**OBJECTIVE:** To explore the attitudes and experiences of abused women to identify characteristics that helped or hindered abuse disclosure to clinicians and to determine how women viewed potential interventions to improve detection and treatment in a medical setting.

**DESIGN:** Focus group data conducted and analyzed with qualitative methodology.

**SETTING:** Three community-based mental health centers and one women’s shelter.

**PARTICIPANTS:** Twenty-one women in group therapy for domestic violence.

**MAIN RESULTS:** Eighteen (86%) of the 21 women had seen their “regular doctor” in the prior year; only 1 in 3 had discussed the abuse with the clinician. The major discussion themes were medical problems that were exacerbated with abuse, lack of ability to access medical care due to abuser interference, emotional attitudes about abuse that acted as barriers to disclosure, clinician characteristics that helped or hindered disclosure, and treatment experiences and preferences. Women described how their medical problems began or worsened during the abusive period. One in three women described how abusers blocked them from receiving medical care. Women reported intense shame about the abuse and described their self-denial of abuse. Women stated they were inclined to discuss abuse if they felt the clinician was perceived to be caring, was easy to talk to, had a protective manner, or if the clinician offered a follow-up visit. There was no consistent clinician gender preference among the women. One in four women had received psychotropic medication for problems associated with abuse. Many feared addiction, or a loss of alertness, increasing their risk for more abuse.

**CONCLUSIONS:** Many abused women experience worsening health and seek medical care; most do not volunteer a history of violence even to their regular clinicians. Many of the barriers to disclosure of abuse could be overcome by a physician’s knowledge of the link between abuse and medical illness, an understanding of the women’s emotions about abuse, and her treatment preferences.

**KEY WORDS:** women; physical abuse; sexual abuse; domestic violence.


Physical or sexual abuse is experienced by 2 million to 4 million U.S. women each year. Childhood and adult abuse are associated with increased numbers of physical symptoms, depression, anxiety, somatization, drug and alcohol abuse, and suicide attempts. Not surprisingly women who have experienced violence have higher medical service utilization. Studies indicate that as many as 44% of women presenting to primary care medical practices have been abused sometime in their lives.

Despite the high prevalence of abuse and the associated medical problems, most physicians do not routinely screen their patients for abuse. Although approximately two thirds of abused female patients have not discussed their abuse with a medical professional, one study found that patients welcome a physician asking about abuse. Abused women are reported to have higher dissatisfaction with their regular physicians, feeling that their physicians do not listen, are difficult to talk to, or are not competent to treat illnesses.

A few studies have described barriers to clinician-patient discussion of abuse and are summarized in Table 1. Sugg and Inui described physician barriers to screening. Physicians feared opening “Pandora’s box” and unleashing patient issues that the clinician had neither the time nor the expertise to address. Other barriers were fear of offending the patient, a feeling of powerlessness to help the women leave an abusive relationship, and disinclination to consider the possibility of abuse among women of higher socioeconomic backgrounds. In another survey Canadian physicians felt that they should screen patients for domestic violence, but few thought they could effectively treat abuse. Lack of clinician education on detection and treatment was found to be a major barrier to screening.

There is conflicting evidence as to whether physician gender is related to detection rates; it is also unclear if abused women have physician gender preferences. Prior professional or personal exposure either to violence or to educational programs on abuse has been associated with increased detection by physicians.
One study has focused on the abused woman’s perspective of physicians and the health care system. In Rodriguez et al.’s focus group study in California, abused women talked about the silence surrounding the topic of abuse and what helped them “break the silence”. The silence was described as a collusion between the abused women and other members of society: “The unspoken agreement between battered women and other members of society to not disclose or address the battering.” Women reported fearing physical retribution, feeling deeply ashamed, having an obligation to keep their families together, and lacking the economic resources to obtain medical help for their abuse. Many stated the California law mandating a police report for domestic violence might lead to added danger from the abuser. In this study, women identified a compassionate attitude, direct questioning, and appropriate referrals as physician characteristics and actions beneficial in helping them discuss the abuse.

Many groups have recommended that clinicians routinely assess women for domestic violence. However, it has been difficult to design interventions and provide evidence that these interventions lead to improved outcomes. Abused women can provide valuable feedback regarding acceptability and potential effectiveness of proposed interventions.

For this study, our objectives were to explore abused women’s experiences with, and perceptions of both clinicians and the health care system to identify characteristics that facilitated or acted as barriers to disclosure of abuse, investigate perceptions of the link between abuse and medical problems, and gain women’s opinions of potential interventions to improve detection and management of abuse in the primary care setting.

**Methods**

To identify abused women who would be willing to participate in focus group sessions, we contacted two sites providing counseling services to people experiencing abuse in Baltimore, Maryland. To be eligible, women had to be at least 18 years of age, English-speaking, and in group therapy for current or past domestic violence (either by self-referral or by court order). The regular therapists reviewed all focus group questions, explained the purpose of the study, and asked for participation the week before the focus groups were conducted. All participants who were approached agreed to participate. Three of our group sessions occurred in a community-based mental health center; the fourth occurred at a women’s shelter for domestic violence. All sessions were audiotaped, the participants’ real names were not used or revealed to the investigators, and the tapes and transcripts were reviewed only by the study team. Participants received a small stipend for their involvement. The Institutional Review Board committee at the shelter approved the study.

**Study Design and Sessions**

We selected a focus group methodology because we felt that women would feel more comfortable discussing this difficult topic in a familiar environment with group and counselor support than individually with a stranger. Focus groups have been shown to be extremely effective in providing in-depth information on the attitudes and feelings of participants about a particular issue. Because we were interested in the range of opinions about our topics, we conducted different groups until there appeared to be little new information from the participants. We found that after four different focus groups new comments were limited. The focus group leader attempted to elicit opinions on all questions from all participants and encouraged different opinions.

The focus group leader was the principal investigator, a female physician with a substantial research background in domestic violence. The focus groups ranged in size from three to eight participants, and each lasted approximately 90 minutes. Each participant completed a short questionnaire with background information prior to the focus group session. The regular therapists were present during all the focus group sessions but did not participate.

Our three major focus group questions were (1) Tell us about an experience you had with a doctor or health care physician concerning violence—was it a good or bad experience and why?, (2) What made it easy or hard for you to discuss the violence with a doctor or other health care professional?, and (3) Is there any other information that you think that doctors should know when treating women who have experienced violence? The group leader also included probe questions based on the participant