate Theme: Asking and Disclosing as a Place

When discussing what it is like to ask a patient about abuse when they experience suspicion, HCPs described their experiences surrounding inquiries in remarkably similar ways. There was a substantial amount of spatial talk around the process of asking, and what it is like for HCPs to ask women about whether they are safe at home, or whether they are being abused. While individuals differed on what this metaphorical place it was that they likened asking to hasten their arrival at a potentially treacherous destination.

The sense that they were going somewhere else, or embarking on a journey with a patient when they began a line of inquiry pervaded their descriptions of asking about abuse and obtaining a resultant disclosure (or non-disclosure).

Subordinate theme: Going somewhere else. All HCPs talked about asking about abuse in ways that made allusions to going to a place, or entering some part of a person that is seldom breached. Similarly, other HCPs talked about disclosure as residing within a person, or as something that comes to the surface with time (or does not come to the surface and remains hidden). This place that one tries to reach when asking about abuse is understood to exist somewhere within a person, though knowledge of the destination does not extend to knowing what will be found there when (or if) it is reached. It is expected that there may be resistance to getting to this place (a disclosure of abuse) on the part of the patient, and the HCPs' route may be blocked entirely, or it may take some time and persistence to arrive at a disclosure.

...you can only go as far as someone is willing to let you go so...um, just wait. [...] It's strange though as you are getting into beginning to question I think probably um there's more of a sense of, I need to go slow, I need to find out where people are willing to go with that. (Roger, family physician)

Roger recognizes that how 'far' he can get in terms of eliciting a disclosure is very much dependent on the will of his patient, and that sometimes there is a need for him to be delicate and careful as he begins to ask about abuse. He also shows his understanding that pushing or probing too hard at the beginning of a dialogue may not be ideal for eliciting disclosure, and that he needs to demonstrate patience and be careful to follow his

patient's lead when discussing this delicate topic. Essentially, he realizes that they have control over how much he will find out.

Karen also talks about how asking about abuse is like embarking on a journey, or going to a different place with a patient.

Um, I always feel a little bit like I'm taking a leap somewhere, you know?

Cause you never know what people are gonna say and um I dunno, I mean

I guess that's the thing, right? (Karen, family physician)

For Karen, embarking on the journey of asking and disclosure with her patients can be analogized to entering unknown territory. She does not know what to expect – whether or not the woman will say that her husband or partner is abusive – when she starts her line of inquiry, and this causes her some unease.

Most participants understood talking about abuse with their patients to be akin to trying to move somewhere else; somewhere outside of the typical conversation between HCPs and patients. While asking and disclosing can be likened to travelling down a road or within a person to arrive at the destination, it is also no foregone conclusion that the end of the journey will be disclosure.

Subordinate: What will you find? While many HCPs feel that they are embarking on unfamiliar territory and moving outside of the bounds of the typical medical encounter when they ask about violence with their female patients, they are also unsure or uncertain about what they will find when they arrive at their 'destination'. Several HCPs convey a sense that they could be opening themselves up to deal with the unexpected when they open a conversation about violence or abuse with a patient. Carl, while he reports seldom having cause to ask his own women patients about battering or

abuse, thinks that physicians and other HCPs may be opening themselves up to many unknowns when asking about abuse.

Now whether these guys today, in asking the question, get ah sort of open

Pandora's box and they get it. (Carl, family physician)

The Pandora 's Box metaphor is significant in that it shows that Carl understands asking and obtaining a disclosure about abuse as something that cannot be undone, and that they are then responsible to deal with the consequences of any disclosure.

...like holy cow, does that ever open up a can of worms that is gonna be a challenge to deal with, usually. (Karen, family physician)

In a similar vein, Karen talks about how asking about abuse can 'open up a can of worms'. She thinks that once you go down the path, what you uncover or reveal can be difficult to manage, and things cannot be untold once someone discloses abuse. While not explicit in either Carl or Karen's phrasing, there is also the sense that asking about violence and abuse with female patients is like opening up oneself to an unknown – at the outset a HCP does not know what the answer to the question will prove to be, or what they should be expected to do about it. This "Pandora's box" or "can of worms" metaphor is not only used in relation to the plight of their patients, but also as it relates to their perceptions of their own abilities to handle these situations. This concern is then both in reference to the unknown character of these lines of inquiry but is also oriented toward protecting the emotions of the HCP and their fear that they will not be able to help their patient.

Subordinate theme: Resistance. As much as participants described asking about abuse as trying to go to a different place, and the patient's disclosure of abuse as being

the destination, or endpoint, they also felt that it can be a difficult place to reach, and that their patients often resist them getting there. Building upon the notion of asking as trying to get to a place, Carl recalls a particularly illustrative example from his practice when he was highly suspicious that one of his patients was being abused physically by her husband:

...I'd get somewhat suspicious and lean into it a bit more. [...] Because you keep questioning, working around it and if you're still getting, you know, a negative attitude, a negative response, then you just stay away from it. [...] And getting nowhere with it. (Carl, family physician)

In his description of how he questioned this woman, the references to space and trying to reach a place abound. He talks about having to work around something, having to essentially come at the topic from different angles, and of having to 'lean into it' in attempt to gain more information as he was getting 'nowhere' in his attempt to elicit a disclosure. His frustration is also apparent, as he is rebuffed in his attempts to find out whether her husband is assaulting her, and eventually is not able to obtain a disclosure from his patient.

Karen also feels as though she must try to get at the information that her patient is holding inside when she senses or 'knows' that she is being held back by her patient.

So I mean, sometimes I know that somebody's hiding something or not telling the whole story or whatever. I- you know, I might pursue it a bit, but I also think it's really important that people not be made to feel uncomfortable in my office more than necessary [...] For most people, you have to drag this out. (Karen, family physician)

She recognizes that her pursuit of this hidden information is important, but at the same time is careful not to go farther than her patient is comfortable. In contrast with her perception that she must know when to stop pursuing, she believes that for most people, a disclosure does not come easily and requires substantial work on her part. This indicates that there is a pronounced tension for Karen between the need to go after information that she believes to be hidden while at the same time ensuring that she does not push her patient farther than she is ready to go. Beth displays a similar orientation towards pursuit of disclosure when asked about how she approaches a woman when she feels suspicious:

I I can only, I don't want to hound people. (Beth, nurse practitioner)

Here Beth is mindful that she can only go so far with people – as far as they will allow her. She does not want to ‘hound’ someone through continued questioning about their partner’s behaviour or whether they feel safe. Use of the term ‘hound’ suggests that she is careful to ensure that her patients do not feel pressured or hunted because of her questioning, and careful that they will not flee from her inquiries as though they were her quarry.

Ultimately, the HCPs recognized that their ability to ascertain the realities of whether or not a patient in their care was experiencing abuse was something that they required cooperation to determine. They were most often careful to work in a non-adversarial way with their patients in order to remain open to receiving a disclosure without applying a great deal of pressure; pressure which the HCPs felt may work against them in reaching a disclosure.

Superordinate Theme: Working (to Guide) Without a Roadmap

In order to feel comfortable asking their patients about whether they may be experiencing abuse from a male partner, all HCPs discussed having to do various forms of cognitive and emotional preparation prior to asking and throughout the process of caring for women who disclose violence or abuse. Interwoven through each person's narrative is a palpable, constant awareness of the importance of being sensitive to the needs of the person they are providing care for, beyond their own needs. Partially, this intent is linked to their understanding of themselves as professionals, and a belief that their own evaluations and feelings should not have a central place in their dealings with patients, or at least should not be visible if this will negatively affect their patients.

Subordinate theme: Fighting the need to 'fix'. A common sentiment among the HCPs is that they experience difficulty dealing with their inability to create a resolution for the abuse a woman may be experiencing at the hands of her male partner.

Yeah, I mean I think it's partly frustration with yourself because we're sort of fixers, right? So you're taught to fix things, and that's a really hard one to fix. So yeah, frustrated with yourself that you can't do more. [Karen]
...and I I mean I have a tendency to want to fix everything, and that's certainly a difficult thing to fix...[Sarah]

I I think you know I think any nurse that tells you they didn't come into this to take care of people and try to fix things would be lying. Because that's what we do, right? We wanna take care we wanna make things better, and so sometimes it's hard not to just tell them how to fix the problem. They've gotta fix their own problem. (Sarah, nurse practitioner)

Both Karen and Sarah reveal how they have to fight their desire to take over care and decision-making for the patient, as they know that it is ultimately not in their patient's best interest even if her intentions are good. For Sarah, truly helping the women in her practice who experience violence involves relinquishing much of her control over the course of treatment and, in turn, the outcomes for her patient. They both also struggle with their feelings of inadequacy – trained to be healers, they are not able to apply the same skills to these problems, and this causes them to express some uncertainty about their ability to fill their self- and culturally-defined role as someone who solves others' problems. So here they are fighting against what comes naturally to them (the desire and often the ability to fix) with a recognition of their own limitations, and that 'fixing' is not relevant in these scenarios.

It's easy to treat the the medical problems. You know, there's clinical practice guidelines everywhere that tells you how to do it, right? You've got high blood pressure you do this, if the blood pressure's not responsive to this, you do that (laughter). It's it's not really rocket science, right? But the psychosocial? That's rocket science. You almost need a degree in social work or you know, psychology to deal with a lot of our clients cause you know if the psychosocial needs are not being met, you're not gonna have compliance with the the physical part of it, the medical part of it. (Diane, nurse practitioner)

Part of Diane's difficulty in not being able to help her patients in the manner that she is accustomed to, has much to do with the nature of the problem with which she is faced. Abuse, while it may have physical implications, is not physiological in origin and

therefore cannot be treated in the same routinized way in which many medical problems are approached. An additional difficulty related to abuse that Diane encounters is the lack of universally accepted best practices for how to help women who experience violence, so practitioners often has to rely on his or her own judgement. Furthermore, she finds psychosocial issues to be more taxing than physical problems, due to their inherent ambiguity., She leaves the impression that she is less comfortable with these problems because she believes them to be outside of her expertise. The cadence of her speech in the first part of the quote reflects this; it sounds as though she is reading from a checklist while talking about physical concerns. However, when talking about more psychosocial issues, this confident tone is replaced by a voice that is more questioning, and less certain. Diane expresses the concern that dealing with more psychosocial problems may be beyond her scope of practice, and that she finds it very challenging to ensure that she does not take over the decision-making for her patient when it comes to the next steps the woman may want to take after her disclosure.

Subordinate theme: Perspective taking and patient centred practice. In order to effectively create and manage a course of action with their patients following a disclosure of violence or abuse, many HCPs talk about the importance of foregrounding their patient's feelings and thoughts above their own. This stance involves a conscious shift of focus from self to patient. Furthermore, it involves an attempt on behalf of the HCPs to understand the experience of another sufficiently well to permit them to choose an approach that will be optimally beneficial to his or her patient. While patient centered care was a term used by only two of the HCPs, it was clear through their talk that each

recognized the importance of tailoring their treatment on a case-by-case basis. Part of this approach for many HCPs was an active attempt to take their patient's perspective.

Um, I guess I I tend to try and uh, to to the limited degree that I can, try to put myself in people's shoes and uh try to imagine how that would make me feel, um and then sort of transpose that that you know... [...] Cause when it first happens there's a tremendous fear, especially if uh they're financially dependent on him, say well, "how am I ever going to cope? where where will I live?" "how will I take care of my kids?" (Glenn, family physician)

Glenn attempts to position himself (as much as possible) as if he were facing the problems of the woman sitting in front of him. This helps him to understand her potential reluctance to make changes (e.g., leave their partner) or otherwise "rock the boat" (Glenn) following a disclosure that their husband or partner is abusive. Likewise, Michael demonstrates his heightened awareness to the sensitivity to judgement or criticism he expects abused women to have.

...anyone that's been abused, their antennae are very highly tuned to sensing labelling and negative um messaging. And I think that we particularly have to be aware of that so if you're aware of that you actively...choose what you do, how you say it, the words you use.

Sometimes I'll use words that I know may be misinterpreted, but I'll talk to that. I'll say stuff like I I realize that what I'm about to say may be seen a certain way I just need to understand need you to understand that this is the way I'm I'm bringing it to you, it's not- so that person doesn't walk

away wondering, going, what did he say? Or did he just like think negatively of me? Or um think I was stupid or think I was you know, didn't care or something like that? (Michael, family physician)

Here Michael shows recognition of the potential impact that his emotions can have on patient encounters and reflexively examines them. Michael, employing a sort of naturalistic hermeneutics, is interpreting his patient's experience at the same moment that he is assessing his own reactions to, and interpretations of, what he believes his patient to be experiencing. Thus, his own first-level interpretation is backgrounded in order to make central his assessment of how his patient may be interpreting his own response. Thus, he is more concerned by the potential (mis)interpretation of his feelings and motivations on behalf of his patient. His metacognitive understanding is that his patient may not understand where he is coming from, and he shows concern that they reach intersubjective understanding.

Sarah also demonstrates an awareness that she can only act as a facilitator and offer her patients options, but ultimately she has little control over whether or when someone will choose to accept a referral or otherwise make attempts to leave their abuser.

...you can always lead a horse to water, but you can't make them drink. And so, you may have to present those resources to patients on different days, in different ways and they just have to decide when they're ready. (Sarah, nurse practitioner)

Therefore, she accepts that she can only take them as far along the path as they are ready to go and can only pose tentative solutions. She recognizes that nothing may ever come of her attempts to offer help, and that she has to accept that in order to support her patient's decision-making and autonomy, even if she believes that she has a solution to

offer. Relinquishing control or supporting patients to make their own decisions can be difficult, but Karen also recognizes this necessity:

...it's hard sometimes and I think you have- you need to ask the questions about what's going- if that's something the woman wants to share...um about what, where, what solutions she sees, what she wants to do, I mean does she see this as a problem? As something that she wants to change, and you'd be shocked by the amount of people who don't, right? We all, from an outsider's perspective think well of course you want to get out of that situation, but lots of women don't, right? So um so I think yeah, you want to find out what's happening, how it's affecting them, what they want to do about it, and be guided by their suggestions and their desires and ah hopefully offer some help. [...]So I'm not going to bombard that woman with a hundred ways to leave her husband if she's just really really not there, you know? (Karen, family physician)

Karen also describes the imperative to understand what her patient is feeling, and to try to bracket her own reactions and assumptions to an abused woman's situation. She describes how she takes her immediate response of surprise and tries to put it aside and figure out what her patient is feeling or needing in order to care for them properly; to remove herself from the equation so that she can focus more clearly on the needs and desires of her patient. It is as though Karen's inability to understand her patient's experience in relation to her own life experiences requires the shift in focus from one's own understanding to that of the woman who is being abused. She believes that if she responds to her patient's potential resistance based on her own immediate surprise or

disbelief about the patient's desire to maintain her relationship, she is then not going to be able to meet the needs of her patient.

CHAPTER V

DISCUSSION

Summary of Emergent Themes

The purpose of this study was to gain an understanding of the lived experiences of HCPs while asking about and providing care for female patients who are abused by their male partners. The present analysis has established that the HCPs who were interviewed do believe violence against women to be under their professional purview, and that they attach diverse meanings to their encounters with women who are abused. Six superordinate themes emerged from the analysis. These themes were: (a) feeling a sense of duty; (b) suspicion; (c) conflicted roles; (d) uncertainty; (e) asking as a journey, and (f) working (to guide women) without a roadmap. These themes, while not necessarily mapping directly onto the individual experience of each participant, nevertheless reflect the convergence (and occasionally divergence) of experiences among HCPs who were interviewed. Of equal importance to the experiences themselves, were the meanings that participants attached and their understandings of their role in relation to woman abuse. These shared higher-order concepts serve to illuminate the complexities of caring for women who are abused and the necessity of managing their emotional and cognitive responses to his or her patient's plight in order to do so effectively.

Roles and Responsibilities

Sense of duty. Each of the nurse practitioners and family physicians who participated in this study felt that it was part of their role as primary care HCPs to be aware of, to be suspicious about, and to ask about suspected woman abuse among the patients in their practice. Pursuant to this, they also reported that they want to do what

they can (e.g. provide emotional and informational support) to help a woman become safe from violence. Some felt that they were duty-bound to help because of their position as a HCP, while others felt this as a personal moral imperative. Other research has demonstrated that a belief that screening for woman abuse is part of a physician's role is a predictor of asking about abuse, particularly in the absence of physical indicators (Chamberlain & Perham-Hester, 2002). Therefore, in this context, the frequency with which HCPs in this sample discussed abuse with their patients can be understood in relation to their beliefs that identification of woman abuse was part of their professional role. All participants reported having encountered woman abuse or suspected woman abuse in their practice, but there was a wide range in how frequently HCPs encountered or addressed this topic with their patients. Though all had experience in dealing with abuse in practice, educational and clinical experiences did not appear to influence participants' feelings of competence or comfort. In general, the HCPs in this study, like other HCPs in Ontario, have received little education about woman abuse (Wathen et al., 2009), though some have chosen to independently seek out additional ongoing training on this and related topics.

Suspicion. Routine screening for woman abuse was rare among the HCPs in this study. Instead participants discussed how they experienced suspicion that things may not be 'right' in a patient's life. This suspicion was a catalyst for engaging in inquiries about abuse or safety at home. Though participants relied upon and trusted their suspicion, they also had a difficult time articulating what exactly suspicion feels like, or what specifically led to them becoming suspicious in a given situation. For most, suspicion resulted from an accumulation of cues or signals that eventually led to a 'trigger' or realization that

there was perhaps more going on in the patient's life than they were cognizant of. A counterpoint to the experience of suspicion was a concern among some HCPs that they were unaware of cases of abuse or that they had missed cases that they thought they should have been able to identify. Ultimately, they trusted, but did not feel as though they had dominion over their suspicion. Because of this, they sometimes feared that it was absent at certain times, or that it should have been present with certain patients. A review of the literature suggests that the role of suspicion is explicitly acknowledged by HCPs as it related to the identification of cases of various forms of abuse (e.g. Levi, Brown & Erb, 2006; Olive, 1997). Taken together with previous research, the findings of this study further speaks to the clinical significance of suspicion for HCPs in relation to identifying the presence of various forms abuse in the lives of their patients. However, to date there have been no investigations that have explored the subjective experience of suspicion in primary care settings. This underscores the need to examine HCP practice experiences qualitatively to uncover these important, yet heretofore unarticulated and unexamined subjectivities and their influence on clinical decisions.

Roles in conflict. Although the HCPs recognized woman abuse as a health issue, they also identified a variety of barriers to effective screening, treatment and referral of women who are abused; for example, lack of education, lack of resources to deal with cultural and language barriers, and finally, for physicians, a lack of time. For these HCPs, on one hand they were granted access to the lives of patients (by virtue of their role) in unique ways, but were on the other hand often constrained by the resources available to them. At times these constraints resulted from a lack of culturally or linguistically appropriate supports for their patients (in the case of some nurse practitioners) and on

other occasions these related to other financial realities, for instance, the number of patients who must be seen per day by family physicians working in private practice in order to cover operational costs. Differential experiences were found with respect to lack of time: The nurse practitioners who participated in this study felt that they had enough time to spend with patients in a given visit to assess comprehensively someone's situation and engage in in-depth discussions about the patient's needs, desires, and concerns. Conversely, family physicians felt pressured to see many patients in a very short period, and that disclosure of abuse or related problems could cause serious disruptions in their day and in their ability to care for other patients.

These results were also consistent with previous research in which physicians have cited time constraints as a barrier to effective screening and intervention in cases of woman abuse (Baig et al., Ferris, 1994; Gerbert et al., 1999; Sugg & Inui, 1992). Consistent with HCPs in previous studies, the physicians and nurse practitioners in this study also did not receive much education in woman abuse while training to become HCPs (Garcia-Moreno, 2002). In turn, HCPs who did receive some training related to woman abuse thought it insufficient to create competency and comfort in dealing with this issue.

Inquiring about Abuse and Handling Disclosures

Uncertainty. Feelings of uncertainty characterized participants' responses to suspected or disclosed abuse. These feelings were not only explicitly expressed throughout the interviews, but they could also be witnessed in the speech of participants' in the form of hesitations, false starts, and self-repair. Participants often reported that they were unsure about the best way to approach or handle a situation despite the fact that

most HCPs appeared to be knowledgeable about woman abuse. This is suggestive that woman abuse remains a topic that is fraught with insecurity and feelings of incompetence for HCPs. On one hand, HCPs view screening for abuse and helping patients through the after-effects of disclosure as part of their role, and on the other hand they feel acutely insecure about their ability to help patients, and unsure about what they should do when confronted with a potentially abused woman. Noting that at times HCPs felt unsure about whether they had missed signifiers of abuse among their patients, and thereby failed to identify cases of abuse. Most of their uncertainty was directed internally in terms of their perceptions of their own knowledge and ability to assist their patient, and insecurity about whether they will be able to do the right thing the right way. In the literature, uncertainty commonly emerges as a theme related to people's experience and understanding of difficult situations, particularly in relation to health-related decision-making (e.g. Cranley, Doran, Tourangeau, Kushniruk & Nagle, 2009). Penrod's (1997) explication of the experience of uncertainty suggests that subjective uncertainty is predicated on lack of confidence and lack of control. For HCPs dealing with woman abuse, it is easy to see how this understanding of uncertainty can be applied to their experience. Having little control over the outcome of a situation, as in the case of woman abuse, manifests as uncertainty. It is perhaps especially poignant for HCPs, who are used to knowing and implementing effective courses of treatment.

Asking as a place. An interesting theme that emerged from the data was that all HCPs conceptualized asking about abuse as attempting to go to a place with or inside of a patient – that the identification or disclosure of abuse resided in a place outside of the regular medical visit, or beneath the surface of regular interaction. Here HCPs are

working to guide patients on this journey to disclosure and help seeking, but they are not themselves expert in how to find the way. To become what they consider a successful guide, they work to meet the patient where they are and use this as a starting point. HCPs appeared to experience some discomfort related to their uncertainty about how to get to this place with patients. At times expressed that they felt frustration with patients' resistance and with their inability to obtain a disclosure or refer a patient to external services for abuse; that they were struggling against the HCPs attempts to act as a guide. The varied spatial metaphors employed by the participants were used to help them understand their own role in eliciting a disclosure in relation to the willingness of their participants to allow them to proceed towards that end. Similar themes emerged from interviews with these physicians in other studies, most notably the fear of opening "Pandora's box" (Sugg & Inui, 1992; Gerbert et al., 2002). It appears then, that HCPs often feel as though they are entering uncharted, potentially dangerous territory as they explore the topic of woman abuse. Not only was this in response to a woman's potential disclosure of abuse, but also to the HCP's fear that they will not be able to handle what is revealed to them competently on a personal or professional level. This fear of opening a "can of worms" or "Pandora's box" then was an indicator that they were concerned with protecting themselves and their patients. The commonplace use of metaphors in HCPs' understandings of their experiences with women who are abused reflects their need to attach a structure to these experiences upon which they can build meaning. That the HCP requires the cooperation of their patient in order to reach the endpoint of the journey (i.e., disclosure) reflects particular elements of patient-centered care; namely, the sharing of responsibility for decisions and outcomes that this approach to care entails (Mead &

Bower, 2000). In the literature, the “journey” metaphor is often ascribed from the perspective of a patient living through an illness experience and it is interesting to see that HCPs make sense of these processes in the same way, suggesting some parallels in experience between provider and patient.

Working (to guide women) without a roadmap. Working through the uncertainty surrounding asking about and dealing with disclosures amounted to trying to work through the problem without a roadmap for these HCPs. Getting through this process involved engaging in emotional work in order to recognize and understand their own emotional reactions to the situation so as to be prepared to address their patient’s situation. This amounts to a type of naturalized phenomenological bracketing of one’s own preconceptions about, and emotional response to, their patient’s plight. Despite their frustrations and uncertainties (or perhaps because of them) it was common for HCPs to recognize that they need to work through their emotional responses to their patients’ situations and responses in order to effectively provide them with help and support. In other words, HCPs had to come to terms with how to help most effectively a woman in the absence of a well-defined set of procedures, for example, acting as a guide in the absence of a roadmap that leads a woman away from her abusive partner. This involved understanding their own frustrations and negative reactions in order to be able to foreground the patient’s experience (rather than their own).

Related to having to engage in concerted cognitive work to get beyond their own emotional responses to their patient’s situation and decisions, HCPs found it necessary to fight their desires to fix a patient’s problem. This relinquishing of control was manifested strongly in the present study and is a theme that has been identified in other relevant

research with HCPs (Rittmayer & Roux, 1999; Sugg & Inui, 1992). This was something that participants universally found difficult—their realization and understanding that they cannot prescribe a course of action, or a medication that a patient can take in order to become free from abuse perpetrated by their male partner. The ability to fix is a strong component of the identity of HCPs; they are trained to be healers and it is their job to fix the problems of others. Therefore, letting go of this aspect of their professional identity presents a challenge that HCPs must overcome in these situations – the challenge of a threatened identity.

Most HCPs in this study seemed to implicitly, and sometimes explicitly, recognize the need for and engage in a reflexive, patient-centered approach to providing care when they suspected or identified abuse. This included taking the patient’s perspective in order to respect and support their decisions, whether they thought their patient’s actions to be wise or not. For the HCPs in the study, reframing the situation from the perspective of their patient was a priority. Furthermore, these HCPs seem to be knowledgeable about and sensitive to a range of risk factors for victimization, as well as potential signifiers of violence or abuse. These findings are promising, given previous research has found that physicians are unlikely to ask about and identify abuse in the absence of obvious (often physical) indicators (Baig et al., 2006; Garcia-Moreno, 2002).

(Re)contextualizing the Problem

This study is a foray into newer territory for IPA research. To date, the majority of IPA research published has explored individuals’ experience of illness and receiving health care. This investigation reversed the focus to examine the *HCP*’s experience in dealing with significant events in the lives of their patients. It is my hope that this study

demonstrates the utility of this method for investigating various aspects of health and medical care, as well as potentially meaningful life events more generally.

Although these findings revealed similarities with some existing studies with HCPs, there were also some unexpected departures from previous research. Specifically, HCPs in the study did not report fear of offending a patient by asking about abuse to be a barrier to initiating conversations about. In contrast to findings from previous research (Baig et al., 2006; Sugg & Inui, 1992), personal discomfort associated with asking about abuse was not sufficient to be considered a barrier to asking in the present study. Perhaps the results of this study depart from these findings due to the frequency in which the HCPs engaged in patient-centered care when faced with this situation in their practice. Unfortunately, it is not possible to ascertain to what extent HCPs who have participated in other studies already engage in patient-centered care. In this study, several participants do intentionally engage in patient-centered practice. Unlike the HCPs in Gerbert and colleagues' (1999) study, these HCPs did not appear to be concerned with the legal implications or professional liabilities associated with screening and identification of abuse (or of failure to identify abuse). While those outside the medical community may expect HCPs to be concerned about the liabilities surrounding woman abuse (related to mandatory reporting, or missing cases of abuse in practice), the HCPs in this study did not orient to these potential legal problems. Instead, any concerns about the implications of identification or non-identification of abuse appeared in relation to their own anticipated feelings in response to a negative outcome for a patient and their anticipated regret related to this. These discrepant orientations may be attributable to differences in the nature of Canadian and American healthcare and legal

systems, with physicians in the United States facing higher risks of or concern about negative legal consequences for their actions (or inaction).

It may be worth considering the possibility that there are individual differences in comfort with woman abuse, which may not be influenced by sociocultural context, experience or education. It may be that those who engage in screening, counselling, and referrals in the absence of a mandate to do so are those that are particularly suited to dealing with sensitive topics in their patient's lives. The relative lack of screening and questioning on the part of HCPs that has been revealed through other investigations may not be attributable to a lack of concern for patient well being, or a lack of awareness on the part of the HCP. Instead, reluctance to screen may be associated with an HCP's feeling that they are not equipped to deal with abuse if it is uncovered.

This study has demonstrated that asking about abuse in outpatient primary care settings is not an easy, comfortable process for HCPs - just as leaving an abusive partner is not a simple process for women who are abused. The results of this study indicate that disclosures in primary care practices are more complicated than previous research with women who are abused has suggested (e.g. Plichta, 2007; Rodriguez et al., 2001). For instance, the HCPs in this study found that patients would typically not disclose the first time they were asked, and that some would never disclose. Therefore, it is necessary to understand the apparent discrepancy between abused women's self-reported willingness to disclose to HCPs and the assessment of HCPs in this study that many women resisted disclosure, at least for a time. This lack of disclosure is common among women who have been victimized, and is also true for women who have been abused by a male partner (e.g. Coker et al., 2005). In other words, absence of disclosure is not necessarily

attributable to failures on the part of the HCP, but rather non-disclosure may be the result of normative processes that surround disclosure and initiation of help seeking among abused women that occur independently of these interactions

The following statement provided by Diane, a nurse practitioner who participated in this study, presents the dilemma faced by HCPs in a nutshell:

I think we all have, as healthcare professionals, knowledge about intimate partner violence, um but then when you actually take the theory and put it to practice, so what do you do about it? And how's your practice set up and how do you you know, go about helping someone who's in the situation? How do you get someone to disclose? That way you can help them and I think those are really important pieces of the puzzle, like we all have knowledge but what do you do about it in your practice, and how do you feel? (Diane, nurse practitioner)

Considering the overall findings of this study and Diane's summary of issues faced by HCPs, it seems that HCP education about woman abuse should target some of the concerns that were identified by the HCPs in this study. These concerns include how to engage with patients while avoiding judgment and remaining sensitive to their needs, and the diversity of options and resources that are available to women. A main priority for health care educators should be to increase HCPs' comfort with asking and handling the after-effects of a disclosure so that they can provide their patients with the best support and care possible and also take care of themselves. This is important not only to increase feelings of subjective comfort and competence among HCPs, but also because higher

levels of comfort are associated with increased rates of screening (Allen, et al., 2007; Elliott et al., 2002; Garimella, Plichta, Houseman, & Garzon, 2000).

Understanding the Processes of Help Seeking and Disclosure

Raising awareness of, and increasing knowledge about, basic information on woman abuse (i.e., rates of abuse, types of abuse and typical outcomes) among HCPs solely will not lead directly to better outcomes for women who are abused. It is also imperative that women's processes of problem identification, disclosure and help seeking, and leave-taking from abusive men are explored in-depth. Some women's reluctance to disclose when asked about abuse could be at least partially explained by considering the stage models of help seeking and leave-taking from abusive relationships. When determining how to best provide support for women who are abused, it is necessary to recognize the complexities associated with the decision to disclose abuse and to seek help from those outside of the relationship. To facilitate this understanding, Brown (1997) applied a stages of readiness to change model (the transtheoretical model) to help understand a battered woman's "readiness to take steps to address the abuse in her life" (p. 6). According to this model, a woman will pass through five stages on the way to leaving an abusive man. The first stage, precontemplation, is defined by unwillingness to change, or sometimes to recognize that a problem exists (i.e., the problem has not been defined as such). The second stage, contemplation, involves considering making a change to one's situation. The third stage, intention, is defined by making plans to change the situation (i.e., planning to disclose, or planning to seek help). In the fourth stage, action, a woman will engage in behaviour aimed at changing the situation. The fifth stage, maintenance, is defined by commitment to the action taken in the previous stage (Brown,

1997; Prochanska, DiClemente & Norcross, 1992). It is not expected that women will pass through these stages of change in a linear fashion; rather, movement forwards and backwards through the stages is expected before a woman reaches the point where she leaves an abusive man permanently.

Later, other researchers drew upon this conceptualization to outline how: (a) identifying a partner's behaviour as abuse; (b) deciding to seek help and disclosing the abuse, and (c) taking steps to become free from abuse, should be conceptualized as a dialectical, non-linear process that is affected by outside feedback at all stages (Dienemann, Campbell, Landenburger & Curry, 2002; Liang, Goodman, Tummala-Narra & Weintraub, 2005). These stages of change and dialectic conceptualizations may be applied to facilitate HCPs' understandings of the ways in which the complex and iterative processes of problem recognition, disclosure, and initiation and continuance of women's help seeking may manifest among their patients. Other research has shown that the problem of identification of abuse for women who are abused is not necessarily straightforward even in the presence of physical violence (e.g. Williston, 2008), and that the leave-taking process for women who are abused can be equally complex (Brown, 1997; Dienemann et al., 2002; Liang et al., 2005). Because the decisions to disclose abuse, seek help, and leave an abusive man are not straightforward, it is important for HCPs to recognize that women may cycle back and forth in terms of their readiness to move from one stage to another. The HCPs in this study expressed frustration in response to resistance exhibited by their patients related to disclosure and referral uptake. It is possible that the feelings of frustration and uncertainty connected to an HCP's ability to help their patients will be alleviated by understanding a patient's resistance in terms of

their readiness to change. This may also motivate HCPs to gently broach the topic with patients over time even if they have not yet had a disclosure or successful referral with a given patient.

HCPs in the present study expressed uncertainty about their abilities to help an abused woman, and frustration when a woman would not disclose abuse or take steps to leave her abuser. Assisting nurses and physicians to understand that leaving an abusive man is often a non-linear process may relieve HCPs of some of their insecurities, frustrations, and uncertainties surrounding their perceived ability to help their patients. Some women who are asked about abuse are not yet ready to disclose, but may disclose in the future. For example, a woman in a precontemplative stage, who has not yet decided for herself that their partner is abusive, or who is in contemplative stage or is only beginning to consider acting to change their situation will not disclose the first time they are approached. For these women, the idea that they are being abused has not yet formed; or if it has, she is not ready to see her abuser's actions as something she wants or needs to change. This would make the disclosure of abuse, having not yet been defined as abuse or as something problematic, impossible. At this stage in decision-making, initiations of help seeking are precluded until a woman has (a) defined their partner's behaviour as abuse, and (b) determined that they want to seek help for his abuse. Even if a woman does not (or is not ready to) disclose abuse, the mere act of a HCP asking a woman about her safety at home may "plant a seed" or "open a door", for disclosure or help seeking to occur in future interactions with HCPs or other possible helpers. It also plants the seed for a woman to recognize that she recognizing she is a victim of abuse (if she has not already

done so), which indicates that screening could propel problem identification forward for some women (e.g. Williston, 2008).

Disclosing to a helpful, supportive person has consequences for an abused woman's future help-seeking efforts as well as her likelihood leaving her abuser. In a study of factors that affect women's leave-taking of abusive men, Koepsell, Kernic and Holt (2006) found that women who attempted to access resources and failed were less likely to end the relationship with their abusive partner, than those who were successful in accessing resources. Moreover, women who are abused who believe that their helpers are supportive and who receive emotional and/or tangible support have better mental health outcomes than women who do not (Carlson et al., 2002). Therefore, the consequences for women who are abused if HCPs are not open to disclosures and prepared to support their patient's decision-making and access to external resources may have far-reaching effects on whether or when a woman is able to become free from abuse by her partner.

Supportive and validating feedback from helpful others is influential in shaping a woman's thoughts and decisions about their partner's behaviours and ascertaining what options are available to them. This feedback is particularly significant when a woman is in the process of problem identification (and has not yet defined her partner's actions as abusive). The responses and feedback she receives from others – how an interactional partner defines the behaviour of her partner – is influential in shaping her perceptions of the situation and the definitions that she attaches to the behaviour of her partner (e.g., Williston, 2008). This speaks to the importance of having HCPs validate what a woman is feeling, and reinforcing the notion that abuse is wrong, and that she is not the cause of

her partner's behaviour (Waldrop & Resick, 2004). Plichta, Duncan and Plichta (1996) found that physician expressions of concern and empathy increased satisfaction with care among women who are abused. It is important for HCPs to recognize the complexities of this process for women who are abused, such that they are able to understand and work through a patient's potential resistance to disclosure or referral uptake, and to facilitate future disclosure and/or help seeking with their patients.

Women's Perspectives on Screening and Care

This study identified components of how HCPs interpret their roles in relation to and interpretations of women who may be abused; however it is also essential to know what abused women take from these interactions, and what would make disclosure more likely from their perspective. Research with women who are survivors of male violence suggest that women want their HCPs to (a) communicate with them about abuse and its effect on health; (b) provide a supportive, confidential environment; (c) be knowledgeable about and provide access to resources; (d) share in the process decision-making with them, and e) be respectful and concerned (e.g. Battaglia, Finley & Liebschutz, 2003; Hathaway et al., 2002; Nicolaidis, 2002; Plichta, 2007). Other research has shown patient-centered approaches to asking about woman abuse are preferred by women who are abused; therefore this should be a training focus for student physicians and nurses (McCord-Duncan, Floyd, Kemp, Bailey, & Lang, 2006). Taken together, these findings suggest that building upon the patient-centered, reflexive approach to care that many HCPs already engage in is important for supporting women who are abused. Ultimately, it is not necessary for an HCP to be an expert in woman abuse, or to have the ability to 'fix' a woman's concerns. Rather, what seems important is that they are

comfortable with the topic of woman abuse and are willing to engage in an open, collaborative dialogue and planning process with their patients. A reflexive, patient-centered approach provides the substrate upon which HCPs can build their knowledge about woman abuse (including the processes of problem identification and help seeking) and knowledge of resources available to their patients.

Implications for Policy and HCP Education

It is apparent based on these findings and those of other studies that a variety of structural, educational, and policy-related factors influence HCP comfort, willingness and ability to screen for and treat woman abuse among their patients. Addressing HCP needs at these levels will have the result of increasing their ability to care effectively for patients who experience woman abuse and other problems of a related nature. To increase HCP comfort and decreasing uncertainty expansion and standardization of woman abuse curricula would be an important step in addressing woman abuse from a public health perspective. However, structural features of the provincial (and national) healthcare system present barriers to effective identification and treatment of abuse. This barrier to eliciting and effectively handling a disclosure of abuse is directly related to the pay-per-patient medical system in Ontario. As long as physicians in private practice are compensated on a per-patient basis, there will be temporal and financial barriers for physicians to provide the care they know their patients need. Implementing a different pay structure for family physicians (i.e. salary-based or based on number of patients in practice rather than number of visits) may help to alleviate some of the time concerns identified by physicians in this study. Allowing physicians greater flexibility in scheduling may result in less strain felt by physicians and greater engagement in patient-

centered care. The bottom line remains that HCPs who ask patients about abuse identify more cases (Glowa, 2003) and that preparedness to deal with a disclosure is key to willingness to ask (Gutmanis, 2004).

Increasing levels of physician comfort with and raising interest in screening does not address the structural barriers to screening that these and other HCPs have identified. Especially for physicians, time remains at a premium. I would argue that, under the present medical system, if a physician is not able or is not willing to spend extra time with a patient in the event of a disclosure, it is advisable for the physician to chart their suspicion and address it on another visit. For if a physician asks about a woman's safety at home, and is then not able to provide validation and shared planning in the event of disclosure, their inquiry may have a deleterious effect (e.g. Koepsell et al., 2006). In the current system, one-size-fits all approach to screening for woman abuse may not be appropriate. Instead, each nurse and physician should be provided with necessary basic knowledge about woman abuse, including: (a) risk factors; (b) incidence and prevalence (c) signs and symptoms; (d) physical and mental health outcomes; (e) the process of problem identification and help seeking, (f) available resources, and (g) how to apply the principles of patient-centered care and reflective practice to the care of women who are abused, with particular emphasis on understanding the patient's perspective (Garimella, 2000; Nicolaidis, 2002).

Effective screening and treatment of woman abuse in primary care practices may be predicated on the practice of reflective and patient-centred care. Reflective practice refers to the HCPs' recognition and interrogation of their own experiences with patients, particularly their thoughts and feelings (Marmede & Schmidt, 2004; 2005). Increasing

self-awareness and supporting HCPs' ability to examine and process their own emotional responses in relation to the treatment of difficult clinical issues is thought to lead to increased well-being for the HCP and better care for their patients (Meier, Back & Morrison, 2001). In their review of the literature, Mead and Bower (2000) identified the central conceptual elements of patient-centered care. These elements included: (a) adopting a biopsychosocial perspective; (b) consideration of the patient's experience and the meanings they attach to their illness; (c) sharing power and control over care with the patient; (d) building a therapeutic alliance and (e) consideration of the experiences shared by HCP's, and how their subjectivities shape the practitioner-patient relationship and decision-making. Already, in the field of nursing, patient-centered care is the educational and practice-based standard of care (see for example Professional Standards, 2009). However, it would be beneficial for the healthcare community more generally to adopt this model in order to increase a sense of collaboration between patient and HCP and to reduce pressures felt by HCPs (family physicians specifically) to make the "right decision".

Training nurses and physicians to be reflective of their own experience and to engage in patient-centered care lends itself to improving treatment for abused women. Patient-centered care addresses the threat to HCP identity that is manifested in frustration over having to let go of parts of their professional role (specifically, having to let go of the desire or ability to 'fix' a patient's problem). This is because by engaging in patient-centred care, and relinquishing some of their control to their patient, they in fact are fulfilling their professional role.

It remains the case that there is no conclusive evidence about the efficacy or outcomes of universal or indicated screening for woman abuse in primary care or in other medical settings (MacMillan & Wathen, 2003; Spangaro et al., 2009). Furthermore, making decisions about the appropriateness of screening in primary care is premature, as the evaluations that do exist have focused primarily on the efficacy of screening and referrals in emergency settings. It is, however, apparent that women who are seen in primary care settings are experiencing abuse and that (at least some) physicians and nurse practitioners inquire about abuse when they have suspicions. Regardless of the efficacy and outcomes associated with screening for abuse and providing ongoing care for women who are abused, a primary care HCP can be someone who shows that they care about whether a woman feels safe with her male partner, and who acts as a source of support and information for abused women.

In the absence of consistent screening recommendations or across primary care health specialties, and inconsistent coverage of woman abuse in nursing and medical schools, I recommend that HCPs who are ambivalent about asking patients about abuse heed the advice of Gerbert and colleagues (2002). Their position is that compassionate asking about abuse by HCPs may be viewed as successful intervention unto itself, and given the body of research on how feedback can moderate problem definition and subsequent help seeking, this is an accurate assessment. Though compassionate asking is important in and of itself, Gerbert and colleagues recommend a four step procedure for HCPs to follow in which asking is merely the first step: 1) ask patients about abuse; 2) validate the patient's feelings and concerns and reinforce notion that abuse is wrong; 3) document suspected or disclosed abuse in the patient's chart, and 4) offer the patient

referrals to outside services (Ask, Validate, Document, Refer; AVDR). This approach dovetails into the principles of reflective and patient-centred care and is a simple set of procedures for HCPs to follow. In practice, this has the potential to be brief enough to address time constraints faced by physicians, and should also leave the door open for future help seeking. This approach to identifying and providing support to abused women should be considered the minimal standard of care with respect to woman abuse. That is, until further investigation maps out a way to effectively screen for abuse and to facilitate positive outcomes for battered women, or until professional guidelines are consistent across primary care helping professions.

Strengths and Limitations

This study has demonstrated that despite the many discomforts, barriers, uncertainties, and sometimes, lack of success in asking about and treating abused women, HCPs do ask about abuse and want to help their patients as best they can. From these interviews, HCPs experiences of uncertainty and of suspicion play key roles in decisions to ask about abuse, and how to handle situations if abuse is disclosed. Furthermore, this study adds to the limited body of research on the how HCPs make meaning and interpret their role in the lives of their patients and how they are affected professionally and personally by their interactions with patients. An additional strength of this study relates to my own position as that of a survivor of woman abuse. My previous encounters with violence inevitably heighten my sensitivity various features of the approach taken by individual HCPs and may reveal meaning or interpretation to which non-survivors may not attend.

The decision to modify the recruitment strategy for this study part way through data collection resulted in a different sample than originally conceptualized. The sample was not as homogenous as initially desired, in terms of both occupation (family physicians vs. nurse practitioner) and population served. In one respect, diversity of experience and role represented a challenge when it came to presenting a narrative that accurately reflected the thoughts and experiences of the majority of the HCPs in the sample. Although the heterogeneity of the sample may have presented a limitation in certain respects, it also demonstrates the robustness of this study's findings. It is significant that, despite the different roles occupied and settings served by these HCPs, their experiences and even the interpretations of their experiences demonstrated a substantial amount of convergence. Ultimately, having the perspectives of both nurse practitioners and family physicians has revealed aspects of HCP experience that would have otherwise remained hidden (i.e., that time constraints are a major factor for family physicians but not for nurse practitioners)

Participation rates were low among HCPs who were not familiar with my committee members or myself or not referred to the study by these known HCPs. The voluntary nature of participation in this project will have necessarily influenced the results, and it seems reasonable to suspect that those who did participate may have an intrinsic interest in this topic. It is possible that woman abuse is not a particularly important or meaningful topic for many or most physicians, and that these differences may explain lower than anticipated participation. Alternatively, given the amount of uncertainty expressed by HCPs who did agree to participate, there may be a high level of discomfort surrounding this topic in the wider community of HCPs. Along these lines,

HCPs may consider this to be a “risky” topic of discussion, especially if they feel that they lack competency in this area, or that there could be liabilities attached. Certainly, those who participated were thoughtful about their experiences treating abused or potentially abused women, but this may not reflect the broader community of HCPs. It seems likely that those who participated in the present study have some sort of interest or concern about this topic, or may have participated because of their knowledge of me or the members of my committee. Thus, while valuable, the range of attitudes about, perspectives on, and experiences of treating women who are abused by their male partners may be different from those who elected not to participate in this study.

While not discussed at length in the analysis, it is important to consider the populations served by the HCPs who participated in the present study. Just over half of these HCPs work primarily with individuals who may be considered marginalized in one or more ways. This could have affected the results in that HCPs who work with marginalized populations have been found to be more aware of woman abuse and more likely to address it in practice (Gerbert et al., 2002; Weeks, Ellis, Lichstein, & Bonds, 2008). Therefore, it is possible that the sample for this study is unusually sensitive to the possibility of abuse among their patients, and therefore suspected more abuse and were more willing to make inquiries related to their suspicions. This may also mean that the participants in this study take a more sophisticated, sensitive approach to screening for and treating woman abuse in their practice. If this is the case, it underscores the need to provide basic information to HCPs generally about woman abuse, and to promote the principles of patient-centered practice to physicians specifically.

Directions for Future Research

While this study is a good first step in determining how HCPs view their role and make meaning from their clinical encounters with abused women, it also reveals directions and topics for future research. For example, in other investigations, either a more homogenous sample or a more idiographic approach may be beneficial for understanding the diversity and commonality in the meanings that HCPs apply to their experiences with abused women. An idiographic approach would allow for the detailed examination of individual experiences and may highlight more specific concerns that HCPs experience. Additionally, although this investigation produced high quality data, it may have been too broad in scope to understand fully the nuances of HCPs' experiences dealing with abused women, and the meaning they attach to these interactions. This is because the orienting questions for the study covered broad aspects of HCP experience, and the resulting breadth of topical coverage may have lead to the sacrificing some depth of exploration. Finally, although the HCPs in this study were confident in the accuracy of their suspicion of abuse even in the absence of a woman's disclosure or indicators of abuse, it is impossible to determine whether their suspicion that a patient was being abused by her male partner was founded.

Before making conclusive decisions about whether to recommend universal or indicated screening in all primary care healthcare settings, more research is necessary in several areas. First, stemming directly from this research, I plan to interview several more nurse practitioners in order to gain a more full understanding of how they understand and navigate their role in relation to asking about woman abuse and helping women who are victimized become free from abuse by their male partners. Increasing knowledge about

the experiences and understandings of other HCPs in relation to intimate partner violence will help direct the development of educational interventions to improve HCP comfort and feelings of competency around treating their patients who experience abuse. Second, researchers must continue to explore the efficacy of screening in primary care healthcare settings, as well as the outcomes associated with referral to various services for abused women. HCPs are often concerned about what they are getting into when they inquire about abuse (i.e., they fear opening a ‘can of worms’ or ‘Pandora’s Box’) and that they will discover something that cannot be dealt with easily or effectively. Knowing what types of intervention and referrals are effective in reducing women’s risk of abuse may make HCPs more comfortable with seeking disclosures. Third, the experiences of women who have disclosed to primary care HCPs should continue to be investigated in detail to ascertain whether and to what degree HCPs are meeting their needs in terms of provision of a safe atmosphere to disclose, emotional and informational support, and appropriate service referral and follow-up. Finally, to best serve abused women, there is a need to better understand leave-taking experiences among women who are abused in order to know how HCPs and other formal and informal sources of support can facilitate these processes. To do this, researchers need to determine both women’s’ preferences for care and which among the services available for referrals best meet these needs.

REFERENCES

- Allen, N. E., Lehrner, A., Mattison, E., Miles, T., & Russell, A. (2007). Promoting systems change in the health care response to domestic violence. *Journal of Community Psychology, 35*(1), 103-120.
- Arias, I., & Corso, P. (2005). Average cost per victim victimized by an intimate partner of the opposite gender: A comparison of men and women. *Violence and Victims, 20*(4), 379-391.
- Baig, A., Shadigian, E., & Heisler, M. (2006). Hidden from plain sight: Residents' domestic violence screening attitudes and reported practices. *Journal of General Internal Medicine, 21*, 949-954.
- Bargai, N., Ben-Shakhar, G., & Shalev, A. Y. (2007). Posttraumatic stress disorder and depression in battered women: The mediating role of learned helplessness. *Journal of Family Violence, 22*, 267-275.
- Barnett, O. W., Martinez, T. E., & Keyson, M. (1996). The relationship between violence, social support, and self-blame in battered women. *Journal of Interpersonal Violence, 11*(2), 221-233.
- Battaglia, T. A., Finley, E., & Liebschutz, J. M. (2003). Survivors of intimate partner violence speak out: trust in the patient-provider relationship. *Journal of General Internal Medicine, 18*, 617-623.
- Beeble, M. L., Post, L. A., Bybee, D., & Sullivan, C. M. (2008). Factors related to willingness to help survivors of intimate partner violence. *Journal of Interpersonal Violence, 23*(12), 1713-1729.

- Bennice, J. A., & Resick, P. A. (2003). Marital rape: History, research, and practice. *Trauma Violence Abuse, 4*(3), 228-246.
- Bertakis, K. D., Helms, L. J., Callahan, E. J., Azari, R., & Robbins, J. A. (1995). The influence of gender on physician practice style. *Medical Care, 33*(4), 407-416.
- Bertakis, K. D., & Rahman, A. (2005). The impact of obesity on primary care visits. *Obesity Research, 13*(9), 1615-1623.
- Bograd, M. (1990). Why we need gender to understand human violence. *Journal of Interpersonal Violence, 5*(1), 132-135.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.
- Brienes, W., & Gordon, L. (1983). The new scholarship on family violence. *Signs, 8*(3), 490-531.
- Brinkmann, S., & Kvale, S. (2005). Confronting the ethics of qualitative research. *Journal of Constructivist Psychology, 18*, 157-181.
- Brown, J. (1997). Working toward freedom from violence: The process of change in battered women. *Violence Against Women, 3*(1), 5-26.
- Bryant, S. A., & Spencer, G. A. (2003). University students' attitudes about attributing blame in domestic violence. *Journal of Family Violence, 18*(6), 369-376.
- Burge, S. K., Schneider, F. D., Ivy, L., & Catala, S. (2005). Parents' advice to physicians about intervening in family conflict. *Annals of Family Medicine, 3*, 248-254.
- Campbell, J. C., & Lewandowski, L. A. (1997). Mental and physical health effects of intimate partner violence on women and children. *Psychiatric Clinics of North America, 20*(2), 353-374.

- Campbell, J. C., & Soeken, K. L. (1999). Women's responses to battering over time: An analysis of change. *Journal of Interpersonal Violence, 14*(1), 21-40.
- Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., ...Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health, 93*(7), 1089-1097.
- Campbell, R., & Wasco, S. M. (2000). Feminist approaches to social science: Epistemological and methodological tenets. *American Journal of Community Psychology, 28*(6), 773-791.
- Caralis, P. V., & Musialowski, R. (1997). Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. *Southern Medical Journal, 90*(11), 1075-1080.
- Carlson, B. E., McNutt, L.-A., Choi, D. Y., & Rose, I. M. (2002). Intimate partner abuse and mental health: The role of social support and other protective factors. *Violence Against Women, 8*(6), 720-745.
- Chamberlain, L., & Perham-Hester, K. A. (2002). The impact of perceived barriers on primary care physicians' screening practices for female partner abuse. *Women & Health, 35*(2-3), 55-69.
- Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health & Gender-Based Medicine, 11*(5), 465-476.

- College of Nurses of Ontario. (2009). Professional Standards. Retrieved from http://www.cno.org/docs/prac/41006_ProfStds.pdf
- Cranley, L., Doran, D. M., Tourangeau, A. E., Kushniruk, A., & Nagle, L. (2009). Nurses' uncertainty in decision-making: A literature review. *Worldview on Evidence-Based Nursing, 6*(1), 3-15.
- Davidson, L. L., Grisso, J. A., Garcia-Moreno, C., Garcia, J., King, V. J., & Marchant, S. (2001). Training programs for healthcare professionals in domestic violence. *Journal of Women's Health & Gender-Based Medicine, 10*(10), 953-969.
- Dearwater, S. R., Coben, J. H., Campbell, J. C., Nah, G., Glass, N., McLoughlin, E., et al. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *Journal of the American Medical Association, 280*(5), 433-438.
- Denzin, N. K. (1969). Symbolic interactionism and ethnomethodology: A proposed synthesis. *American Sociological Review, 34*(6), 922-934.
- Denzin, N. K., & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Handbook of Qualitative Research* (2nd ed., pp. 1-30). Thousand Oaks: Sage.
- Dienemann, J., Campbell, J., Landenburger, K., & Curry, M. A. (2002). The domestic violence survivor assessment: A tool for counseling women in intimate partner violence relationships. *Patient Education and Counseling 46*, 221-118.
- Dunham, K., & Senn, C. Y. (2000). Minimizing negative experiences: Women's disclosure of partner violence. *Journal of Interpersonal Violence, 15*(3), 251-261.

- Dutton, D. G., & Painter, S. (1993). The battered woman syndrome: Effects of severity and intermittency of abuse. *American Journal of Orthopsychiatry*, 63(4), 614-622.
- Eatough, V., Smith, J. A., & Shaw, R. (2008). Women, anger, and aggression: An interpretive phenomenological analysis. *Journal of Interpersonal Violence*, 23(12), 1767-1799.
- Edley, N. (2001). Unravelling social constructionism. *Theory & Psychology*, 11(3), 433-441.
- Eisenstat, S. A., & Bancroft, L. (1999). Domestic violence. *The New England Journal of Medicine*, 341(12), 886-892.
- Ellington, L., & Wiebe, D. J. (1999). Neuroticism, symptom presentation, and medical decision making. *Health Psychology*, 18(6), 634-643.
- Elliott, L., Nerney, M., Jones, T., & Friedmann, P. D. (2002). Barriers to screening for domestic violence. *Journal of General Internal Medicine*, 17(2), 112-116.
- Ferris, L. E. (1994). Canadian family physicians' and general practitioners' perceptions of their effectiveness in identifying and treating wife abuse. *Medical Care*, 32(12), 1163-1172.
- Fleury, R. E., Sullivan, C. M., Bybee, D. I., & Davidson II, W. S. (1998). "Why don't they just call the cops?": Reasons for differential police contact among women with abusive partners. *Violence and Victims*, 13(4), 333-346.
- Frank, E., Elon, L., Saltzman, L. E., Houry, D., McMahon, P. M., & Doyle, J. (2006). Clinical and personal intimate partner violence training experiences of U.S. medical students. *Journal of Women's Health*, 15(9), 1071-1079.

- Franks, P., & Bertakis, K. D. (2003). Physician gender, patient gender, and primary care. *Journal of Women's Health, 12*(1), 73-80.
- Garcia-Moreno, C. (2002). Dilemmas and opportunities for an appropriate health-service response to violence against women. *The Lancet, 359*(9316), 1509-1514.
- Garimella, R., Plichta, S. B., Houseman, C., & Garzon, L. (2000). Physician beliefs about victims of spouse abuse and beliefs about the physician role. *Journal of Women's Health, 9*(4), 405-411.
- Gerbert, B., Caspers, N., Bronstone, A., & Moe, J. (1999). A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. *Annals of Internal Medicine, 131*, 578-584.
- Gerbert, B., Gansky, S. A., Tang, J. W., McPhee, S. J., Carlton, R., Herzig, K., et al. (2002). Domestic violence compared to other health risks: A survey of physicians' beliefs and behaviours. *American Journal of Preventive Medicine, 23*(2), 82-90.
- Gerbert, B., Moe, J., Salber, P., Feldman, M., Herzig, K., & Bronstone, A. (2002). Physicians' response to victims of domestic violence: Toward a model of care. *Women & Health, 35*(2), 1-22.
- Goodman, L., Dutton, M. A., Vankos, N., & Weinfurt, K. (2005). Women's resources and use of strategies as risk and protective factors for reabuse over time. *Violence Against Women, 11*(3), 311-336.
- Gross, R., McNeill, R., Davis, P., Lay-Lee, R., Jatrana, S., & Crampton, P. (2008). The association of gender concordance and primary care physicians' perceptions of their patients. *Women & Health, 2008*(2), 123-144.

- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 105-118). Thousand Oaks: Sage.
- Gubrium, J. F., & Holstein, J. A. (2000). Analyzing interpretive practice. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed., pp. 487-508). Thousand Oaks: Sage.
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2006). Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health*, 7(12). doi:10.1186/1471-2458-7-12
- Hathaway, J. E., Willis, G., & Zimmer, B. (2002). Listening to survivors' voices: Addressing partner abuse in the healthcare setting. *Violence Against Women*, 8(6), 687-719.
- Holtgraves, T. & Lasky, B. (1999) Linguistic power and persuasion. *Journal of Language and Social Psychology*, 18(2), 196-205.
- Houry, D., Kaslow, N. J., Kemball, R. S., McNutt, L. A., Cerulli, C., Straus, H., et al. (2008). Does screening in the emergency department hurt or help victims of intimate partner violence? *Annals of Emergency Medicine*, 51(4), 433-442.
- Janssen, P., Dascal-Weichhendler, H., & McGregor, M. (2006). Assessment for intimate partner violence: Where do we stand? *Journal of the American Board of Family Medicine*, 19(4), 413-415.

- Klap, R., Tang, L., Wells, K., Starks, S. L., & Rodriguez, M. (2007). Screening for domestic violence among adult women in the United States. *Journal of General Internal Medicine, 22*, 579-584.
- Koepsell, J. K., Kernic, M. A., & Holt, V. L. (2006). Factors that influence battered women to leave their abusive relationships. *Violence and Victims, 21*(2), 131-147.
- Kothari, C. L., & Rhodes, K. V. (2006). Missed opportunities: Emergency department visits by police-identified victims of intimate partner violence. *Annals of Emergency Medicine, 47*(2), 190-199.
- Levi, B. H., Brown, G., & Erb, C. (2006). Reasonable suspicion: A pilot study of pediatric patients. *Child Abuse and Neglect, 30* 345-356.
- Levondosky, A. A., Bogat, G. A., Theran, S. A., Trotter, J. S., von Eye, A., & Davidson, W. S. (2004). The social networks of women experiencing domestic violence. *American Journal of Community Psychology, 34*(1-2), 95-109.
- Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *American Journal of Community Psychology, 36*(1-2), 71-84.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park: Sage.
- MacMillan, H. L., Wathen, C. N., Jamieson, E., Boyle, M. H., Shannon, H. S., Ford-Gilboe, M., et al. (2009). Screening for intimate partner violence in healthcare settings: A randomized trial. *Journal of the American Medical Association, 302*(5), 493-501.

- MacMillan, R., & Gartner, R. (1999). When she brings home the bacon: Labor-force participation and the risk of spousal violence against women. *Journal of Marriage and the Family*, 61, 947-958.
- Mamede, S., & Schmidt, H. G. (2004). The structure of reflective practice in medicine. *Medical Education*, 38, 1302-1308.
- Mamede, S., & Schmidt, H. G. (2005). Correlates of reflective practice in medicine. *Advances in Health Sciences Education*, 10, 327-337.
- McCaw, B., Golding, J. M., Farley, M., & Minkoff, J. R. (2007). Domestic violence and abuse, health status, and social functioning. *Women & Health*, 45(2), 1-23.
- McCloskey, K., & Grigsby, N. (2005). The ubiquitous clinical problem of adult intimate partner violence: The need for routine assessment. *Professional Psychology: Research and Practice*, 36(3), 264-275.
- McCord-Duncan, E. C., Floyd, M., Kemp, E. C., Bailey, B., & Lang, F. (2006). Detecting potential intimate partner violence: Which approach do women want? *Family Medicine*, 38(6), 416-422.
- Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine*, 51, 1087-1110.
- Michalski, J. H. (2004). Making sociological sense out of trends in intimate partner violence: The social structure of violence against women. *Violence Against Women*, 10(6), 652-675.
- Meier, D. E., Back, A. L., & Morrison, R. S. (2001). The inner life of physicians and care of the seriously ill. *Journal of the American Medical Association*, 286(23), 3007-3014.

- Michalski, J. H. (2005). Explaining intimate partner violence: The sociological limitations of victimization studies. *Sociological Forum*, 20(4), 613-640.
- Minsky-Kelly, D., Hamberger, L. K., Pape, D. A., & Wolff, M. (2005). We've had training, now what? Qualitative analysis of barriers to domestic violence screening and referral in a healthcare setting. *Journal of Interpersonal Violence*, 20(10), 1288-1309.
- Murray, C. E., & Graybeal, J. (2007). Methodological review of intimate partner violence prevention research. *Journal of Interpersonal Violence*, 22, 1250-1269.
- Naumann, P., Langford, D., Torres, S., & Campbell, J. (1999). Women battering in primary care practice. *Family Practice*, 16(4), 343-352.
- Nelson, H. C., Ngyren, P., McInerney, Y., & Klein, J. (2004). Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. preventive services. *Annals of Internal Medicine*, 140(5), 387-396.
- Olive, P. (2007). Care for emergency department patients who have experienced domestic violence: a review of the evidence base. *Journal of Clinical Nursing*, 16(9), 1736-1748.
- Pagelow, M. D. (1992). Adult victims of domestic violence: Battered women. *Journal of Interpersonal Violence*, 7(1), 87-120.
- Peekover, S., & Chidlaw, R. G. (2007). Too frightened to care? Accounts by district nurses working with clients who misused substances. *Health and Social Care in the Community*, 15(3), 238-245.
- Penrod, J. (2007). Living with uncertainty: Concept advancement. *Journal of Advanced Nursing*, 57(6), 658-667.

- Perkins, L., & Milroy, L. (1997). Sharing the communicative burden: A conversation account of aphasic/non aphasic interaction. *Multilingua*, 16(2/3), 199-215.
- Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system. *Trauma, Violence & Abuse*, 8(2), 226-239.
- Plichta, S. B., Duncan, M. M., & Plichta, L. (1996). Spouse abuse, patient-physician communication, and patient satisfaction. *American Journal of Preventive Medicine*, 12, 297-303.
- Prochanska, J., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9), 1102-1114.
- Reid, S. A., & Glasser, M. (1997). Primary care physicians' recognition of and attitudes towards domestic violence. *Academic Medicine*, 72(1), 51-53.
- Riger, S. (1992). Epistemological debates, feminist voices: Science, social values, and the study of women. *American Psychologist*, 47(6), 730-740.
- Rittmayer, J., & Roux, G. (1999). Relinquishing the need to "fix it": Medical intervention with domestic abuse. *Qualitative Health Research*, 9(2), 166-181.
- Rodriguez, M. A., Bauer, H. M., McLoughlin, E., & Grumbach, K. (1999). Screening and intervention for intimate partner abuse: Practices and attitudes of primary care physicians. *Journal of the American Medical Association*, 282(5), 468-474.
- Rodriguez, M. A., Sheldon, W. R., Bauer, H. M., & Pèrez-Stable, E. J. (2001). The factors associated with disclosure of intimate partner abuse to clinicians. *The Journal of Family Practice*, 50(4), 338-344.

- Rubin, H. J., & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks: Sage.
- Saunders, D. G. (2002). Are physical assaults by wives and girlfriends a major social problem?: A Review of the literature. *Violence Against Women*, 8(12), 1424-1445.
- Saunders, D. G., Hamberger, K., & Hovey, M. (1993). Indicators of women abuse based on a chart review at a family practice center. *Archives of Family Medicine*, 2, 537-543.
- Seidman, I. (2006). *Interviewing as qualitative research*. New York: Teachers College Press.
- Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harré & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 9-26). Thousand Oaks: Sage.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretive phenomenological analysis in health psychology. *Psychology and Health*, 11, 261-271.
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1, 39-54.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Thousand Oaks Sage.

- Smith, J. A., Flowers, P., & Osborn, M. (1997). Interpretive phenomenological analysis and the psychology of health and illness. In L. Yardley (Ed.), *Material discourses of health and illness* (pp. 68-91). New York: Routledge.
- Spangaro, J., Zwi, A. B., & Poulos, R. (2009). The elusive search for definitive evidence on routine screening for intimate partner violence. *Trauma, Violence & Abuse, 10*(1), 55-68.
- Statistics Canada (2005). *Family violence in Canada: A statistical profile 2005 (No: 85-224-XIE)*. Ottawa: Canadian Centre for Justice Statistics.
- Sugg, N. K., & Inui, T. (1992). Primary care physicians' response to domestic violence: Opening Pandora's box. *Journal of the American Medical Association, 267*, 3157-3160.
- Taylor, C. A., & Sorenson, S. B. (2005). Community-based norms about intimate partner violence: Putting attributions of fault and responsibility into context. *Sex Roles, 53*(7/8), 573-589.
- Thompson, M. P., Saltzman, L. E., & Johnson, H. (2003). A comparison of risk factors for intimate partner violence-related injury across two national surveys on violence against women. *Violence Against Women, 9*(4), 438-457.
- Thurston, W. E., & Eisener, A. C. (2006). Successful integration and maintenance of screening for domestic violence in the health sector: Moving beyond personal responsibility. *Trauma, Violence & Abuse, 7*(2), 83-92.
- van Ryn, M., Burgess, D., Malat, J., & Griffin, J. (2006). Physicians perceptions of patients social and behavioural characteristics and race disparities in treatment

- recommendations for men with coronary artery disease. *American Journal of Public Health*, 96(2), 351-357.
- Waldrop, A. E., & Resick, P. A. (2004). Coping among adult female victims of domestic violence. *Journal of Family Violence*, 19(5), 291-302.
- Walker, L. E. (1999). Psychology and domestic violence around the world. *American Psychologist*, 54(1), 21-29.
- Walker, L. E. A. (1989). Psychology and violence against women. *American Psychologist*, 44(4), 695-702.
- Wathen, C. N., MacMillan, H. L., & Canadian Task Force on Preventive Health Care (2003). Prevention of violence against women: Recommendation statement from the Canadian Task Force on Preventive Health Care. *Canadian Medical Association Journal*, 169(6), 582-584.
- Wathen, C. N., Tanaka, M., Catallo, C., Lebner, A. C., Friedman, M. K., Hanson, M. D., et al. (2009). Are clinicians being prepared to care for abused women? A survey of healthcare professional education in Ontario, Canada. *BMC Medical Education* 9(34).
- Weeks, E. K., Ellis, S. D., Lichstein, P. R., & Bonds, D. E. (2008). Does health care provider screening for domestic violence vary by race and income? . *Violence Against Women*, 14(7), 844-855.
- West, A., & Wandrei, M. L. (2002). Intimate partner violence: A model for predicting interventions by informal helpers. *Journal of Interpersonal Violence*, 17(9), 972-986.

- Willis Esqueda, C., & Harrison, L. A. (2005). The influence of gender role stereotypes, the woman's race, and level of provocation and resistance on domestic violence culpability attributions. *Sex Roles, 53*(11-12), 821-834.
- Williston, C. J. (2008). Characterizations of intimate partner violence in an online support group. (Unpublished Honours thesis). University of Guelph.
- Wofford, M. S., & Elliott, D. (1997). If violence is domestic, does it really count? *Journal of Family Violence, 12*, 293-311.
- Woods, S. J. (2005). Intimate partner violence and post-traumatic stress disorder symptoms in women: What we know and need to know. *Journal of Interpersonal Violence, 20*(4), 394-402.
- Worthen, J. B., & Varnado-Sullivan, P. (2005). Gender bias in attributions of responsibility for abuse. *Journal of Family Violence, 20*(5), 305-311.
- Zimmerman, C., Del Piccolo, L., & Finset, A. (2007). Cues and concerns by patients in medical consultations: A literature review. *Psychological Bulletin, 133*(3), 438-463.

APPENDIX A

RECRUITMENT SCRIPT

Hello Dr. _____

My name is Courtney Williston, and I am a Masters student at the University of Windsor in the Department of Psychology under the supervision of Dr. Kathryn Lafreniere. I am contacting you to see whether you are interested in participating in a research study. I am interested in investigating physicians' experiences of treating female patients who may have experienced intimate partner violence. I would like to ask whether you would be willing to be interviewed by me about your experiences about this topic, whatever they may be. I expect that the interviews will take approximately 45-60 minutes, and can be conducted at a time and location that you and I agree upon.

If you think that you might be interested, I will send you further information about the study (via e-mail or conventional mail). If you choose to participate, your name and the experiences you share will remain confidential, and will not be shared with any other researchers, nor will personally identifying information appear in any documents.

If the physician indicates strong or possible interest, I will ask them whether I can mail them (e-mail or conventional mail) more information about the research and my contact information. I will then ask whether I can contact them again in 2-3 weeks regarding the project.

If the physician indicates disinterest, I will thank them for their time.



LETTER OF INFORMATION

Title of Study: How Physicians View their Role in Relation to Intimate Partner Violence Against Women

You are asked to participate in a research study conducted by Courtney Williston, B.A.H. (M.A. student) under the supervision of Dr. Kathryn Lafreniere (faculty supervisor), from the Department of Psychology at the University of Windsor. The results of this study will be used to contribute to the requirements of the M.A. thesis of the first investigator.

If you have any questions or concerns about the research, please feel to contact:

Courtney Williston
Daytime phone: 519-253-3000 ex. 2185
willistc@uwindsor.ca
or

Dr. Kathryn Lafreniere
Daytime phone: 519-253-3000 ex. 2233
lafren1@uwindsor.ca

PURPOSE OF THE STUDY

The purpose of this study is to explore how physicians understand their role and interactions with patients who disclose Intimate Partner Violence (IPV), otherwise known as woman abuse, and patients whom physicians suspect are experiencing abuse. The study is designed to explore physicians' IPV-related training during medical school, experiences with patients who disclose intimate partner violence, and experiences with patients who may be experiencing intimate partner violence. The results of this study are expected to contribute to the development of intimate partner violence-related educational initiatives for physicians and other health care providers.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

Participate in a single one-on-one interview with the principal investigator (Courtney Williston). The interview is expected to take 45-60 minutes and will be digitally audio-recorded. The interview will take place at a location agreed upon by you and the interviewer (e.g. your office or workplace, a private office on the University of Windsor campus, or alternate). You will also be asked to complete a brief demographics questionnaire at the end of the interview session

You may choose to review a typed transcript of your interview to make any changes or omissions you choose.

If you desire, you will be contacted following completion of the research project and provided with a copy of the results.

POTENTIAL RISKS AND DISCOMFORTS

Given the potentially sensitive nature of the topic under investigation, it is possible that you will experience some discomfort during the interview. You may choose to withdraw from the study or take a break at any point in the interview process surrounding professional role and responsibility conflicts. The psychological and emotional risks associated with participation in this study are not expected to be any greater than those

you would encounter in your own encounters with patients or in discussions with colleagues. You will be provided with contact information and resources to better help women who experience male partner violence.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Participants will receive no direct benefits from the present study. There are potential benefits to the scientific community as well as society. Intimate partner violence is a distressingly common phenomenon both globally and in Canadian society. , This research will contribute to existing knowledge of physicians' experiences in treating woman abuse. Because woman abuse is detrimental to many individuals in society, increasing understanding of treatment experiences may serve to improve training programs for healthcare professionals who treat victims of abuse, eventually leading to improved outcomes for those who experience violence at the hands of their male partners.

PAYMENT FOR PARTICIPATION

You will not receive payment for participation in this study. The primary investigator (Courtney Williston) will offer to provide you with a meal or refreshments of your choosing during the interview.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. Your name will not be associated with your interview, or your demographic information.

Interview and demographic data will be stored in locked file cabinets in the office of the primary investigator, and digital audio files will be stored on a password-protected personal computer belonging to the primary investigator. Digital and physical files will be retained for 6 years following publication of the study. After 6 years, digital audio files will be erased, and physical files will be shredded. Information will not be provided to a third party for any reason.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. You also have the option to remove your data from this study at any time prior to completion of the research project.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

The findings of this research will be available by December 30, 2010. At this time, you will be contacted by the primary investigator (Courtney Williston) and a paper copy of the results of this investigation will be made available to you if desire.

SUBSEQUENT USE OF DATA

These data may be used in subsequent studies.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

APPENDIX C



CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: How Physicians View their Role in Relation to Intimate Partner Violence Against Women

You are asked to participate in a research study conducted by Courtney Williston, B.A.H. (M.A. student) under the supervision of Dr. Kathryn Lafreniere (faculty supervisor), from the Department of Psychology at the University of Windsor. The results of this study will be used to contribute to the requirements of the M.A. thesis of the first investigator.

If you have any questions or concerns about the research, please feel to contact:

Courtney Williston
Daytime phone: 519-253-3000 ex. 2185
willistc@uwindsor.ca

or

Dr. Kathryn Lafreniere
Daytime phone: 519-253-3000 ex. 2233
lafren1@uwindsor.ca

PURPOSE OF THE STUDY

The purpose of this study is to explore how physicians understand their role in treating patients who experience woman abuse.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

Participate in a single one-on-one interview with the first investigator (Courtney Williston). The interview is expected to take 45-90 minutes and will be digitally audio-recorded. The interview will take place at a location agreed upon by you and the interviewer (e.g. your office or workplace, a private office on the University of Windsor campus, or alternate). You will also be asked to complete a brief demographics questionnaire at the end of the interview session

You may choose to review a typed transcript of your interview to make any changes or omissions you choose.

If you desire, you will be contacted following completion of the research project and provided with a copy of the results.

POTENTIAL RISKS AND DISCOMFORTS

Given the potentially sensitive nature of the topic under investigation, it is possible that you will experience some discomfort during the interview. You may choose to withdraw from the study or take a break at any point in the interview process surrounding professional role and responsibility conflicts. The psychological and emotional risks associated with participation in this study are not expected to be any greater than those you would encounter in your own encounters with patients or in discussions with colleagues. You will be provided with contact information and resources to better help women who experience male partner violence.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Participants will receive no direct benefits from the present study. There are potential benefits to the scientific community as well as society. Intimate partner violence is a distressingly common phenomenon both globally and in Canadian society. This research will contribute to existing knowledge of physicians' experiences in treating woman abuse. Because woman abuse is detrimental to many individuals in society, increasing understanding of treatment experiences may serve to improve training programs for healthcare professionals who treat victims of abuse, eventually leading to improved outcomes for those who experience violence at the hands of their male partners.

PAYMENT FOR PARTICIPATION

You will not receive payment for participation in this study. The primary investigator (Courtney Williston) will offer to provide you with a meal or refreshments of your choosing during the interview.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. Your name will not be associated with your interview, or your demographic information.

Interview and demographic data will be stored in locked file cabinets in the office of the primary investigator, and digital audio files will be stored on a password-protected personal computer belonging to the primary investigator. Digital and physical files will be retained for 6 years following publication of the study. After 6 years, digital audio files will be erased, and physical files will be shredded. Information will not be provided to a third party for any reason.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. You also have the option to remove your data from this study at any time prior to completion of the research project.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

The findings of this research will be available by December 30, 2010. At this time, you will be contacted by the primary investigator (Courtney Williston) and a paper copy of the results of this investigation will be made available to you if desire.

SUBSEQUENT USE OF DATA

This data may be used in subsequent studies.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario, N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF RESEARCH SUBJECT/LEGAL REPRESENTATIVE

I understand the information provided for the study How Physicians View their Role in Relation to Intimate Partner Violence Against Women as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Signature of Subject (X)

Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

Signature of Investigator

Date



CONSENT FOR DIGITAL AUDIO TAPING

Interviewee:

Title of the Project: How Physicians View their Role in Relation to Intimate Partner Violence Against Women

I consent to the digital audio-taping of this interview.

I understand these are voluntary procedures and that I am free to withdraw at any time by requesting that the taping be stopped. I may choose to stop audio-taping for parts or all of the interview at any time. I also understand that my name will not be revealed to anyone and that taping will be kept confidential. Digital audio recording files will be filed by number and stored on a password-protected computer.

I understand that confidentiality will be respected and that the audio tape will be for professional use only.

Interviewee

Date

APPENDIX E

DEMOGRAPHICS QUESTIONNAIRE

The following questions ask about your personal and professional background. These questions are for descriptive purposes only.

Gender: Female Male Transgender
 Other (e.g. two-spirited, please specify): _____

Age (in years): _____

Relationship Status: single, never in relationship
 single, not currently in relationship
 currently in relationship
 common-law
 married
 separated/divorced
 widowed
 other (please specify): _____

4. Which Ethnic group(s) do you most identify with?

- European Canadian (e.g. English-Canadian, French-Canadian)
- Aboriginal (e.g., Iroquois, Métis)
- Asian or Southeastern Asian-Canadian
- Middle Eastern (e.g. Persian, Arabic)
- Central American or Latin-Canadian
- Black or African Canadian
- Oceanian or Pacific Islander
- Multiracial/multi-ethnic (please specify): _____
- Other (please specify): _____

5. Where did you complete your medical education?

Country: _____
Province/State/Region: _____

6. What is your medical specialization? _____

7. For how many years have you been in practice? _____

8. What is the nature of your present practice? (e.g. private family practice, community care centre) _____

APPENDIX F

INTERVIEW GUIDE

A. Role of the Physician in Woman abuse Screening and Treatment

1. Can you tell me what you consider woman abuse to be?
2. What do you perceive a physician's role to be in screening for woman abuse?
3. What do you perceive a physician's role to be in treating woman abuse in medical practices?

Follow up questions/prompts:

How do you feel/think about your role in screening?

How do you think other physicians interpret their role?

B. Educational Experiences

1. Could you tell me about your woman abuse-related training in medical school or during residency?
2. Could you tell me about any training that you have received since you have been in practice?
3. What do you perceive a physicians' role to be in relation to woman abuse prevention and treatment?

Follow up questions/prompts:

What were these experiences like?

How did this make you feel? What did it make you think?

Were there any aspects that you feel were particularly meaningful or important to you?

What did you think about your training?

How did you feel while you received the training?

Is there anything that I have missed that you would like to talk about?

C. Encounters with patients who disclose abuse

1. Have you ever treated a patient who disclosed abuse by an intimate partner?

Follow-up questions/prompts:

What was this experience like for you?

What is suspicion like?

Did you ask about abuse, or did your patient bring it up?

How did you feel during this experience?

had on you professionally? Personally?

If no experience with patient who has disclosed abuse

Is there anything that I have missed that you would like to talk about?

D. Encounters with patients who the physician suspects may be experiencing abuse

1. Have you ever treated a patient whom you suspect may have been experiencing abuse but they did not disclose this to you?

Follow-up questions:

What was this experience like for you?

Did you talk about abuse-related issues with your patient?

How did you feel during this experience?

How did you feel afterwards?

Is there anything that I have missed that you would like to talk about?

D. Closing Question: at the close of the interview, if the interviewee has not discussed their usual woman abuse-related screening practices, they will be asked:

1. What are your usual practices for screening patients in your practice?

Follow-up questions:

Do you do this with all of your patients?

How do you approach the subject?

How do you feel when you ask about abuse?

VITA AUCTORIS

Courtney Williston was born in 1984 in Burlington, Ontario. Courtney graduated from Lester B. Pearson High School in 2003. Following this, she attended the University of Guelph, and graduated with distinction from the Honours Psychology program in 2008. Courtney is currently a candidate for the Master's degree in Applied Social Psychology at the University of Windsor and hopes to graduate in Fall 2010.