

**« Que va-t-il m'arriver si je parle? »
L'expérience des Latino-Américaines victimes
de violence face à la prestation des soins**

Ursula Kelly

L'identification des cas de violence conjugale et la prestation de services adéquats aux victimes font couramment partie du travail en soins infirmiers. La présente étude phénoménologique vise à améliorer, grâce à une approche interprétative, notre compréhension de l'expérience des Latino-Américaines victimes de violence face à la prestation des soins. Dix-sept femmes ont été interrogées en espagnol ou en anglais; les données ont été analysées suivant la méthode de van Manen. La peur que ressentent les victimes à l'idée que leur situation puisse être détectée et divulguée par les prestataires de soins est analogue à celle qu'elles éprouvent devant leur agresseur et leurs actes. Ces craintes sont suscitées par les conséquences éventuelles du dévoilement. En dépit de celles-ci, les répondantes se sont montrées disposées à être interrogées et à recevoir de l'aide. L'auteure dégage plusieurs parallèles entre la relation des victimes avec leur agresseur et celle qui s'établit avec les intervenants de la santé. Elle dresse à l'intention des prestataires de soins une liste de critères à respecter en matière de divulgation des cas de violence conjugale.

Mots clés : violence conjugale, soins de santé, soins infirmiers, Latino-Américaines.

“What Will Happen If I Tell You?” Battered Latina Women’s Experiences of Health Care

Ursula Kelly

Identifying and appropriately responding to victims of intimate partner abuse is a standard of health care. The purpose of this interpretive phenomenological study was to improve health-care providers’ understanding of the health-care experiences of battered Latina women. Seventeen women were interviewed in either Spanish or English. Data were analyzed using van Manen’s approach. The themes of fear, worry, and uncertainty were found to permeate the women’s lives. The women’s fear of their abusers and the abuse was matched by their fear of detection and disclosure of the abuse to health-care providers. Their fears were based on the consequences of the abuse becoming known. Despite their fears, the women wanted to be asked about intimate partner abuse and to receive help. Several parallels in the women’s relationships with the abusers and with their health-care providers were identified. Requisites for safe disclosure of intimate partner abuse to health-care providers are discussed.

Keywords: Intimate partner abuse, qualitative research, health care, nursing, Latina, immigrant, cultural competence

Introduction

Domestic abuse is recognized as a growing public health problem in the United States. Reduction in the incidence of domestic abuse is one of the 28 focus areas of Healthy People 2010 (US Department of Health and Human Services, 2000). Health-care providers are faced with the challenge of appropriately identifying and responding to victims of domestic abuse in every health-care setting. In fact, professional standards of practice have been in place for over a decade, dictating that providers screen for and intervene in cases of domestic violence.

The challenge of responding to intimate partner abuse (IPA) is compounded by the social complexity of this problem and the increasing diversity of the general population. Extant literature in the area of IPA and health care has focused on the perspectives and practices of providers. Studies with patients experiencing domestic abuse have been carried out with largely Caucasian populations. This study was designed to address this health-care challenge and the lack of perspective in the literature of victims of IPA from ethnic minority populations.

Background

In the United States, between 20% and 30% of women will be physically abused, and up to 50% psychologically abused, by an intimate partner at least once in their lifetime (Rennison, 2002; Tjaden & Thoennes, 2000). A recent study by the World Health Organization (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005) involving 15 countries found a range of lifetime abuse of 13% to 61%, with a median range between 23% and 49%. The same study reported a lifetime occurrence of sexual violence by an intimate partner in a range between 6% and 59%, with most sites falling between 10% and 50%. Campbell and associates (Campbell, 2002; Humphreys, Sharps, & Campbell, 2005) and McFarlane, Groff, O'Brien, and Watson (2005) identify IPA as a significant global health problem across ethnic groups and a leading cause of morbidity and mortality in women, for which effective interventions are lacking.

The population of the United States is becoming increasingly ethnically diverse. Ethnic minorities are projected to represent 45% of the US population by the year 2050, with Hispanics projected to form more than 24% of the general population (US Census, 2004). Racial and ethnic disparities in health status and health care are significant problems in the United States (Smedley, Stith, & Nelson, 2003). Humphreys et al. (2005) suggest that intra-ethnic and cultural group variations and macro-level systematic discrimination in the health-care system require further investigation.

Screening for IPA is the current standard of care for health-care providers across disciplines (American Academy of Family Physicians, 1994; American Academy of Pediatrics, 1998; American College of Obstetricians and Gynecologists, 1999; American Medical Association, 1992; American Nurses Association, 1991; JCAHO, 1995).

Despite the proliferation of screening protocols and training for clinicians, IPA is often overlooked or simply missed (McFarlane, Soeken, & Wiist, 2000). Several barriers to patients' disclosing domestic abuse to health-care providers are described in the literature: embarrassment and shame; denial; confidentiality concerns; distrust of the health-care provider; fear of retribution by the abuser; fear of reaction of friends, family, or health-care providers; lack of financial resources for medical care and housing without the abuser's support; and fear of police and court involvement (McCauley, Yurk, Jenckes, & Ford, 1998; Plichta, Duncan, & Plichta, 1996; Sleutel, 1998). Health-care providers have been described as uncaring, unhelpful, judgemental, unsupportive, and ineffective (Bacchus, Mezey, & Bewley, 2003; Gerbert et al., 1996), as well as humiliating, blaming, and dismissive (Campbell, Pliska, Taylor, &

Sheridan, 1994). Gerbert, Abercrombie, Caspers, Love, and Bronstone (1999) describe a subtle “dance of disclosure” between health-care providers and patients, in which miscommunication could occur.

In only a few studies have the investigators specifically explored the health-care experiences of battered Hispanic women (Bauer & Rodríguez, 1995; Belknap & Sayeed, 2003; Rodríguez, Bauer, Fores-Ortiz, & Szkupinski-Quiroga, 1998). Barriers to medical help seeking by these battered women include a code of silence, maintained by both the women and their providers, and misdiagnosis and mistreatment of their abuse and attendant problems. In a study of health care received by women with a history of IPA, Rodríguez, Sheldon, Bauer, and Perez-Stable (2001) report that among the Latina women (29% of the sample), 34% identified language barriers and 21% had concerns about immigration authorities. In another study, Latina women described *confianza* (trust, confidentiality, support, comfort, and safety) as critical to any discussion of IPA within a patient-provider relationship (Rodríguez et al., 1998).

The purpose of this interpretive phenomenological study was to increase health-care providers' knowledge about the health-care experiences of battered Latina women. The specific aims of the study were to (1) describe the meanings that battered Latina women give to their health-care experiences, and (2) identify battered Latina women's expectations of health-care providers and health-care systems.

Method

Study Design

The research question and the design and implementation of the study were guided by a feminist framework and the concept of marginalization (Hall, Stevens, & Meleis, 1994). The study used Van Manen's (1990) phenomenological method, which is meant to elicit and articulate the informants' versions of reality and the meanings they give to their experiences — in this case what the women's health-care experiences were like, given the social, cultural, and political influences on such experiences. This method was well suited to the present study, as the health-care experiences of Latina women often span linguistic and cultural divides. Further, this method inherently involves the investigator in the research process, including one's assumptions, biases, and situatedness — critical features given the ethnic, cultural, and linguistic disparity between the researcher and the informants.

Sample

A purposive sample was recruited from a population of women using a service agency for battered women and a legal services program in an

urban area situated in the northeastern United States. The informants self-identified as Hispanic or Latina and were Spanish-speaking, English-speaking, or bilingual. The study included women who self-identified as previously abused by an intimate partner, no longer in an abusive relationship, and received health care during the abuse. Adequacy of sample size ($n = 17$) was determined by redundancy in the statements made by the women about their health-care experiences and the emergence of a profound understanding of their experiences.

Data Collection

Dialogic interviews were conducted in the language of the informant's choice (Spanish or English). They lasted from 60 to 120 minutes and were audiotaped. Whenever possible, two or three interviews were conducted per informant. The interviews conducted in Spanish were transcribed in Spanish and English. Stipends of \$25 per interview and child care were provided. Field notes and memos were considered data as well.

Demographic information, basic information about the abuse itself, and the women's health-care history were collected, followed by the dialogic interviews, which became conversations with evolving topics of interest. The women inevitably spoke about the abuse experience itself before raising any other topic. Important topics that emerged and were critical to understanding the meanings of the women's health-care experiences were their motherhood role, previous life experiences, and immigration experiences.

Data Analysis

Data analysis took place concurrent with data collection. For interviews conducted in Spanish, data analysis was carried out using both Spanish and English transcripts, to ensure that the essence of the text was captured. The interview data were analyzed thematically using Van Manen's (1990) method, which calls for reflection and entails three approaches to the data. In the holistic or sententious approach, each text is considered as a whole: the researcher seeks a phrase that captures the fundamental meaning of the text as a whole. In the selective approach, the tapes and texts are reviewed several times as the investigator searches for essential phrases describing the informants' experiences; narrative statements are written, capturing each informant's experiences and providing detail and explication. Finally, in the line-by-line coding approach, the researcher considers what each line or sentence says about the experience being described; when coding is complete, relationships between the codes and the narrative statements are considered and organized into themes.

Themes were discussed with the informants in the second or third interview, thereby allowing for clarification and co-creation of an interpretive analysis of their experiences. Validity of data analysis was ensured by means of checking with the informants via a focus group session and consulting with bicultural advocates. These discussions involved a presentation of the major themes, challenging and discussing the researcher's thoughts and presuppositions.

Rigour and Protection of Human Subjects

Within the interpretive paradigm, rigour in qualitative research ensures trustworthiness. Trustworthiness in this study was ensured through application of the criteria for rigour in feminist research established by Hall and Stevens (1991), with slight revisions reflecting the interpretive paradigm. Institutional Review Board approval was obtained from the relevant institutions. Informants provided written informed consent in the language of their choice. Pseudonyms were assigned to all informants. Any safety concerns that emerged in the interviews were discussed immediately with the informant's case workers or attorney.

Findings

This discussion begins with a description of the sample, followed by findings regarding the women themselves, the defining roles and concerns of their daily lives, and their experiences of living and leaving the abuse, all of which contextualize their health-care experiences. Next, the women's experiences of health care are described, followed by the requisites for ensuring safe disclosure and discussion of the abuse.

Description of Sample

The 17 participants ranged in age from 19 to 53 years. Spanish was the primary language for thirteen of the women: ten spoke Spanish only, six spoke English and Spanish, and one spoke English only. The women came from five Latin-American countries and Puerto Rico. They had been living in the United States for a range of 2 to 23 years. Eight of the women were undocumented, five were US citizens from Puerto Rico, and four were permanent residents. They had been in their most recent abusive relationship for a range of 6 months to 23 years and out of the abusive relationship for a range of 3 months to 4 years. Their years of education ranged from 4 to 14. All of the women had at least one child, with a range of one to four children.

Pervasive Fear and Despair

Challenges to one's sense of self and safety: "My children above all else, come rain, thunder, or lightning." Mothering was the most important

aspect of these women's lives. For the women, living as they did in dangerous homes in an alien world, mothering their children was a responsibility against which all of their decisions and actions were weighed. Worry about their own and their children's well-being was unremitting. They put their children's needs before their own, often making difficult decisions and personal sacrifices for the sake of their children. Several of the women stayed with their abuser despite the suffering, in the belief that their children needed a father. They hid the abuse from others in order to preserve the family unit. Iliana was pregnant with her fourth child, the result of rape by her ex-boyfriend:

Temor de que si yo digo, que él es violento conmigo, ¿yo voy a ir a dónde? Yo voy a perder mi trabajo, yo tengo tres hijos en Colombia, por quien yo debo trabajar llueva, truene, o relampaguee, haga lo que haga yo tengo que trabajar para sostener a mis hijos en Colombia. Yo prácticamente el temor era de que, si yo no tenía una vivienda, de que si yo perdía mi trabajo, ¿qué iba a ser de mis hijos?

[Fear that if I said he was violent towards me, where would I go? I'd lose my job. I have three children in Colombia whom I need to work for, come rain, thunder, or lightning. Whatever happens, I have to support my children in Colombia. If I had nowhere to live, if I lost my job, what would become of my children?]

Living beneath the radar: Undocumented and undetected. The women lived their lives beneath the radar, avoiding anyone who might cause harm to themselves or their children: the abusers, their health-care providers, child protection services, the police, and, for some, US Citizenship and Immigration Services. The need to be invisible permeated their lives, causing them to approach interactions with outsiders, including health-care providers, with caution and personal withholding. Language barriers and their avoidance of official agencies left many of the women ignorant of their rights and of the laws that might protect them.

Even the English-speaking women, who had no particular fear of the justice system, worried that any information about domestic abuse would result in the loss of their children to child protection services. Sheila, who had lost custody of her older daughter to her emotionally and psychologically abusive husband, felt penalized for being abused:

They [health-care providers] get you in trouble... As soon as a woman is in domestic violence they all assume the kid is in danger...so you get scared sometimes and you don't talk.

Being battered: Alone, abused, afraid, and having nowhere to turn. Fear, despair, worry, and uncertainty permeated the women's lives.

Abused and isolated, they felt they had nowhere to turn for help. Their lives were complex and rife with conflict and danger. They feared their abusers and the abuse to come. They were trapped in a catch-22 situation whereby they risked harm and even death by either staying with or trying to leave the abuser. They worried about threats made by their abusers that if they disclosed the abuse to anyone, including family and friends, but particularly to anyone in authority — a police officer or health-care provider — they or their children would suffer worse abuse or even be killed. The women faced the prospect of being deported or their abuser being deported, the loss of their children to the abuser or his family or to the authorities, harm coming to their families, and lacking the economic and personal resources to survive. Lacking information about their social and legal rights and about the availability of resources and support, the women took these threats seriously. The threats had a particular hold over those women who were undocumented or spoke no English and who were therefore more likely to be completely isolated — in some cases not knowing a single person in the United States other than the abuser and his family. Iliana had a chilling story:

Casi siempre, lo que él me decía que si yo le decía a alguien lo que nos estaba pasando, que a él lo iban a arrestar, que lo iban a deportar, que cuando lo deportaran a él, él se iba a mi país, y que iba a matar a mi familia.

[What he almost always said to me was that if I told anyone what was happening he would be arrested and deported, and when he was deported he would go to my country and kill my family.]

“Staying, then leaving, for the sake of my children.” For most of the women, fully realizing the harm that the abuse was causing to their children was the impetus for leaving the abuser. For many, the last straw was seeing their children behave like the abuser — “[my son] started yelling at me just like my husband did” — or reacting to the abuser as they did themselves:

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

For others, the motivation to act was the escalating violence and imminent danger of their children being left motherless. Long after sepa-

rating from the abuser, they still struggled to gain the strength needed to move forward in life. The women's fragile sense of self and sense of security greatly influenced both their experiences of the abuse and their encounters with health-care providers.

Interactions with Health-Care Providers

Fear was the women's constant companion. Isolated from loved ones, not knowing whom to trust, their only certainty was fear. Fear always took a toll. Some women paid with hearts that raced, stomachs that bled, hands that trembled, weight that could not be controlled. Some women withdrew into themselves.

“What will happen if I tell you?”: Fear of detection and disclosure of IPA. Fear of talking about the abuse and being “found out” pervaded the women's health-care experiences. Misperceptions about the consequences of the IPA becoming known increased their fear and worry. The stakes were high: the women could not have been in a more vulnerable position, the word vulnerable being defined as “can be wounded, open to attack” (*Webster's New World Dictionary and Thesaurus*, 2002, p. 711). The women were already so deeply wounded that to discuss the abuse with a health-care provider would be to lay themselves open to being wounded again, even with the hope of help. Many of the women feared child protection services and US Customs and Immigration Services more than they feared the abuser. This fear was fuelled by the abuser and it paralleled and overlapped their fear of the abuser. Many of the women believed that disclosure of the abuse to a health-care provider would set in motion a series of steps beyond their control, with grave consequences for themselves and their children: loss of their children to child protection services and deportation of the abuser or themselves, resulting in economic hardship or their children becoming motherless. They could not discuss the abuse with their health-care provider because of one burning question: “What will happen if I tell you?”

The women's fear of their abusers and of the authorities prevented them from disclosing the abuse. Cecilia saw her health-care provider two or three times a month for management of depression and a variety of physical complaints. Her provider never asked her why she felt depressed or screened her for IPA, even though a flyer about domestic abuse was posted on his office wall. The flyer made Cecilia realize she needed help, but she did not tell her provider about the abuse:

It was always in his room...and it was in Spanish. I wanted to say something but I didn't because I didn't know what would happen or what he would say, because I couldn't take it any more. I was pregnant again... I didn't know what would happen to me because they say they have

shelters or something and I said, "Maybe they're going to take me out of the house and they're going to take my kids..." Oh!

Sylvia thought that child protection services would take her children away with very little cause. When her health-care provider suspected abuse after she arrived for an appointment with facial bruises, she was worried and frightened:

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

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

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

Relinquishing control. Despite the pervasive sense of fear and the risks involved, the women wanted to be asked about abuse and to receive help. They longed for someone to take control of the situation. They harboured a wish that someone, such as their health-care provider, would ask them about abuse or, better yet, figure it out for themselves. However, they would not disclose the abuse unless asked. A code of silence prevailed, maintained by both the woman and her health-care provider, with many of the women left with a continuing sense of isolation and resignation. They relinquished control to their provider by maintaining a posture of "If you ask me, I will tell you." Magdalena saw many health-care providers for herself and her disabled son, and was often tearful during the visits:

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

Giving clues: "But no one understood what I was trying to say."

In the absence of direct questioning by health-care providers, dropping

hints and giving clues was one way the women tried to prompt questioning that would enable them to disclose the abuse. This strategy failed to garner the support or help they needed. Several of the women described their partners to their health-care provider as having “*un caracter fuerte*,” which means a bad temper although it translates literally as strong character. To Iliana, this was an obvious clue that “something bad was happening to me, but no one understood what I was trying to say!” Others used more subtle clues. One woman commented that her partner “tell me I’m fat” — only to have her health-care provider suggest diet and exercise in order for her to lose weight. Many women used the words “stressed,” “tension,” and “depressed” as clues, but without success.

“How can they be so cold?”: Seeking a connection but not finding one.

Most of the women sought a sense of connection with their health-care provider, ranging from showing basic human decency to friendship of sorts. For many, this became clear only by its absence. They were surprised and dismayed to receive cold and distant treatment from their providers: “For many, many years, it felt like I was just a number, not even a patient.” Where they sought help, they found none. They looked for a person to whom they could confide their deepest, darkest secret, but instead found an untrustworthy person who treated them disrespectfully and uncaringly. Many of the women viewed their health-care providers as mechanistic in their approach to their jobs, treating their patients like parts on an assembly line. Central themes were “they’re just there to do their job,” “they do what they have to do and that’s it,” and “your five minutes are up.” Julia mimicked the typical behaviour of health-care providers: rushing in to the room, speaking rapidly without making eye contact — “Sit down. How are you? What do you need? Here you go. Goodbye.”

Creating Safety for Disclosure: What Women Need

None of the women had ever had a direct and fully honest conversation with a health-care provider about the IPA they were enduring. There was a nearly universal feeling that it was unsafe to reveal the IPA to a health-care provider. The risks involved in securing help to leave the abuser outweighed the risks of staying with the abuser. One set of fears overrode another. However, the women identified several requisites for safe disclosure, derived from their experiences with health-care providers.

“Where’s the love?”: Needing to know that health-care providers care.

The women needed to be recognized as human beings and to interact with their health-care provider on a human level. They were vulnerable and were reluctant to expose themselves for no reason: “Why should I be telling you my whole life if you’re not going to do anything for me?” Some women knew within a few minutes of meeting a new health-care

provider if he or she was a caring person. They observed body language, mannerisms, and eye contact, as well as verbal communication. Magdalena described the process:

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

“Can I trust you with my life?”: Needing to trust health-care providers.

The need for trust emerged as a major theme in the women's experiences of health care, and as an absolute prerequisite for honest communication about the IPA. The women needed to trust their health-care provider in a variety of ways: interpersonally, professionally, and practically. Interpersonal trust emerged in relationships in which the health-care provider demonstrated sincere caring behaviour over time. Professional trustworthiness was important only in its absence. Practical trust related to trusting health-care providers with information about the IPA and believing that no harm would come to the women or their children as a result.

“They didn't ask so I didn't tell”: Needing to be asked about IPA.

The women did not volunteer information about the IPA they were enduring, even when they were being seen for injuries or health problems directly related to the abuse. Their passivity and the failure of their health-care providers to ask about IPA, directly or indirectly, combined to create a code of silence about the abuse. Many of the women described the act of asking questions about their lives, and about IPA specifically, as an indication of caring and a critical step in building the requisite trust for disclosure:

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

Just as important as the need for health-care providers to ask questions was the need for them to listen to the answers. The women described the importance of truly listening — to silences as well as to responses, to both verbal and non-verbal reactions. Many felt that attentive health-care providers could detect as much from a woman's silence as from her words. A few of the women described listening as a response in itself: “All they have to do is listen!”

“What’s Going to Happen Next?”: The Need to Know the Consequences of Disclosure in Advance

Knowing the specific consequences of disclosure (or detection) of the IPA in advance was critical to the establishment of a safe environment for disclosure. Cecilia trusted her health-care providers, a physician and a nurse practitioner. She saw them several times a year and felt cared for by them. There were flyers posted in the offices about domestic abuse that read, “Talk to your doctor, we can help.” However, she did not disclose the IPA to them for fear of what would happen. She was afraid she would be forced to go to a shelter or would lose her children. Sylvia did her best to hide the abuse from her providers and from her pediatrician, whom she adored. In one encounter, the pediatrician suspected abuse and called a social worker in to speak with Sylvia:

Yo solamente pasaba por mi mente lo que iba a pasar si yo hablaba... Yo pienso que fue eso lo que, que, esa persona no me hizo sentir, como la suficiente seguridad para, para yo hablar, o sea, de pronto fue muy cortante, muy, si, cortante,... Y yo no fijate que yo no voy a decir nada.

[All that was going through my mind was what would happen if I talked... I think what happened was that this person really didn’t make me feel, like, safe enough to talk. And she was very curt — very, yes, curt... And I said, “No, I’m not going to say anything.”]

The women had advice for health-care providers based on several requisites for safety: show that you care, ask questions and listen to the answers, provide information and support before and after screening for IPA, open the door and be there when women are ready, and abandon the need to “fix it.”

Parallels in Relationships: Abusers and Health-Care Providers

Several parallels emerged between the women’s relationships with their abusers and their relationships with their health-care providers. These related to the women’s emotional responses and their behaviours within the relationships, as well as the behaviours of the abuser and the health-care provider. The women’s parallel emotional responses included fear, lack of control and power, feeling controlled, feeling invisible, relinquishing control, and protecting the other.

Discussion

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

In summary, phenomenologically, being in the world was excruciating for these battered Latina women. They were abused, alone, and afraid, and they did not know whom to trust and where to turn for help. They worried about their children, their well-being, and their future. They struggled to manage everyone and everything around them, living beneath the radar, avoiding detection and notice. They had been made invisible by their life circumstances and by their abusers, and they chose to remain invisible — even to themselves — in order to protect themselves. They found interactions with health-care providers to be threatening, as providers represented authority, with the power to involve “officials” who could do them harm. The women’s fear, worry, and despair did not obviate their desire and need for help. They craved support and guidance, both emotional and logistical, from their health-care providers, but did not receive it.

Current State of Knowledge

The findings closely parallel extant knowledge about women’s experiences of IPA and the health-care experiences of abused women. The participants described similar experiences of abuse, health-care interactions, and barriers to disclosure as those reported in the literature (Bauer & Rodríguez, 1995; Belknap & Sayeed, 2003; Rodríguez et al., 1998). One of the most significant findings of this study was the women’s concern about the lack of support from their health-care providers, whom they described as uncaring, not listening, rushed, untrustworthy, and not asking about abuse. Rodríguez et al. (1998) similarly found that *confianza* was critical to communication between health-care providers and patients and that the participants were concerned about the loss of decision-making control and the outcome of disclosure, including intervention by police, child protection services, and US Customs and Immigration Services. In the present study, language barriers were less of a concern than in the study by Rodríguez et al. (2001), with the women being more concerned about interpersonal dynamics.

Contributions to the Current State of Knowledge

Nursing practice. These findings further our understanding of the health-care experiences of battered Latina women in two areas. An unexpected finding was the multiple parallels in the women’s relationships with their abusers and their health-care providers. We health-care providers think of ourselves as the antithesis of abusers. We are there to help, not to harm. But from the women’s viewpoints, the health-care system and health-care providers were an ominous threat. On an interpersonal level, the context, content, and character of the patient-provider relationship had the potential to mirror the abusive relationship. Perhaps the revelation of

these parallels should not be surprising. However, nursing has yet to recognize them and the reactions they can trigger. Such recognition is critical to the provision of effective health care to the Latina population, including effective identification of and intervention for IPA. The findings strongly suggest that health-care providers could significantly reduce barriers to disclosure of IPA by carefully attending to the interpersonal dynamics of their relationships with and communication with patients, striving to create a safe and supportive environment for those most in need.

The added dimensions of immigration status and Latin culture made the experiences of these battered women unique and intensified the fear of detection and disclosure of the IPA. For the Latina women in this study, concerns about the behaviours of health-care providers and the involvement of various authorities were much greater barriers to disclosure than the internal barriers experienced by Anglos: shame and embarrassment, denial, and fear of the reactions of friends and family. Their paramount question and concern was, "What will happen if I tell you?"

Health-care providers need to address this unspoken concern by providing anticipatory information about screening questions and the consequences of disclosure, proactively addressing confidentiality concerns very specifically. Screening strategies could be revised to include anticipatory guidance, while pamphlets and public education campaigns on domestic violence could be revised to include information about the consequences of disclosure. Health-care providers should screen patients in a meaningful way, fully cognizant of the possible significance of the question in a woman's life. Screening should be consistent over time, with the patient being asked about IPA at each visit, since a Latina battered woman may have to be asked several times before she feels secure enough to respond honestly.

Nursing research and health policy. The findings of this study illustrate the need for improved access to and quality of health care for battered Latina women and other immigrant women. The barriers to the disclosure and discussion of IPA contribute to poor health care and thus to health-care disparities for this population. The results of this qualitative study provide a foundation on which to develop more generalizable studies to address these barriers and disparities. Interdisciplinary collaboration within health-care systems and coalition-building within communities are critical to this process. For battered Latina women, the complexity of their situation requires a combination of approaches.

The primary strength of this study is the inclusion of Spanish-speaking battered women, whose voices, experiences, and health-care needs are underrepresented in the literature. The study was limited by the exclusion of the perspectives of women currently in abusive relationships,

particularly those who do not seek or receive health, legal, or battered women's services. The findings are generalizable in the universality of human emotions — for example, the desire and need for interpersonal connection and caring and the fear that accompanies violence. They are not generalizable across all cultural and linguistic groups, or to women who cannot or are reluctant to access health and social services for abuse.

Conclusions

Health-care providers have a responsibility to identify and respond to victims of domestic abuse in every health-care setting, according to professional standards that include culturally competent care. This responsibility is made all the more challenging by the social complexity of the problem of domestic abuse and the increasing diversity of the general population. Extant literature fails to provide an understanding of the health-care perspectives of battered women from immigrant and ethnic minorities, and of effective strategies for identifying IPA and intervening effectively.

The findings of this study provide some understanding of battered Latina women's perspectives on health-care interactions and the meaning they give to them. The result is patient-centred information that guides the development of improved health-care interventions for this population, increased patient satisfaction with health care, and enhanced patient-provider relationships.

References

- American Academy of Family Physicians. (1994). Family violence: An AAFP white paper. *American Family Physician*, *50*, 1636–1646.
- American Academy of Pediatrics. (1998). The role of the pediatrician in recognizing and intervening on behalf of abused women. *Pediatrics*, *101*, 1091–1092.
- American College of Obstetricians and Gynecologists. (1999). *Domestic violence*. ACOG Educational Bulletin No. 257. Chicago: Author.
- American Medical Association. (1992). Violence against women: Relevance for medical practitioners. *Journal of the American Medical Association*, *267*, 3190–3190.
- American Nurses Association. (1991). *Position statement on physical violence against women*. Washington: Author.
- Bacchus, L., Mezey, G., & Bewley, S. (2003). Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health and Social Care in the Community*, *11*(1), 10–18.
- Bauer, H., & Rodríguez, M. (1995). Letting compassion open the door: Battered women's disclosure to medical providers. *Cambridge Quarterly of Health Care Ethics*, *4*, 459–465.

- Belknap, R. A., & Sayeed, P. (2003). Te contaría mi vida: I would tell you my life, if only you would ask. *Health Care for Women International, 24*, 723–737.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet, 359*, 1331–1336.
- Campbell, J., Pliska, M. J., Taylor, W., & Sheridan, D. (1994). Battered women's experiences in the emergency department. *Journal of Emergency Nursing, 20*(4), 280–288.
- García-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women*. Geneva: WHO Press.
- Gerbert, B., Abercrombie, P., Caspers, N., Love, C., & Bronstone, A. (1999). How health care providers help battered women: The survivor's perspective. *Women and Health, 29*(3), 115–135.
- Gerbert, B., Johnston, K., Caspers, N., Bleecker, T., Woods, A., & Rosenbaum, A. (1996). Experiences of battered women in health care settings: A qualitative study. *Women and Health, 24*(3), 1–17.
- Hall, J. M., & Stevens, P. E. (1991). Rigor in feminist research. *Advances in Nursing Science, 13*(3), 16–29.
- Hall, J. M., Stevens, P. E., & Meleis, A. I. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *Advances in Nursing Science, 16*(4), 23–41.
- Humphreys, J., Sharps, P.W., & Campbell, J. C. (2005). What we know and what we still need to learn. *Journal of Interpersonal Violence, 20*(2), 182–187.
- JCAHO. (1995). *Accreditation manual for hospitals*. Oakbridge Terrace, IL: Author.
- McCauley, J., Yurk, R., Jenckes, M., & Ford, D. (1998). Inside "Pandora's box": Abused women's experiences with clinicians and health services. *Journal of General Internal Medicine, 13*, 549–555.
- McFarlane, J., Groff, J., O'Brien, J., & Watson, K. (2005). Prevalence of partner violence against 7,443 African American, white, and Hispanic women receiving care at urban public primary care clinics. *Public Health Nursing, 22*, 98–107.
- McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2006). Secondary prevention of intimate partner violence: A randomized controlled trial. *Nursing Research, 55*(1), 52–61.
- McFarlane, J., Soeken, K., & Wiist, J. (2000). An evaluation of interventions to decrease intimate partner violence to pregnant women. *Public Health Nursing, 17*(6), 443–451.
- Meleis, A. I., & Im, E. O. (1999). Transcending marginalization in knowledge development. *Nursing Inquiry, 6*, 94–102.
- 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.
- Rennison, C. M. (2002). *Intimate partner violence, 1993–2001*. Publication No. NCJ-197838. Washington: US Department of Justice, Bureau of Justice Statistics.

- Rodríguez, M., Bauer, H., Flores-Ortiz, Y., & Szkupinski-Quiroga, S. (1998). Factors affecting patient-physician communication for abused Latina and Asian immigrant women. *Journal of Family Practice, 47*, 309–311.
- Rodríguez, M. A., Sheldon, W. R., Bauer, H., & Perez-Stable, E. J. (2001). The factors associated with disclosure of intimate partner abuse to clinicians. *Journal of Family Practice, 50*(4), 338–344.
- Sleutel, M. (1998). Women's experiences of abuse: A review of qualitative research. *Issues in Mental Health Nursing, 19*, 525–539.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington: National Academies Press.
- Tjaden, P., & Thoennes, N. (2000). *Full report of the prevalence, incidence, and consequences of violence against women*. Washington: US Department of Justice, National Institute of Justice.
- US Census. (2004, March). *Projected population of the United States, by race and Hispanic origin: 2000 to 2050*. Retrieved April 30, 2006, from <http://www.census.gov/ipc/www/usinterimproj/natprojtab01a.pdf>
- US Department of Health and Human Services. (2000). *Healthy people 2010* (2nd ed.). Washington: US Government Printing Office.
- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Ontario, NY: State University of New York.
- Webster's new world dictionary and thesaurus*. (2nd ed.). (2002). New York: Hungry Minds.

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Comments or queries may be sent to Ursula Kelly, 130 Colberg Avenue, Roslindale, Massachusetts 02131 USA.

Ursula Kelly, PhD, APRN, BC, is Assistant Professor and Coordinator, Adult Nurse Practitioner Specialty Track, MGH Institute of Health Professions, Boston, Massachusetts, United States.