ORIGINAL ARTICLE

Emergency healthcare experiences of women living with intimate partner violence

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Aim and objectives. To explore healthcare experiences of Australian women living with intimate partner violence (IPV) and consider how these influence their understanding of IPV and sense of self.

Background. Despite international campaigns condemning violence against women, IPV remains a worldwide problem and recent Australian community attitudes demonstrate ongoing beliefs condemning women in abusive relationships. Women experiencing IPV are over-represented in healthcare-seeking populations; however, they are rarely identified as experiencing abuse and are often not provided care directed towards achieving ongoing safety. While women seek empathetic healthcare, disclosure of abuse often results in being judged negatively or blamed.

Design. A grounded theory study drawing on Clarke's (Sage Publications, London, 2005) analytic approach of situational analysis.

Methods. Semi-structured interviews conducted with seven women. Data was analysed using NVIVO 8 software within a Situational Analysis framework.

Results. Four major categories were identified: Accessing healthcare: challenges and barriers; Care women need vs. care women receive; Discourses of IPV and constructions of self; and Acknowledging IPV: moving on and re-constructing self. Women faced significant challenges in accessing emergency healthcare and healthcare then often lacked empathy. Women created an understanding of self from a world dominated by an abusive partner and needed assistance re-labelling their experiences as IPV. Healthcare professionals who provided empathetic care were instrumental in assisting this process, enhancing women's abilities to explore options for limiting abuse and assisting them to enhance their self-efficacy and reconstruct a positive sense of self.

Conclusions. Healthcare is one of the few avenues women living with IPV have to receive emotional and physical support. Healthcare that ignores psychosocial issues further damages women's sense of self.

Relevance to clinical practice. Women require timely information and empathetic support from healthcare professionals to assist them in understanding and labelling their experiences as IPV. This enhances women's ability to feel deserving of, and ideally achieve, a life without violence.

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Introduction

Intimate partner violence (IPV), a global health concern (World Health Organization 2005), is any act of violence [by a current or past intimate partner] that results in, or is likely to result in, 'physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivation of Liberty' (Ellsberg & Heise 2005, p. 9). Worldwide 15–71%, of women experience IPV (World Health Organization 2005, Garcia-Moreno *et al.* 2006), with prevalence for women from the USA, UK and Australia around 20–30% (Heise *et al.* 2002, Mouzos & Makkai 2004, Alhabib *et al.* 2010). These statistics relate to more 'easily' measured forms of IPV (physical and sexual violence), rather than emotional, financial and social abuse/violence, and as many women do not report IPV the prevalence may be substantially greater than available statistics suggest (Mouzos & Makkai 2004, Alhabib *et al.* 2010).

In 2002–2003 the financial cost of IPV in Australia was estimated as $8·1 billion (VicHealth 2004). The human cost was equally significant for Victorian, Australian women aged 15–44 years, with IPV being 'the leading preventable contributor of death, disability and illness' (VicHealth 2004, p. 10). Experiencing IPV increases risks for physical and mental illness and death (VicHealth 2004, Ramsay *et al.* 2009). It is associated with acute and chronic injuries, pain syndromes, depression, posttraumatic stress disorder, drug and alcohol abuse and gynaecological health concerns for women. It also has a significantly negative impact on children living within a violent home (Feder *et al.* 2006, Ramsay *et al.* 2009).

The Australian Government responded to this crisis in the mid-2000s with the 'Australia says NO' media campaign, (Abetz 2004) denouncing violence against women and highlighting criminal aspects of IPV. At the same time Australian male sporting groups received 'training' that emphasised the importance of treating women with respect. High profile sportsmen were encouraged to act as community role models (Donovan & Vlais 2005). Whether such programs influence men's behaviour or women's decision-making when defining their experiences in abusive relationships is debatable. Of interest is whether campaigns highlighting alternative social discourses, as opposed to what are often common understandings of IPV, impact on women's decisions to seek healthcare and the type of care they then receive. Women's experiences of healthcare when seeking emergency care while living with IPV is the focus of this paper, as is the way in which their experiences of IPV and healthcare impact on their sense of self and self-efficacy.

Literature review

Women experiencing IPV are significant in the healthcare-seeking population (Boyle *et al.* 2004, Sethi *et al.* 2004). A systematic review of studies from the USA, UK, Australia and France by Olive (2007) demonstrated that more than 6% of emergency department patients experienced IPV in the previous 12 months. Women, however, are often not identified in emergency departments (EDs), or other healthcare environments, as experiencing abuse (Henderson 2001, Ramsay *et al.* 2002, Yonaka *et al.* 2007, Boursnell & Prosser 2010, Robinson 2010) and are therefore not provided with care directed towards achieving ongoing personal safety (Feder *et al.* 2006, Robinson 2010). While women seek empathetic, supportive healthcare (Yam 2000, Taft 2002, Feder *et al.* 2006), open disclosure of abuse often results in being disbelieved, blamed for the abuse, judged (negatively), and in a lack of empathetic holistic care (Henderson 2001, Flinck *et al.* 2005, McMurray 2005, Robinson 2010, Thapar-Björkert & Morgan 2010). Despite the negative experiences of emergency IPV-related care, research suggests women continue to seek assistance from emergency departments as a means of accessing external help and support not only for immediate physical injuries but also for other healthcare concerns potentially related to IPV (Olive 2007).

Misconceptions persist around IPV's causes and effects, negatively impacting on women's ability to seek and receive appropriate healthcare (Feder *et al.* 2006, Robinson 2010). Social discourses supporting these misconceptions allow 'acts that would be punished if directed at an employer, a neighbour, or an acquaintance [to] often go unchallenged when men direct them at women especially within the family' (Heise *et al.* 2002, p. S5). Societal beliefs or discourses tacitly condoning IPV include those that 'justify, excuse, minimise, or hide physical or sexual violence against women' (VicHealth 2010, p. 15).

Research suggests such beliefs remain strong in Australia, with 80% of respondents in a national survey demonstrating minimisation, indicating they could not understand why women would not leave abusive relationships and 50% believing a woman could leave 'if she really wanted to' (VicHealth 2010, p. 8). Negative influences from these beliefs are evident in research of emergency and perinatal nurse's attitudes, finding nurses often blamed the victim and ignored signs of abuse when they believed women chose not to leave abusive partners (Henderson 2001, Furniss *et al.* 2007, Robinson 2010). Abused women often hold similar misconceptions; believing what they are experiencing is 'normal' or that they precipitate or deserve abuse because of 'bad' behaviour (Hegarty & Taft 2001, Flinck *et al.* 2005, Feder *et al.* 2006).

Studies have explored the prevalence and impact of IPV on women and their families (Alhabib *et al.* 2010), women's understanding of IPV (Feder *et al.* 2006, Furniss *et al.* 2007, Robinson 2010) and their experiences of healthcare while living with IPV (Yam 2000, Flinck *et al.* 2005, Feder *et al.* 2006). However research is lacking, particularly in an Australian context, of women's experiences of healthcare and how social discourses or understandings influence their experiences and constructions of IPV. Consequently, this study's purpose was to explore emergency healthcare experiences for women living with IPV and how these influenced their understanding of IPV and their sense of self.

Methodology

Design

The research design drew on traditional (Glaser & Strauss 1967, Strauss & Corbin 1998) and contemporary (Clarke 2005, Charmaz 2006) approaches to grounded theory, particularly a modified form of Clarke's Situational Analysis approach, which, like Strauss and Corbin, is underpinned by symbolic interactionism, but also draws on Foucault's poststructural theories of discourse, power and knowledge. Symbolic interactionism contends that meaning, 'comes into existence in and out of …[an individual's] engagement with the…world' (Crotty 2003, p. 8). As such there may not be a fixed unwavering reality. Rather, meaning will be constructed by a society or individual reflective of many elements, interactions and experiences that have and are occurring at any moment (Clarke 2005); just as meaning of an event or thing is constructed, so is an individual's sense of self. Within this context, the self is seen as the thoughts, feelings and emotions, conscious and unconscious, and the way in which an individual views and understands themselves in relation to the world (Weedon 1997).

Clarke (2005), drawing on Foucault, describes discourse as: 'communication of any kind around/about/on a particularly socially or culturally recognisable theme — contemporary and/or historical.' It therefore 'influences perception, and creates objects of knowledge' (p. 148). Truth is seen to be created through the triad of discourse, knowledge and power, acknowledging that 'power relations structure all areas of life' (Weedon 1997, p. 1) and have a role in determining social and individual understanding of truth and reality (Clarke 2005).

In analytic terms Clarke's (2005) situational analysis (SA) approach uses 'maps' that allow researchers to view elements of the research situation and their relationships (situational maps), the 'social/symbolic interaction' (p. 110) of the individuals and groups within the situation (social worlds/arena maps) and the different discursive positions taken by individuals, groups or institutions within the research (positional maps). In this way significance is given to discourses and their influence on and within the situation. Whilst drawing on the general principles of SA, mapping in this study was undertaken conceptually rather than visually, identifying the 'important human and non-human elements in the situation of inquiry' (Clarke 2005, p. 292). Use of SA, as described, moved the study beyond the somewhat positivist-focused analysis of basic social process[es] of traditional Grounded Theory, and acknowledged the largely constructed nature of research and the impact of individuals, groups, hierarchies, locations, environments, discourses and histories of the elements or players, within the situation (Clarke 2005).

Reflective of poststructural approaches which deny permanence, SA aims through research to theorise and suggest areas for further exploration, rather than providing a grand theory that explains a particular concept (Clarke 2005). Thus, as previously noted, this study's intent is to understand the meaning given by women to their experiences of healthcare related to IPV and the impact on their sense of self, self-efficacy and decision-making. Ethical approval was sought and obtained from a University Human Research Ethics Committee.

Data collection

Women who had sought ED or primary healthcare while experiencing IPV were recruited through methods including announcements on local radio and in metropolitan newspapers and snow-balling techniques. While only seven women (all of whom had since left the abusive relationship) were recruited, data saturation was reached by the fifth interview where no new themes related to the research purpose and related questions were identified. It is worth noting that despite the multiple recruitment methods used, only seven women were able to be recruited and none were still experiencing IPV.

Individual semi-structured audio-taped interviews over one to two hours were conducted using an interview schedule. Women were asked to provide generic background data and describe their experiences of emergency healthcare, whether they identified or were identified as experiencing IPV, and how they (and others) labelled the abuse. Women were also asked why they accessed emergency healthcare and their perceptions of the type of care they received. Questions posed sought to explore physical and emotional care, what they considered healthcare professionals could do to improve provision of healthcare and how they felt about themselves during and after care.

Data analysis

Interviews were immediately transcribed verbatim and studied for patterns and significant absences that were then pursued in subsequent participant interviews. Using NVIVO 8 (QSR International Pty Ltd, Doncaster, Victoria, Australia), data were initially coded using a segment by segment approach where initial codes were given to the emerging phenomena. As sequential interviews were coded comparison between the identified phenomena was constant. Using these codes, within conceptual SA maps, relationships were identified in and between codes, which were then merged into categories to develop an explanation of the phenomena.

Data analysis focused on women's experiences within the situation and discourses of IPV (sometimes referred to in the literature as myths) were used as decision-making guides and markers within the data. During analysis of women's narratives, additional emphasis was placed on exploring their understanding of IPV and their ongoing reflexive reconstruction(s) of self.

Findings

All women reported ongoing abuse throughout their relationships. Table 1 provides demographic data, types of abuse experienced and related medically diagnosed mental health effects of violence.

All women received healthcare in an emergency department and visited a general practitioner while living with IPV. Jill and Maggie also met with a psychologist/psychiatrist during their abusive relationships.

Four major categories were identified:
1 Accessing healthcare: challenges and barriers
2 Care women need vs. care women receive
3 Discourses of IPV and the construction of self
4 Acknowledging IPV, moving on and re-constructing self.

Accessing healthcare: challenges and barriers

All women reported abuser controlled contact with 'the world'. Consequently they faced unique challenges when attempting to access healthcare for incidents related to IPV and decreased opportunities for initiating discussions or responding to questions about their relationships.

The women proactively sought healthcare for routine illnesses as legitimate opportunities for outside contact, although few did so without their partner's presence or permission. As Jill noted, her husband 'always came with me to everything'. At the same time they usually only accessed emergency healthcare for significant injuries sustained from IPV and did not seek medical care for less severe injuries or emotional distress.

When presenting to an ED or doctor with IPV-related injuries with their abuser, the true causes of injuries were

Table 1 Background and demographic data

Name*	Age	Type(s) of IPV disclosed	Years since abuse ceased	Children	Education level	External employment	Current medically diagnosed anxiety and/or depression
Anna	35–40	Extreme and ongoing physical, sexual, financial and emotional abuse	4	0	Tertiary	Yes	No
Sandra	45–50	Ongoing emotional and one episode of physical abuse	2	0	Tertiary	Yes	No
Jill	40–45	Ongoing emotional, sexual and financial abuse and infrequent physical abuse	3	3	Secondary	Yes	Yes
Belinda	30–35	Ongoing physical, sexual, financial and emotional abuse	3	1	Tertiary	No	Yes
Natalie	25–30	Ongoing physical, financial, sexual and emotional abuse	3	2	Tertiary	Yes	No
Helen	45–50	Extreme and ongoing physical, sexual, financial and emotional abuse	8	1	Secondary	No	Yes
Maggie	40–45	Ongoing physical, sexual, financial and emotional abuse	3	3	Tertiary	Yes	Yes

*Pseudonyms used to protect privacy.

concealed or described by the partner as something else. As Helen said:

He would always say 'oh she fell' or…'she rolled down the hill'… you know he would always make up some kind of excuse why I've got bruises or why my ribs are broken …I didn't cry, I didn't do anything because my then husband always stood there, so I dared not do anything.

When presenting without their abuser for emergency healthcare they varied in their decisions to disclose violence. A severe injury, or a first presentation due to violence, increased the chance of disclosure.

Presenting with police or ambulance meant the mechanism of injuries was usually known. However, disclosure by self or emergency services personnel generally did not induce empathetic healthcare. Anna reflected other women's experiences of disclosure saying: 'The first time I was [honest] and then after the way that I got treated, I started to make up lies [about how the injuries were sustained].' Later, following a particularly violent attack, Anna revealed the cause of her injuries, stating, 'I told them the outright truth because I was so scared.' The women reported that when the cause of injury was acknowledged as IPV, the healthcare provided often made them hide future violence and only severe fear and/or injury could then induce disclosure.

While the women sought help for physical injury, it was only when their situations became extreme that they accessed healthcare for non-physical health effects. Jill sought healthcare for severe depression and suicidal thoughts, saying: 'And I did go and see [the doctor] and speak to him a little bit about…how I felt…I'd often… thought how I'd kill myself…but of course X was sitting there.' As her husband's presence prevented disclosure of IPV she was, not unreasonably, prescribed antidepressants rather than receiving the help she needed.

Maggie first threatened suicide to her then husband, an event which led to a hospital admission and psychiatric review, recalling 'I burst into tears and…said [to her abuser] 'I'm going to kill myself because I don't know what else to do…I need help, I just need to go to the doctor [crying]'. At this point her partner called the police and then violently assaulted her before leaving. Maggie perceived her husband's decision to call the police (and his following assault) identified her as being at fault and that his abuse occurred because she was crazy and irrational, and needing subduing/punishment. She viewed his calling the police as an extension of his abuse and as means of punishment for her behaviour.

Both these women were initially labelled as mentally ill. This proved to be a turning point for Maggie, as during her mandatory ED psychiatric review she disclosed IPV and accepted healthcare assistance for safety planning. Jill remained silent about IPV her husband's presence removing the opportunity for disclosure. A subsequent increase in antidepressant medication reinforced Jill's sense that she was the one who needed 'fixing', that she was the problem and precipitator of her (unacknowledged) abuse.

Care women need vs. care women receive

Care women need vs. care women receive represents the women's needs and experiences of healthcare in emergency contexts. While they reported generally receiving skilled physical care, their desire for acknowledgement of IPV and psychosocial care was consistently overlooked. Women wanted empathy, respect and a place where their 'self', even more than their 'body', was safe from further damage. Rather than receiving empathetic care they reported being pitied and blamed, with consequent negative effects on their feelings of self and self-worth.

Participants reported feeling constrained by fear and shame and were adept at 'keeping the secret' of their abuse. This multi-layered protective behaviour was an attempt to keep at bay the judgement of others, and to prevent further violence from their partners as a reprisal for disclosure. As Helen said: 'I had to tell everybody that everything was fine, we have a wonderful marriage…I had to say that, because if I didn't, once again I'd be beaten up'.

Despite maintaining secrecy, they agreed that being given the opportunity of talking about IPV in an ED, or other healthcare environment, was an important aspect of care, emphasising that this needed to be carried out safely. Perversely, most stated that they would have (at least initially) denied experiencing IPV during healthcare. Nonetheless, as Belinda said 'I would have been relieved if they had asked: I might have denied it, but then I have taken an interest [seen a way forward]'. All the women were adamant that their denial of IPV did not remove the need for provision of opportunities to discuss IPV. The women judged it safe to discuss IPV when healthcare staff provided physical safety and created an open, informed and supportive emotional environment.

Unfortunately, almost all expressed disappointment with the types of emotional care they routinely received. Helen recalled her desire to be 'touched' with compassion saying: 'There was no feeling, there was nothing there. There was no interaction…everything is cold'. She noted that this accentuated her sense of being untouchable saying:

My mouth was bleeding, my nose was bleeding, my eyes were bruised, my face was bruised, my ribs were broken… Downstairs was bleeding because he tore me, so they took swabs…It's as if you've got some kind of disease, nobody wants to come close to you, nobody wants to catch it. I haven't got a disease; all I've got is a…husband that's abusive to me.

The few who had positive healthcare experiences valued them as they allowed women to understand their experiences, provided validation and supported them in making decisions at their own pace. Belinda spoke of an emergency nurse who 'just listened…taking time to get to know me, [and let me know] that I am worth treatment, started to make me think – what's going on?'

Women needed empathic treatment demonstrated in words and actions. Anna said 'I would've loved some empathy and just to feel, you know, care and affection, and someone to listen to me.' Natalie added 'what I wanted was someone to sit on my bed and tell me that they understand, talk to me about some options that I may have had; umm and hold my hand'.

Women's accounts demonstrated they were finely attuned to nuances in the healthcare professional's words and actions, with most reporting that physical care was often provided in a detached manner leaving them feeling even more violated, ashamed and vulnerable. They needed to see, hear and feel empathetic support as a means of making sense of their experiences and thus enable them to re-construct a positive, non-guilty, sense of 'self'.

Discourses of IPV and the construction of self

Discourses or myths of IPV, attributing blame to women who stay in abusive relationships, and related discourses of women precipitating abuse by behaviour, influenced the women's perceptions of self and responsibility for IPV. Un-empathetic healthcare further reinforced this perception to the detriment of the women's sense of self and ongoing well-being, with the women feeling that healthcare professionals often blamed them for the abuse and for staying in an abusive relationship, particularly if they thought the woman chose not to leave when advised to do so by the professional. The most damaging aspect of 'blaming discourses' was that they caused the women to minimise and normalise the abuse they experienced, or accept blame for abuse because of their 'bad behaviour'.

In the early stages of an abusive relationship participants invariably reported believing their behaviour caused or exacerbated violence. Natalie recalled thinking: 'my husband loves me very much, but if I am in his face… he'll throw something at me or push me'. Believing they precipitated violence, women amended their behaviour to minimise violence. Helen described striving to decrease violence, saying: 'His handkerchiefs had to be ironed a special way. Cleaning had to be done a special way, if not I'd get a beating'. Violence often ensued despite behaviour modification.

Experiences of judgmental healthcare, where participants felt blamed for ongoing violence for 'choosing' not to leave their abuser, further compounded their guilt. Anna recalled one experience: 'I could hear some of the [nurse's] comments like 'why would she do that to herself', meaning you know, obviously why won't she get out, but those specific words; it's making me feel bad about myself, I wasn't doing it to myself.'

Belinda and Anna compared living with IPV to cancer, stressing both could be lethal, but only cancer would necessarily engender sympathetic care. Belinda said of emergency nurses: 'when you have cancer, they tend to [do] a lot more to help you…whereas with domestic violence…they kind of think, why did you stay? Why did you get yourself involved?' All the women stressed that being blamed by healthcare staff for the abuse made them distance themselves and thus decreased opportunities for disclosure and support.

Several women (Natalie, Anna, Sandra, Maggie and Helen) also experienced the impact of discourses that viewed IPV as being incited by behaviour of 'crazy' or mentally ill women, which reinforced their belief that they needed fixing rather than care. Maggie spoke of being seen as causing her husband's violence, recalling the care from an emergency doctor who assessed her obvious injuries after an assault saying: 'He never acknowledged I'd been abused. He just checked the physical side of things…he asked me if I was taking my sleeping tablets…it was all my fault because I wasn't sleeping, I was a tired and grumpy woman, there was nothing wrong with [X].' From Maggie's perspective this doctor appeared to blame her, vindicating her abuser. Similarly, Helen recalled being labelled crazy and responsible for her injuries, saying of her then husband: 'he used to tell them that I was the one going crazy so he had to subdue me…I wasn't made as if I was the victim but the culprit.'

These women felt that being labelled mentally ill removed their right to empathy and support, and reinforced their sense of responsibility for violence. This made them less likely to label their experiences as IPV. Consequently, they 'worked harder' to decrease violence. Exposure to blaming decreased the women's chances of labelling and disclosing ongoing abuse and limited opportunities for receiving supportive care.

At some level all initially believed their actions caused violence. They emphasised the importance of empathy and support to enable them to understand their experiences and attribute appropriate responsibility. Empathy and support, when present, strengthened their sense of self and self-efficacy for achieving ongoing safety. Sadly, this was often lacking in healthcare and only infrequently did some women (Maggie and Natalie) receive supportive care. The women stated that being blamed for the violence by someone else with authority and power over them and their bodies reinforced shame, guilt and a sense of worthlessness, and created another barrier to seeking help.

Acknowledging IPV, moving on and re-constructing a sense of self

Acknowledging IVP, moving on and reconstructing self represents an ongoing process as individual women realised that the abuse was not their fault, they wanted to end the relationship and rebuild their self-confidence. All the women recalled finally acknowledging abuse. To achieve ongoing safety they then needed to accept that they were not responsible for the violence and could not 'fix' the relationship or abuser. They considered healthcare staff had a particular role to play in this process.

Participants' understandings of what constituted abuse were often a factor preventing 'disclosure' of IPV. In the early stages (or years) of abuse most did not identify their experiences as abnormal/abusive and therefore did not 'disclose'. Within this context, although increasing community awareness, none thought that current Australian television advertisements condemning IPV, would have made any difference to their own understanding or decision-making around IPV: as Helen said: 'it's still a no-go zone'.

Routinely normalising or minimising abuse made living with violence easier; however, it effectively prolonged abuse as women did not openly seek help during this time. As Belinda said, 'Don't expect the woman to tell anyone, because they won't, they may not know themselves…they might think it is just normal.' Several women, within the interview, continued to minimise and normalise their recollection of abuse. For example, Helen said 'my ex-husband just occasionally slapped me around but nothing to the point of abuse or bruises'.

The women recalled being shocked when others identified their experiences as abuse; 'He [ED nurse]… told me how anything that is abusive is not acceptable and I got all teary and started to understand that maybe I was a victim of domestic violence' (Natalie). This moment of identification was often a turning point and once they redefined the abuse

they were less likely to see aggressive behaviour as acceptable. This shift of responsibility for violence from themselves to their abusers began a process of lessening their sense of guilt and enabling them to seek a way forward. Natalie spoke of her realisation that she needed to leave, saying: '[I realised] it wasn't normal to be pushed around and made to feel like nobody else would take me because I was an awful person and I am lucky to have this man in my life, who pushes me around and takes drugs and has guns around my children'.

Acknowledging abuse was the first step in a process of redefining a sense of self; a self not at fault. However, leaving an abusive relationship usually took time and was often linked to a sense of powerlessness and fear; fear of reprisal, financial hardship, losing their children, isolation and escalating violence were significant concerns.

The women felt leaving an abusive relationship required them to return 'blame' for the violence to the abuser. In doing this they acknowledged IPV and identified their self as being 'good' and 'capable' and deserving a violence-free life. Jill, who had endured years of severe but predominantly emotional, abuse spoke of the care she received [from her psychologist] which assisted her in redefining her 'self' and enhancing her self-efficacy saying: '[initially] she made me really uncomfortable because she said things like, you are a good mother…she used to keep telling me I was a remarkable woman, and I used to squirm in the chair because no, no it's not what I'm used to hearing'. Being given a new way of viewing herself was a vital step forward for Jill in seeking safety.

All the women spoke of a process of rebuilding a positive sense of self and moving from a situation where they were used to think of themselves negatively. Redefining their sense of self in a positive way was assisted by empathetic healthcare staff.

Discussion

All the women (with the exception of Sandra) were socially and financially isolated, with limited ability to access external care and support. All initially assumed responsibility for their abuse, modified their behaviour and minimised and normalised their experiences. These findings build on the work of Hegarty and Taft (2001) and Flinck *et al.* (2005) where women experiencing IPV believed violence was their fault, normal, occurring in many relationships, or not bad enough to justify reporting, and worked to self-manage the problem.

With a situational analysis (Clarke 2005) lens, women in this study were seen as constructing their understanding of

violence and their sense of self in a world dominated by their abuser, often resulting in skewed perceptions. Seeking healthcare was a legitimate, albeit controlled, means of accessing external help. When receiving healthcare the women reported being treated for physical injuries competently, but felt their psychosocial needs were neglected. Unfortunately these findings are consistent with a meta-analysis of 25 qualitative studies exploring 847 women's experiences of care related to IPV by Feder *et al.* (2006).

Reflecting the findings of others (Flinck *et al.* 2005, Feder *et al.* 2006, Furniss *et al.* 2007), disclosure of IPV to healthcare professionals was variable, with those disclosing often feeling blamed for the abuse for reasons that included choosing not to leave the abuser and/or provoking violence by behaviour or mental illness. With disclosure, healthcare was often viewed as dismissive, lacking compassion and provided with an emotional distance. This upholds research by Thapar-Björkert and Morgan (2010) where healthcare workers were found to withhold emotional care when they judged a woman responsible for her own abuse.

Interactions with healthcare professionals were found to influence how the women (re)-constructed their understanding of IPV and self and were important in aiding women to acknowledge the abnormality of abuse. Healthcare professionals who were judgemental and lacking in empathy were damaging for the women as they reinforced blame and further alienated women from understanding their experiences in a way that enabled them to seek help to end the abuse. These findings in relation to Australian women's experiences are similar to those of previous studies conducted in Finland (Flinck *et al.* 2005), North America (Henderson 2001, Robinson 2010) and the United Kingdom (Henderson 2001, Thapar-Björkert & Morgan 2010) and supported by Feder's *et al.* (2006) systematic review, which also found that women needed healthcare staff to assist them in understanding and labelling their abusive experiences.

Reflective of findings in a study by Hegarty *et al.* (2008), once the women in this study defined and understood their experiences as abusive and wrong, they started to verbalise their desire to leave the relationship and sought information to do so safely. This study then further demonstrated that healthcare professionals' efforts in helping the women to define their experiences as IPV positively influenced their sense of self, self-efficacy, ability to achieve and right to safety. Similar to previous research (Hegarty & Taft 2001, Feder *et al.* 2006, Kramer 2007, Robinson 2010), this study also found compassionate, respectful and empathetic healthcare that was a positive experience and often featured in the women identifying their experiences as IPV. Provid-

ing women with the opportunity to talk about their experiences and supporting them to understand that they were not to blame was seen as vital in this, as in previous research (Flinck *et al.* 2005, Kramer 2007, Kendall *et al.* 2009, Thapar-Björkert & Morgan 2010).

In summary, this study highlighted the negative influence of social discourses that blame women for abuse; either as a result of perceived 'bad behaviour' or mental illness, and for choosing to stay rather than leave. It also identified the damaging effect of these beliefs when evinced by healthcare staff, contrasting with empathetic supportive health care that had the potential to enhance women's sense of self. Implicit in care that enhanced women's sense of self were alternative discourses (including feminist discourse) stressing women's right to dignity, safety and freedom from violence.

What this study adds and recommendations for further research

This study explored Victorian, Australian women's experiences of healthcare, particularly emergency care, while living with IPV. It adds to the body of knowledge of abused women's experiences of healthcare and how this can aid or inhibit women defining their experiences as IPV (rather than the norm) and thus promote ongoing health and positive decision-making. In particular, this study demonstrates the influence healthcare staff may have on enhancing or damaging women's sense of self and self-efficacy. A positive sense of self was identified as necessary for women to label their experiences as IPV and take the initial steps towards seeking ongoing safety.

Women will continue to seek healthcare from a variety of environments, including EDs. Future research is required to elicit healthcare interventions women find beneficial in validating their experiences, improving their sense of self and self-efficacy and leading to safer outcomes. Further research is also required to explore what discourses of IPV are pervasive in Australian society, including how women experiencing violence are perceived and how various discourses or understandings of IPV influence healthcare professionals providing care to women.

Study limitations

Being a qualitative study with seven participants, the findings of this study should be considered as one construction of women's experiences of healthcare related to IPV. The fact that all women in the study had left their abuser, undertaken counselling and wished to help other women in violent rela-

tionships may have influenced their recollections of their experiences during the interview. However, the women's narratives were moving and exceptionally clear in their recall of events. Nevertheless, it must be acknowledged that exploring their experiences of care from a distance and with a stronger sense of self-efficacy may have influenced the women's recollections of events. Interviewing women currently in IPV relationships may have identified the changing nature of the women's experiences and their perception of events.

Conclusion

Women living with IPV often have limited opportunities to seek help. Healthcare staff are in a unique position to offer assistance. Despite appropriate physical care given to women in emergency departments, it often lacks compassion and understanding and does not provide opportunities for women to take steps to improve their health and well-being. Women attempting to define and understand experiences of IPV are especially vulnerable to negative messages from healthcare staff who blame them for the abuse. Alternatively, positive reinforcement aids women to identify experiences as wrong and abusive and promotes a shift of responsibility for violence from the woman to her abuser.

Relevance to clinical practice

Women experiencing IPV need supportive, empathic and informed care from healthcare staff to enable labelling of their experiences as abusive and help redefine perceptions of self and self-worth. Emergency healthcare is an avenue where women can be assisted to understand and label their experiences as abusive rather than normal, and gain resources (internal and external) to assist in achieving ongoing safety and well-being. Healthcare staff need to provide opportunities to discuss IPV and role-model respectful attitudes in providing care to abused women. Discussing the possibility of violence or abuse as a normal part of a health assessment and in a non-judgmental manner is important, as is allowing women to disclose when they are ready. Once abuse has been disclosed, validating women's experiences as abusive and providing resources for ongoing support is essential. Although the impact of empathetic and respectful interactions may not be immediately evident to the healthcare professional, the study findings suggest women are open to opportunities for developing better understandings of their self and situation. Rather than expecting healthcare interventions will enable women to immediately leave their abuser and achieve safety, healthcare priorities may need to focus on enhancing women's sense of self and understanding of their experiences. Prioritising women's self-esteem, right to self-determination and enhancing their sense of safety (physical and emotional) within the healthcare environment may aid women to develop the internal and external resources they need to leave an abusive relationship.

The last word is left to Helen:

We've just gone through a hell of an ordeal…we're human, we're the victims. Just talk to us, be patient, hug us if we [need it]. Just be human towards us, that's all we ask.

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