REVIEW ARTICLE

Women Exposed to Intimate Partner Violence

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

Gene S. Feder, MD; Madeleine Hutson, MBBS; Jean Ramsay, PhD; Ann R. Taket, MSc

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, nondirective, 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.

Arch Intern Med. 2006;166:22-37

Author Affiliations: Centre for Health Sciences, Barts and the London, Queen Mary's School of Medicine and Dentistry (Drs Feder, Hutson, and Ramsay), and Institute of Primary Care and Public Health, London South Bank University (Ms Taket), London, England.

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 nonabused women[8] 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 debate[10-12] has overshadowed questions 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. Studies[13] 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-analysis[16] 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 Schutz[17] framework of constructs. Our method is based on the metaethnography proposed by Britten[18] and Campbell[19] 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 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.

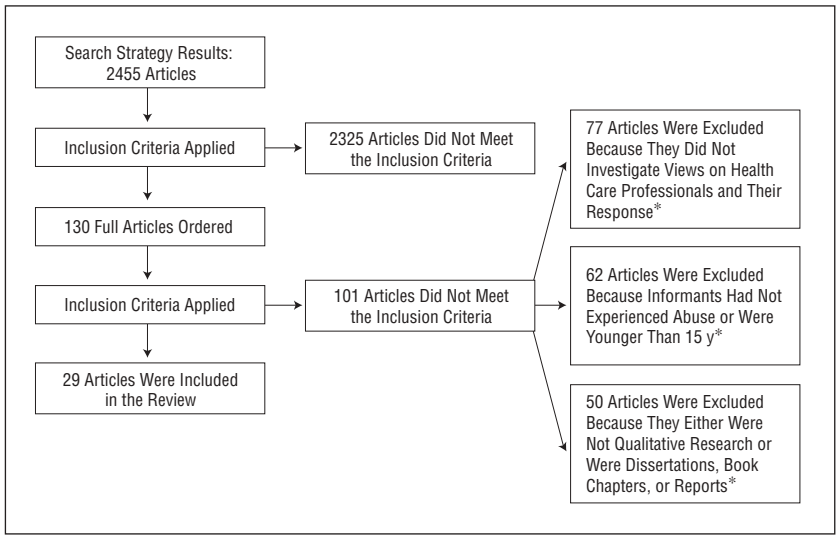

Figure 1. Flowchart of primary study selection. The asterisk indicates that articles could be excluded from the review for more than 1 reason.

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 history 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

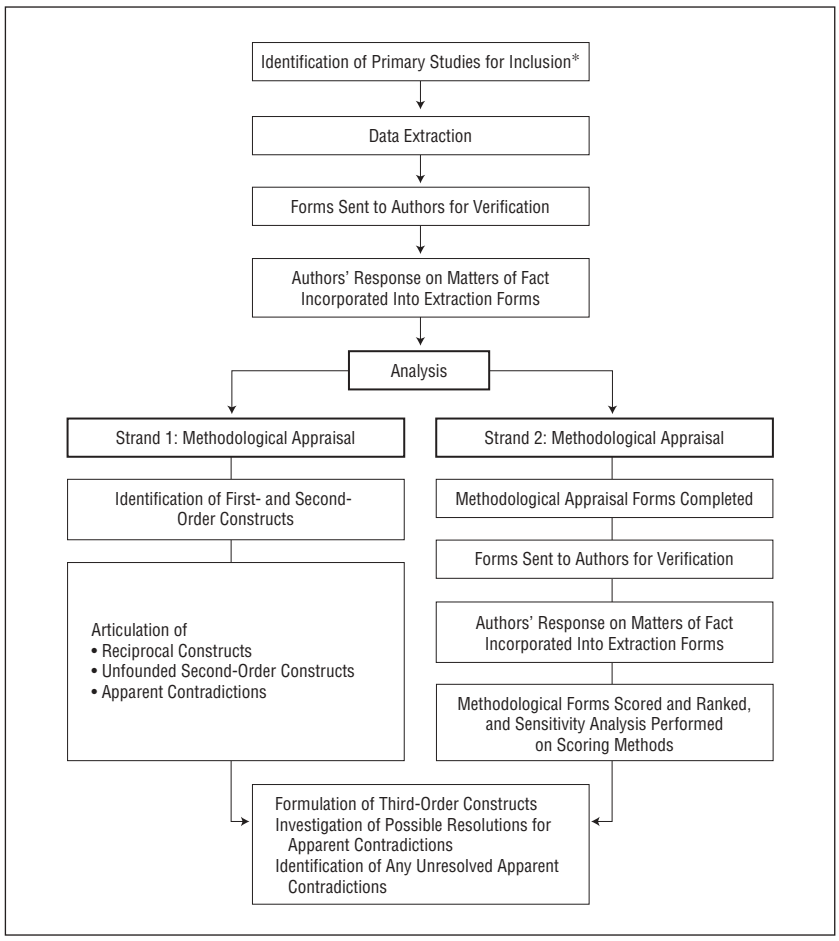

Figure 2. Stages in the meta-analysis. The asterisk indicates that this identification was done in Figure 1.

Table 1. First-, Second-, and Third-Order Constructs

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 (intrastudy) 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 reexamination of constructs in relation to study quality. The apparent contradictions and their possible resolution were also reexamined 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 professionals 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.

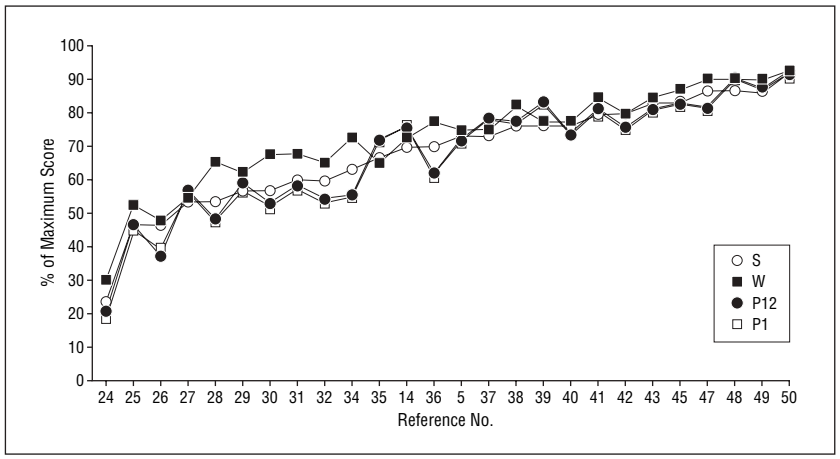

Figure 3. Methodological quality of the studies. S indicates equal weighting of all Critical Appraisal Skills Programme (CASP) items; and W, P12, and P1, 3 forms of differential weighting of CASP items.

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

	Study Characteristics				Participant Characteristics				
Source	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)

	Study Characteristics				Participant Characteristics				
Source	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)

	Study Characteristics				Participant Characteristics				
Source	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)

	Study Characteristics				Participant Characteristics				
Source	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)

	Study Characteristics				Participant Characteristics				
Source	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)

	Study Characteristics				Participant Characteristics				
Source	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)

	Study Characteristics				Participant Characteristics				
Source	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 advertise-ments; 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	Semistruc-tured 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 Ameri-can, 47% European Ameri-can, 7% Latino, and 3% other	Attempted femicide victims	Not stated	Participants living away from the perpetrator in a safe environment
Zink and Jacob-son,[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 manage-ment (in terms of their abuse) in the health care setting	Interviews	Immersion crystalliza-tion techniques	Primary care practition-ers	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 questioning, 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 contradiction. 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 Peckover[34] 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]
	HCPs should try to understand the woman's perspective[34,39,41,50]
Confidentiality	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 general[52] 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 colleagues[54] 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 al[55] 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 colleagues[56] 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 Musialowski[57] 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*
	Ensure (and reassure the women) that the environment is private and confidential, and provide time for abused women
Immediate response to disclosure	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.

Accepted for Publication: August 4, 2005.
Correspondence: Gene S. Feder, MD, Centre for Health Sciences, Barts and the London, Queen Mary's School of Medicine and Dentistry, 2 Newark St, London E1 2AT, England (g.s.feder@qmul.ac.uk).
Author Contributions: Dr Feder had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Financial Disclosure: None.
Funding/Support: This study was supported by a student bursary from Queen Mary, University of London, London (Dr Hutson).
Role of the Sponsor: The funding body had no role in data extraction and analyses, in the writing of the manuscript, or in the decision to submit the manuscript for publication.
Acknowledgment: We thank Nancy Schumann, MA, for manuscript preparation and the authors who gave us additional information about their studies.

REFERENCES

1. Jewkes R. Intimate partner violence: causes and prevention. *Lancet*. 2002;359:1423-1429.
2. Campbell J, Jones AS, Dienemann J, et al. Intimate partner violence and physical health consequences. *Arch Intern Med*. 2002;162:1157-1163.
3. Coid J, Petruckevitch A, Chung WS, Richardson J, Moorey S, Feder G. Abusive experiences and psychiatric morbidity in women primary care attenders. *Br J Psychiatry*. 2003;183:332-339.
4. Rapkin AJ, Kames LD, Darke LL, Stampler FM, Naliboff BD. History of physical and sexual abuse in women with chronic pelvic pain. *Obstet Gynecol*. 1990;76:92-96.
5. Yam M. Seen but not heard: battered women's perceptions of the ED experience. *J Emerg Nurs*. 2000; 26:464-470.
6. Coker AL, Sanderson M, Dong B. Partner violence during pregnancy and risk of adverse pregnancy outcomes. *Paediatr Perinat Epidemiol*. 2004; 18:260-269.
7. Kellermann AL, Mercy JA. Men, women, and murder: gender-specific differences in rates of fatal violence and victimization. *J Trauma*. 1992;33: 1-5.
8. Campbell JC. Health consequences of intimate partner violence. *Lancet*. 2002;359:1331-1336.
9. Plichta S. The effects of woman abuse on health care utilization and health status: a literature review. *Womens Health Issues*. 1992;2:154-163.
10. Wathen CN, MacMillan HL. Interventions for violence against women: scientific review. *JAMA*. 2003;289:589-600.
11. Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? systematic review. *BMJ*. 2002;325:314-318.
12. Taket A, Wathen CN, Macmillan H. Should health professionals screen all women for domestic violence? *PLoS Med*. 2004;1:e4.
13. Yoshihama M. Breaking the web of abuse and silence: voices of battered women in Japan. *Soc Work*. 2002;47:389-400.
14. Nicolaidis C. The voices of survivors documentary: using patient narrative to educate physicians about domestic violence. *J Gen Intern Med*. 2002;17:117-124.
15. Nelson HD, Nygren P, McInerney Y, Klein J. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the US Preventive Services Task Force. *Ann Intern Med*. 2004;140:387-396.
16. Schreiber R, Crooks D, Stern P. Qualitative meta-analysis. In: Morse J, ed. *Completing a Qualitative Project: Details and Dialogue*. Thousand Oaks, Calif: Sage Publications; 1997:311-326.
17. Schutz A. *On Phenomenology and Social Relations: Selected Writings*. Chicago, Ill: University of Chicago Press; 1970.
18. Britten N, Campbell R, Pope C, Donovan J, Morgan M, Pill R. Using meta ethnography to synthesise qualitative research: a worked example. *J Health Serv Res Policy*. 2002;7:209-215.
19. Campbell R, Pound P, Pope C, et al. Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Soc Sci Med*. 2003;56:671-684.
20. Noblit G, Hare R. *Meta-Ethnography: Synthesizing Qualitative Studies*. Newbury Park, Calif: Sage Publications; 1988.
21. Heath I. *Domestic Violence: The General Practitioner's Role*. London, England: Royal College of General Practitioners; 1998.
22. Wathen CN, MacMillan HL. Prevention of violence against women: recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ*. 2003;169:582-584.
23. Family Violence Prevention Fund. *National Consensus Guidelines on Identifying and Responding to Domestic Violence in Health Care Settings*. Washington, DC: Family Violence Prevention Fund; 2002.
24. New Zealand Ministry of Health. *Family Violence Intervention Guidelines: Child and Partner Abuse*. Auckland, New Zealand: Ministry of Health; 2002.
25. Drake VK. Battered women: a health care problem in disguise. *Image (IN)*. 1982;14:40-47.
26. Mayer BW. Female domestic violence victims: perspectives on emergency care. *Nurs Sci Q*. 2000; 13:340-346.
27. Schaffer J. Older and isolated women and domestic violence project. *J Elder Abuse Negl*. 1999; 11:59-77.
28. Bauer HM, Rodriguez MA, Quiroga SS, Flores-Ortiz YG. Barriers to health care for abused Latina and Asian immigrant women. *J Health Care Poor Underserved*. 2000;11:33-44.
29. Draucker CB. The psychotherapeutic needs of women who have been sexually assaulted. *Perspect Psychiatr Care*. 1999;35:18-28.
30. Belknap RA, Sayeed P. Te contaria mi vida: I would tell you my life, if only you would ask. *Health Care Women Int*. 2003;24:723-737.
31. Gerbert B, Johnston K, Caspers N, Bleecker T, Woods A, Rosenbaum A. Experiences of battered women in health care settings: a qualitative study. *Women Health*. 1996;24:1-17.
32. Hathaway JE, Willis J, Zimmer B. Listening to survivors' voices: addressing partner abuse in the health care setting. *Violence Against Women*. 2002; 8:687-719.
33. Humphreys C, Thiara R. Mental health and domestic violence: "I call it symptoms of abuse." *Br J Soc Work*. 2003;33:209-226.
34. Peckover S. Supporting and policing mothers: an analysis of the disciplinary practices of health visiting. *J Adv Nurs*. 2002;38:369-377.
35. Peckover S. "I could have just done with a little more help": an analysis of women's help-seeking from health visitors in the context of domestic violence. *Health Soc Care Community*. 2003;11:275-282.
36. Hegarty KL, Taft AJ. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Aust N Z J Public Health*. 2001;25:433-437.
37. McMurray A, Moore K. Domestic violence: are we listening? do we see? *Aust J Adv Nurs*. 1994; 12:23-28.
38. Nicolaidis C, Curry MA, Ulrich Y, et al. Could we have known? a qualitative analysis of data from women who survived an attempted homicide by an intimate partner. *J Gen Intern Med*. 2003; 18:788-794.
39. McCauley J, Yurk RA, Jenckes MW, Ford DE. Inside "Pandora's box": abused women's experiences with clinicians and health services. *J Gen Intern Med*. 1998;13:549-555.
40. Battaglia TA, Finley E, Liebschutz JM. Survivors of intimate partner violence speak out: trust in the patient-provider relationship. *J Gen Intern Med*. 2003;18:617-623.
41. O'Campo P, McDonnell K, Gielen A, Burke J, Chen YH. Surviving physical and sexual abuse: what helps low-income women? *Patient Educ Couns*. 2002;46:205-212.
42. Lutenbacher M, Cohen A, Mitzel J. Do we really help? perspectives of abused women. *Public Health Nurs*. 2003;20:56-64.
43. Bates L, Hancock L, Peterkin D. "A little encouragement": health services and domestic violence. *Int J Health Care Qual Assur Inc Leadersh Health Serv*. 2001;14:49-56.
44. Rodriguez MA, Quiroga SS, Bauer HM. Breaking the silence: battered women's perspectives on medical care. *Arch Fam Med*. 1996;5:153-158.
45. Rodriguez MA, Bauer HM, Flores-Ortiz Y, Szkupinski-Quiroga S. Factors affecting patient-physician communication for abused Latina and Asian immigrant women. *J Fam Pract*. 1998; 47:309-311.
46. Bacchus L, Mezey G, Bewley S. Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service. *BJOG*. 2002; 109:9-16.
47. Bacchus L, Mezey G, Bewley S. Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health Soc Care Community*. 2003;11:10-18.
48. Gerbert B, Abercrombie P, Caspers N, Love C, Bronstone A. How health care providers help battered women: the survivor's perspective. *Women Health*. 1999;29:115-135.
49. Zink T, Elder N, Jacobson J, Klostermann B. Medical management of intimate partner violence considering the stages of change: precontemplation and contemplation. *Ann Fam Med*. 2004;2:231-239.
50. Zink T, Jacobson J. Screening for intimate partner violence when children are present: the victim's perspective. *J Interpers Violence*. 2003; 18:872-890.
51. Chang JC, Decker M, Moracco KE, Martin SL, Petersen R, Frasier PY. What happens when health care providers ask about intimate partner violence? a description of consequences from the perspectives of female survivors. *J Am Med Womens Assoc*. 2003;58:76-81.
52. Sandelowski M. Using qualitative research. *Qual Health Res*. 2004;14:1366-1386.
53. Green J, Britten N. Qualitative research and evidence based medicine. *BMJ*. 1998;316:1230-1232.
54. Hamberger LK, Ambuel B, Marbella A, Donze J. Physician interaction with battered women: the women's perspective. *Arch Fam Med*. 1998; 7:575-582.
55. Hayden SR, Barton ED, Hayden M. Domestic violence in the emergency department: how do women prefer to disclose and discuss the issues? *J Emerg Med*. 1997;15:447-451.
56. Rodriguez MA, Sheldon WR, Bauer HM, Perez-Stable EJ. The factors associated with disclosure of intimate partner abuse to clinicians. *J Fam Pract*. 2001;50:338-344.
57. Caralis PV, Musialowski R. Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. *South Med J*. 1997;90:1075-1080.
58. Eakin JM, Mykhalovskiy E. Reframing the evaluation of qualitative health research: reflections on a review of appraisal guidelines in the health sciences. *J Eval Clin Pract*. 2003;9:187-194.
59. Balk EM, Bonis PA, Moskowitz H, et al. Correlation of quality measures with estimates of treatment effect in meta-analyses of randomized controlled trials. *JAMA*. 2002;287:2973-2982.