

Women Exposed to Intimate Partner Violence

Expectations and Experiences When They Encounter Health Care Professionals: A Meta-analysis of Qualitative Studies

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Background: The appropriate response of health care professionals to intimate partner violence is still a matter of debate. This article reports a meta-analysis of qualitative studies that answers 2 questions: (1) How do women with histories of intimate partner violence perceive the responses of health care professionals? and (2) How do women with histories of intimate partner violence want their health care providers to respond to disclosures of abuse?

Methods: Multiple databases were searched from their start to July 1, 2004. Searches were complemented with citation tracking and contact with researchers. Inclusion criteria included a qualitative design, women 15 years or older with experience of intimate partner violence, and English language. Two reviewers independently applied criteria and extracted data. Findings from the primary studies were combined using a qualitative meta-analysis.

Results: Twenty-nine articles reporting 25 studies (847 participants) were included. The emerging constructs were

largely consistent across studies and did not vary by study quality. We ordered constructs by the temporal structure of consultations with health care professionals: before the abuse is discussed, at disclosure, and the immediate and further responses of the health care professional. Key constructs included a wish from women for responses from health care professionals that were nonjudgmental, non-directive, and individually tailored, with an appreciation of the complexity of partner violence. Repeated inquiry about partner violence was seen as appropriate by women who were at later stages of an abusive relationship.

Conclusion: Women's perceptions of appropriate and inappropriate responses partly depended on the context of the consultation, their own readiness to address the issue, and the nature of the relationship between the woman and the health care professional.

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INTIMATE PARTNER VIOLENCE IS THE systematic abuse of persons by their current or former intimate partner. The violence may be physical, sexual, emotional, or economic in the context of coercive control, often escalating in severity.¹ This violence causes short- and long-term medical problems.² Women abused by their partners or ex-partners are more likely to experience mental ill health,³ particularly depression and posttraumatic stress disorder, substance abuse, chronic pain,⁴ sexually transmitted diseases,⁵ and perinatal complications.⁶ Escalating violence can culminate in murder.⁷ Women experiencing intimate partner violence seek care from emergency departments approximately 3 times more often than non-abused women⁸ and are also more likely to present to primary care and women's health services.⁹ Despite the many opportunities for disclosure of abuse in clinical settings, only a few women with a current or past history of partner violence are identified by health care professionals, leading to proposals for screening in health services. The ensuing debate¹⁰⁻¹² has overshadowed ques-

tions about the nature of appropriate responses by clinicians to women who have disclosed intimate partner violence to them.

Controlled studies^{10,11} provide quantitative evidence on the effectiveness of interventions following disclosure of abuse. There is also substantial qualitative research literature that analyzes women's perspectives on the response of health care professionals to disclosure. Studies¹³ based on interviews allow participants to discuss their expectations and experiences and to reflect on them in conversation. Women's perceptions of appropriate immediate and longer-term responses to disclosure should inform clinical guidelines, health care policy, and the training of health care professionals.¹⁴

Systematic reviews^{10,11,15} underpin clinical guidelines and policy internationally, including the field of domestic violence, yet qualitative studies have been largely excluded from the growing pool of reviews that are available to clinicians and policy makers. Although qualitative research does not easily lend itself to synthesis, this is essential if find-

ings from individual studies are to contribute to health care decision making and policy.

The aim of this meta-analysis of qualitative studies is to determine how abused women perceive the response of health care professionals when they discuss abuse and how they would like these professionals to respond. The findings from this analysis will be useful in designing training for professionals and supporting the development of more appropriate responses from health systems to partner violence.

There is no standard method for combining qualitative studies. The term qualitative meta-analysis¹⁶ covers a range of methods, from reanalysis of primary data collected in multiple studies to analysis of results reported in published articles. In this article, we will use the latter approach, drawing on the Schutz¹⁷ framework of constructs. Our method is based on the metaethnography proposed by Britten¹⁸ and Campbell¹⁹ and colleagues, and first described by Noblit and Hare.²⁰ We prefer the term meta-analysis, because the studies we are analyzing are not ethnographies. We also compared our findings with previously published national guidelines.²¹⁻²⁴

In this article, we report a meta-analysis of qualitative studies to answer 2 questions: (1) How do women with histories of intimate partner violence perceive the responses of health care professionals? and (2) How would women with histories of intimate partner violence want their health care providers to respond to disclosures of abuse?

METHODS

DATA SOURCES

We searched for studies on 5 bibliographic databases from their respective start dates (given in parentheses) to July 1, 2004: MEDLINE (1966), Applied Social Sciences Index and Abstracts (1987), Social Science Citation Index (1970), CINAHL (1982), and PsychINFO (1806). For each of the databases, an inclusive search was initiated using subject headings, text words, and keywords; the Boolean logic terms “or” and “and” were also used to combine searches. In the first instance, a search was conducted for articles pertaining to intimate partner violence against women and other related terms (such as

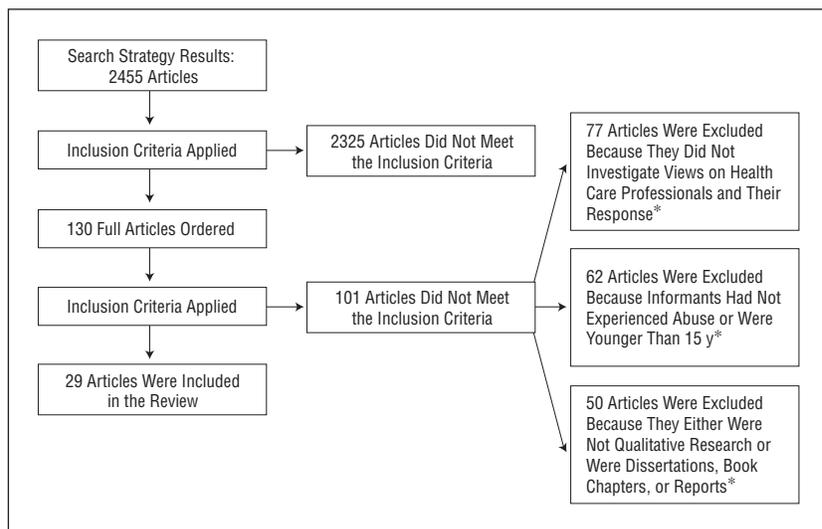


Figure 1. Flowchart of primary study selection. The asterisk indicates that articles could be excluded from the review for more than 1 reason.

domestic violence, battered women, and spouse abuse). Following from this, search terms were used to identify articles that reported studies using a qualitative research design. The specific search terms varied as a function of the bibliographic database but were comparable across the 5 databases. We complemented these searches with forward and backward citation tracking and contact with researchers in the field of domestic violence research.

STUDY SELECTION CRITERIA

The bibliographic database search produced 2455 abstracts. Two reviewers (M.H. and J.R.) independently applied the following inclusion and exclusion criteria to these abstracts. The inclusion criteria included the following: (1) a qualitative design; (2) published articles/reports; (3) investigation of abused women’s views of health care professionals; (4) presence of verbal interaction between the researcher and the participant to facilitate the formulation of the results; (5) female participants; (6) participants 15 years and older; (7) participants report some lifetime experience of intimate partner violence; (8) if the study presents domestic abuse victims as a subset, the abused women’s views are discussed separately; (9) no demographic or geographic restriction placed on sample participants or study setting; and (10) only English-language articles. The exclusion criteria included the following: (1) randomized control trials, (2) cohort studies, (3) case-control studies, (4) cross-sectional studies, (5) clinical case studies, (6) surveys, (7) surveys with written open-ended questions, (8) dissertations/reports/book chapters, (9) participants younger than 15 years, and (10) participants with no his-

tory of domestic violence. However, if the randomized control trials, cohort studies, case-control studies, cross-sectional studies, surveys, and surveys with written open-ended questions had a qualitative component, they were potentially eligible for inclusion.

The result after the application of these criteria was 130 articles that were assessed by 1 reviewer (M.H.) against the inclusion and exclusion criteria, with a second reviewer (J.R.) checking all decisions. Disagreements between reviewers were resolved by discussion or adjudication of a third reviewer (G.S.F. or A.R.T.). Twenty-nine articles^{5,14,25-51} reporting 25 studies met the inclusion criteria and were included in the review (**Figure 1**).

DATA EXTRACTION

Two reviewers (M.H., J.R., or A.R.T.) independently extracted data onto a standardized form for each article pertaining to women’s perceptions and experiences of health care professionals; any differences in data extraction between reviewers were resolved by discussion. We extracted 2 types of data: the understandings of the women as reported in the article(s) describing the study (first-order constructs) and the interpretations or conclusions of the authors (second-order constructs). First-order constructs reflect the understandings of the informants and, in some instances, express their lay theories about their experiences; second-order constructs reflect the researchers’ theorization across the women in their sample. The completed extraction form for each study was sent electronically to its first author, with a

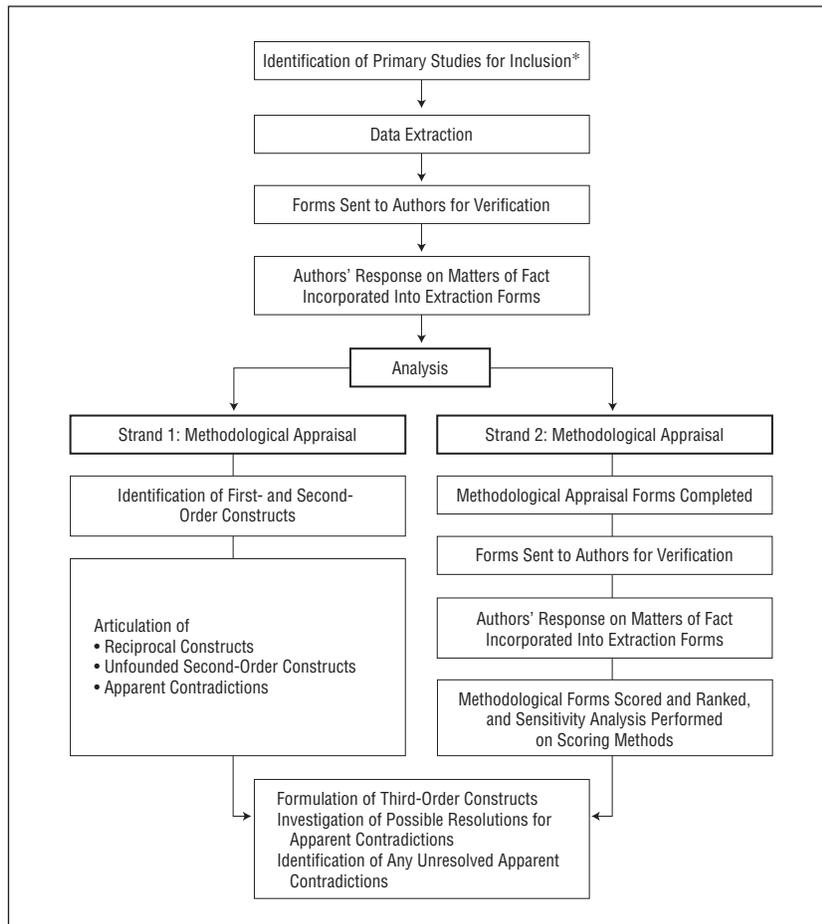


Figure 2. Stages in the meta-analysis. The asterisk indicates that this identification was done in Figure 1.

| Construct Order | Definition |
|-----------------|--|
| First | Understandings of abused women about encounters with health care professionals as reported in the articles describing the primary studies |
| Second | Interpretations or conclusions of the researchers reporting the primary studies; for identification of second-order constructs in which the investigators had only presented recommendations, we have inferred the authors' conclusions from these |
| Third | Interpretations or conclusions of the meta-analysis of reports of primary studies |

request to check for accuracy and completeness of extraction. Of the authors, 18 responded and 9 provided additional information with which we amended extracted data.

ANALYSIS

The analysis started with 2 parallel strands: (1) identification and examination of first- and second-order constructs and (2) methodological appraisal. These strands were brought together in the formulation of third-order constructs expressing the conclusions of the meta-analysis (Figure 2). We summarize the meaning of the terms first-, second-, and third-order

constructs in Table 1. These constructs are the main outcomes of the meta-analysis.

To map the relationships between first- and second-order constructs across studies, we tabulated the constructs and the primary studies. Other study characteristics were also tabulated: sample, setting, data collection, type of health care professional, and level of contact with the health care professional.

We examined 3 different types of relationship between the constructs extracted from the studies: (1) We identified constructs that were similar across several studies (reciprocal constructs), and through a process of repeated reading and

discussion articulated third-order constructs, which expressed our synthesis of findings that were consistently supported across the studies. (2) We identified constructs that seemed in contradiction between studies; we have called these apparent contradictions. There are 2 types of contradiction: those arising within a single study (inrastudy) and those arising between studies (interstudy). We sought to explain these apparent contradictions by examining factors in the studies. Where there was a plausible explanation (eg, an apparent contradiction between studies potentially explained by different health care settings), we expressed this as a third-order construct. (3) We looked for unfounded second-order constructs (ie, conclusions by primary study authors that were not supported by first-order constructs).

We assessed each study included in the review with a modified version of the Critical Appraisal Skills Programme tool (available at: <http://phru.nhs.uk/casp/qualitat.htm>), which consists of 10 questions (available from the authors) covering credibility and relevance of the studies and has been used in previous reviews of qualitative studies.^{18,19}

Two reviewers (M.H. and J.R.) independently appraised each study, and differences were resolved by discussion or adjudication by a third reviewer (G.S.F.).

We formulated 4 alternative scoring systems: equal weighting of all Critical Appraisal Skills Programme items and 3 forms of differential weighting based on the perceived importance of different items. The resulting scores were used to rank the methodological quality of the different studies (Figure 3). The quality ranking was relatively insensitive to the different methods of scoring investigated, so we used the score based on equal weighting of all Critical Appraisal Skills Programme items, the simplest of the 4 scoring systems.

The next stage in the analysis was re-examination of constructs in relation to study quality. The apparent contradictions and their possible resolution were also re-examined at this stage. We tested whether methodological quality affected our conclusions by assessing the distribution of quality scores across the studies on which each first-order construct was based.

Our third-order constructs place the first- and second-order constructs and the resolved apparent contradictions temporally in relation to disclosure of abuse in the consultation with a health care professional: before the abuse is discussed, at disclosure, and the immediate and further responses of the health care professional. These constructs represent how women who have experienced partner violence want their health care providers to address

this issue and respond to women in their situation. In that sense, they can be construed as recommendations to health care professionals, and we have compared them with recommendations in 4 national guidelines from the United States, Canada, United Kingdom, and New Zealand.²¹⁻²⁴ In addition, the robustness of each third-order construct was tested by checking if it was supported by studies in the upper tertile of quality scores.

RESULTS

Twenty-nine articles^{5,14,25-51} in 24 journals reporting 25 studies were included in the review (**Table 2**), and incorporated data from 847 women with a history of partner violence discussing their perceptions of health care professionals. The women's ages in the primary studies ranged from 18 to 78 years, with varying ethnicity and socioeconomic status. Of the 26 studies, 23 recruited women from community settings, 2 were hospital based, and 1 recruited women from various community and health care settings. Of the studies, 19 were based in the United States, 3 in the United Kingdom, and 4 in Australia.

FIRST-ORDER CONSTRUCTS

We identified 14 first-order constructs (**Table 3**). The detailed charting of constructs between studies is available (http://www.ichs.qmul.ac.uk/partner_violence/). For each first-order construct, there were studies in the top tertile of methodological quality scores that supported the construct. There were no systematic differences in the first-order constructs by health care setting, by North American region, or between the US, United Kingdom, and Australian studies. None of the studies reported variation in expectation from different health care professionals. To illustrate the interaction between these constructs, 3 different areas are considered.

DESIRED CHARACTERISTICS OF HEALTH CARE PROFESSIONALS

Constructs 2, 3, 6, 9, and 14 taken together reflect a clear view from the informants in the primary studies on the desirable and undesirable characteristics of health care profession-

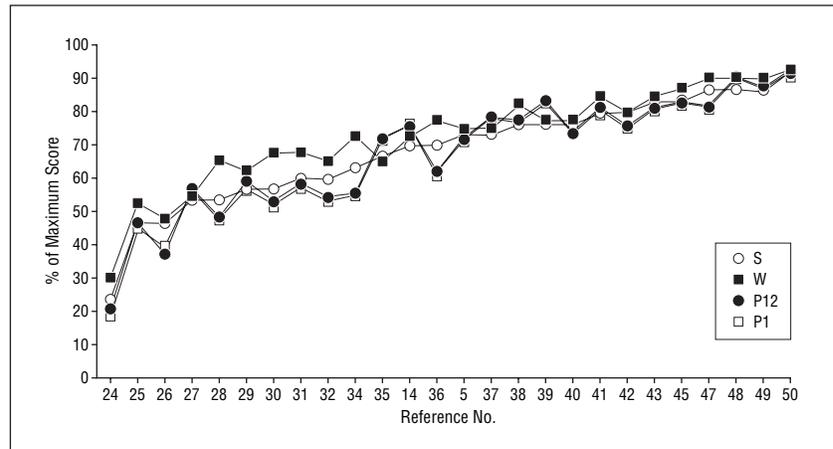


Figure 3. Methodological quality of the studies. S indicates equal weighting of all Critical Appraisal Skills Programme (CASP) items; and W, P12, and P1, 3 forms of differential weighting of CASP items.

als in relation to discussions about partner abuse. Women wanted health care professionals to be nonjudgmental, compassionate, and sensitive, and to maintain confidentiality. They wanted the professional to display an understanding of the complexity of domestic violence, to understand its long-term nature (and, hence, the difficulty of a quick resolution), and to understand its social and psychological ramifications. Women wanted health care professionals to avoid medicalizing the issue.

NATURE OF THE CONSULTATION WITH HEALTH CARE PROFESSIONALS

First-order constructs 1, 2, 5, 6, 10, 11, 12, 13, and 14 represent women's views about what they find helpful and unhelpful in consultations with health care professionals. Raising the issue in a sensitive and confident manner is important, as is not rushing or hurrying the discussion. Women value confirmation that the violence they have experienced is unacceptable and undeserved, and they wanted the health care professional to challenge false assumptions made by some abused women (eg, that the abuse was somehow their fault). They hoped the health care professional would bolster their confidence. Women wanted to be able to progress at their own pace and not to be pressured to disclose, leave the relationship, or press charges against their partner or ex-partner. Women wanted the

health care professional to respect their decisions and to share decision making with them.

WOMEN'S EXPRESSION OF THEIR NEEDS

Constructs 8, 9, 10, and 13 are all connected to women's views about their needs or what is important to them. Women's feelings about their abuse were complex and affected their decision about whether to discuss abuse with a particular health care professional in a particular consultation. Women specifically acknowledged the importance of the health care professional in helping address these feelings.

SECOND-ORDER CONSTRUCTS

All the second-order constructs (**Table 4**) were supported by first-order constructs within the same study. We found that the interpretations or conclusions of the authors were linked to the data reported in the articles, although the degree of extrapolation varied. The main themes in the conclusions were as follows: autonomy, confidentiality, health care professional behavior, disclosure of violence, education of health care professionals, cultural issues, and documentation (details available from the authors).

APPARENT CONTRADICTIONS

We summarize our analysis of the 7 apparent contradictions in

Table 2. Study and Participant Characteristics of Included Studies

| Source | Study Characteristics | | | | Participant Characteristics | | | | |
|---|---|--|---------------------------|--------------------|---|--|---|--|--|
| | Objective | Method | Theories Used | HCP Studied | Sample (Age Range, y) | Ethnicity | Abuse Type and Duration | Contact With Clinician | Current Status of the Relationship |
| Drake, ²⁵ 1982 | To provide a description to enable clinical nurses to increase their knowledge and skills for identifying battered women to render improved patient care | Focused interviews | Not stated | Not stated | 12 Female victims of DV (19-38) | 41% White and 59% black | A perceived intentional act of physical violence that occurs during an interpersonal relationship with a spouse or male partner | 92% Had sought health care in relation to their battering at some time | 67% Residing within the shelter and 33% residing outside the confines of the shelter |
| McMurray and Moore, ³⁷ 1994 | To examine problems faced by victims of spousal abuse once they enter the Australian hospital system | Interview | Phenomenological approach | All hospital staff | 4 Women identified from women's refuges; all had been hospitalized for treatment of injuries inflicted by a partner | Not stated | Women who were hospitalized for treatment of injuries, so definitely physical abuse | All received care for injuries inflicted by a partner | Not stated |
| Gerbert et al, ³¹ 1996 | To explore from the battered women's perspective if and what barriers exist that may prevent them from being recognized as victims of abuse and from receiving appropriate treatment, and what factors exist that may allow them to receive such care | Interviews asking open-ended questions | The systems' model | All HCPs | 31 Women who had experienced DV and who were identified via a random digit-dialing telephone survey and a publicity recruitment campaign | 80% White, 10% Hispanic, and 6% Native American | Not stated | 55% Of women reported a total of 38 incidents for which they had sought health care | Range, including living with the batterer, having restraining orders, being stalked, or living in shelters |
| Rodriguez et al, ⁴⁴ 1996 | To determine the barriers to identification and management of DV from the battered women's perspective | Focus group design | Not stated | HCPs | 51 Women who had experienced DV in the past 2 y, recruited from community-based organizations that included advocate groups for women's and family issues, battered women's shelters, transitional programs, and drug rehabilitation treatment programs | 45% Born in the United States; the rest were Latino or Asian in origin | Not stated | 86% Discussed previous interactions with physicians or nurses, and 71% discussed lying to the physicians or nurses | 43 Responded to the marital status question; of these, 21% were married or living with a partner and 79% were divorced, separated, or single |

(continued)

Table 2. Study and Participant Characteristics of Included Studies (cont)

| Source | Study Characteristics | | | | Participant Characteristics | | | | |
|-------------------------------------|--|--|--------------------------------|---|--|--|---|---|------------------------------------|
| | Objective | Method | Theories Used | HCP Studied | Sample (Age Range, y) | Ethnicity | Abuse Type and Duration | Contact With Clinician | Current Status of the Relationship |
| Rodriguez et al, ⁴⁵ 1998 | To focus on abused immigrant Latina and Asian women and to provide an analysis of their experiences | Semistructured focus group discussions | Not specifically stated | Not stated | 28 People who had experienced DV in the past 2 y and were recruited from community-based organizations primarily serving Asian/Latino communities | 50% Latina and 50% Asian | Uses the term DV | Not stated | Not stated |
| Bauer et al, ²⁸ 2000 | To present the major social, political, and cultural barriers that affected help seeking and patient provider communication among abused Latino and Asian participants | Focus groups | Not stated | Not stated | 28 Women who had experienced DV in the past 2 y and were recruited from community-based organizations primarily serving Asian and Latino populations | 50% Asian and 50% Latino | Intimate partner abuse | Not stated | Not stated |
| McCauley et al, ³⁹ 1998 | To explore women's experiences with and perceptions of clinicians and health care systems to identify characteristics that facilitated or acted as barriers to disclosure of abuse | Focus groups | Not stated | Physicians or other health care professionals | 21 Women in group therapy for current or past DV (either self-referred or court ordered) | 62% Were African American and 38% were white | Not stated | 86% Had seen a regular physician in the past year, 38% had discussed abuse with the HCP, and 29% had the physician question the woman about abuse | Not mentioned specifically |
| Draucker, ²⁹ 1999 | To understand if survivors' perceptions of their therapeutic experience and beliefs about their therapeutic needs could help clinicians understand how formal mental health services may better meet the needs of women who have been sexually assaulted | In-depth face-to-face interviews | The unfolding tributary method | Nurses or mental health workers | 7 DV victims recruited via referral by area professionals and advertisements | Ethnicity for the total sample, not just women who experienced DV (n = 33): 73% were white, 21% were African American, 3% were Asian American, and 3% declined to identify | Forced or violent sex committed by someone to whom they were committed, typically a spouse or long-term partner | 4 Of 7 Women who experienced DV underwent formal mental health treatment related to the abuse they had experienced | Not stated |

(continued)

Table 2. Study and Participant Characteristics of Included Studies (cont)

| Source | Study Characteristics | | | | Participant Characteristics | | | | |
|-----------------------------------|--|---|---|--|---|---|--|--|---|
| | Objective | Method | Theories Used | HCP Studied | Sample (Age Range, y) | Ethnicity | Abuse Type and Duration | Contact With Clinician | Current Status of the Relationship |
| Gerbert et al. ⁴⁸ 1999 | To describe from participants' perspective/ in their own language what helped them and how disclosure to and identification by an HCP were related to these helpful experiences | Semistructured interviews | Grounded theory with constant comparative analysis | Physicians, nurses, and nurse practitioners, but not psychiatrists | 25 Women who had been physically hurt by an intimate partner, recruited from print media and referral from knowledgeable informants | 76% White, 16% black, and 8% Hispanic | Hit, slapped, kicked, punched, choked, beaten up, physically threatened with a knife or gun, forced to have sex, or otherwise physically hurt by an intimate partner | 88% Sought medical care for injuries caused by DV, 84% sought routine medical care while in the violent relationship, 84% disclosed to the HCP, and 96% of HCPs identified the women as DV victims | 88% Were either married or living with the abuser |
| Schaffer, ²⁷ 1999 | To identify and explore the needs of older women who are living or have lived with a violent partner to influence public policy and to advocate for more appropriate and accessible services for older women | Cross-sectional self-nominated telephone interviews, carried out over a 21-h weekend period | Not stated | GPs, physicians, psychotherapists, and psychiatrists | 90+ Women in self-nominated telephone interviews carried out over a 21-h period (50-78) | Not specified in detail | Not defined | Not stated | Not specified |
| Mayer, ²⁶ 2000 | To describe the perceptions of female DV victims' experiences in the ED and to determine potential barriers to outcomes | Focus groups | Constant comparison method and King's theory of goal attainment | ED staff | 35 Women who were all female residents of a DV shelter | 62% White and 31% African American | Not stated | 57% Indicated they had gone to the ED for care of injuries after abuse | Not stated, but all shelter residents |
| Yam, ⁵ 2000 | To describe battered women's perceptions of their experiences in the ED | Semistructured interviews | Phenomenology | ED staff: physicians and nurses | 5 Abused women recruited from battered women's shelters (22-36) | 40% African American, 40% white, and 20% mixed race | Physical force by a male partner | All women sought help from the ED at least once in the past year for injuries related to abuse (13 total visits; each woman, 2-4 visits) | Data not collected |

(continued)

Table 2. Study and Participant Characteristics of Included Studies (cont)

| Source | Study Characteristics | | | | Participant Characteristics | | | | |
|--------------------------------------|---|---------------------------|----------------------------|--|--|---|--|--|--|
| | Objective | Method | Theories Used | HCP Studied | Sample (Age Range, y) | Ethnicity | Abuse Type and Duration | Contact With Clinician | Current Status of the Relationship |
| Bates et al, ⁴³ 2001 | To identify elements of health care that women who have experienced DV consider to represent quality care and to explore opportunities for public health service to improve its service delivery to these women | Focus groups | Thematic analysis approach | Not stated | 65 Women who had experienced DV recruited via a recruitment agency from refuges and women's support services | 27% Aboriginal or Torres Strait Islander origin and 73% not stated (one woman was a non-English speaker) | Not mentioned, other than DV | Not stated | Not stated |
| Hegarty and Taft, ³⁶ 2001 | To present qualitative and quantitative information on barriers and rates of disclosure to GPs by abused women, and inquiry rates by GPs | Interviews | Phenomenological analysis | GPs | 20 Women from 8 DV services; all were older than 20 y, had been abused, and had a support worker | 60% Were Australian born, 10% were English, 5% were from New Zealand, 5% were Latina American, 5% were Greek, 5% were Italian, and 5% were from the Netherlands | All women experienced physical violence, 90% experienced psychological violence, 55% experienced economic abuse, and 35% experienced sexual violence | Reported frequent attendance to many GPs; 80% disclosed abuse to a GP | 95% Were living apart from the abuser |
| Bacchus et al, ⁴⁶ 2002 | To describe women's perceptions and experiences of routine inquiry for DV in the maternity setting | Semistructured interviews | Thematic content analysis | Any HCP involved in pregnancy or postpartum care | 16 Women who had been identified as abused (in a previous study) when attending maternity services at 2 large teaching hospitals | Not stated | Any adult experience of physical or sexual violence perpetrated by a current or former partner or family member | All at some stage in pregnancy or post partum; therefore, they must have had some experience with an HCP in the past year | Not stated |
| Bacchus et al, ⁴⁷ 2003 | To examine current and past psychological health in a sample of women who had experienced DV and to describe their experiences of seeking help from an HCP | Semistructured interviews | Thematic content analysis | GPs, HVs, and A&E staff | 16 Women who had been identified as abused (in a previous study) when attending maternity services at 2 large teaching hospitals | 38% Black African, 25% white, 6% black Caribbean, 19% black British, 6% Bangladeshi, and 6% mixed race | Any adult experience of physical or sexual violence perpetrated by a current or former partner or family member | All saw an HV, 12.5% told the HV about the DV, 25% told a GP about the abuse, 31% sought treatment from an A&E staff member (25% of these disclosed abuse) | 50% Still in a relationship with the abusive partner |

(continued)

Table 2. Study and Participant Characteristics of Included Studies (cont)

| Source | Study Characteristics | | | | Participant Characteristics | | | | |
|------------------------------------|--|---------------------------|----------------------------|---------------|--|--|--|---|--|
| | Objective | Method | Theories Used | HCP Studied | Sample (Age Range, y) | Ethnicity | Abuse Type and Duration | Contact With Clinician | Current Status of the Relationship |
| Hathaway et al, ³² 2002 | To learn about conditions that enabled women to talk with their providers about the abuse and provider responses that were most helpful | Semistructured interviews | Content analysis | Not stated | 49 Women who had participated at a hospital-based DV program for at least 6 mo, recruited via telephone (21-61) | 51% White, 35% Latina, 6% Asian, and 8% other | All women stated being emotionally hurt, 82% stated being physically hurt, and 59% reported sexual abuse | 80% Reported disclosing abuse to an HCP, as women from a hospital-based project, assuming that all have had some level of HCP contact | 65% Of the women were separated or divorced from their abuser, 20% were living apart from their abuser, 12% were living with the abuser, and 2% were widowed |
| Nicolaidis, ¹⁴ 2002 | To find out what DV survivors want to teach physicians and to use this information to develop an educational tool for the HCP (a documentary) | Semistructured interviews | Not stated | Physicians | 21 Participants recruited via announcements and brochures distributed to clinics and DV agencies | 90% White, 5% African American, and 5% Native American | Intimate partner abuse | Variable—some had extensive contact with clinicians, and others, little contact | 95% Had left the relationship, and 5% were still with the abusive partner |
| O'Campo et al, ⁴¹ 2002 | To ascertain what assistance and services women seek when in abusive relationships, during episodes of violence, or when trying to leave abusive relationships, and to assess women's knowledge of and experience with services for abused women | Interviews | Not specifically stated | Not specified | 78 Women who had experienced DV, older than 18 y, not pregnant, recruited from various settings, including O&G clinics, drug rehabilitation centers, homeless shelters, community centers, and HIV clinics | Not stated | Intimate partner included current or ex-husband, boyfriend, or same-sex partner; abuse included being hit, slapped, kicked, pushed, or shoved or otherwise physically hurt and forced into sexual activities | Not stated | Not stated |
| Peckover, ³⁴ 2002 | To examine the practice of HVs in relation to women experiencing DV | Semistructured interviews | Feminist poststructuralism | HVs | 16 Domestic abuse victims recruited from specialist voluntary organizations (mothers and children) | Not stated | Not stated | As mothers with young children, all had contact with HVs | Not stated |

(continued)

Table 2. Study and Participant Characteristics of Included Studies (cont)

| Source | Study Characteristics | | | | Participant Characteristics | | | | |
|---|---|---|--|--|---|---|--|--|---|
| | Objective | Method | Theories Used | HCP Studied | Sample (Age Range, y) | Ethnicity | Abuse Type and Duration | Contact With Clinician | Current Status of the Relationship |
| Peckover, ³⁵ 2003 | To explore the extent to which abused women disclose or conceal DV to HVs and their success in accessing support or protection | Semistructured interviews | Feminist poststructuralism | HVs | 16 Women who had experienced abuse and have small children, identified via voluntary organizations | Not stated | Emotional, sexual, and financial abuse; physical violence; intimidation; and threats | Not stated | Not stated |
| Battaglia et al. ⁴⁰ 2003 | To study the characteristics of trust in the patient-provider relationship from the perspective of IPV survivors | Interviews | Grounded theory | Physician or nonphysician health care provider | 27 Women with a history of IPV in the past 3 y, referred from community-based counseling or sheltering programs through response to fliers sent to such organizations (18-56) | 33% African American, 33% Hispanic, 19% white, and 15% mixed or other | IPV | All women reported multiple medical contacts during the period of abuse (169 total; average, 6 per woman; range, 2-13) | 67% In a residential program for battered women |
| Belknap and Sayeed, ³⁰ 2003 | To identify behaviors women desired from the HCP during the screening process | In-depth interviews and participants' observation | Leininger culture care theory (ethnonursing) | HCP or nurse | 7 Women recruited from a single DV agency (19-38) | Mexican | Physical and emotional abuse from a partner | Not stated | Not stated |
| Chang et al. ⁵¹ 2003 | To ascertain how female survivors of IPV describe positive and negative consequences of health care screening experiences | Semistructured focus groups | Grounded theory approach to analysis | Physician or nurse | 41 Women with a history of IPV, using IPV group counseling (22-77) | 29% White, 34% black, and 36% Latino | Physical, sexual, or emotional abuse | 78% Saw a physician in the past year | 12% Were living with a partner |
| Humphreys and Thiara, ³³ 2003 | To determine women's experiences in relation to their mental health and to use aspects of the women's narrative to explore more general problems arising from response of mental health professionals | Interviews | Thematic basis | Mental health professionals, A&E staff, and GP | 20 Women affiliated with Women's Aid and offering outreach services | 80% White and 20% black or ethnic minority | All subjected to physical abuse as part of a pattern of power and control exerted by their partners or ex-partners | Not stated | Not stated |

(continued)

Table 2. Study and Participant Characteristics of Included Studies (cont)

| Source | Study Characteristics | | | | Participant Characteristics | | | | |
|---------------------------------------|---|------------------------------------|--------------------------------------|--|--|--|---|--|---|
| | Objective | Method | Theories Used | HCP Studied | Sample (Age Range, y) | Ethnicity | Abuse Type and Duration | Contact With Clinician | Current Status of the Relationship |
| Lutenbacher et al, ⁴² 2003 | To describe factors that inhibit, support, and sustain women's abilities to leave abusive relationships and stay out once they have left | Focus groups | Not stated | Not specified | 24 Women recruited from advertisements; the women had experienced domestic abuse (21-51) | 67% White | Long-term abuse by current or former intimate partner | 60% Have regular checkups with a primary care provider | 13% In an abusive relationship, 29% trying to leave an abusive relationship, and 58% have left the relationship |
| Nicolaidis et al, ³⁸ 2003 | To explore in depth the lives of women who survived an attempt on their lives by an intimate partner and to identify themes that may aid clinicians to predict, prevent, or counsel about femicide and attempted femicide | Semistructured in-depth interviews | Thematic analysis | Not stated | 30 Women who had experienced attempted femicide by a current or ex-intimate partner, identified via law enforcement, district attorney's office, DV shelters, and trauma centers (17-54) | 43% African American, 47% European American, 7% Latino, and 3% other | Attempted femicide victims | Not stated | Participants living away from the perpetrator in a safe environment |
| Zink and Jacobson, ⁵⁰ 2003 | To understand the experiences and wishes of IPV mothers/survivors when their children are with them in the health care setting | Interviews | Thematic analysis approach | Physicians and nurses in primary care and emergency care and prenatal and pediatric HCPs | 32 Mothers/survivors staying in battered women's shelters or community support groups | 50% European American and 50% African American | Intimate partner abuse | Not stated | 28% Have an ongoing relationship with the abuser |
| Zink et al, ⁴⁹ 2004 | To understand the preferences of mothers who were DV victims and their identification and management (in terms of their abuse) in the health care setting | Interviews | Immersion crystallization techniques | Primary care practitioners | 32 Women from local DV shelters/community support groups (18-45) | 50% African American and 50% white | Intimate partner abuse | Not stated | 28% Had an ongoing abusive relationship |

Abbreviations: A&E, accident and emergency; DV, domestic violence; ED, emergency department; GP, general practitioner; HCP, health care professional; HIV, human immunodeficiency virus; HV, health visitor; IPV, intimate partner violence; O&G, obstetrics and gynecology.

Table 3. First-Order Constructs

| Construct No. | Construct Name | Construct Description |
|---------------|--------------------------------------|--|
| 1 | Raising the issue | Women stated that they believed partner abuse should be raised in the medical encounter as long as it is addressed in a sensitive and confident manner. There were variations in the way the women believed they should be asked (directly or indirectly). Women reported positive consequences, including feeling supported, encouraged, and relieved, when abuse was discussed. Negative consequences were also discussed. |
| 2 | Judgments and attitudes of the HCP | Dissatisfaction occurred when the women perceived the HCP as judging, pitying, blaming, or trivializing. Satisfaction was expressed when the HCP was nonjudgmental, compassionate, and sensitive. |
| 3 | Important attributes of the HCP | Women wanted an HCP to listen, express compassion, be supportive, and engage in open communication with them. They also wanted an HCP who used nonverbal communication, was confident, and had an understanding of domestic violence. There were variations in the preferred sex of the HCP. |
| 4 | Repeated inquiry | Women suggested that HCPs should continue to offer assistance while being patient and supportive. This builds a trusting relationship and allows the woman to disclose at a later date. |
| 5 | Pressure from the HCP | Women reported positive experiences when they were allowed to progress at their own therapeutic pace and were not pressured to disclose, leave the relationship, or press charges. |
| 6 | Complexity of the issue | Abused women believed that medical staff did not understand the complexity of their situation and, therefore, made judgments. Women wanted HCPs to understand the chronicity and social and psychological issues surrounding domestic violence. |
| 7 | Additional services | The abused women stated that the HCP should have good knowledge of the available services and should offer referrals. Women expressed a need for more immediate specialist response and additional training for HCPs. |
| 8 | Women's own feelings about the abuse | The emotions of the abused women were often stated as barriers to disclosure, including shame, embarrassment, fear, self-blame, loneliness, humiliation, and denial. |
| 9 | Fear | This was a major barrier to disclosure. The abuser was a large source of fear, as were the repercussions of disclosing and the consequences for the children; there was also a fear of being judged, not being believed, and lack of confidentiality. |
| 10 | Confidentiality | Lack of privacy in the medical consultation and a fear of lack of confidentiality were stated as barriers to disclosure. Women suggested that the HCP should reassure the women about issues of confidentiality and privacy. |
| 11 | Autonomy | Women were dissatisfied when they believed their decisions were not respected and suggested that the HCP should share all decision making with the abused women. |
| 12 | Time | Dissatisfaction occurred when the women believed the HCP was too rushed/hurried; women perceived this as an uncaring and uncompassionate approach. |
| 13 | Validation | Women stated that if the HCP confirmed the issue of domestic violence, then they believed their feelings and experiences were legitimized and appropriate. Women suggested that the HCP should challenge the woman's inaccurate assumptions (eg, that the abuse was her fault) and bolster confidence. |
| 14 | Medicalization | Abused women were uncertain as to whether domestic violence was a valid problem to broach in the medical consultation. Women perceived the HCP to be disinterested in social problems and were concerned that the HCP would reframe the situation as a medical problem, something that was not valued by the women. |

Abbreviation: See Table 2.

Table 5, which also shows any second-order constructs developed by authors regarding the contradiction and any third-order constructs that we have developed that resolve the apparent contradiction.

Three of the contradictions (1, 2, and 3 in Table 5) are intrastudy contradictions only. Apparent contradiction 1 regards the method of questioning by the health care professional: women expressed preferences for direct and indirect questioning about abuse within one study. The second-order construct of the authors suggests that the nature and extent of the relationship between the health care professional and the abused woman may explain the preferences of the informants. Women in this study who were well known to their health care professional preferred indirect ques-

tioning, and the researchers use this as a possible explanation of the variation. Therefore, the preferred form of identification, direct or indirect, is likely to be associated with the context of the medical encounter. Health care professionals, therefore, have the difficult task of determining an appropriate approach to the individual patient, wanting to raise the issue of abuse in the health care setting but needing to judge whether indirect or direct questioning should be used.

In the case of contradiction 2, whether a mother finds it appropriate or not that her child is present in the consulting room when the issue of abuse is discussed, the investigators have given reasons for apparently contradictory data, providing second-order constructs that resolved the apparent contradic-

tion. The second-order construct recognized that the issue of openness was related to the stage of the abusive relationship: openness was seen as compromising safety while the woman was still in the relationship with her abuser but as potentially beneficial once separation had occurred. The clinician needs to carefully elicit the mother's wishes in this regard. Contradiction 3 was resolved by Peckover³⁴ who found that women did not particularly value increased contact with their health care professional. Their satisfaction with the health care professional's response was based on practical advice and referral to specialist support.

Contradictions 4 and 5, about the consequences of disclosure and repeated inquiry, respectively, can also be resolved by second-order con-

Table 4. Second-Order Constructs

| Construct | Description |
|---------------------------|--|
| Autonomy | HCPs should respect the patients' autonomy: share decision making and respect those decisions ^{31,40,44,48} and put patient-identified needs first ⁴⁰ |
| Confidentiality | HCPs should try to understand the woman's perspective ^{34,39,41,50} HCPs should specifically address confidentiality issues when approaching DV abuse victims ^{32,40} HCPs should provide a safe and private environment ^{5,31,33,46,47,50} HCPs should use an interpreter other than partner ³⁰ HCPs should be sensitive to the presence of a child when discussing DV issues ⁵⁰ |
| HCP behavior | HCPs should be aware of the impact of their behaviors on patients ⁴⁰ They should be nonjudgmental ^{25,29,32,33,37,46} They should provide validation ^{29,31,37,48} They should provide empowerment ^{29,44} They should not pressure the woman ³² and give women time ⁴⁷ They should develop trust and be trustworthy ^{29,37,40} They should listen to the patient ^{30,37} They should be empathetic ^{29,46} They should show concern ⁵ and kindness ²⁹ They should acknowledge what is said ³⁷ |
| Disclosure of information | HCPs should be sensitive to clues to DV (verbal or nonverbal), warning symptoms, or illnesses ^{35,37,48,50} HCPs should also be alerted by any lies or discrepancies as indirect forms of disclosure ⁴⁸ HCPs should be willing to initiate discussion about DV ^{30,37,45,47} The DV should be discussed if clinical indicators are present ^{31,36,37} Case finding in high-risk groups and pregnant women is desirable ^{36,37} HCPs should ask more than once to give opportunity to disclose at a later time ^{30,32} The issue of DV should be discussed in a sensitive manner ^{32,51} |
| Resources | Women should be provided with referrals and continued support ^{5,31,37,44,46-48} HCPs should know appropriate resources available—be active in connecting the women to them ^{5,14,26,30,35,37} HCPs should assess safety and offer safety planning ^{14,25,30,48} There should be multidisciplinary-coordinated approaches available to respond effectively ^{37,42,44,47} There should be on-site counseling and specialist care ^{31,32,44,46} There should be increased promotion of available services within health care facilities, posters, and leaflets ^{35,37,43,46} |
| Education | Training on DV is needed for the HCP to understand the issues and raise awareness ^{25,35,37,39,42,47} Training should also focus on relevant communication skills required to discuss the issue of DV ^{35,36,46,47} |
| Culture | HCPs should improve their awareness of cultural issues and provide culturally congruent care and health policy ^{28,30,43,45} |
| Documentation | HCPs should decide on an appropriate way of documenting IPV ⁵⁰ HCPs should document all signs and symptoms of abuse, ⁴⁸ suspicions, ³⁷ and subjective and objective findings ³⁷ |

Abbreviations: See Table 2.

structs. Women in 4 studies discussed the positive consequences that occurred when the issue of violence was discussed. In contrast, women in 2 studies stated negative consequences. There was interstudy and intrastudy variability. The second-order constructs suggest that the issue of positive and negative consequences may be determined by the stage of the abusive relationship. Women who do not recognize their partner's behavior as abusive seem to be more likely to be offended by the initiation of the discussion whereas women who have an awareness of the situation and are beginning to consider the possibility of change seem to be more positive. Contradiction 6, about prescribing psychotropic medication, was resolved by consideration of appropriateness of prescribing and availability of other treatments and practical support. We were unable

to resolve contradiction 7 about the sex of the health care professional preferred by women: the evidence from these studies is conflicting.

THIRD-ORDER CONSTRUCTS

By synthesizing the first- and second-order constructs, we have identified desirable characteristics of health care professionals in consultations in which partner violence is raised, as articulated by abused women and the authors of the primary studies, respectively (**Table 6**). These characteristics can be used to guide professionals at various stages of the clinical consultation: before disclosure, when the issue of abuse is raised, immediately after disclosure, and later responses. Our third-order constructs represent our interpretation, across the studies, about what women find helpful. In expressing

them as recommendations, we effectively shorten them by omitting an explicit statement that expresses the way in which they are helpful. Restriction of the analysis to studies in the top tertile of methodological quality did not change these third-order constructs.

COMPARISON TO NATIONAL GUIDELINE RECOMMENDATIONS

None of the third-order constructs emerging from our review conflict with the 4 national guidelines we examined. The detail of these constructs contrasts with the paucity of detail in the guideline recommendations. It is striking that none of the guidelines explicitly use evidence from qualitative studies to support their recommendations.

Table 5. Analysis of the Apparent Contradictions Within the Data

| Apparent Contradiction No. | Apparent Contradiction Description | Second-Order Construct Resolved | Third-Order Construct Resolved | Resolution |
|----------------------------|---|---------------------------------|--------------------------------|--|
| 1 | The issue of abuse should be raised directly or indirectly | Yes | * | The way the issue is raised should depend on the context of the situation. |
| 2 | The issue of abuse should be discussed in front of children or without children present | Yes | * | This is dependant on the stage of the relationship the abused woman is in: when still in the relationship, safety is the woman's top priority and this may be compromised by discussion in front of children; when she has left the relationship, openness and honesty are more important. |
| 3 | Women received or did not receive increased contact with the HCP after disclosure | Yes | * | Satisfaction with an HCP occurs when the practical advice or other specialist support is given, rather than increased contact. |
| 4 | When the issue of abuse was raised, there were positive and negative consequences for the women | Yes | Yes | Factors that have been shown to have an effect on the perceived consequences of the issue being discussed include the stage of the abusive relationship and whether the woman has children (the implications of disclosure were greater). |
| 5 | Women wanted repeated inquiry or found repeated inquiry offensive | Yes | * | Women were in favor of repeated inquiry if they were at a later stage of the abusive relationship (ready to make changes). |
| 6 | Women were satisfied or dissatisfied with taking medication | Yes | Yes | This was an issue more of whether the use of medication is appropriate to the woman's situation and if medication is given without any additional help, such as counseling or practical advice. |
| 7 | Women preferred a female HCP or a male HCP or the sex of the HCP did not matter | No | No | This issue was not resolved: no good explanatory model of sex preference was found. |

Abbreviation: See Table 2.

*The second-order construct fully explained the variation; therefore, the third-order construct is not appropriate.

COMMENT

Qualitative research with patients remains an underused source of evidence for health care policy in general⁵² and for guidance in the field of intimate partner violence in particular, with some notable exceptions.⁴⁸ As a result, evidence-based clinical guidelines and health care policy may seem impervious to the perceptions of patients and service users.⁵³ One of the problems in drawing on qualitative research is finding an appropriate method of systematically reviewing primary studies and synthesizing their findings. We have applied a method of meta-analysis that has generated recommendations based on what women who have experienced partner violence say they want from their health care professionals around disclosure of abuse and its aftermath.

These recommendations, representing the third-order constructs in our meta-analysis, are not based on evidence of improved health or quality-of-life outcomes but rather are complementary to guidance based on quantitative evidence, including experimental evaluations of interventions and questionnaire surveys of women. The third-order constructs

are largely consistent across primary studies, despite differences in design, participants, health care settings, regions, and countries.

Our results are concordant with the findings of quantitative surveys of women who have experienced partner violence. In a survey of 115 women with a history of abuse from a partner, Hamberger and colleagues⁵⁴ found that, in general, physicians listened carefully and were sensitive and compassionate. However, they were not as good when it came to delivering elements of care that specifically targeted abused women's unique needs, such as asking about how an injury occurred, history of violence, children's safety, support information and referrals, and follow-up appointments. Respondents in this study valued emotional support from physicians in the form of confidentiality, careful and nonjudgmental listening, and reassurance that the abuse is not their fault and that negative feelings are understandable. In a survey of 130 women presenting to an emergency department with a history of partner violence, Hayden et al⁵⁵ found variation in the preferred sex of the health care provider, with three quarters saying they would

prefer to discuss violence with a female physician. Rodriguez and colleagues⁵⁶ investigated factors associated with disclosure of abuse with a telephone questionnaire survey of a random sample of 375 women from ethnically diverse backgrounds. They found that direct questioning by the clinician was an independent predictor of past communication with clinicians about abuse and that concerns about confidentiality were barriers to this communication. From interviews with 460 women in ambulatory clinics, Caralis and Musialowski⁵⁷ concluded that women expect physicians to act as their advocates and, in partnership with other community professionals, to assist abuse victims and stop the violence.

Comparison of the constructs emerging from our meta-analysis with recommendations in 4 national guidelines revealed no contradictions, but it highlights the limited content of these guidelines with regard to the clinical consultation. The detail in the third-order constructs (Table 6) would enhance these guidelines, adding to their research evidence base. The added value of the meta-analysis, beyond the primary

Table 6. Third-Order Constructs in Terms of Recommendations to HCPs by Stage of Interaction With Abused Women

| Third-Order Construct | Recommendations to HCPs |
|---|--|
| Before disclosure or questioning | Have a full understanding of the issue of domestic violence, including knowledge of community services and appropriate referrals Try to ensure continuity of care Assure abused women about privacy, safety, and confidentiality issues Place brochures and posters in the medical setting so that women are aware that domestic violence is an issue that can be broached Ensure that the clinical environment is supportive, welcoming, and nonthreatening Use verbal and nonverbal communication skills to develop trust Be compassionate, supportive, and respectful toward abused women Be alert to the signs of abuse and think about domestic violence along with other possibilities |
| When the issue of domestic violence is raised | Raise the issue of domestic violence in the clinical consultation Be nonjudgmental, compassionate, and caring when questioning about abuse Be confident and comfortable asking about domestic violence and ask questions in a caring manner Do not pressure women to disclose Be aware that simply raising the issue of domestic violence can help women because it raises awareness, abused women may begin to feel validated, and it communicates concern Ask about abuse several times because this may allow the women to discuss the situation at a later date* |
| Immediate response to disclosure | Ensure (and reassure the women) that the environment is private and confidential, and provide time for abused women Respond in a nonjudgmental way, showing compassion, support, and belief of the women's experiences Acknowledge the complexity of the issue of domestic violence, be willing to respect the women's unique concerns and decisions, and put patient-identified needs first Take time to listen to the women, provide information, and offer referrals and specialist help and services Validate the women's experiences, challenge assumptions, and provide encouragement Ensure that the women believe that they have control over the situation, and address safety concerns Make sure that the social and psychological needs (in addition to the medical needs) of the women are addressed |
| Response in later interactions | Be patient and supportive, and allow the women to progress at their own therapeutic pace Understand the chronicity of the problem and provide follow-up and continued support Respect the women's wishes and do not pressure them into making any decisions about changing the situation Be nonjudgmental if the abused women do not follow up referrals immediately Give abused women an opportunity to disclose at a later date |

Abbreviation: See Table 2.

*This construct is based on contradictory data: women were in favor of repeated inquiry if they were at a later stage of the abusive relationship (ready to make changes); women who did not recognize their partner's behavior as abusive may be more likely to be offended by the repeated initiation of the discussion regarding domestic violence.

qualitative studies, lies in the synthesis of findings, including analysis of apparently contradictory findings within and between studies and the structuring of constructs by the temporal order of disclosure and its sequelae in the clinical consultation.

The strengths of our review include the systematic identification of studies with prespecified inclusion and exclusion criteria, a transparent and reproducible method of data extraction that minimizes selection bias, an iterative analytic method with an explicit theoretical basis, an explicit quality assessment method, and contact with investigators in primary studies to clarify and, where appropriate, supplement data. An important limitation of our review method is dependence on investigators' reporting of data from the primary studies, which may be more problematic for qualitative than quantitative studies.¹⁶ It is possible that the results of

the meta-analysis would have been different if we had gone back to the transcripts from the primary studies and had to address the complexity of data from each study. Other limitations include exclusion of dissertations and book chapters and use of methodological appraisal criteria that only have face validity. The use of quality checklists for qualitative research has been challenged,⁵⁸ and even the validation of quality criteria for randomized controlled trials has proved difficult.⁵⁹

Future qualitative research on health care professionals' response to women experiencing partner violence should include longitudinal studies of women's experiences at different stages and qualitative studies in parallel with trials of health care-based interventions.

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