

HEALTHCARE PROVIDERS' EXPERIENCES WITH SCREENING FOR INTIMATE
PARTNER VIOLENCE AMONG MIGRANT AND SEASONAL FARMWORKING WOMEN:
A PHENOMENOLOGICAL STUDY

by

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Migrant and seasonal farmworking (MSFW) women experience greater levels of intimate partner violence (IPV) and have lower awareness of available resources than the general population. Although healthcare providers have the capacity to screen for IPV and provide resources to MSFW patients who have been victimized by IPV, most healthcare providers who work with MSFW patients choose not to screen for IPV. In order to develop a better understanding of the lived experiences of healthcare providers who serve the MSFW community and have encountered patients who have experienced IPV, two research articles were completed: (a) a policy brief designed to explore previous literature pertaining to IPV screenings in healthcare settings and to recommend policies that may help improve the detection, intervention, resources, and available science with respect to the MSFW population, and (b) a descriptive phenomenological study designed to capture the lived experiences of screening for and addressing IPV of nine healthcare providers. The policy brief revealed that (a) IPV prevalence among the MSFW community is higher than the general population; (b) awareness of resources among MSFW women who have been victimized by IPV is low; and (c) no studies have been published regarding IPV screenings of MSFW women in healthcare settings. The research study

revealed four emergent themes describing the experiences of healthcare providers who have screened for or addressed IPV among their MSFW women patients: provider-centered factors, patient-centered factors, clinic-centered factors, and community-centered factors. Implications and recommendations developed from both articles are extended for clinicians, researchers, and policy makers who care about the needs of members of the MSFW community who have experienced IPV and the healthcare providers who serve them.

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Doctor of Philosophy in Medical Family Therapy

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DEDICATION

To my wife, Grace, whose love is unlike any I have ever known. You have supported me over the past eight years with ceaseless words of encouragement and unyielding confidence in my ability to reach my dream of finishing a doctorate degree. When I wanted to quit, you would never let me, and when I thought I was not good enough, you showed me that I was. This dissertation is for you – as it symbolizes the culmination of our academic journey together, a journey filled with love and laughter, pain and sorrow, and exceeding joy to finally finish the journey with you. As we stand on the precipice of the next stage of our lives together, I can think of no other person with whom I would rather share the journey. I love you with all of my heart, and this dissertation is for you. My darling, we made it!

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PREFACE

This dissertation is comprised of six chapters that address healthcare providers' experiences screening for and addressing intimate partner violence (IPV) with migrant and seasonal farmworking (MSFW) women patients. Throughout my undergraduate and graduate educational experiences, I felt a strong interest in learning more about IPV and the devastating effects it can have on couples and families. This strong interest to learn more and to create new knowledge through research led me to pursue a PhD in Medical Family Therapy (MedFT) at East Carolina University (ECU). By combining traditional marriage and family therapy (MFT) principles with a biopsychosocial systems approach (BPS; Engel, 1977, 1981), I developed a more comprehensive understanding of the effects of IPV on various levels within the individual and various levels of the family and healthcare systems.

My interest in healthcare providers' experiences with addressing IPV with their patients developed while completing a clinical assistantship at Snow Hill and Kate B. Reynolds Medical Centers in Snow Hill, NC. During this internship, I noticed that several patients were presenting for medical treatment as a result of being physically assaulted by their partners. Many of these women would walk to the check-in counter in tears, sometimes holding their arm or covering their eye with their hand to cover the places where their partner had struck them. Consistent with the patient populations served by these medical centers, many of the patients presenting with these injuries were members of the MSFW community.

I spoke very briefly with a few of the providers at these medical centers, and to my astonishment, all of them indicated that IPV was a pervasive problem for which they did not feel equipped to address. These conversations inspired me to consult the literature to review any sources pertaining to screening for or addressing IPV within the MSFW community. The

scarcity of available literature on this topic encouraged me to write the first article of this dissertation – a policy brief which, after an examination of relevant previous research pertaining to IPV among MSFW women, recommends policies that may help improve the detection, intervention, resources, and available science with respect to the MSFW population.

The second article was inspired by the results of the first in addition to anecdotal evidence and casual conversations with the medical providers and nurses at Snow Hill and Kate B. Reynolds Medical Centers. I began to wonder more about the experience of healthcare providers in screening for and addressing IPV with their patients. After reviewing the available literature, it became apparent to me that a better understanding of healthcare providers' experiences in this area was needed in order to inform future clinical practice, research, and policy. Thus, I decided to move forward with a descriptive phenomenological qualitative study to learn more about the experiences of healthcare providers in screening for and addressing IPV with MSFW patients.

The findings confirmed that healthcare providers, by and large, do not feel informed or equipped to effectively address this issue, particularly with MSFW patients, who come from a cultural background that arguably exacerbates the severity of IPV. It is my hope that the findings of these studies will lead to more research and changes in policy, affording healthcare providers who serve MSFW patients more culturally relevant training and resources to aid those patients who have been victimized by IPV. This will hopefully lead to systemic improvements in integrated care models (e.g., universal screening for IPV) used by healthcare teams, and care provided to MSFW patients and their families.

CHAPTER ONE: INTRODUCTION

Intimate partner violence (IPV) is a pervasive public health problem (Garcia-Moreno, Jansen, Ellsberg, Heise. & Watts, 2006) with serious consequences for women's health (Campbell, 2002). Findings demonstrate that Latina women are at a greater risk for IPV and are victimized by IPV at a greater rate than the general public (e.g., Hazen & Soriano, 2007). Migrant and seasonal farm working (MSFW) women, most of whom are Latina (NCFH, 2013), are particularly at risk of experiencing IPV because of cultural beliefs, environmental factors, and health disparities (Denham et al., 2007; Duke & Cunradi, 2011; Lambert, 1995). Despite previous researchers indicating that IPV screenings in healthcare settings increases IPV identification rates (e.g., Nelson, Bougatsos, & Blazina, 2012; Ramsay, Richardson, Carter, Davidson, & Feder, 2002), many providers opt not to screen (Jonassen & Mazor, 2003; Smith, Danis, & Helmick, 1998). The primary objective of this dissertation project is to further examine the role of healthcare providers in screening for and addressing IPV with MSFW women.

Migrant and Seasonal Farmworkers

In order to fully consider the influence of intimate partner violence (IPV) among the migrant and seasonal farmworker population, and the associated cultural factors contributing to IPV, it is important to gain a basic understanding of migrant and seasonal farmworker history and culture. Migrant and seasonal farmworkers are considered to be one of the most underprivileged groups in the United States (U.S.) (Lambert, 1995), as indicated by numerous environmental factors, including challenges with the migratory lifestyle, limited finances, and poor working and living conditions (Denham et al., 2007; Duke & Cunradi, 2011). According to the National Center for Farmworker Health (NCFH) the size of the migrant farm worker population in the U.S. is estimated to be between 3 to 5 million people (NCFH, 2013).

Population estimates are difficult to arrive at due to the transitory nature of planting, cultivating, and harvesting crops (NCFH, 2013).

Since arriving in the late 1800's, migrant and seasonal farmworkers have significantly contributed to the farming industry in the U.S. One of the most significant contributions to the growth of the U.S. agricultural economy was the establishment of the Bracero Program, in which more than 4 million Mexican workers came to work in the U.S. fields (The Bracero Program, 2013). This influx of Mexican workers coincided with the entry of the U.S. into World War II and the demands in manual labor that resulted. Independent farmers associations and the "Farm Bureau controlled the bracero work contracts (The Bracero Program, 2013). The contracts were usually in English, and the braceros would sign them without fully understanding the terms of the contract or the rights they were giving away (Mexican Immigrant Labor History, 2013; The Bracero Program, 2013). The braceros were allowed to return to their native lands only in the case of an emergency, which required written authorization from their employer (Mexican Immigrant Labor History, 2013). Nevertheless, the braceros labored in the fields, and became the foundation upon which the North American agriculture was developed (The Bracero Program, 2013).

Despite their significant contribution to the agricultural economy in the U.S., the braceros suffered harassment and oppression from extremist groups and racist authorities (The Bracero Program, 2013). Although many braceros came to the U.S. with dreams of becoming wealthy, they were drastically underpaid for their labor efforts (Mexican Immigrant Labor History, 2013). With the development of mechanical farm equipment, the Bracero Program began to fade, and was eventually dismantled in 1964 (The Bracero Program, 2013).

Despite the end of the Bracero Program, immigrant farmworkers remain active in the U.S. agricultural industry, and are typically referred to as migrant and seasonal farmworkers (Lambert, 1995). Although typically grouped together, “migrant” and “seasonal” farm workers are two different types of workers. A migrant farmworker can be defined as “an individual whose principal employment is in agriculture on a seasonal basis and who establishes a temporary residence for such employment” (Lambert, 1995, p. 265). On the other hand, a seasonal farmworker is “an individual whose principal employment is in agriculture on a seasonal basis but who remains in the area throughout the year” (Lambert, 1995, p. 265).

Demographics

The National Center for Farmworker Health (NCFH, 2013) estimates that approximately 83% of MSFW are Latino (including Mexican-Americans, Mexicans, Puerto Ricans, Cubans, and workers from Central and South America). Other farmworkers include African-Americans, Jamaicans, Haitians, Laotians, Thais, and other minorities (NCFH, 2013).

Language and education. Over 80% of farmworkers speak Spanish, around 18% speak English, and 2% speak other languages (NCFH, 2009; 2013). The average education level among migrant and seasonal farmworkers is low – usually through 7th grade (NCFH, 2013). Their work sites and lodging are usually located in isolated rural areas with limited access to medical care (NCFH, 2013).

Gender and family. Approximately 79% of migrant and seasonal farmworkers are male and 21% are female (NCFH, 2009). However, a greater percentage of women (33%) are born in the U.S. compared to migrant and seasonal farmworking men (20%; NCFH, 2009). Most (58%) farmworkers are married (NCFH, 2009). Fifty-one percent (51%) of farmworkers are parents, of whom 66% were not accompanied by their children when they migrated (NCFH, 2009).

Labor force. NCFH (2009) reported the following statistics pertaining to the migrant and seasonal farmworker labor force. Forty-two percent (42%) of migrant and seasonal farmworkers are migrants, having traveled a minimum of 75 miles during the previous year to obtain a farmworking job. Of these migrant farmworkers, 35% travel back and forth from a foreign country, primarily Mexico, and 26% travel within the U.S. alone. Mexican born workers report an average of 36 working weeks in the U.S. per year, while U.S.-born farmworkers report an average of 31 working weeks per year. Seventy-nine percent (79%) of migrant and seasonal farmworkers are paid hourly, and only 2% are paid by salary. The average individual income among farmworkers ranges from \$10,000 to \$12,499 with the average family earning between \$15,000 and \$17,499. In 2009, a mere 8% of farmworkers reported being covered by employer-provided health insurance.

Migrant Streams

Frequent migration is a necessary, but unavoidable circumstance for MSFW. The NCFH (2013) indicated that many farmworkers move 11-13 times a year in search of employment. Although many workers travel alone to each of their job locations, others travel with their entire families. Most have a permanent residence in the western and southern states, many of which are near the U.S. and Mexico borders. From these locations, MSFW fan out across the U.S. on various migratory streams, as new crops are ready for harvest.

The NCFH (2013) described the three loosely defined migratory streams followed by MSFW: the East, the Midwest, and the West. The migrants who travel the Eastern Stream typically follow the east coast of the U.S. through North Carolina, Ohio, and New York. Typical crops harvested along the east coast include citrus, sugar cane, tobacco, tomatoes, blueberries, and apples. MSFW who follow the Midwest Stream typically migrant between two destinations:

(a) the Great Lakes Region to the Rocky Mountains; (b) or to the Northern Pacific region through the Texas Panhandle. Crops representative of the Midwest region include onions, citrus fruits, beans, cucumbers, and potatoes. Finally, migrants who follow the Western Stream are usually based in California and travel along the Pacific coast through Oregon and Washington. Alternatively, some MSFW travel from central California to North Dakota. The West Stream contains more workers than any other stream. Common crops harvested in the West Stream include citrus fruits, grapes, apples, tomatoes, strawberries, cherries, peaches, and onions. Although crucial to the production of foods and various other products in the U.S., the farmworking industry is a highly demanding field that inevitably takes its toll on workers and their families alike.

Occupational Stressors and Family Life

MSFW and their families face several unique work-related stressors that impact family life negatively. Regardless of their immigration status, the general population in the U.S. considers MSFW to be undocumented workers (Duke & Cunradi, 2011). As a result, migrant and seasonal farmworkers are subjected to a wide range of discriminatory practices (Duke & Cunradi, 2011). They have few legal avenues for filing grievances against their employers, as well as few labor protections (Duke & Cunradi, 2011). Additionally, many MSFW have been limited in their education (NCFH, 2013) and struggle with English proficiency (Hancock, 2006). Given these barriers, many MSFW in the U.S. have fewer opportunities for employment outside of farm work or other low-paying industries (Duke & Cunradi, 2011). Researchers have begun to link variables of work stress such as low income and unemployment (Cunradi, Todd, Duke, & Ames, 2009), and male work status (i.e., blue-collar or low-status jobs) (Fox, Benson, Demaris,

& Van Wyk, 2002), with serious psychosocial consequences such as IPV (Duke & Cunradi, 2011).

Intimate Partner Violence

Although there appears to be no consensus among researchers pertaining to an appropriate definition for IPV, it can be defined as a pattern of assaultive and coercive behaviors designed to establish control by a person who is, was, or wishes to be involved in an intimate or dating relationship (Runner, Yoshihana, & Novick, 2009). More than 1 in 3 women (35.6%) in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011). IPV is considered to be the primary cause of injury to women across all racial and ethnic groups between the ages 15 to 44 (Graham-Bermann, 2001) and has resulted in significant inpatient and outpatient health costs and devastating social and family intergenerational consequences (McCord-Duncan, Floyd, Kemp, Bailey, & Lang, 2006). Regarding prevalence, women comprise of 73.5% of the victims of IPV and are 6 times more likely to be victimized by IPV than men. One team of researchers indicated that migrant women were 47% more likely to be abused than seasonal farmworking women, and women whose partners used drugs and/or alcohol were six times more likely to be abused by their partner (Van Hightower, Gorton, & Demoss, 2000). Although few researchers calculated prevalence rates of IPV among MSFW women, initial findings indicate that MSFW women experience significantly more IPV than the general population (Hazen & Soriano, 2007).

Women experiencing IPV utilize a disproportionate share of health care services, making more visits to emergency departments, primary care facilities, and mental health agencies than women who have not experienced IPV (Coker, Smith, McKeown, & King, 2000). IPV presents numerous harmful health effects, such as pelvic inflammatory disease (Letourneau, Holmes, &

Chasedunn-Roar, 1999), sexually transmitted infections, including HIV (Wingood, DiClemente, McCree, Harrington, & Davies, 2001), brain injuries (Corrigan, Wolfe, Mysiw, Jackson, & Bogner, 2003) and even death (Brock, 2003). Psychological injuries are also a common result of IPV as well (Murdaugh, Hunt, Sowell, & Santana, 2004).

Intimate Partner Violence Screening

Universal screening for IPV in healthcare settings could increase identification rates of women at risk and lead to interventions that reduce IPV and improve health outcomes (Nelson et al., 2012). The Institute of Medicine (IOM, 2011) and other professional organizations (e.g., American Congress of Obstetricians and Gynecologists [ACOG], 2013; Berg [U.S. Preventative Services Task Force], 2004; National Advisory Council on Violence and Abuse, 2008; Nelson, Nygren, McInerney, & Klein, 2004) agreed that screening is a helpful and worthwhile step in IPV identification. Although most physicians receive training on IPV in medical school (Jonassen & Mazor, 2003), provider-reported barriers to IPV screenings remain, including lack of time (Colarossi, Breitbart, & Betancourt, 2010), training (Colarossi et al., 2010; Waalen, Goodwin, Spitz, Peterson, & Saltzman, 2000), referral resources (Colarossi et al., 2010), and self-assessed competence in identifying IPV (Jonassen & Mazor, 2003).

Although resources to aid MSFW women victimized by IPV exist, previous researchers (e.g., Kugel et al., 2009) have indicated that awareness of such resources is limited. Specifically, only 22% of MSFW women in one study were aware of resources (e.g., shelter, police). Furthermore, 87% of MSFW women indicated that they would seek help in a violent relationship if they were aware of available resources (Kugel et al., 2009). This “unawareness” of available resources is perhaps the most disturbing aspect of IPV victimization of MSFW women.

Theoretical Perspective

For the purposes of this study, the construct of IPV was processed through a biopsychosocial lens (BPS; Engel, 1977, 1981). The biopsychosocial (BPS) perspective is an attempt to comprehend health and illness through a lens of biological, psychological, and social elements. The BPS model has highlighted the limitations of reducing explanations of dysfunction to any of its three major components (biological, psychological, or social) and the associated variables, considerations, and factors (Engel, 1977). A more recent formulation of this perspective is presented by McDaniel, Doherty, and Hepworth (2013), who utilized the term “biopsychosocial systems model” to highlight the interactive nature of biological, psychological, and social phenomena regarding health and illness. According to this model, each of the phenomena has a consistent and reciprocal impact on one another, as opposed to simply existing in an arranged hierarchical setting (McKenry et al., 1995).

Purpose and Design of Study

Despite the prevalence of IPV among MSFW women compared to the general population (Hazen & Soriano, 2007), recommendations to screen all women patients for IPV (e.g., ACOG, 2013), and lack of awareness of available resources among MSFW women patients victimized by IPV (Kugel et al., 2009), many providers choose not to screen for IPV (Colarossi et al., 2010; Jonassen & Mazor, 2003; Waalen et al., 2000). This is particularly unfortunate considering that MSFW women have a limited awareness of available resources to lend aid (Kugel et al., 2009). Because few researchers to date have addressed IPV among MSFW women, and no studies have been published regarding IPV screenings of MSFW women in healthcare settings, it is necessary to better understand healthcare providers’ experiences with screening for and addressing IPV among their MSFW women patients in order to inform future clinical practice, research, and

policy developments alike. Thus, the purpose of this study was to identify the essence of healthcare providers' experiences when screening for and treating IPV in the MSFW women population IPV in healthcare settings among MSFW women patients.

The second chapter, a policy brief regarding IPV among MSFW women will be presented. The policy brief reviewed previous research related to IPV among MSFW women and, based on the findings, recommend policies that may help improve the detection, intervention, resources, and available science with respect to this underserved population. Studies pertaining to IPV prevalence, IPV screenings in healthcare settings, available resources for MSFW women who have been victimized by IPV, and unique risk factors for IPV among MSFW women will be included and discussed. Finally, recommendations were extended to aid in the development of policies to advance the science, screening, and resources available to MSFW women who have experienced IPV.

The third chapter includes an in-depth review of the literature on IPV among MSFW women. In order to better organize the information, the biopsychosocial model (Engel, 1977; Engel, 1980; Wright, Watson, & Bell, 1996) was used as a framework for presenting the biological, psychological, and social processes of IPV. Additionally, available literature on IPV screenings in healthcare settings, especially studies pertaining to Latina or MSFW women, was reviewed as well. A brief discussion of the role of healthcare providers in IPV screenings and equipping patients with resources to minimize the harmful effects of IPV is also provided.

The fourth chapter includes a description of the methodology used to construct the proposed descriptive phenomenological study. This study attempted to attain and describe the subjective experiences of how healthcare professionals providing services to MSFW women address IPV with the MSFW women patients. Purposive sampling techniques were used to

recruit participants – healthcare providers who serve MSFW women. Participants were recruited from within various community health centers in North Carolina and via a listserv maintained by the Migrant Clinicians Network. Data were collected via individual interviews and analyzed using a descriptive phenomenological approach described by Colaizzi (1978). By documenting providers’ lived experience of this phenomenon (screening for IPV among MSFW women), clinicians, researchers, and policy makers alike will be better equipped in their specific disciplines to improve the current IPV screening practices (or lack thereof) among MSFW women in healthcare settings.

The fifth chapter is the second article of this dissertation project, and includes the results of this qualitative study. It is intended to portray an overall summary of this project, effectively capturing the lived experiences of healthcare providers who have screened for or addressed IPV among MSFW patients. Brief summaries of the literature review, method, and discussion chapters are also included in chapter five. Finally, chapter six discusses the implications of this study for research, clinical practice, policy, and Medical Family Therapy (MedFT).

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CHAPTER TWO:
INTIMATE PARTNER VIOLENCE AMONG MIGRANT/SEASONAL FARMWORKING
WOMEN AND HEALTHCARE: A POLICY BRIEF*

Migrant and seasonal farm working (MSFW) women report higher rates of intimate partner violence (IPV) as compared to the national average (e.g., Hazen & Soriano, 2007). Although prior researchers have indicated that implementing IPV screenings in healthcare settings significantly increases rates of identifying IPV (e.g., Nelson, Bougatsos, & Blazina, 2012; Ramsay, Richardson, Carter, Davidson, & Feder, 2002); many providers opt not to screen (Jonassen & Mazor, 2003; Smith, Danis, & Helmick, 1998). The purpose of this policy brief is to review previous research related to IPV among MSFW women and based on the findings; recommend policies that may help to improve the detection, intervention, resources, and available science with respect to this underserved population.

Introduction

Intimate partner violence (IPV) is a serious public health problem (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006) with substantial consequences for women's physical, sexual, and mental health (Campbell, 2002). Migrant and seasonal farm working (MSFW) women are particularly at-risk in an intimate relationship because of cultural beliefs and environmental factors, which include challenges with the migratory lifestyle, limited finances, and poor working and living conditions (Denham et al., 2007; Duke & Cunradi, 2011). Compared to other ethnic groups, MSFW are less aware of resources to advocate for themselves within the healthcare system, creating difficulties for providers to properly intervene (Denham et

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al., 2007). This lack of awareness is due, in part, to cultural and environmental factors (e.g., migratory lifestyle) among the MSFW population (Denham et al., 2007). Without knowledge of and access to resources (e.g., domestic violence hotlines and women's shelters), MSFW women who are victims of IPV are diminished in their ability to seek aid voluntarily (Kugel et al., 2009).

Latino culture places the highest priority of life on marital and family relationships, referred to as "familismo." Despite the relative importance of marital and family relationships within the culture, rigid sex roles (e.g., machismo) and the objectification of women heighten the perceived power of the male partner and require submissiveness and obedience of the female partner (Moreno, 2007). As such, MSFW women, many of whom are Latina, experience considerable oppression due to the cultural influences on their gender roles and norms. This dynamic alone creates an environment conducive for IPV (Mattson & Ruiz, 2005). MSFW women commonly define a "good wife" as someone who "supports the husband, stays at home with the children, and does not have affairs" ("Migrant Clinicians Network," 1999, p. 12). According to Kamm and Rosenthal (1999), national reductions in gender discrimination and sexual harassment have been reported among women living in the United States (U.S.) but this finding has not been extended to include MSFW women. Additionally, Latinos in the U.S. (especially the migrant population) live, disproportionately, in poverty and have lower educational levels than non-Latinos, both of which are also considered risk factors for IPV (Guzman, 2001). All of these findings point toward a need to advance the safety, rights, and health of MSFW women and families residing in the US.

Researchers have indicated that universal screening of all women for IPV significantly increases the number of victims who are identified, especially within healthcare settings (Bradley, Smith, Long, & O'Dowd, 2002; Richardson et al., 2002; Siegel, Hill, Henderson,

Ernst, & Boad, 1999; Thackeray, Seltzer, Downs, & Miller, 2007). Prior researchers have indicated that, while many community resources are available to victims of IPV, poor Latina women, in particular, are less likely than other women to seek out these services (Lipsky, Caetano, Field, & Larkin, 2006), perhaps due to a lack of awareness of such resources (Kugel et al., 2009). Healthcare providers have the potential to serve as a medium through which victims of IPV could obtain such resources.

Although most physicians receive training on IPV in medical school (Jonassen & Mazor, 2003), provider-reported barriers to IPV screenings remain, including lack of time (Colarossi, Breitbart, & Betancourt, 2010), training (Colarossi et al., 2010; Waalen, Goodwin, Spitz, Peterson, & Saltzman, 2000), referral resources (Colarossi et al., 2010), and self-assessed competence in identifying IPV (Jonassen & Mazor, 2003). Furthermore, immigrant women often enter the U.S. as dependents of their partners, and attempts to separate from their partner and/or family may result in an inability to remain in the U.S. (Merchant, 2000) and undoubtedly influences their decision of whether or not to disclose IPV to their healthcare providers. Despite the growing amount of attention provided to immigrant women and IPV in the research literature (e.g., Hancock, 2006; Hazen & Soriano, 2007; Prosman, Jansen, Lo Fo Wong, & Lagro-Janssen, 2011; Runner, Yoshihama, & Novick, 2009), studies and publications on intervention and policy efforts related to immigrant populations are limited (Ely, 2010), particularly for the MSFW population.

The purpose of this policy brief is to review available literature pertaining to IPV among MSFW women regarding screening, intervention practices, and research conducted with this population in healthcare settings. Specifically, this policy brief will include articulating the implications of the current status of IPV and IPV screenings for the MSFW population, and

provide recommendations for healthcare policy changes such as: (a) improving provider education and training pertaining to IPV, (b) developing screening protocols for detecting IPV, and (c) initiating on-site assistance/community-based resources provided to victims of IPV.

Literature Search Method

A search of the literature was conducted via two of the most common databases for healthcare research (MEDLINE and CINAHL) and PsycINFO (1990 to present) using the following search terms: *intimate partner violence, domestic violence, partner abuse, migrant farm worker, seasonal farm worker, immigrant farm worker, screening, and assessment.*

Retrieved articles consisted of: (a) descriptive commentaries of the nature of IPV among MSFW; (b) research articles written examining IPV among MSFW women (e.g., prevalence rate survey studies); and (c) studies conducted to examine IPV screenings of MSFW women in healthcare settings. Reference lists of included articles were also searched, but did not result in additional inclusions. Altogether, eight articles met the inclusion criteria for this brief. It was determined that saturation had been reached when no new articles were generated by either CINAHL or PsycINFO that were not previously discovered by MEDLINE. Furthermore, because of the narrow scope of the topic being researched, it was deemed unlikely that searching additional databases or using additional search terms would contribute additional information. Articles were divided into four themes after a careful review of how the outcomes coalesced (some articles were included in multiple thematic categories when applicable). The themes are: (a) IPV prevalence, (b) screenings in healthcare settings, (c) resources, and (d) additional risk factors.

Results

IPV Prevalence

Five studies containing IPV prevalence data for heterosexual MSFW women were identified and included in this article (See Table 1). Across the five studies reviewed, lifetime prevalence rates for IPV among MSFW women were high when compared to the general population. Prevalence rates of IPV ranged from 5% to over 70%, but the discrepancies in findings can be attributed to varied definitions about IPV (e.g., physical abuse, sexual abuse, psychological abuse) and contrasting research methodologies. Most of the researchers divided IPV into two categories: physical violence and sexual violence/coercion. However, one study done by Hazen and Soriano (2007) also included psychological aggression as a form of IPV.

MSFW women in Hazen and Soriano's (2007) study indicated a lifetime prevalence rate of 24.5% for physical violence. Prevalence rates of physical violence within the previous year ranged from 16.4% (Duke & Cunradi, 2011) to over 70% (Hazen & Soriano, 2007). Hazen and Soriano (2007) also identified a 20.9% lifetime prevalence rate of sexual coercion among MSFW women, with 18.4% reporting having experienced it within the previous year alone.

Screenings in Healthcare Settings

No studies have been published regarding IPV screenings of MSFW women in healthcare settings. Researchers have examined screening practices in healthcare settings (e.g., Colarossi et al., 2010; Macmillan et al., 2009; Nelson, Bougatsos, & Blazina, 2012), but none exclusively have focused on the screening of MSFW women. In a review of 34 IPV victimization assessment instruments endorsed by the Centers for Disease Control and Prevention for use in healthcare settings (Basile, Hertz, & Back, 2007), only four instruments had a Spanish version available with demonstrated reliability and validity, none of which were specifically tested with

MSFW populations. To date, there appears to be no empirically validated screening tool designed for use with the MSFW population. Short and Rodriguez (2008) tested an IPV assessment measure (the “Intimate Partner Violence Assessment Icon Form”) with MSFW women, but were unable to generate conclusive evidence of its usefulness. This form was taken from an adaptation of the Abuse Assessment Scale (AAS), a screening tool developed by nursing researchers (MacFarlane, Christoffel, Bateman, Miller, & Bullock, 1991). Although inter-rater reliability and criterion validity were achieved, no test examining the content validity of the measure was completed. However, as this was the only culturally relevant screening tool discovered by this review, it potentially could be useful in the future development of an IPV screening tool for MSFW women.

Resources

Eight studies pertaining to resources for MSFW women who have been victimized by IPV were reviewed for this brief. Despite the high prevalence of IPV among MSFW women, Kugel et al. (2009) indicated that MSFW women’s awareness of resources (e.g., shelter, clinic, church, legal services, counseling, police, and national domestic violence hotline) to aid victims of IPV was low – approximately 22% of their sample - and more than half of these women identified the police as a resource rather than shelters, clinics, or churches. Interestingly, 86% reported that they would seek help (i.e., be willing to act) if they witnessed or experienced IPV and were aware of available resources, such as women’s shelters, legal services, and police. Essentially, an overwhelming majority (86%) wanted to seek help, but had no means of doing so, which further supports the notion that healthcare providers have tremendous potential to identify patients experiencing IPV and educate MSFW women about known and/or available resources accordingly. No studies indicated primary care providers’ awareness of resources.

Additional Risk Factors

Two articles were identified that included predictors of IPV among MSFW women (Kugel et al., 2009; Van Hightower, Gorton, & Demoss, 2000). Predictors included the following: (a) women who were pregnant were less likely to experience IPV than non-pregnant women (Van Hightower et al., 2000); (b) migrant farmworker women were more likely to experience IPV than seasonal farmworker women (Van Hightower et al., 2000); (c) alcohol/drug abuse by the abusive partner was identified most frequently among IPV victims (72%) as the cause of IPV (Kugel et al., 2009); and (d) immigration status was a predictor of IPV among MSFW women (Van Hightower et al., 2000). It is possible that the incorporation of these predictors would aid health care providers in detecting IPV among their MFSW patients. For example, if a MSFW female patient reports alcohol or drug abuse by her partner, providers may be alerted to screen for IPV.

Implications

IPV is a delicate topic for healthcare providers to address with their patients. Screening for IPV involves complex interactions between the screener and the victim, and screeners must be sensitive to the shame and guilt that are commonly associated with disclosing IPV (Thackeray et. al., 2007). Identifying and addressing IPV with patients in a culturally-appropriate manner has the potential to be a very difficult task – one that some providers may not feel equipped to take on properly. Perhaps one of the most challenging aspects of screening for and addressing IPV for providers is the ambiguity, or lack of definitive protocols for how to respond. Unlike violence toward a child, where providers are mandated to report the abuse to the appropriate authorities by their states of practice, the general consensus among healthcare providers is that IPV requires no such protocol unless children are present when the abuse takes place or the

abusive partner expresses homicidal intent (specific protocols on intervening vary by state). Mandatory reporting of child maltreatment is designed to protect those who cannot help themselves. While many women are aware of the resources available to them when they are ready to escape their abusive relationships, a significant proportion of MSFW women remain uninformed (Kugel et al., 2009). One team of researchers indicated that 86% of MSFW women would seek available resources if they were aware of what was accessible to them (Kugel et al., 2009).

MSFW men and women experience acculturative and work-related stressors that further exacerbate IPV prevalence including language barriers, insecure jobs and legal status, and financial restraints, among other factors (Duke & Cunradi, 2011). Although cultural values of the Latino/Latina population cannot be assumed to be true among MSFW women, it is reasonable to expect many similarities between the two. For example, the Latino belief in male domination (*machismo*), which tends to be most evident among less educated, poorer men (Humphreys & Campbell, 2004), likely influences violent characteristics among MSFW men, and reinforces the associated subservient role of women (Kim-Godwin & Fox, 2009).

Routine screening for IPV in healthcare settings is one vehicle to identify women at risk and intervene by providing them with resources to reduce violence and consequentially improve their health outcomes (Nelson et al., 2012). The Institute of Medicine (IOM; 2011), and several professional organizations (e.g., American Congress of Obstetricians and Gynecologists [ACOG], 2012), recommend universal IPV screenings for all women. Although progress has been made advocating for this action, neither a uniform screening protocol in healthcare settings, regardless of the cultural group, nor an endorsement by the IOM or ACOG for one exists

currently (Elliott, Nerney, Jones, & Friedman, 2002; Erickson, Hill, & Siegel, 2001; Lapidus et al., 2002; Thackeray et al., 2007).

While the MSFW community has existed in the U.S. for nearly a century, dating back to the Immigration and Nationality Act passed by Congress in 1917 (“National Center for Farmworker Health,” 2013), the effects of IPV continues to subjugate and disenfranchise women. Although understanding IPV among immigrant women in general is only in its infancy (Ely, 2010), policies protecting the MSFW women and research specific to their needs has largely been absent.

Recommendations

There are four primary recommendations being extended in this brief that may help in the development of policies to advance the science, screening, and resources available to MSFW women who have experienced IPV.

1. Annual IPV Screenings for MSFW women - Policies should be written making it possible for MSFW women to be screened for IPV at least annually by their healthcare providers. These policies should include reimbursement for screenings to cover the costs and hire bilingual staff to assist where needed. Numerous researchers (e.g., Bradley et al., 2002; Parkinson, Adams, & Emerling, 2001; Richardson et al., 2002; Thackeray et al., 2007) have indicated that universal screening for IPV significantly increases the number of identified victims. However, the screening tools available are not validated with the MSFW population. While annual screenings are the goal, concurrent work to further the science regarding the types of instruments used to detect IPV that are sensitive to the contextual factors of the MSFW population should be supported through healthcare policy.

2. Expansion of MSFW Advocacy Groups and Community Resources - Not only are MSFW women disproportionately victimized by IPV (Hazen & Soriano, 2007), and constrained by numerous cultural factors (see Kamm & Rosenthal, 1999), but most (86% according to Kugel et al., 1999) would seek help if they were aware of what resources were available to them. However, in order for providers to effectively respond to positive screenings for IPV among their MSFW patients, they should be aware of the cultural factors, financial barriers, bilingual and culturally-relevant IPV resources, and respect any fears related to issues such as deportation (depending on legal status) that may be common to this population. Although some governmental sanctions, such as the Violence Against Women Act (VAWA, 1994), provide relief to migrant victims of IPV (e.g., free medical care, permission to work in the US and a green card without spousal assistance), many women are unaware of such protections. Providers who work with MSFW women will benefit from using the available resources of the National Center for Farmworker Health (NCFH; www.ncfh.org), a private, not-for-profit agency dedicated to improving the health of farmworker families by providing information and training products to health centers that work with migrant farmworkers across the U.S.. Additionally, the Migrant Clinicians Network (MCN; www.migrantclinician.org), an organization that serves healthcare providers who provide services to MSFW and their families, can equip providers with helpful education resources and networking opportunities to collaborate with others serving the MSFW population. Flyers for patients about the VAWA are also available in English and Spanish (among other languages) from the Immigrant Legal Resource Center (ILRC, 2013). Expansion of these agencies to include more

resources available to screening, intervening, and studying IPV in the MSFW populations is needed through policy and advocacy efforts that funnel more funds specific to this effort in their direction.

3. Education and Training on IPV in the MSFW Community - We suggest supporting the development of face-to-face and/or web-based educational opportunities to increase awareness and prepare providers effectively for the culturally unique needs of this population. Additionally, given that many of the IPV stories told by the MSFW women will be powerful and emotionally challenging to hear, education and training curriculum to help healthcare providers debrief the gravity of this work should also be funded. For example, it is entirely possible that a healthcare provider working with the MSFW population may encounter victims of IPV who are pregnant (Jasinski & Kantor, 2001; Van Hightower, et al., 2000), and in a relationship with abusive partner who drinks alcohol excessively, often resulting in physical violence from the intoxicated partner, (Kim-Godwin & Fox, 2009), but are afraid of being deported and/or separated from their family if they try to seek help (Kim-Godwin & Fox, 2009; Van Hightower et al., 2000). By debriefing and educating providers about the specific circumstances in which MSFW women live, and how to respond to IPV when working with MSFW women patients, providers will be much more prepared to provide assistance.
4. Research-Informed Advancements in Detecting IPV in the MSFW Community – As noted above, the primary recommendation is for researchers, in collaboration with the MSFW community (providers, patients, and advocacy groups), to develop culturally relevant screening tools for IPV specifically designed for MSFW women. Such

screening tools should display empirical validity and reliability with the MSFW population, or at least the migrant Latino population at large. Additionally, future researchers should examine the impact of screening tools, assessment/response protocols, and screening environments on the comfort of MSFW women victims. Although previous researchers (Thackeray et al., 2007) have documented the preferences of women in general regarding IPV screening (e.g., being screened in-person, verbally, and by female providers) no one has specifically considered the unique cultural and legal influences of screening and identification on the MSFW population. Providers are encouraged to build upon the recommendations of Thackeray et al. (2007) by specifically attending to the unique needs of MSFW women until more studies are available that may influence provider training, community resource, and healthcare policy changes.

Conclusion

Although IPV impacts women of all racial and ethnic groups, MSFW women are disproportionately victimized (Hazen & Soriano, 2007; Kim-Godwin & Fox, 2009; Prosman et al., 2010). Despite high prevalence rates of IPV among MSFW women, the truth remains that many providers do not screen their patients for IPV (Jonassen & Mazor, 2003; Smith, Danis, & Helmick, 1998). If women victimized by IPV are not identified, resources cannot be given to provide assistance. Furthermore, if culturally-relevant resources are not made available, sensitive to the predictors of abuse and legal concerns of the MSFW community, these women may remain trapped in a dangerous home environment. Developing resources to raise healthcare provider awareness of the pervasive problem of IPV among MSFW women will serve as an important step toward a solution. In sum, although MSFW women are significantly exposed to

more IPV than other women in the U.S. (e.g., Hazen & Soriano, 2007; Kim-Godwin & Fox, 2009; Prosman et al., 2010), and have access to fewer resources (Kugel et al., 2009), many remain unidentified due to the lack of IPV screenings in healthcare settings.

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Table 1

IPV Prevalence Rates among MSFW Women

Study	Description of IPV	<i>n</i> *	<i>n</i> **	Lifetime**	Previous Year**
Duke & Cunradi (2011)	Intimate Partner Violence	61	61	n/a	10 (16.4%)
Hazen & Soriano (2007)	Physical Assault	292	49	12 (24.5%)	7 (14.3%)
	Sexual Coercion	292	49	10 (20.4%)	9 (18.4%)
	Psychological Aggression	292	49	39 (79.6%)	35 (71.4%)
Kim-Godwin & Fox (2009)	Domestic Violence	291	67	n/a	51 (76.3%)
Van Hightower et al. (2000)	Spousal Abuse*	1001	1001	n/a	190 (19%)
	Sexual Abuse	1001	1001	n/a	46 (5%)
Rodriguez (1998)	Physical Abuse	304	304	n/a	76 (25%)
	Forced Sexual Activity	304	304	n/a	49 (16%)

* Total sample size; ** MSFW women participants

CHAPTER THREE: LITERATURE REVIEW

Intimate partner violence (IPV) is a widespread public health problem (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006) with significant consequences for women's health (Campbell, 2002). Migrant and seasonal farm working (MSFW) women are particularly at risk in an intimate relationship because of cultural beliefs, environmental factors, and health disparities (Denham et al., 2007; Duke & Cunradi, 2011; Lambert, 1995).

Migrant and Seasonal Farmworker Demographics

According to the National Center for Farmworker Health (NCFH), there are over 3 million MSFW in the United States (U.S.; NCFH, 2012), with the majority (72%) of whom were foreign-born (Carroll, Georges, & Saltz, 2011). While both migrant and seasonal farmworkers' principal employment is in agriculture on a seasonal basis, migrant workers establish temporary residences during such employment while seasonal farmworkers remain in the area throughout the year (Lambert, 1995). The National Agriculture Worker Survey (NAWS) is an employment-based, random survey of the demographic, employment, and health characteristics of the crop labor force in the U.S. Data is collected from farmworkers directly through interviews. The following statistics highlight data from the 2007-2009 NAWS' results (Carroll, Georges, & Saltz, 2011):

- Seventy-eight percent (78%) of crop workers were male and 22% were female.
- Fifty-nine percent (59%) of farmworkers surveyed were married, and 52% were parents.
- Thirty-five percent (35%) said they could not speak English "at all," 30% said they could speak English "well," 27% said they could speak English "a little," and 8% said they could speak English "somewhat."

- The average level of completed education was 8th grade. Specifically, 40% had completed grades 1 to 6, 17% completed grades 7 to 9, 28% had completed grades 10 to 12, and 9 % attained some form of higher education.
- Forty-two percent (42%) of farmworkers surveyed were migrants, having traveled at least 75 miles within the prior year to obtain work.
- Eighty-three percent (83%) of farmworkers said they were paid by the hour.
- Sixty percent (60%) of farmworkers said their current job was seasonal, and most spend on average 66% of the year working in the U.S. farms.
- Only 39% of farmworkers reported being covered by unemployment insurance, 54% said they were not covered, and 8% did not know.

Migrant and seasonal farmworkers (MSFW) are considered to be one of the most underserved and underprivileged groups in the U.S. (Kandel, 2008; Lambert, 1995). A study conducted by the New York State Department of Health indicated that poverty, frequent mobility, low literacy, language and cultural barriers impede MSFW access to social services and cost effective primary health care (New York State Department of Health, 2007). Furthermore, the small percentage of MSFW who actually take advantage of available healthcare services are faced with further challenges, including limited means of transportation, prejudice because of their status as migrants, and lack of time-efficient healthcare delivery methods (California Institute for Rural Studies, 2002). Additionally, Latinos in the U.S. (especially the migrant population) live, disproportionately, in poverty and have lower educational levels than non-Latinos, both of which are also considered risk factors for intimate partner violence (IPV; Guzman, 2001). Although not all migrant and seasonal farmworkers are Latino/Latina, previous studies of the Latino population provide some initial insights on which to develop research studies specific to the migrant and seasonal farmworker population.

Intimate Partner Violence

Intimate partner violence (IPV) can be defined as a pattern of assaultive and coercive behaviors designed to establish control by a person who is, was, or wishes to be involved in an intimate or daring relationship (Runner, Yoshihana, & Novick, 2009), although innumerable definitions for IPV have been posited in prior studies. IPV describes physical or sexual assault (Kim-Godwin & Fox, 2009), psychological or emotional abuse, progressive social isolation, stalking, deprivation, intimidation, and threats (Runner et al., 2009). The Centers for Disease Control and Prevention (CDC) have identified four types of IPV, including: physical violence, sexual violence, threats of physical or sexual violence, and psychological/emotional violence (Centers for Disease Control and Prevention, 2009). These definitions illustrate a few of many attempts by researchers to effectively define IPV. It is likely that the varying definitions of IPV contribute greatly to the vastly different reports of IPV in the literature.

IPV is considered to be the primary cause of injury to women ages 15 to 44 (Graham-Bermann, 2001) and has resulted in significant inpatient and outpatient health costs (e.g., medical costs incurred treating injuries from IPV) and devastating social and family intergenerational consequences (e.g., isolation of victim and intergenerational transmission of violence) (McCord-Duncan, Floyd, Kemp, Bailey, & Lang, 2006). Women experiencing IPV use a disproportionate share of health care services, making more visits to emergency departments, primary care facilities, and mental health agencies than women who have not experienced IPV (Coker, Smith, McKeown, & King, 2000b).

IPV Prevalence Rates

While women comprise 51.6% of the US population, they encompass 73.4% of the victims of IPV and are 6 times more likely to be victimized by IPV in comparison with men

(Chambliss, 2008). Furthermore, women have evidenced significantly higher lifetime and 12-month IPV prevalence, and are more likely to report IPV-related injury than men (Breiding, Black, & Ryan, 2008). The following prevalence data are reported directly from the 2010 NIPSVS, a survey conducted by the National Center for Injury and Prevention Control. Overall, more than one-third of women in the U.S. (35.6% or approximately 42.4 million) have experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime (Black et al., 2011).

One in 3 women (32.9%) has experienced physical violence by an intimate partner at some point in her lifetime. Examples reported by women include being slammed against something by a partner (17.2%), being hit with a fist or something hard (14.2%), and being beaten by an intimate partner (11.2%). Regarding sexual violence, 1 in 10 woman (9.4%) has been raped by an intimate partner in her lifetime, while 1 in 6 women (16.9%) has experienced sexual violence other than rape by an intimate partner. One in 10 women (10.9%) has been stalked at least once in her lifetime, and nearly half of all women in the US (48.8%) have experienced at least one form of psychological aggression by an intimate partner during their lifetime.

Among MSFW women. Although numerous researchers routinely publish studies documenting IPV prevalence in the general population, only a few have considered IPV prevalence among MSFW women. Although comparisons of IPV prevalence among Latina women and non-Latina women have been conflicting (Kim-Godwin & Fox, 2009), the majority of research has found that Latinas experience higher rates of IPV than non-Latinas (Caetano, Ramisetty-Mikler, & Field, 2005; Lipsky, Caetano, Field, & Bazargan, 2006; McFarlane, Groff, O'Brien, & Watson, 2005). Hazen and Soriano (2007) included psychological aggression as a

form of IPV, and reported incidence of physical violence victimization ranged from 18.5% (Hazen & Soriano, 2007) to 20% (Rodriguez, 1998) within the previous year, and between 19% (Van Hightower, Gorton, & Demoss, 2000) and 33.9% (Hazen & Soriano, 2007) over one's lifetime. Hazen and Soriano (2007) also identified a 20.9% lifetime prevalence rate of sexual coercion among MSFW women, with 14.4% reporting having experienced it within the previous year alone.

It is worth noting that underreporting of IPV appears to be a significant concern among Latino couples (Hazen & Soriano, 2007). Prior researchers have indicated that the rates of male-to-female partner violence reported by women were significantly lower than rates reported by male partners (Aldarondo, Kaufman Kantor, & Jasinski, 2002; Caetano, Schafer, Field, & Nelson, 2002). Among immigrant women in particular, concerns about legal status and the repercussions of reporting violence, fear of reprisal from a partner or family members, shame, or a desire to preserve peace among the family as a whole (e.g., Aldarondo et al., 2002; Hass, Dutton, & Orloff, 2000; Hazen & Soriano, 2007) may have contributed to underreporting of IPV. Although no researchers have confirmed this trend among MSFW women, it remains a high possibility that similar patterns will emerge in future studies.

Health Effects of IPV

IPV presents numerous harmful health effects, such as pelvic inflammatory disease (Letourneau, Holmes, & Chasedunn-Roar, 1999), sexually transmitted infections, including HIV (Wingood, DiClemente, McCree, Harrington, & Davies, 2001), brain injuries (Corrigan, Wolfe, Mysiw, Jackson, & Bognar, 2003) and even death (Brock, 2003). Other common injuries from IPV include bruises, black or swollen eyes, cuts, knife wounds, fractured bones, muscular injury, scratches, and psychological injuries (Murdaugh, Hunt, Sowell, & Santana, 2004). IPV also

results in higher rates of unintended pregnancies (Hathaway et al., 2000) and psychological distress (Nelson et al., 2012). Long-term biomedical conditions associated with IPV include chronic pain, neurologic disorders, gastrointestinal disorders, migraine headaches, and other physical disabilities (Campbell & Lewandowski, 1997; Coker et al., 2000). IPV is also associated with posttraumatic stress disorder, depression, anxiety disorders, substance abuse, and suicide (Campbell, 2002; Campbell & Lewandowski, 1997; Chuang et al., 2012; Coker et al., 2000; Golding, 1999; Lehmann, 2000; Silverman & Loudon, 2010). Healthcare costs related to IPV are estimated to be around \$2 billion each year (Brown, Finkelstein, & Mercy, 2008). Healthcare providers can potentially lower many of these costs by recognizing risk factors of IPV and responding appropriately.

Risk Factors for IPV

Risk factors are associated with an increased likelihood of IPV victimization and perpetration. Researchers who studied general population samples found that IPV prevalence is highest among members of racial or ethnic minority groups, younger couples, and couples with factors associated with low socioeconomic status (SES), such as unemployment and low income (Duke & Cunradi, 2011; Field, Caetano, & Nelson, 2004). Furthermore, stressors related to immigration, challenges of acculturation, language, legal, and economic pressures have the potential to exacerbate IPV (Mattson & Rodriguez, 1999). Each of these risk factors are common among the MSFW population, and have the capability to create stressful conditions that can result in acts of IPV (Duke & Cunradi, 2011; Hazen & Soriano, 2007; Grzywacz, Rao, Gentry, Marín, & Arcury, 2009).

In their study of prevalence and predictors of IPV among MSFW women, Van Hightower, Gorton, and DeMoss (2000) indicated that migrant women were 47% more likely to

be abused than seasonal farmworking women, and that women whose partners used drugs, and/or alcohol were six times more likely to be abused by their partner. IPV has also been associated with depression.

Occupational stressors. MSFW and their families face several unique work-related stressors that negatively impact family life, and are associated with IPV. The undocumented status of MSFW women contributes to persistent discrimination and diminished options to promote advocacy and equality in the workplace (Duke & Cunradi, 2011). Additionally, given their limited education (NCFH, 2013), and lack of English proficiency, MSFW in the U.S. have few opportunities for employment outside of farm work or other low-paying industries (Duke & Cunradi, 2011). Lack of English proficiency and fewer work options contributes to fewer social relationships and greater isolation, both of which may exacerbate IPV (Duke & Cunradi, 2011). Other variables of work stress (e.g., low income, unemployment) (Cunradi, Todd, Duke, & Ames, 2009), and male work status (i.e., blue-collar or low-status jobs) (Fox, Benson, Demaris, & Van Wyk, 2002) have been associated with IPV as well (Duke & Cunradi, 2011).

Substance use. Heavy alcohol use is believed to be common but is poorly documented among MSFW men (Grzywacz, Quandt, Isom, & Arcury, 2007). Heavy alcohol consumption increases risk of violence (Kim-Godwin & Fox, 2009). One team of researchers indicated that men were six times as likely to abuse their female partners if the man abused drugs and/or alcohol (Van Hightower, Gorton, & DeMoss, 2000). Another group of researchers found that Latino couples had an eight times greater risk of IPV when both partners had problems with alcohol (Caetano, Cunradi, Clark, & Shafer, 2000).

Acculturation and gender roles. Caetano, Ramisetty-Mikler, Caetano-Vaeth, and Harris (2007) discussed the relationship between acculturation and risky behaviors, which

included IPV. Changes resulting from acculturation and new economic demands may be interpreted as a threat to the machismo of Latino males (Kim-Godwin & Fox, 2009). Interestingly, Ingram (2007) indicated increasing IPV prevalence the longer Latinos and their families lived in the U.S. Gender disparities resulting from acculturation, or adoption of American customs and norms, can lead to higher stress levels among Latino immigrants, which can lead to increased rates of IPV (Adames & Campbell, 2005; Klevens, 2007; Mattson & Ruiz, 2005).

Healthcare needs and access to healthcare. MSFW of both genders rank among some of the most disadvantaged, medically underserved populations in the U.S. (Slesinger & Ofstead, 1996). Various factors including poverty, frequent mobility, low literacy, language and cultural barriers impede MSFW access to social services and cost effective primary health care (New York State Department of Health, 2007). Lambert (1995) discussed several specific health issues of MSFW in regard to healthcare needs and access to healthcare. Outreach to and assessment of healthcare needs of MSFW men and women is difficult, and many MSFW have multiple healthcare needs. Individuals within the MSFW population are prone to numerous health conditions, including accidental injuries, dental disease, mental health problems, substance abuse issues, malnutrition, diabetes, hypertension, tuberculosis, parasitic infections, and anemia. Many women in this population are of childbearing age, and even those who are pregnant sometimes work in the fields to supplement family income.

Awareness of resources. Although resources to aid MSFW women victimized by IPV exist, previous researchers (e.g., Kugel et al., 2009) have indicated that awareness of such resources among MSFW women is low. Specifically, Kugel et al indicated in their study that only 22% of MSFW women respondents were aware of available resources (e.g., shelter, legal

services, police, etc.). Among the resources indicated by MSFW women, police was the most frequently chosen option (Kugel et al., 1990). Perhaps the most disturbing finding of this particular study is that an overwhelming majority of respondents (87%) indicated that they would seek help if they were in a violent relationship and were aware of available resources (Kugel et al., 2009).

Intimate Partner Violence Screening

Routine screening for IPV in healthcare settings could identify women at risk and lead to interventions that reduce violence and improve health outcomes (Nelson et al., 2012). Although IPV screening in healthcare settings has not always been recommended (e.g., Nelson, Nygren, & McInerney, 2004), new recommendations from the Institute of Medicine (IOM; 2011) and several professional organizations (American Congress of Obstetricians and Gynecologists [ACOG], 2013; Berg [U.S. Preventative Services Task Force], 2004; National Advisory Council on Violence and Abuse, 2008; Nelson, Nygren, McInerney, & Klein, 2004) agree that screening is a helpful and worthwhile step in IPV identification. Although more than 35% of women experience IPV at some point in their lives (Black et al., 2011), most providers do not routinely screen for IPV (Colarossi, Breitbart, & Betancourt, 2010).

Barriers to IPV Screening

Although previous researchers have indicated that most providers do not routinely screen for IPV among their patients (e.g., Colarossi et al., 2010), barriers to disclosing IPV to healthcare providers exist among MSFW women as well. Developing an understanding of both patient and provider barriers is an important step in understanding where the gaps in clinical practice currently lie in regard to this issue.

Among patients. Several researchers studied the barriers MSFW women report to disclosing their experiences with IPV to their healthcare providers (e.g., Thackeray, Stelzner, Downs, & Miller, 2007). Likewise, many women face barriers to disclosing a history of IPV. Many women feel shame and embarrassment associated with disclosing a history of IPV (Thackeray et al., 2007). For example, one research team found patients often believe that clinicians lack the time to discuss abuse and/or are not interested in discussing abuse with them (Rodríguez, Sheldon, Bauer, & Pérez-Stable, 2001).

Barriers to disclosing IPV among Latina and MSFW women have been published as well. One team of researchers (Murdaugh et al., 2004) indicated that nearly three fourths (74%) of their sample of Latina women who had been injured by IPV and received medical treatment in the southeastern U.S. did not tell their doctor or person treating them how they were hurt. The major reasons indicated for not telling were feeling ashamed or embarrassed (59%), inability to speak English and no access to a translator (41%), fear of being deported or separated from their family (Kim-Godwin & Fox, 2009; Van Hightower et al., 2000), or fear that their abuser would find out and make things worse (40%). Additionally, illiteracy among MSFW has been indicated as a significant barrier to IPV screening, disclosure of IPV from MSFW women patients to their providers, and to health in general (Eng, Maxfield, Patrick, Deering, Ratzan, & Gustafson, 1998). Although very little has been published regarding research with illiterate populations (Short & Rodriguez, 2008), one study indicated that telephone surveys received higher response rates among illiterate groups than mailed paper and pencil surveys (Harris, Weinberger, & Tierney, 1997). Short and Rodriguez (2008) attempted to counteract the problem of illiteracy regarding IPV screenings by developing an IPV assessment form using icons rather than typed text. This form, however, did not deliver conclusive evidence of its usefulness. Although inter-

rater reliability and criterion validity were achieved, no test examining the content validity of the measure was completed (Short & Rodriguez, 2008).

Among providers. Healthcare providers report barriers to screening for IPV as well. Examples of such barriers include lack of time (Colarossi et al., 2010), training (Colarossi et al., 2010; Waalen, Goodwin, Spitz, Peterson, & Saltzman, 2000), referral resources (Colarossi et al., 2010), and/or self-assessed competence in identifying IPV (Jonassen & Mazor, 2003). Other barriers include lack of confidence in the ability to make referrals, discomfort in asking the IPV screening questions, and no ready access to medical social workers (Jonassen & Mazor, 2003).

Role of Healthcare Providers

Healthcare providers play an important role in the identification of IPV and providing resources to those victims of IPV. Patients should be offered information that includes community resources (e.g., mental health services, crisis hotlines, rape relief centers, shelters, legal aid, and police contact information) and, when necessary, appropriate referrals (ACOG, 2012). According to ACOG (2012), clinicians should not try to force patients to accept assistance. Additionally, to assist clinicians in responding to IPV, a local domestic violence agency is a useful resource. Kamm and Rosenthal (1999) recommend increasing the number of health service agencies devoted to serving MSFW women.

Cultural sensitivity. It is important for healthcare providers to consider the unique cultural factors and associated challenges faced by MSFW women. IPV, as noted above, is of particular concern with this particular population due to occupational stressors (e.g., NCFH 2013), drug and alcohol abuse (e.g., Kim-Godwin & Fox, 2009), acculturation and gender roles (e.g., Harris, 2007; Kim-Godwin & Fox, 2009), healthcare needs and access to healthcare (Lambert, 1995; Slesinger & Ofstead, 1996), and lack of awareness of resources (Kugel et al.,

2009). Case findings and self-reporting sometimes are made difficult because of factors such as mobility, economic status, and uncertain immigration status in some of the migrant farm worker population (Lambert, 1995). Providers must strive to achieve cultural sensitivity in order to provide quality health care services to MSFW patients. Assessment/screening protocols for IPV as well as treatment plans for MSFW women patients should be developed to in ways that reflect an understanding of the patient's culture and how she has been influenced by her culture (Caudle, 1993). Becoming culturally competent is an ongoing process, and is achieved by the provider by developing the capacity to appreciate differences and continue to assess one's reactions to different cultures (Lambert, 1995).

Theoretical Influence

Various theories have been associated with IPV including (but not limited to): attachment theory (Alexander, 1992); feminist theory and contextual theory (Bell & Naugle, 2008); and commitment theory (Rusbult & Martz, 1995). For the purposes of this study, however, the construct of IPV was processed through a biopsychosocial lens. Although spiritual factors may influence IPV, previous researchers (e.g., Todhunter & Deaton, 2010) have indicated that no such relationship exists.

Biopsychosocial Model

The biopsychosocial (BPS) perspective is an attempt to comprehend health and illness through an understanding of how biological, psychological, and social elements mutually influence one with the BPS model has highlighted the limitations of reducing explanations of dysfunction to any of its three major components (biological, psychological, or social) and the associated variables, considerations, and factors (Engel, 1977). The following quote from Engel

emphasizes the importance of recognizing the influence of each of these three components in healthcare settings:

The boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations. By evaluating all of the factors contributing to both illness and patienthood, rather than giving primacy to biological factors alone, a biopsychosocial model would make it possible to explain why some individuals experience as “illness” conditions that others would regard merely as “problems of living,” be they emotional reactions to life circumstances or somatic symptoms (Engel, 1977, pp. 132-133).

A more recent formulation of this perspective is presented by McDaniel, Doherty, and Hepworth (2013), who utilized the term “biopsychosocial systems model” to highlight the interactive nature of biological, psychological, and social phenomena regarding health and illness. According to this model, each of the phenomena has a consistent and reciprocal impact on one another, as opposed to simply existing in an arranged hierarchical setting (McKenry et al., 1995). The influence of the BPS model on research and clinical work alike is significant as evidenced by the further expansion of this model to include the spiritual dimension of human experience (e.g., Hodgson, Lamson, & Reese, 2007; Prest & Robinson, 2006; Wright, Watson, & Bell, 1996) to what is now referred to as the biopsychosocial-spiritual model (BPS-S; Bischoff, Springer, Felix, & Hollist, 2011). Although several published studies indicate a relationship between biopsychosocial factors and IPV, previous researchers have indicated that IPV perpetration and victimization cannot be predicted by religious/spiritual factors (Todhunter & Deaton, 2010).

Regarding IPV, some theoretical researchers have attempted to integrate the BPS aspects of IPV. McKenry and colleagues (1995) released a study pertaining to a BPS model of IPV utilizing a sample of married men. In this study, excessive alcohol use, low family income, and poor relationship quality were each associated with IPV. Previously, Dutton (1995) utilized a variety of theoretical frameworks in presenting an ecologically nested theory of IPV, including factors related to genetic predisposition, physiological arousal, emotional labeling, power issues, neighborhood influences, unemployment, and the effect of cultural and societal characteristics.

Biological factors. The most significant biological risk factor of IPV victimization among women is depression (Stith, Smith, Penn, Ward, & Tritt, 2004). Specifically, women who are depressed are more likely to be victimized by IPV. Although understanding biological risk factors of IPV victimization is necessary, biological factors associated with IPV perpetration must be considered as well. High testosterone levels tend to be associated with aggressive behaviors, dominance status, and pathological forms of aggression (Archer, 1991; McKenry et al., 1995; Meyer-Bahlburg, 1981). The recurring link between testosterone and aggression could mean that men with high testosterone levels tend to carry contentious and hostile behavior into relationships with the opposite sex (McKenry et al., 1995). Booth and Dabbs (1993) found in their sample of former servicemen that testosterone was positively and linearly related to every aspect of marital quality, including hitting and throwing things at spouses.

Serotonin – the universal transmitter that modulates the action of other brain chemicals – has also been indicated as a biological indicator of violent behavior (McKenry et al., 1995). Various impulsive and violent behaviors have been associated with low levels of serotonin (Burrowes, Halles, & Arrington, 1988; Coccaro et al., 1989). While testosterone is more strongly correlated with outward-directed aggressiveness and lack of socialization than it is with

impulsiveness (McKenry et al., 1995), serotonin is more closely-related to impulsive aggression (Virkkunen & Linnoila, 1993).

Psychological factors. Previous researchers have indicated that female depression and fear of partner violence are moderate risk factors for IPV (Stith et al., 2004). Of course, it is reasonable to assume that depression and fear do not cause IPV, but are results of IPV (Stith et al., 2004). Regarding IPV perpetration, Abram (1989) posited that antisocial disorders may trigger violent behaviors. Additionally, having attitudes condoning violence and anger/hostility are further risk factors for perpetrating violence (Stith et al., 2004).

Social factors. One team of researchers indicated that female violence toward male partners is a strong risk factor for female victimization (Stith et al., 2004). Of course it is difficult to know whether this violence from females is a means of self-defense in response to male violence, or if the female violence leads to male violence itself, but the two variables remain associated nonetheless (Stith et al., 2004). Women who use alcohol are also at greater risk of IPV victimization than women who do not (Stith et al., 2004).

Regarding IPV perpetration, IPV is highly related to social stress (Gelles, 1987). Negative life events, especially those threatening the status of the traditional male role, are highly related to spousal abuse (Gelles, 1989; Steinmetz, 1987). Furthermore, men with fewer coping resources (e.g., lower income, poorer marital quality, less social support) are most vulnerable to violent reactions (Gelles, 1994; Steinmetz, 1987). Social support, in general, is also an insulator for family violence (McKenry et al., 1995). The ability to call on friends, family and the community at large for assistance has been shown to mediate violent reactions to stress (Gelles, 1994; Steinmetz, 1987). In general, the more a family is integrated into society, the less likely they are to exhibit violent behaviors within the family (Milner & Chilamkurti,

1991; Straus, Gelles, & Steinmetz, 1980). Men who use drugs and alcohol are significantly more likely to be violent toward their partner(s) than men who do not use drugs and/or alcohol (Stith et al., 2004).

Conclusion

To date, no studies have been published regarding IPV screenings of MSFW women in healthcare settings. Researchers have examined screening practices in healthcare settings (e.g., Colarossi et al., 2010; Macmillan et al., 2009; Nelson et al., 2012) but none have exclusively focused on the screening of MSFW women. Nevertheless, it is reasonable to expect that healthcare providers who treat MSFW women ascribe to commonly-reported provider barriers to IPV screening, including lack of time (Colarossi et al., 2010), training (Colarossi et al., 2010; Waalen, Goodwin, Spitz, Peterson, & Saltzman, 2000), referral resources (Colarossi et al., 2010), and/or self-assessed competence in identifying IPV (Jonassen & Mazor, 2003).

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CHAPTER FOUR: METHODOLOGY

Intimate partner violence (IPV) is a pervasive public health problem (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006), of which migrant and seasonal farm working (MSFW) women are particularly at risk (Denham et al., 2007; Duke & Cunradi, 2011; Lambert, 1995). Despite the prevalence of IPV among MSFW women compared to the general population (Hazen & Soriano, 2007), recommendations to screen all women patients for IPV (e.g., ACOG, 2013), and lack of awareness of available resources among MSFW women patients victimized by IPV (Kugel et al., 2009), many providers choose not to screen for IPV (Colarossi et al., 2010; Jonassen & Mazor, 2003; Waalen et al., 2000). To date, little is known about how healthcare professionals providing services to migrant and seasonal farmworking (MSFW) women screen for intimate partner violence (IPV). Thus, the primary goal of this study was to identify the essence of healthcare providers' experiences when screening and treating for IPV in the MSFW women population. This chapter includes an overview of the phenomenological method of inquiry selected, the procedures followed in the recruitment, data collection and data analysis phases of the study, and a description of the verification methods used to reinforce the study's trustworthiness. Approval for this methodology was gained from the (a) East Carolina University and Medical Center Institutional Review Board (UMCIRB; See Appendix A), and (b) Migrant Clinicians Network (MCN) Institutional Review Board (see Appendix B) prior to data collection. Institutional oversight by UMCIRB was adhered to throughout this project to protect research participants.

Overview of Phenomenology

Phenomenology is based within the Humanistic research paradigm and follows a qualitative approach (Denscombe, 2003). The primary goal of phenomenology is to document

individuals' lived experiences of a particular phenomenon with full and rich detail (Flood, 2008). Phenomenologists emphasize that only those who have actually experienced phenomena can communicate them to the outside world (Todres & Holloway, 2004). Thus, phenomenological studies are used to answer questions of meaning in understanding experiences from those who have experienced them (Flood, 2008).

Schools of Phenomenology

The two primary phenomenological approaches evident in social science and nursing literature include descriptive (eidetic) phenomenology and interpretive (hermeneutic) phenomenology (Cohen & Omery, 1994). Two of the primary differences between these approaches are in how findings are generated and used to supplement professional knowledge (Lopez & Willis, 2004). It is important for the qualitative researcher to understand these differences when designing a phenomenological study.

Descriptive phenomenology. Husserl's (1970) descriptive phenomenological method values the subjective experiences, as perceived by human consciousness, as the primary object of scientific study (Lopez & Willis, 2004). An important component of the descriptive phenomenological method is the belief that it is necessary for the researcher to discard all prior personal knowledge to grasp the essential lived experiences of those being studied (Lopez & Willis, 2004). This means that the researcher must clear his or her consciousness to minimize one's biases (Natanson, 1973). The goal of the researcher is to attain "transcendental subjectivity," meaning that the impact of the researcher on the inquiry is constantly assessed and biases are neutralized, so as not to influence the object of study (Lopez & Willis, 2004, p. 727).

Husserl's drive for phenomenological inquiry was derived from the belief that experimental scientific research could not be used to study all human phenomena and had

become so detached from the fabric of the human experience, that it was, in fact, obstructing our understanding of ourselves (Crotty, 1996; Flood, 2008). Designed to establish a rigorous science that found truth in the lived experience, phenomenology is used to develop insights from the perspectives of those involved who are detailing their lived experiences of a particular phenomenon in their lives (Clark, 2000). This method is about searching for meanings and essences of the experiences through first-person accounts during in-depth informational one-to-one interviews, which are then transcribed and analyzed for themes and meanings (Colaizzi, 1978; Moustakas, 1994) allowing for the experience to be understood.

Interpretive phenomenology. Founded by Heidegger (1962), interpretive phenomenology posits that the relationship of the individual with the world should be the focus of phenomenological inquiry (Lopez & Willis, 2004). Heidegger (1962) asserted that people are entrenched in their world to such an extent that subjective experiences are intricately linked with social, cultural, and political contexts. This assertion is evident in the types of questions asked by interpretive phenomenologists, and how these questions differ from those asked by descriptive phenomenologists. For example, a descriptive phenomenologist studying what it is like to be a healthcare provider living with cancer might ask the general question, “Tell me what it is like to be a healthcare provider and a cancer survivor” and follow up with questions to arrive at common concepts central to the experience. On the other hand, the interpretive phenomenologist would seek to obtain the participant’s description of a typical day in detail as a healthcare provider and cancer survivor, and would encourage the participant to describe interactions, workload, relations to others, experiences of the body in regard to the cancer, etc. (Smith, 1987). The interpretive phenomenologist, rather than seeking purely descriptive categories of the real, perceived world in the narratives of participants (as typically seen in

descriptive phenomenology), will focus on describing the meanings of the individuals' being in the world and how these meanings influence the choices they make (Lopez & Willis, 2004).

While each of these methods has value in the qualitative research venue, the research questions (Appendix C) of this study are more closely aligned with the descriptive phenomenological methodology. Specifically the primary goal of this study was to identify the essence of healthcare providers' experiences when screening for and treating IPV in the MSFW women population. While this goal holds similarities with the tenets of interpretive phenomenology, the primary emphasis was placed on *describing* providers' experiences as opposed to the meanings they ascribe to these experiences. Therefore, for the purposes of this study, descriptive phenomenology was implemented to answer the primary research question for this study: What is the essence of healthcare providers' experiences when screening for and treating IPV in the MSFW women population?

Participants

Purposive sampling techniques were used to recruit participants (Nelson, 1996). Because participants for this study must meet very specific criteria (see Appendix D), purposive sampling was deemed most appropriate. Healthcare providers (e.g., physicians, nurses, medical assistants, mental health providers, etc.) who provide healthcare services to migrant and seasonal farmworking women (MSFW) were invited to participate. Regarding data saturation, one of the unique aspects of qualitative research is the subjective nature of determining when data saturation has been achieved. Because qualitative researchers seek to identify saturation of qualitative themes associated with their topic of study (as opposed to quantitative outcomes), it can be difficult to identify when data saturation has occurred. As Sandelowski (1995, p. 175) states:

Determining adequate sample size in qualitative research is ultimately a matter of judgment and experience in evaluating the quality of the information collected against the uses to which it will be put, the particular research method and purposeful sampling strategy employed, and the research product intended.

Although the exact number of participants to reach saturation is ultimately unpredictable, researchers referred to a review of 57 phenomenological studies, which indicated a mean n of 25 participants with a median of 20 (Mason, 2010). The PI and his research team recognized that saturation had been achieved when there were no new themes being discussed by co-researchers that had not been mentioned in previous interviews.

Participants were screened for the following inclusion criteria before their interview was scheduled: (a) the participants must be clinically-active healthcare providers who provide healthcare services for but not exclusively to the MSFW community and their families; (b) the participants must be bilingual (Spanish & English) *or* fluent in English and have access to a nurse (or other medical provider) who translates into Spanish during patient care; (c) the participants must have provided care for one or more MSFW female patients believed to be experiencing IPV; (d) the participants must be 18 years of age or older. These criteria were determined to be most characteristic of providers likely to address IPV among MSFW women by the primary investigator and his research advisors.

Procedures

Recruitment

Participants were recruited from two sources. First, healthcare providers were recruited from within various community healthcare centers across eastern North Carolina. Additionally, providers were recruited via a listserv maintained by the Migrant Clinicians Network, a national

organization that serves health professionals across the United States (U.S.) who extend healthcare services to MSFW men and women, as well as their families. Because the Migrant Clinicians Network is a national organization, it provided access to healthcare professionals from across the U.S. as opposed to one specific geographical region. A letter of introduction (Appendix D) was distributed via email to healthcare providers across all North Carolina community healthcare centers, in addition to providers identified through the Migrant Clinicians Network. This letter was used to describe the study and provide information for contacting the primary investigator (PI) to schedule an interview. Participants who wanted more information about participating in this study were asked to contact the PI by phone or via email to schedule an interview or ask any questions related to the study.

Data Collection

Data were collected through individual interviews. As stated previously, individual interviews are considered the optimum method for data collection among phenomenological researchers (Van Teijlingen & Ireland, 2003). The advantages to using interviews are that they draw from each participant a vivid picture of the experience, which leads to understanding of shared meanings (Sorrell & Redmond, 1995). This fulfills the goal of descriptive phenomenology – to describe peoples’ experiences of phenomena and how they understand it (Flood, 2008). The process of saturation, or the point at which no new information, dimensions or relationships emerge during analysis (Strauss & Corbin, 1998), guides the length of a descriptive phenomenological interview. While collecting data using interviews can be time consuming and labor intensive (Flood, 2008), researchers can produce meaningful descriptive phenomenological studies if they select and adhere to a set of specific steps for data analysis.

Before scheduling an interview, the PI screened participants via telephone or email to see if they meet the inclusion criteria for this study (Appendix D). If the participants met all of the inclusion criteria, and consented to participate in the study, the PI sent an individualized link so each participant could read and sign the informed consent document (Appendix E) via an online survey tool (Qualtrics). Subsequent to obtaining consent, an interview was scheduled. Each participant was asked to set aside 45 minutes for the interview. Participants were given the option to complete their interviews by telephone or via Skype, a secure and encrypted internet-based video conferencing software (“Skype,” 2013). Ultimately, every participant chose to conduct his or her interview via telephone. Interviews were recorded with a digital voice recorder.

Before beginning the interview, participants were asked to verbally complete the demographic questionnaire (Appendix F), which was read to them by the PI. The PI discussed the potential risks and benefits associated with participating in the study with each participant prior to each interview. The PI informed each participant of his or her right not to answer any question and to end the interview at any time.

Though written or online consent was required, the PI obtained verbal consent from each participant. Once verbal consent was provided, the interview began. Upon completing the interview, the PI thanked the participant and provided him or her with a list of resources related to IPV that could be distributed to interested patients and/or colleagues. This handout (Appendix G) included resources for immediate assistance, and financial and medical resources (the PI verified the validity of these resources for use with the MSFW population via email prior to this study). Finally, the PI made an anonymous \$10 contribution in the participants’ honor to the

National Domestic Violence Hotline. No identifying information about participants was disseminated to this hotline.

Interview structure. The PI utilized the interview guide (Appendix C) to structure the interview. The interview guide method (Patton, 2002, p. 343), which lists questions to be explored, is designed to ensure that each interview follows the same basic format. The interview guide provides topics within which the interviewer is free to explore and probe for further information that is related to the study's guiding research question. The PI began the interview with an organizing, or grand tour, question (Brown & Kimball, 2013; Miller, 2008) and asked participants to describe their experiences with identifying, screening for, and/or addressing IPV among MSFW women (i.e., "How would you describe your experience caring for migrant and/or seasonal farmworking women patients who have experienced intimate partner violence?"). To elicit further detail, various probing questions were also used to encourage participants to elaborate on certain details to achieve clarity and stay close to the lived experience (Starks & Trinidad, 2007). The probing questions are based on findings from a policy brief examining current IPV research on the MSFW population, and on the principles of biopsychosocial-spiritual model (Engel, 1977; Engel, 1980; Wright, Watson, & Bell, 1996). Examples of probing questions include: "In your experience, how prevalent is intimate partner violence among this population?" "What protocols do you follow for determining who and when to screen?" and "What has been the most challenging in your experiences screening for and/or addressing intimate partner violence with migrant and/or seasonal farmworking women?" (For a complete list of probing questions used, see Appendix C). Although no participants reported experiencing secondary trauma exposure that has occurred in the context of treating patients exposed to IPV, the PI was prepared to provide applicable resources if necessary.

Upon completion of the first interview, the PI listened to the taped interviews and reflected on the experiences that the participants had shared. The PI spent time bracketing his own experience of the interview and personal reflections of reactions that he had. Finally, he compiled individual summaries of each interview to return to each participant. Each summary included: (a) a copy of the grand tour and probing questions from the interview; (b) a brief 2-5 sentence summary by the PI of the participant's response; and (c) a few direct quotes from the participant extracted directly from the transcript. Each participant received these summaries at their personal e-mail addresses in order to protect the confidentiality of their individual summaries. Participants were invited to review their individual summaries and to inform the PI if they felt the summary fully captured their experiences, or if they had any additional information to add. Participants had the option to type any additional content they wanted to add or schedule an additional interview with the PI. Of the nine participants who were sent summaries, six indicated that the summary had fully captured their experience, while three participants did not respond. Finally, the PI contacted the participants a third time – to share with them the preliminary findings of the study and to receive feedback about how the findings compared with the participants' experiences (step seven of the data analysis). The e-mail contact was conducted after the initial analyses had been completed in order to complete a member check (Colaizzi, 1978). This step was completed after the PI completed an exhaustive description of the phenomena. All nine participants had previously agreed to be contacted and zero participants had anything additional to share at that stage.

Confidentiality. The confidentiality of participants was protected in a variety of ways. First, at the onset of the study, each participant was assigned a pseudo-name, by which he/she was referred to throughout the analysis phase and in all publications and presentations that will

come from this study. Each participant was assigned an identification number that was written on his or her demographic sheet. A document containing all of the assigned identification numbers was stored on a password-protected computer and was made available to the PI's research advisors for audit and data verification purposes. Additionally, all digital audio files and transcription documents were labeled with the same identification number to allow for cross-referencing with the demographic surveys. Only the PI and research advisors had access to this information.

In addition to each digital file being password-protected, the external hard drive itself required a password to access its contents. All research materials, including the digital voice recorder, demographic surveys, and any notes taken during the interview were stored in a locked filing cabinet in the PI's research office. Access to these materials was granted only to the PI and members of the research team who received UMCIRB and MCN IRB clearance. All transcribed data was saved to a password-protected external hard drive and each data file was password protected as well. The external hard drive was stored in the locked office of the PI. After the digital recordings were transcribed, the PI removed identifying information from the transcripts (e.g., names of specific persons, places, etc). All data will be stored for 3 years from the completion of this study and will then be destroyed.

Data Analysis

There are several distinct methods of analysis available when using a Husserlian descriptive phenomenological approach (Flood, 2008). These are devised by Colaizzi (1978), Giorgi (1985), Moustakas (1994), and Van Kaam (von Eckartsberg, 1998). Although no two of these methods are identical, they share commonalities that reaffirm their utility in phenomenological research. Flood (2008) briefly described the similarities and differences of

these methods. In general, each of these methods relies on qualitative interviews for data collection purposes, but differences lie in how the data is analyzed (see Flood, 2008). Robinson (2006) indicated that Colaizzi's (1978) method is the most user-friendly and can be applied by researchers to provide a clear description of the phenomenon being studied. Colaizzi's (1978) analysis method will be utilized in this study.

Subsequent to the completion of each interview, the PI's research assistant transcribed each audio recording using an electronic word processor program. This research assistant, whose duties included transcribing the interviews only, was formally approved by UMCIRB to assist the PI with transcription. Fidelity checks by the PI helped to ensure uniformity during the transcription process. After all transcriptions were complete, the PI enlisted the help of a triangulated researcher, who did not have access to any identifying information of participants, including audio files. The triangulated researcher, a senior undergraduate student, was selected due to her specific interests in qualitative research, her previous training in research methods, and her demonstrated academic success as evidenced by her class performance and recommendations from her faculty members. With the assistance of the triangulated researcher, the PI utilized Colaizzi's (1978) method for analyzing descriptive phenomenological data, which consists of the following seven steps:

1. The first step was to acquire a sense of each transcript (Colaizzi, 1978). To accomplish this, the PI read through all protocols multiple times to gain a better understanding of the participants' experiences (Colaizzi, 1978). Haase and Myers (1988) recommended listening to each audiotape several times. The PI listened to each audio file while simultaneously reading each transcript several times, while the

triangulated researcher read each transcript multiple times without listening to the audio files.

2. The second step was to “extract significant statements” (Colaizzi, 1978, p. 59) from the transcripts that together form the whole meaning of the experience (Sanders, 2003). The PI coded these statements, and non-relevant or non-significant phrases or sentences were excluded at this point in the analysis process. Significant statements were cross-checked with the triangulated researcher, and were exchanged with the PI’s research advisors for verification purposes. Examples of these significant statements can be seen in Table 1 below. A full list of these significant statements can be found in Appendix H.
3. The third step in this data analysis process was to “formulate meanings” (Colaizzi, 1978, p. 59). During this step, the PI and triangulated researcher formulated more general restatements or meanings for each significant statement extracted from the text. Examples of these formulated meanings can be seen in Table 2 below. A full list of these formulated meanings can be found in Appendix I. Ashworth and Hagan (1993) emphasized the need at this stage for the researcher to identify and acknowledge any biases or presuppositions to avoid any misinterpretation of the participants’ views. An essential aspect of this stage is phenomenological reduction, or “bracketing.” According to Husserl (1964; 1970) and Colaizzi (1973, 1978), bracketing is a crucial prerequisite to any additional steps in the phenomenological research process. Bracketing essentially entails suspending as much as possible the researcher’s meanings and interpretations and entering into the world of the participant (Hycner, 1985). The PI wrote a statement of bias (Appendix J) to assist

- with the bracketing process. Additionally, the triangulated researcher constructed a bias statement (Appendix K) as well. Constructing these bias statements and sharing them among members of the research team decreased the likelihood that these biases would influence the manner in which data were analyzed. All bias statements were shared among the research team to create an open analysis process.
4. The fourth step was to repeat the above steps using only the protocols, and then organize the meanings into “clusters of themes” (Colaizzi, 1978, p. 59). In other words, small clusters of formulated meanings from step III were joined to form thematic clusters. Additionally, during this step, data that did not fall into any of the resulting themes, and was not shared by many participants was placed in a separate category. Finally, thematic clusters were combined into the broadest group of data organization, “emergent themes” (Colaizzi, 1978). See Table 4 below for an example of the development of one emergent theme, “clinic-centered factors,” in this study. A full list of emergent themes and thematic clusters can be found in Appendix L.
 5. The fifth step was to create an “exhaustive description” (Colaizzi, 1978) of the topic using the results from step four. This description was presented as a narrative account, and contained all the dimensions of the lived experiences of the phenomenon being studied for the participants interviewed (Sanders, 2003). Emergent themes, thematic clusters, and formulated meanings were integrated into the description to generate its structure as a whole. This exhaustive description was reviewed by the triangulated researcher for accuracy, and then turned in to the PI’s research advisors for validation. This exhaustive description is provided in the results section.

6. The sixth step was to provide a statement of identification of the organization of the exhaustive description. Specifically, the PI sought to “formulate the exhaustive description in as unequivocal a statement of identification of its fundamental structure as possible” (Colaizzi, 1978, p. 61). Essentially, this is a reduction of the exhaustive description into its essential structure, including a brief description of how the exhaustive description is organized. This statement of identification is provided in the results section.
7. The seventh and final step was to validate the findings. The PI accomplished this in a number of ways. The PI followed Colaizzi’s (1978) recommendation to return to participants. First, the PI emailed a summary of each interview along with a copy of the interview guide (Appendix C) to each participant, asking the participants how the results compared with their experiences. Participants were invited to speak with the PI for a short follow-up interview, and any new data collected was incorporated into the final product of the research findings. Next, the PI emailed each participant a copy of chapter five of this dissertation project, once again inviting them to contribute any additional information they may have. Additionally, the PI’s statement of bias (Appendix J), reflexive journal and audit trail documents were reviewed for final validation. Each of these actions helped to ensure the trustworthiness of the findings.

Addressing Trustworthiness

When conducting qualitative research, it is imperative that the investigator employs strategies for establishing the trustworthiness of the data (Lincoln & Guba, 1985). Establishing verification of the results is “the process of checking, confirming, making sure, and being certain” (Morse, Barrett, Mayan, Olson, & Spiers, 2002, p. 9). In phenomenological research,

the data must reflect the essence of the phenomenon from the participant's perspective to be considered trustworthy (Baker, Wuerst, & Stern, 1992). Although some researchers have argued that reliability and validity were terms pertaining to the quantitative paradigm and were not applicable to qualitative research (Altheide, & Johnson, 1998; Leininger, 1994), others have suggested new criteria for determining reliability and validity in qualitative inquiry (Lincoln & Guba, 1985; Leininger, 1994; Rubin & Rubin, 1995).

In their influential research in the 1980's, Lincoln and Guba established the term "trustworthiness" as a substitute for the traditional quantitative terms of reliability and validity (Morse, Olsen, & Spiers, 2002). Trustworthiness in qualitative research consists of four criteria: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Within these aspects were specific methodological strategies for ensuring that the qualitative study demonstrated sufficient rigor including the audit trail, member checks when coding, categorizing, or confirming results with participants, peer debriefing, negative case analysis, structural corroboration, and referential material adequacy (Guba & Lincoln, 1981, 1982; Lincoln & Guba, 1985).

"Credibility" entails insuring that the findings of the study truly reflect the participants' experiences, similar to the concept of "validity" in quantitative research (Lincoln & Guba, 1985). To accomplish this task, the PI utilized his research advisors and triangulated researcher to assist him in remaining cognizant of his biases (see Appendix J) by assisting with bracketing his experiences so that he could best represent the experiences of the participants (Lincoln & Guba, 1985). Additionally, the PI utilized the triangulated researcher to simultaneously examine each transcript using the steps listed above, and met at least bi-weekly with this additional researcher throughout the data collection, analysis, and writing process. The triangulated researcher also

constructed a bias statement to ensure that these biases do not influence the manner in which data are analyzed. All bias statements were shared among the research team to create an open analysis process. Feedback from the triangulated researcher was integrated into the study's final analysis. Furthermore, the PI maintained a reflexive diary as a means of bracketing his experiences throughout the study.

“Transferability” refers to the criteria that future researchers, who would like to further explore the findings of this study by applying it to another time or place, have sufficient information to deduce the similarities or differences between the “sending and receiving” contexts (Lincoln & Guba, 1985). Transferability is for the qualitative researcher what “generalizability” is for the quantitative researcher (Lincoln & Guba, 1985). In accordance with their recommendations, the PI compiled a thick and detailed description of the time and context in which the research was conducted. Doing so allowed someone interested in making a transfer of the results of this study to another context to make an informed decision (Lincoln & Guba, 1985).

“Dependability” and “confirmability” are interrelated concepts that refer to the criteria that the findings be grounded in sound and reliable methodology (Lincoln & Guba, 1985). These concepts are for the qualitative researcher what “reliability” and “objectivity” are for the quantitative researcher (Lincoln & Guba, 1985). In accordance with the recommendations of Lincoln and Guba (1985), the PI maintained an audit trail and utilized a triangulated researcher to review the transcripts, reflexive journal, analyses, and other related materials to ensure that sound methodology was practiced. The triangulated researcher was utilized by the PI in the phenomenological method and analysis process used. Her feedback was integrated into the final analyses of the study.

Audit Trail Documents

The following documents were included in the audit trail, as indicated above. The purpose of the audit trail documents is to verify the rigor of the study and confirmability of the data collected (Lincoln & Guba, 1985; Patton, 2002). First, each of the following were stored on file: (a) raw audio files, which were stored as indicated above; (b) UMCIRB and MCN approval (and eventually closure) forms; and (c) research articles related to this study. In addition to these, the PI also maintained six working documents during the course of the study, including the following (Knight, 2012):

1. Research Log: a dated, timed log of all activities, contacts, and decision points that occurred during the course of the research study.
2. Field Notes: handwritten notes taken during and after an interview. Notes taken during each interview will be brief, while those taken after expanded upon those taken during each interview.
3. Analysis and Interpretation Memos: electronic notes taken during data analysis about how the researcher is making sense of (analyzing) the data. These memos were stored in a dated, timed log.
4. Reflexive Journal: an electronic, dated diary of the research study. This journal helped the PI stay in touch with his reactions, assumptions, biases, and growing self-awareness about the study, its participants, and the socio-cultural context of the study. The PI also included his personal reactions to the research process in this journal, including (but not limited to) what was going well, what was not going so well, disappointments, disasters, frustrations, challenges, and successes.

5. Code Book: consists of an electronic list of analytical codes and their descriptions/definitions
6. Drafts: working copies of the dissertation document will be saved for further review. Additionally, feedback from committee members was included as each new draft is constructed.

Triangulated Researcher

As mentioned above, the PI utilized the assistance of a triangulated researcher to increase the trustworthiness of this study. Prior to completing data analysis steps as described above, the PI completed a series of training steps with the triangulated researcher. First, the triangulated researcher was provided reading materials pertaining to phenomenological analysis (e.g., Colaizzi, 1973). The triangulated researcher was also required to write a statement of bias (see Appendix K) similar to the PI's (see Appendix J), which was included as an appendix in the final version of this study. Finally, the PI and triangulated researcher completed a trial run through the data analysis steps with a discarded interview. The purpose of this step was to ensure that the triangulated researcher had reached a sufficient level of competency to participate in the data analysis portion of this study. Each of these steps was documented in the research log.

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Table 1

Examples of Significant Statements

Significant Statements	Transcript No.	Page No.	Lines No.
“It’s a national shame that we treat these folks like we do. And that makes me all the more intent on giving them good physical and mental health care.”	3	16	672-675
“I feel like I am comfortable about talking about the issue and asking the questions and listening and like kind of setting a plan...”	4	6	230-231
“Time is a huge barrier for us because we often see the patient once or twice and we’re dealing with all of these other things like diabetes and hypertension and obesity”	4	10-11	427-429
“I mean I hate to say a lot but we have [women who have experienced IPV] frequently.”	6	5	161-162
“Frequently, we would have couples or family members come together now and want to go in one room. Even though we would see them at the same time we do try to...break them up so they have the opportunity if they want to tell anything.”	6	8	300-304
“If they’re coming in for their annual physical then... I’m going to go do my normal screening of tobacco use, alcohol use, substance use ... and, ‘Do you have partner violence?’”	8	6	202-208

Table 2

Examples of Creating Formulated Meanings from Significant Statements

Significant Statements	Formulated Meanings
“It was obvious that she had been beaten. She was afraid, but that’s why she came. Because she felt that she didn’t get... actually it’s not that she didn’t really get the treatment that she needed in Texas but she left before she could complete it.” (Transcript 6, page 6, lines 219-224).	Provider administers IPV screening if physical evidence of violence is present.
“So it’s something we are screening for and actually patients are asked the same question twice once by the midwife at the new O.B. and once before that at intake with the health educator.” (Transcript 1, page 4, lines 123-126).	Provider specifies the time of and/or frequency of IPV screening.
“Something that I try to do is... develop a plan... often times especially with migrant and seasonal workers you’re only seeing them one time... or maybe twice, and then you’re not sure where they’re going to be going next and so... you know there’s a lot of uncertainty, so ... once you know that they are safe, just developing some goals and a plan... like, ‘What are you going to do if you are unsafe’ or ‘who are you going to call?’” (Transcript 4, page 7, lines 281-286).	Provider develops safety plan with patient.
“I wish my Spanish were adequate to really explore this one on one. But I do call in an interpreter in most instances because I’m not 100% sure I’m getting all the information” (Transcript 3, page 12, lines 491-494).	Provider’s inability to speak Spanish is a barrier to effective IPV screening.
“We also developed... a tiny handout that can’t be more than 2 by 4... that they could tuck in a bra... that gave the phone number for the domestic violence” (Transcript 3, page 5, lines 171-175).	Provider gives contact information of resources (e.g., IPV hotline, local agencies) to patient.

Table 3

Development of Emergent Themes

Formulated Meanings	Thematic Clusters	Emergent Theme
<p>Provider indicates required IPV screening protocol used in their practice.</p> <p>Interpreters enable providers to administer IPV screenings to MSFW women who do not speak English.</p> <p>Provider refers patient to on-site social worker, therapist, etc. if IPV is disclosed or if they feel uncomfortable addressing IPV.</p>	<p>Some clinics have protocol/resources in place to address IPV with patients.</p>	<p>Clinic-Centered Factors</p>
<p>Provider indicates a lack of required IPV screening protocol used in their practice.</p> <p>Provider experienced resistance from employer regarding IPV screening/response protocol.</p> <p>Provider indicates clinic general protocol (e.g., what happens during intake) getting in the way of addressing IPV.</p>	<p>Some clinics unintentionally create barriers to effectively addressing IPV with patients.</p>	

CHAPTER FIVE: HEALTHCARE PROVIDERS' EXPERIENCES SCREENING FOR
INTIMATE PARTNER VIOLENCE AMONG MIGRANT AND SEASONAL
FARMWORKING WOMEN: A PHENOMENOLOGICAL STUDY

“It’s a national shame that we treat these folks like we do. And that makes me all the more intent on giving them good physical and mental health care.” ~ Donna, a participant in this study

The aim of this phenomenological study was to explore the experiences of healthcare providers who have screened for and/or addressed intimate partner violence (IPV) with migrant and seasonal farmworking (MSFW) women patients. MSFW patients experience greater levels of IPV than the general population (Hazen & Soriano, 2007), but few healthcare providers screen their patients for IPV (Jonassen & Mazor, 2003; Smith, Danis, & Helmick, 1998). This study utilized Husserlian descriptive phenomenology (Husserl, 1970) to explore the experiences of nine healthcare providers who have screened for and/or addressed IPV with MSFW patients. Data were collected using in-depth, semi-structured interviews and analyzed using Colaizzi’s (1978) seven-stage framework. The phenomenon of participants’ experiences is captured in four emergent themes: (1) provider-centered factors; (2) patient-centered factors; (3) clinic-centered factors; and (4) community-centered factors. Participants experienced numerous barriers to effectively screening for and addressing IPV with their patients – some from their own lack of resources and/or comfort with the topic of IPV, and some from the resistance experienced from the MSFW patients. Participants recognized the need for healthcare providers to screen MSFW patients for IPV and for changes in clinical practice to be made to better support healthcare providers. Equipping providers with knowledge about IPV among the MSFW community and

available resources will improve their self-assessed competence as well as their ability to effectively address IPV with their MSFW patients.

Introduction

Intimate partner violence (IPV) is a pervasive public health problem (Garcia-Moreno, Jansen, Ellsberg, Heise. & Watts, 2006) with serious consequences for women's health (Campbell, 2002). Migrant and seasonal farm working (MSFW) women are particularly at risk of experiencing IPV because of cultural beliefs, environmental factors, and health disparities (Denham et al., 2007; Duke & Cunradi, 2011; Lambert, 1995). Despite previous researchers indicating that IPV screenings in healthcare settings increases IPV identification rates (e.g., Nelson, Bougatsos, & Blazina, 2012; Ramsay, Richardson, Carter, Davidson, & Feder, 2002), and previous reports that MSFW women report higher rates of IPV than the general population (Hazen & Soriano, 2007), many providers opt not to screen for various reasons (Jonassen & Mazor, 2003; Smith, Danis, & Helmick, 1998). The authors present the findings of a study that examined the experiences of healthcare providers who have screened for IPV among MSFW women patients using a phenomenological qualitative tradition.

Literature Review

IPV is considered to be the primary cause of injury to all women ages 15 to 44 (Graham-Bermann, 2001) and has resulted in significant inpatient and outpatient health costs (e.g. medical costs incurred treating injuries from IPV) and devastating social and family intergenerational consequences (McCord-Duncan, Floyd, Kemp, Bailey, & Lang, 2006). More than 1 in 3 women (35.6%) in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011). Among MSFW women, physical violence victimization ranged from 18.5% (Hazen & Soriano, 2007) to 20% (Rodriguez, 1998) within the

previous year, and between 19% (Van Hightower, Gorton, & Demoss, 2000) and 33.9% (Hazen & Soriano, 2007) over one's lifetime. Hazen and Soriano (2007) also identified a 20.9% lifetime prevalence rate of sexual coercion among MSFW women, with 14.4% reporting having experienced it within the previous year alone.

Risk Factors for IPV

Studies among general population samples reveal that IPV prevalence is highest among members of racial or ethnic minority groups, younger couples, and couples with factors associated with low socioeconomic status (SES), such as unemployment and low income (Duke & Cunradi, 2011; Field, Caetano, & Nelson, 2004). Furthermore, stressors related to immigration, acculturation, language assimilation, legal, and economic pressures have the potential to exacerbate IPV (Mattson & Rodriguez, 1999). The undocumented status of MSFW women contributes to persistent discrimination and diminished options to promote advocacy and equality in various settings, including work, health care, and social areas (Duke & Cunradi, 2011). Lack of English proficiency and fewer work options contributes to fewer social relationships and greater isolation, both of which may increase the occurrence IPV (Duke & Cunradi, 2011). Other variables of work stress (e.g., low income, unemployment) (Cunradi, Todd, Duke, & Ames, 2009), and male work status (i.e., "low-status" jobs) (Fox, Benson, Demaris, & Van Wyk, 2002) have been associated with IPV as well (Duke & Cunradi, 2011). Heavy alcohol consumption is also considered a risk factor for IPV perpetration among MSFW men. One team of researchers indicated that males were six times as likely to abuse their female partners if they abused drugs and/or alcohol (Van Hightower, Gorton, & DeMoss, 2000). Gender disparities resulting from acculturation stress have been demonstrated to increase the

incidence of IPV among this population (Adames & Campbell, 2005; Klevens, 2007; Mattson & Ruiz, 2005).

MSFW are among some of the most disadvantaged, medically underserved populations in the U.S. (Slesinger & Ofstead, 1996). Various factors including poverty, frequent mobility, low literacy, language and cultural barriers impede MSFW access to social services and cost effective primary health care (New York State Department of Health, 2007). Awareness of available resources (e.g., women's shelters, police, domestic violence hotlines, etc.) among MSFW women is low as well. Specifically, Kugel et al (2009) indicated in their study that only 22% of MSFW women respondents were aware of available resources (e.g., shelter, legal services, police, etc.), but 87% indicated that they would seek help if they were in a violent relationship and were aware of available means of assistance.

Intimate Partner Violence Screening

Routine screening for IPV in healthcare settings could identify women at risk and lead to interventions that reduce violence and improve health outcomes (Nelson et al., 2012). Although IPV screening is recommending by the Institute of Medicine (IOM, 2011) and several professional organizations (e.g., American Congress of Obstetricians and Gynecologists, 2013), most providers do not routinely screen for IPV (Colarossi, Breitbart, & Betancourt, 2010).

Barriers to IPV screening. Previous studies indicate that providers report numerous barriers to screening for IPV including lack of time (Colarossi et al., 2010), training (Colarossi et al., 2010; Waalen, Goodwin, Spitz, Peterson, & Saltzman, 2000), referral resources (Colarossi et al., 2010), and/or self-assessed competence in identifying IPV (Jonassen & Mazor, 2003). Other barriers include lack of confidence in the ability to make referrals, discomfort in asking the IPV screening questions, and no ready access to medical social workers (Jonassen & Mazor, 2003).

Barriers to disclosing IPV among MSFW patients have been indicated as well and include feeling ashamed or embarrassed (Murdaugh, Hunt, Sowell, & Santana, 2004), inability to speak English and no access to a translator (Murdaugh et al., 2004), fear of being deported or separated from their family (Kim-Godwin & Fox, 2009; Van Hightower et al., 2000), fear that their abuser would find out and make things worse (Murdaugh et al., 2004), and illiteracy (Eng et al., 1998). These barriers prevent healthcare providers from effectively assessing for IPV and providing assistance to patients as needed. Furthermore, it is possible that the patient barriers to disclosing IPV may reinforce provider barriers to screening for IPV and vice versa.

The Current Study

Researchers have examined screening practices in healthcare settings (e.g., Colarossi et al., 2010; Macmillan et al., 2009; Nelson et al., 2012) but none have exclusively focused on the screening of MSFW women. The purpose of this study was to examine healthcare providers' experiences screening for and treating IPV among MSFW women patients.

Method

Design

Husserlian descriptive phenomenology (Husserl, 1970) was chosen for this study to describe the lived experiences of healthcare providers screening for and treating IPV among MSFW patients. This particular method values the subjective experiences, as perceived by human consciousness, as the primary object of scientific study (Lopez & Willis, 2004). The goal of the researcher is to attain "transcendental subjectivity," meaning that the impact of the researcher on the inquiry is constantly assessed and biases are neutralized, so as not to influence the object of study (Lopez & Willis, 2004, p. 727). As the researcher responsible for data collection and analysis, the primary author (JBW) acknowledges his biases that may result from

his privileges as a white, heterosexual, upper-middle class male who has never personally experienced IPV. The PI bracketed his experiences by compiling a statement of bias that was made available to all members of the research team in addition to composing a reflexive diary to write down his thoughts, feelings, and perceptions throughout the research process (Chan, Fung, & Chien, 2013). A triangulated researcher and reflexive diary were utilized to reduce the possibility that these biases could unintentionally influence the data.

Participants

Purposive sampling techniques were used to recruit participants from across the United States. The Migrant Clinicians Network (MCN; www.migrantclinician.org), an organization that serves healthcare providers who serve MSFW patients and their families, assisted the PI with recruiting participants from within their network of members. Participants were contacted via email with a letter of introduction (Appendix A), inviting them to participate in the study. In order to participate in this study, participants had to: (a) be clinically-active healthcare providers who serve the MSFW community; (b) be bilingual in English and Spanish or have access to a translator; (c) have treated MSFW patients who have experienced IPV; and (d) be 18 years of age or older. Of the 18 participants invited to participate in this study, ten agreed to participate. One interview, however, was discarded because the length of the interview was shortened due to technology difficulties and the participant was unavailable for a follow-up interview.

All nine participants were female healthcare providers ranging in age from 29 to 75 years. Three participants were bilingual in English and Spanish and six participants spoke English only. Six participants were white, two were Hispanic/Latino, and one was African-American. Participants from three different regions in the United States were included. Table 1 provides demographic information of the 9 participants included in this study.

Data Collection and Analysis

Data were collected using in depth, semi-structured individual guide (Patton, 2002; see Table 2). Interviews were designed to answer the grand-tour question, “How would you describe your experience caring for migrant and/or seasonal farmworking women patients who have experienced intimate partner violence.” The interviews, which were conducted via telephone and lasted 30-45 minutes, were audiotaped and transcribed.

Data analysis was conducted using Colaizzi’s (1978) phenomenological analysis framework (Table 3). To become familiar with the data, the PI listened to each audio recording and read each transcript several times. Significant statements were then extracted from the transcripts directly and each statement was assigned a formulated meaning. Common formulated meanings became evident and were organized into thematic clusters. In order to establish verification of the results of this study, Lincoln and Guba’s (1985) four criteria of credibility, transferability, dependability, and confirmability were used to enhance the rigor of this study (Table 4). These thematic clusters were reviewed using Lincoln & Guba’s criteria and eventually collapsed into 13 thematic clusters and then four emergent themes common to all participants’ experiences (Table 5). Selected examples of narratives and emergent theme formation are included in Table 6.

Ethical Considerations

This study was approved by the University and Medical Center Institutional Review Board (UMCIRB) at East Carolina University, and the Migrant Clinicians Network Institutional Review Board (MCN IRB). Confidentiality of participants was ensured in a variety of ways. Pseudo-names were assigned to participants and utilized in transcripts and written accounts of the results of this study. Identification numbers were assigned to all raw data (i.e., audio files of

interviews and demographic information documents). In addition to each digital file being password-protected, the external hard drive itself required a password to access its contents. All research materials, including the digital voice recorder, demographic surveys, and any notes taken during the interview were stored in a locked filing cabinet in the PI's research office. Access to these materials was granted only to the PI and members of the research team who received UMCIRB and MCN IRB clearance. All transcribed data was saved to a password-protected external hard drive and each data file was password protected as well. The external hard drive was stored in the locked office of the PI. After the digital recordings were transcribed, the PI removed identifying information from the transcripts (e.g., names of specific persons, places, etc). All data will be stored for 3 years from the completion of this study and will then be destroyed.

Findings

The findings revealed four emergent themes, 13 thematic clusters, and 108 formulated meaning statements, and 391 significant statements, which reflect the essence of the experiences of screening for IPV among MSFW women patients for healthcare providers. The emergent themes revealed by this study include: (a) provider-centered factors; (b) patient-centered factors; (c) clinic-centered factors; and (d) community-centered factors. Under each emergent theme below, a brief overall summary statement and detailed summary of each thematic cluster is provided. A summary of the thematic clusters and emerging themes is provided in table 5. Lastly, an exhaustive description was developed from the findings to highlight the essence of the participants' lived experiences and reflect the essential structure of the phenomena under investigation (Colaizzi, 1978).

Emergent Theme 1: Provider-Centered Factors

Participants shared their personal experiences with implementing and utilizing IPV screening protocols, responding to patient disclosures of IPV, and encountering barriers to screening for and addressing IPV with their patients. The following thematic clusters illustrate these experiences.

Thematic cluster 1a: Screening protocols. Participants discussed various components of the IPV screening process, such as determining when, whom, how (e.g., verbal or written, how frequently), and where to screen. Eight participants indicated that they typically administer verbal IPV screenings. Brenda described one of the screening questions she usually administers, “Have you ever been hit, kicked, slapped called names?” ... it’s very, very specific.” Connie added, “We ask it on our health histories actually to everybody. We ask, ‘Do you feel safe in your home?’ ... and we ask men... everybody.” Carol contributed, “That was one question we always had to ask them when we did the interview on them... Is, ‘Have you ever been kicked, punched, hit, threatened in your home?’”

Six participants commented on their experiences of determining whom and when to screen. Some participants indicated that they would screen for IPV if they suspected it. For example, Erin indicated, “I would definitely address it if the answer was yes or if the patient brought it up to me. If I suspected it I would address it, but I wouldn’t go fishing for it.” Sharon added, “Most of the time if the patient comes in for falls or injuries, the provider will ask them about...any violence or anything.” Other providers, like Karen, indicated that they screen for IPV during routine questionnaires. Specifically, Karen indicated, “It’s a screening question so I always screen for [IPV] during my questionnaires so, there are a couple different times that...it would be brought up.”

Five participants indicated that the provider typically initiates conversations about IPV, whereas only two participants indicated that the patient normally initiates such conversations. Brenda, one of the participants who routinely initiates conversations of IPV with patients, commented, “[IPV is] something we are screening for, and actually patients are asked the same question twice, once by the midwife at the new O.B. and once before that at intake with the health educator.” Comparatively, Karen indicated, “Probably [patients] bring it up to me most often, because if they’re at the point of being willing to talk about it, or if they’re coming in to talk about anxiety or depression then...that’s pretty frequent.”

Participants discussed various other screening protocols as well. Three participants indicated screening for IPV when patients present with depression or anxiety symptoms. Two participants commented on each of the following: (a) determining who to screen (e.g., everyone, only females, only MSFW women, etc.); and (b) discussion of sex, HIV, contraception, etc. with patients. Donna discussed her experiences determining whether to screen patients individually or as part of a group, “We concluded: we need to do this on an individual basis rather than a group discussion.” Finally, Connie described her experience discovering IPV while the patient was in labor/delivering a child:

I realized I had to ask her to move her hair...she had this long thick hair that she had wrapped all around her. And I had to lure her boyfriend out of the room... and anyways ... here she is 9 months pregnant having a baby and he had tried to kill her. He had tried to strangle her. She had these horrible bruise marks all over her neck and her chest. Oh my god it was horrible.

Thematic cluster 1b: Provider response to patient disclosures of IPV. Participants described several aspects of their own experiences responding to MSFW patient disclosures of IPV. All nine participants commented on their self-assessed confidence/comfortability with screening for and responding to IPV with their MSFW patients. Erin described her experience, “I feel like I am comfortable about talking about the issue and asking the questions and listening and like kind of setting a plan.” Sharon added, “I feel comfortable with it. But I would definitely notify the provider and... the medical family therapist...to intervene, so they could have somebody else to talk to.” Some participants indicated that, while they are comfortable discussing IPV, they are not confident in their ability to effectively respond to patient disclosures of IPV. For instance, Lucy commented, “I have no trouble having the conversation about what’s going on with them. Now, I do not feel perfectly comfortable figuring out what to do about it.”

Four participants described their experiences encouraging patients to advocate for themselves. For instance, Sharon explained, “[MSFW patients] don’t know that it doesn’t have to be that way over here. And once they learn that... that’s when it changes.” Donna shared her experience as well, “I can make clear that that is not acceptable ‘that someone pounds you because you didn’t cook the right frijoles.’” Four participants indicated extending verbal support to their patients. For instance, Erin indicated that, “Well just questions like, ‘What happened?’ If they don’t feel safe definitely that’s the first thing I’ll address. Like, ‘Why don’t you feel safe?’, ‘Who is making you feel unsafe?’...find out what their situation is and what’s going on.”

Three participants described their experiences with formulating a safety plan with patients. Erin discussed the challenge of creating a safety plan with patients you only see once or twice, “Something that I try to do is... develop a plan... often times especially with migrant and seasonal workers you’re only seeing them one time... or maybe twice, and then you’re not sure

where they're going to be going next." Two participants indicated that they empower patients to make informed decisions about responding to IPV. Furthermore, two participants explained that they report IPV to the police regardless. Brenda commented, "If someone reports violence, we call the police... if we see bruising we have to call the police." Erin indicated that she only addresses IPV if she suspects that IPV is occurring by evaluating the severity of the situation and the safety of the patient.

Thematic cluster 1c: Provider-reported barriers to IPV screening. All participants indicated barriers that make IPV screening among MSFW patients more difficult. Five participants reported lack of resources (or awareness of resources) available to patients as a barrier to screening for IPV. For example, Lucy described her experience, "When it comes time to figure out, 'Okay well what are we going to do about this?' That's where I feel like I'm not equipped... I feel equipped to talk but not equipped to act." Three participants described the importance of establishing and keeping the trust of her patients before screening for IPV. Lucy indicated, "If I don't have a good rapport with my patients before I start asking such serious questions, I do worry that I'm not going to be as helpful as I could." Three participants described their inability to speak Spanish as a barrier to IPV screening. Donna commented, "I wish my Spanish were adequate to really explore this one on one." Additionally, three participants identified patient accessibility as a barrier to screening for and addressing IPV. Karen described her experience, "I'm not able to follow-up and I don't know what's going on, if they're okay, or if they need further assistance. I can't keep in contact with them because they're migrant." Other barriers described by participants include lack of priority (when other medical needs are present) for IPV screening for providers (n=1), and lack of time with patients to fully address all presenting patient concerns (n=1).

Thematic cluster 1d: Access to resources/services. Participants commented how access to various resources for MSFW patients experiencing IPV both on-site and out in the community can be helpful. Two participants believed that access to additional professionals (e.g., social worker, medical family therapist) could be helpful in addressing IPV with patients. Two participants described their experiences with providing patients contact information for local resources. Donna described a resource developed by her colleagues for MSFW patients who have experienced IPV, “We also developed...a tiny handout that can’t be more than 2 by 4 [inches]... that they could tuck in a bra... that gave the phone number for the domestic violence [hotline].” One participant, Carol, emphasized the importance of having IPV resources available. Furthermore, Karen indicated that she had distributed phone resources such as, the National Domestic Violence Hotline (www.thehotline.org; available in Spanish) to MSFW patients. Three providers described a general feeling of understanding of the available resources for MSFW patients experiencing IPV. For instance, Brenda indicated, “I feel like our community...now, offers good resources and it... it’s not dependent on having a social security number.” Erin added, “But where I am, because it’s a Federal Qualified Health Center, and we have lots of resources [for the MSFW population].”

Thematic cluster 1e: Healthcare system improvements for MSFW IPV treatment. Participants discussed changes that they believed necessary, ranging from healthcare provider trainings to adaptable, culturally sensitive IPV response protocols. Seven participants believed that trainings regarding IPV were needed for healthcare providers working with MSFW patients. Erin indicated, “I just wish I had like more...knowledge about it or better ways to go about it...I feel like I haven’t had any real training on it so I’m just doing [my] best.” Carol mentioned that IPV trainings are not offered at her place of employment, “[Training] is not an option... it’s not

that it's not an option but that is not available here." Bonnie also suggested the utility of provider trainings about IPV among MSFW patients, "[My employer] could offer something... Maybe once a year, if...[my employer] wanted to bring in someone to bring up the latest resources and the latest things that are available." Two participants disclosed their belief that healthcare providers need to be doing more to help MSFW patients who are victimized by IPV. Donna commented, "It's a national shame that we treat these folks like we do. And that makes me all the more intent on giving them good physical and mental health care."

Two providers suggested the development of a standardized IPV screening tool for MSFW patients. Erin later suggested the development of a standardized IPV screening tool for MSFW patients:

Yeah what I really like...when we... for example depression, those PHQ9 screening tools ...I think it's a really nice thing and something that might be beneficial for me because it's...clear cut questions, it gives you an open door to talk and to really divide out what they're going through, so... that would be helpful.

Thematic cluster 1f: Providers are confronted by patients' partners. Participants discussed their experiences interacting with MSFW patients' partners and the impact that these interactions have had on their attempts to address IPV with patients. Five participants indicated feeling uncertain about further violence, or denial of medical care from partners after patient discloses IPV. Sharon described her experience, "Then I don't know if they get scared or they have second thoughts, [but] then they leave. Sometimes we don't see them again. So you don't know whether they're okay or they're not ok... and that bothers [me] sometimes." Karen added, "Of course I worry that...if I address this with them... that there's going to be a negative impact when they get home." Two participants described attempting to separate partners from patients.

Karen described, “Somehow we figured out a way to keep the husband in the waiting room and got the patient back to the exam room by herself.” One participant, Connie, described her fears for her own safety during a previous encounter with a patient’s partner:

I wasn’t terrified of [the partner], although when the... cops came to talk to her they told me...he was from some particularly horrible group of gang people...and they told me that I should have security escort back and forth from my car for a few months.

Emergent Theme 2: Patient-Centered Factors

Participants shared several patient-centered factors (i.e., lived experiences and circumstances of MSFW patients observed by participants) pertaining to IPV screening and treatment of their MSFW patients including various forms of IPV, differences in responses to IPV perpetration, and barriers to IPV disclosure among MSFW women. The following thematic clusters illustrate these factors.

Thematic cluster 2a: Various forms of IPV among MSFW patients. Participants described their experiences treating multiple forms of IPV presented by MSFW patients. Three participants indicated that IPV often occurs during pregnancy within the MSFW community. Brenda commented, “They often start... actually the abuse during pregnancy... it’s a big deal.” Erin indicated that, in her experience, MSFW patients feel a greater need to hide the IPV when they are pregnant, “I’d say 70% of the women I see are pregnant so it’s even more of a big secret to hide it...because they’re under all this family stress, they’re having a baby.” One participant, Carol, indicated that MSFW patients often present for treatment after being raped by their partners:

So they come in and they’re very upset. They want to be tested for STDs, because they have been raped by someone that they know. Maybe that has been a previous boyfriend

or maybe even in a relationship that they were in at that time. But they were not a willing participant.

Participants also spoke of various cultural traditions among the MSFW population that cause or intensify IPV. Two participants indicated that some of the MSFW patients had been raped by men other than their partners. Connie added that violence during pregnancy often occurs by men other than the patient's partner as well. Participants indicated that violence does not necessarily stop after a patient discloses IPV either. For instance, Lucy described one experience where a patient had reported her partner for IPV and he was subsequently deported. Later, the patient's partner was threatening her family of origin with violence, and the partner's family was threatening the patient with violence as well. Bonnie described that violence in MSFW relationships often involves violent behaviors from both partners.

Thematic cluster 2b: Responses to IPV among MSFW women. Participants described their experiences observing the responses of MSFW women to being victimized by IPV by their partners and being screened for IPV by their healthcare providers. Carol noted that variability is evident regarding when patients disclose IPV to providers. Five participants described how patients respond to being asked about their interest in intervening in an abusive relationship. For instance, Donna explained, "So often, the person's response is, 'Oh I don't think it's dangerous... It's only if I don't cook on time...' Those kinds of responses." Connie added, "I've had...over the years maybe 10 or 15 women who've... admitted to what was going on but...couldn't do anything about and didn't want to do anything about it and weren't willing to accept any kind of help." Carol indicated that many patients blame themselves for the violence they are enduring. Similarly, Connie explained that some patients simply refuse to accept

services or assistance from their healthcare providers. Contrastingly, two participants described instances when patients had asked them to call the police. For example, Brenda described:

[Patients are] very receptive of having us calling the police on their behalf. Very receptive. It's sort of like...they want to do it...but for whatever [reason] they're afraid... and are relieved that we do it and then they can say, 'Well they had to... I didn't have any choice.

Brenda explained that many of her patients actually have a plan, or safety plan, in place for violent situations, which often includes calling the police. Two participants indicated that patients had disclosed that their partners were currently in jail.

Thematic cluster 2c: Barriers to disclosing IPV or seeking resources. Perhaps one of the most heavily discussed thematic clusters involved barriers for MSFW patients to disclosing IPV and seeking resources to help end the violence. Eight participants indicated that having partners or other family members in the room is often a barrier to IPV disclosure for patients. Sharon spoke of her experience, "I noticed that if the husbands come in with them, [the patients] don't say anything." Bonnie added, "A lot of times the partner is present, because he's the one paying... So, being careful because even you're asking him to step out it may already send red flags to him." Donna added that many of her MSFW patients feel obligated to maintain their role as family caregiver, despite having to endure violence.

Four participants reported lack of transportation as a barrier to IPV disclosure as well. Sharon explained, "It's those who... have limited English that have to depend on [their partners] to take them to the doctor. They don't have [a driver's] license so they have to depend on them to do everything." In addition to transportation barriers, five participants described the financial barriers reported to them by many of their MSFW patients. Connie indicated:

I think the fear is that... if they get rid of the boyfriend or if they try to leave him... well then what's their other choice? They can't make enough money on their own, then they have to go to back to their home family in Mexico who will look at them like a failure. Furthermore, four participants also described language barriers that are present for many MSFW women. Karen commented on the language barrier, "So that tends to be a very large barrier, the language barrier. It doesn't mean that they're not going to open up and talk to me. It just means that it's going to be a little bit more difficult." Three participants indicated that patients tend to be unaware of the resources available to them as IPV victims. For example, Brenda described, "Very, very unaware. Yeah. Very, very unaware. I think they think it's either they get the guy arrested or nothing." This unawareness, according to Brenda, is one reason why MSFW patients do not seek resources to aid IPV victims. Additionally, Donna indicated that MSFW patients often have no access to health insurance and mental health services.

Seven participants indicated immigration status of patients (including fear of deportation) as a barrier to disclosing IPV. Erin described her experience, "A lot of our patients are undocumented, so calling the police and sending their spouse to jail where there's the possible deportation or on the other side where [our patients] might get deported. That's a huge thing for people." Four participants indicated confidentiality/privacy barriers to IPV disclosure for MSFW patients, especially when delivering medical services at the migrant camps. Erin described her experience, "A lot of times when we go see patients we're in an area... we don't have an exam room so we set up in barns or community centers and so there's not a lot of privacy so that's a barrier." Finally, two participants described that the gender of healthcare providers as a hindrance for some MSFW patients to disclosing IPV. For instance, Carol

described, “The females a lot of times might not want to speak with Dr. Jones because he’s a male... And I would try to put them with a female.”

Emergent Theme 3: Clinic-Centered Factors

Participants revealed clinic-centered factors including screening protocol/resources in place to address IPV with patients, and unintentionally-created barriers to effectively addressing IPV with patients created by some clinics. The following thematic clusters illustrate these factors.

Thematic cluster 3a: Clinic protocol/resources for IPV screening. Participants described available resources within their clinics to assist providers in addressing IPV with MSFW patients. Six participants indicated that they refer patients to on-site social workers, medical family therapists, etc. if IPV is disclosed or if they feel uncomfortable addressing IPV with their patients. For example, Brenda mentioned a few such resources available on site in her clinic, “We have a whole behavioral health component of our clinic so they can get free counseling services... We have our own social worker that specializes... in prenatal and perinatal issues.” Karen added, “If there’s a MedFT available onsite I always bring in the MedFT. I think there’s always resources that I don’t have...I think a group approach is always more helpful than a...singular provider approach.” Interestingly, only one participant indicated that IPV screening of MSFW patients was required at her place of employment. Three participants explained that, in their experiences, interpreters had enabled them to administer IPV screenings to MSFW patients who do not speak English. Donna noted, “I wish my Spanish were adequate to really explore this one on one. But I do call in an interpreter in most instances because I’m not 100% sure I’m getting all the information.”

Thematic cluster 3b: Clinics can create barriers. While most participants indicated that the clinics at which they work have some resources available to assist with screening for and addressing IPV with their MSFW patients, some participants indicated that the clinics could unintentionally create barriers for providers as well. Erin was one of three participants who indicated no IPV screening protocol in place, “Yeah I don’t have any screening that we have here that we use.” Carol shared that she was once turned away by her employer when she suggested a change in the way that her clinic currently addressed IPV, “I think when I first came here I did bring it up... and then I kind of backed off because I thought they’d think I’m crazy. Like, ‘Look at all the things we could be doing.’”

Emergent Theme 4: Community-Centered Factors

Participants discussed the unique community-centered factors associated with IPV within the MSFW community including IPV prevalence, available resources for MSFW women experiencing IPV, and outcomes for IPV victims and perpetrators within the MSFW community. The following thematic clusters illustrate these factors.

Thematic cluster 4a: IPV is a considerable problem. Participants discussed the prevalence of IPV among the MSFW community, and all nine participants agreed that the prevalence of IPV among the MSFW community is substantial. Sharon indicated, “I think [IPV] is pretty common with the migrant [population].” Carol added, “I mean I hate to say a lot but we have [women who have experienced IPV] frequently.” Brenda concurred, “I am afraid that [IPV among this population] is very high.” Bonnie compared IPV among MSFW to the general population, “More often. A lot more often. Yeah. I would say like... at least in the 80%... 80-85.” One participant indicated that IPV among MSFW women happens frequently at homeless shelters. Another participant, Bonnie, indicated that IPV actually decreases once a family is in

the United States for a while, contrary to the findings presented by previous researchers (e.g., Adames & Campbell, 2005; Klevens, 2007; Mattson & Ruiz, 2005), “A lot of times if they’re from Mexico or from Central America, then the violence ... sometimes it either stops or it...gets reduced a lot when they move into the U.S.”

Thematic cluster 4b: MSFW cultural factors exacerbate IPV. Participants discussed numerous unique cultural factors in the MSFW community that exacerbate IPV. Seven participants described how traditional gender roles in the MSFW community influence the prevalence of IPV among their patients. Lucy explained, “I hear other patients talking about how their husbands expect them to have food on the table and expect them to do this or that with the children, which I don’t hear my non-migrant patients talking about.” Donna added:

Women who are may be in the United States, especially for the first time, and who are not documented, tend to be quite submissive to the male partner. I think they have trouble believing that they can make some decisions or stop the partner... stop the partner’s actions.

Three participants described that the presence of children in the family increased their overall sensitivity and desire to screen for IPV. Karen specified:

Of course I’m considering if...there’s domestic violence going on with the partner, if there is going to be domestic violence going on with the children as well... That makes it...an easier end road for reporting and for getting the process started because if there is [domestic violence] ... it’s not necessarily a reportable offense for an adult but it is a reportable offense for a child.

Erin and Carol indicated that stressors of being away from family might intensify IPV. Two participants, Brenda and Erin, discussed the common co-occurrence of drug/alcohol abuse and

IPV. Brenda noted, “It’s alcohol and substance abuse... it’s almost like it goes hand-in-hand. I mean, maybe not 100% but you know...” Donna and Connie described situations in which abused MSFW patients and their families took the abusive partner back into the family following the occurrence of IPV. Connie gave the following case example:

I actually did have a lady once...when I was a brand new midwife and I was all energetic and stuff... and she did say she wanted to leave her guy. And she came to the clinic and the idea was that she was going to leave straight from the clinic to the safe house. And she did that, but then she was back a couple weeks later with the guy... so it didn’t work out.

Bonnie described that patients within the MSFW community normalize IPV as part of life, and that she often worries that violence will extend beyond the partner relationship to other members of the family. Brenda emphasized that the MSFW community maintains a cultural independence from mainstream society. Additionally, Donna explained that stressors associated with immigration status and occupational stressors among IPV perpetrators may exacerbate IPV. Carol emphasized that family values are evident in the MSFW culture. Connie indicated that MSFW families migrate around the country to maintain work, and that the MSFW culture values gentle interactions with children.

Thematic cluster 4c: Communities provide resources to aid IPV victims. Participants discussed various resources available within their communities for MSFW patients who have experienced IPV. Three participants indicated having access to local resources within the community to aid MSFW women experiencing IPV. Carol indicated having access to a safe house to send patients to, “We knew exactly... who to put them in contact with, number to give them, you know like Safe House.” Brenda indicated that local churches and other community

resources are available as well, “We have connections with the churches... We’re well connected with the community and therefore we can connect our patients with their community resources.” One participant, Donna, later described one case example where she actually drove one of her patients from a dangerous home environment to a local shelter, “We had the capacity to just load up that family and bring them back to [my town] about 150 miles from the small city, which we did.”

Thematic cluster 4d: Outcomes for IPV perpetrators vary. Participants described a few different outcomes that they had observed for IPV perpetrators in their experiences. Four participants indicated that IPV perpetrators were required to serve jail time as a result of their violence. Donna described a specific example of an encounter she had with a MSFW patient, “This woman was really very frightened of the husband... and as it happens... he was sent to jail.” One participant, Lucy, reported that the partner of one of her patients was actually deported as a result of his violent behaviors, “She reported her husband, and he was deported for the domestic violence.” Finally, one participant indicated that a local women’s shelter would not accept the teenage son of one of her patients who had decided to leave her abusive partner.

Exhaustive Description

Healthcare providers who serve the MSFW community display considerable passion, dedication, and commitment towards caring for MSFW women who have been victimized by IPV. A competent practitioner must not only have the necessary skill set and training to administer IPV screenings, but also the awareness of available resources to aid MSFW women who have been victimized by IPV. When these healthcare providers administer IPV screenings or address IPV with their MSFW patients, they recognize their influential position to assist victims of IPV. Despite their desire and willingness to lend aid, many healthcare providers feel

unequipped (e.g., lack of IPV training, lack of awareness of available IPV resources) to respond in such a manner that equips their patients with the knowledge and resources necessary to escape dangerous relationships. In addition to feeling unequipped, healthcare providers face several barriers to screening for and addressing IPV with MSFW patients, some of which are provider-related (e.g., inability to speak Spanish), some patient-related (e.g., lack of patient accessibility), and some clinic related (e.g., lack of required IPV screening protocol). Despite these barriers, healthcare providers recognize the importance of IPV screening among MSFW women. Additionally, healthcare providers observe various outcomes among IPV perpetrators (e.g., going to jail, being deported).

Although many healthcare providers feel confident in their abilities to discuss IPV with MSFW patients, most indicated a sense of uncertainty in their ability to truly help their patients without placing them at risk for further abuse. Because MSFW patients often present for their medical visits with their partners, healthcare providers struggle to effectively and discreetly screen for and address IPV with their patients. Providers believe that being as educated and informed as possible about the multifaceted problem of IPV among the MSFW community is essential. Provider trainings are one method in which to better educate healthcare providers about IPV among the MSFW population.

Healthcare providers recognize the complexities and pervasiveness of IPV among the MSFW community. Not only does IPV take multiple forms among MSFW patients (e.g., physical violence, rape, abuse during pregnancy, abuse by non-partner), but variability is evident in the ways that MSFW women respond to IPV as well. Additionally, just as healthcare providers experience barriers to screening for and addressing IPV with MSFW patients, providers observe numerous barriers to disclosing and responding to IPV faced by MSFW

patients. Although healthcare providers understand that they cannot conquer all of these barriers for their patients, they understand that developing a genuine empathetic desire to help is a step in the right direction.

Healthcare providers also encounter clinic and community-centered factors that influence their abilities to effectively screen for and address IPV among their MSFW patients. Despite the common perception among participants that IPV among the MSFW community is much more prevalent than the general population, and the many unique cultural factors among MSFW families that exacerbate IPV (e.g., traditional gender roles), variability is evident in the amount of support providers receive from the communities and healthcare clinics in which they serve. These healthcare providers consider a multidisciplinary team approach to be an important element in the management of MSFW patients who have experienced IPV.

Discussion

This study aimed to generate a greater understanding of the experiences of healthcare providers with screening for and addressing IPV with MSFW clients. Prior to this study, no studies had been published regarding IPV screenings of MSFW women in healthcare settings. Researchers have examined screening practices in healthcare settings (e.g., Colarossi et al., 2010; Macmillan et al., 2009; Nelson et al., 2012) but none have exclusively focused on the screening of MSFW women. This study was conducted in order to explore these experiences of providers assessing for IPV among MSFW women in healthcare settings.

Consistent with previous researchers who have indicated higher IPV prevalence rates among MSFW women (e.g., Hazen & Soriano, 2007) and Latina women alike (Caetano, Ramisetty-Mikler, & Field, 2005; Lipsky, Caetano, Field, & Bazargan, 2006; McFarlane, Groff,

O'Brien, & Watson, 2005), participants indicated that IPV among the MSFW population was more prevalent than the population at large.

Risk Factors for IPV

Stressors related to immigration, challenges of acculturation, language, legal, and economic pressures have the potential to exacerbate IPV (Mattson & Rodriguez, 1999). Each of these risk factors are common among the MSFW population, and have the capability to create stressful conditions that can result in acts of IPV (Duke & Cunradi, 2011; Hazen & Soriano, 2007; Grzywacz, Rao, Gentry, Marín, & Arcury, 2009).

Occupational stressors. MSFW and their families face several unique work-related stressors that negatively impact family life, and are associated with IPV. Given their undocumented status (Duke & Cunradi, 2011), limited education (NCFH, 2013), and lack of English proficiency (Duke & Cunradi, 2011), MSFW in the U.S. have few opportunities for employment outside of farm work or other low-paying industries (Duke & Cunradi, 2011). Other variables of work stress (e.g., low income, unemployment) (Cunradi et al., 2009) have been associated with IPV as well (Duke & Cunradi, 2011).

Participants spoke of many of these occupational stressors that no-doubt influence the likelihood of IPV within the family. Immigration status was one of the most common aspects of participants' experiences discussed over the course of the interviews. Although participants acknowledged the stress of being undocumented and the burden it places on their patients, not all participants were aware of protective clauses in place to protect undocumented patients who report their violent partners to the proper authorities.

Substance use. This study confirms previous research that alcohol abuse and IPV commonly occur together. One prior team of researchers suggested that heavy alcohol use is

believed to be common but is poorly documented among MSFW men (Grzywacz, Quandt, Isom, & Arcury, 2007). Previous researchers have indicated that heavy alcohol consumption increases risk of violence (Kim-Godwin & Fox, 2009). Consistent with previous research findings, several participants reported that IPV perpetrators, in their experiences, also had issues with alcohol abuse.

Acculturation and gender roles. Changes resulting from acculturation and new economic demands may be interpreted as a threat to the machismo of Latino males (Kim-Godwin & Fox, 2009). Ingram (2007) indicated increasing IPV prevalence the longer Latinos and their families lived in the U.S. Gender disparities resulting from acculturation, or adoption of American customs and norms, can lead to higher stress levels among Latino immigrants, which can lead to increased rates of IPV (Adames & Campbell, 2005; Klevens, 2007; Mattson & Ruiz, 2005). For the most part, participants indicated similar experiences pertaining to acculturation and gender roles. One participant, interestingly, indicated that her patients tended to be less violent the longer they lived in the United States, contrary to previous studies (e.g., Adames & Campbell, 2005; Ingram, 2007; Klevens, 2007; Mattson & Ruiz, 2005). Participants agreed that traditional gender roles among the MSFW community exacerbate IPV, because they encourage women to be unquestionably subservient to their partners at all costs.

Healthcare needs and access to healthcare. Individuals within the MSFW population are prone to numerous health conditions, including accidental injuries, dental disease, mental health problems, substance abuse issues, malnutrition, diabetes, hypertension, tuberculosis, parasitic infections, and anemia. Although participants did not speak much into the specifics of what health conditions MSFW women are prone to, participants did mention that addressing IPV

is often difficult because patients present with several other health conditions, and finding enough time to address IPV in addition to these health conditions is often difficult.

Awareness of resources. Although resources to aid MSFW women victimized by IPV exist, previous researchers (e.g., Kugel et al., 2009) have indicated that awareness of such resources among MSFW women is low. Specifically, Kugel et al indicated in their study that only 22% of MSFW women respondents were aware of available resources (e.g., shelter, legal services, police, etc.). Among the participants in this study, the general consensus was that MSFW women are unaware of what options they have. In fact, many participants admitted their own unawareness of available resources for their patients experiencing IPV as well.

Barriers to IPV Screening

Participants in this study described many barriers they have faced in the efforts to screen for and address IPV with their MSFW patients. Previous researchers have reported barriers among patients including feeling ashamed or embarrassed, inability to speak English and no access to a translator, fear of being deported or separated from their family or fear that their abuser would find out and make things worse (Kim-Godwin & Fox, 2009; Van Hightower, Gorton, & Demoss, 2000). Previous researchers have also indicated provider-reported barriers including lack of time (Colarossi et al., 2010), training (Colarossi et al., 2010; Waalen, Goodwin, Spitz, Peterson, & Saltzman, 2000), referral resources (Colarossi et al., 2010), and/or self-assessed competence in identifying IPV (Jonassen & Mazor, 2003). Throughout the course of this study, every one of these barriers was mentioned by at least one participant, with some participants indicating many of these as part of their experience.

Limitations

Although participants were given the option to contribute information to this study on three separate occasions, none elected to do so. Additionally, the participants' responses tended to be very consistent with one another. Although this may represent the similarity of their perspectives, it is possible that the interviews were conducted in such a way that participants were unintentionally swayed to respond in a certain manner. Additionally, because interviews were conducted via telephone, it is possible that the lack of richness associated with face-to-face interviews may have influenced the PI's overall understanding of the participants' experiences. Furthermore, all participants in this study were female healthcare providers. Thus, future research studies should seek to attain the lived experiences of male healthcare providers in this area, especially considering the unique gender-related aspects of IPV. Finally, it is possible that the PI's own experiences working with the MSFW population in healthcare settings influenced how he interviewed participants and analyzed the data. However, several methods for ensuring the trustworthiness of the data were carried out in this study as previously described (see Table 4).

Implications and Recommendations

Research Implications

Further research is needed to better understand the experiences of other healthcare provider groups who have screened for or addressed IPV with MSFW patients. Provider factors such as age, experience, race/ethnicity, relationship status, gender, and sexual orientation could all impact the experiences of these providers. Future research studies are also needed to better understand how healthcare providers make the decision to screen, and how they prepare and equip themselves to screen effectively. Additionally, collecting data via focus groups could

yield some interesting group interactions among participants who share a common experience with one another. Additionally, future researchers should examine the impact of screening tools, assessment/response protocols, and screening environments on the comfort of MSFW women victims. Although previous researchers (Thackeray, Seltzer, Downs, & Miller, 2007) have documented the preferences of women in general regarding IPV screening (e.g., being screened in-person, verbally, and by female providers) no one has specifically considered the unique cultural and legal influences of screening and identification on the MSFW population

Clinical Implications

It should be noted that, before large-scale clinical changes can be suggested, a better understanding of this topic is needed. However, the results of this study have revealed that the healthcare system, as it stands, is not meeting the needs of MSFW patients who have experienced IPV at the current time. At the very least, these patients need to know what their options are when they are experiencing IPV. Medical and behavioral health clinicians alike should be prepared to give information about local, state, and national resources available to MSFW victims of IPV and the protections that these resources can offer. Clinicians who serve the MSFW community should seek assistance from national organizations, such as the Migrant Clinicians Network (www.migrantclinician.org) for support and information about IPV among the MSFW community and available resources. Clinicians should also become better educated on the particular contexts of culture and violence in the MSFW community as well as the importance of becoming familiar with the research that informs us about these particular issues. Because many MSFW women who elect to seek safety from their abusive partners will have little to no support systems in place in their local communities, it is important for clinicians to be comfortable dealing with several systems at once and assisting patients and their families in

navigating their relationships within these systems. It will be essential that clinicians understand the various needs of patients and seek assistance from other professionals within the community (e.g., family therapists, social workers, etc.) who can provide assistance.

Policy Implications

Policies should be written making it possible for MSFW women to be screened for IPV at least annually by their healthcare providers. These policies should include reimbursement for screenings to cover the costs and hire bilingual staff to assist where needed. Expansion of agencies that assist healthcare providers who serve MSFW communities (e.g., National Center of Farmworker Health [NCFH; www.ncfh.org], Migrant Clinicians Network [MCN; www.migrantclinician.org]) to include more resources available to screening, intervening, and studying IPV in the MSFW populations is needed through policy and advocacy efforts that funnel more funds specific to this effort in their direction. Furthermore, policies and funding should be implemented that assist in the development and support of community, state, and national resources (e.g., women's shelters) to assist IPV victims and the healthcare providers who serve them. We also suggest supporting the development of face-to-face and/or web-based educational opportunities to increase awareness and prepare providers effectively for the culturally unique needs of this population. By debriefing and educating providers about the specific circumstances in which MSFW women live, and how to respond to IPV when working with MSFW women patients, providers will be much more prepared to provide assistance.

Conclusion

In summary, the phenomenon of screening for and addressing IPV with MSFW patients presented the participants with many opportunities for reflection, growth, and the opportunity to consider the ways in which the current healthcare practices in this area can improve. At the same

time, it presented challenges that the participants continue to struggle through. Some of these challenges were self-imposed while others were imposed by the imperfect healthcare system in which the participants serve. Overall, it appeared that participants agreed that IPV among the MSFW community is a significant problem that needs to be better addressed by the healthcare system, but many participants were unsure how they could really make a difference. These participants were attempting to find the line between where their own responsibility as providers ends and the responsibility of the healthcare system at large to support its' providers in this area begins.

In considering their overall experiences, participants expressed that even given the challenging aspects, screening for and addressing IPV with MSFW patients is a worthwhile endeavor. In fact, some participants are not required by their employers to screen for IPV but choose to do so voluntarily. Although participants agreed that MSFW patients should be screened for IPV, they recognize the many inherent challenges may be too much to overcome for some providers at this time. Participants also looked to the future with hope that more resources and educational materials for patients and providers alike will be soon developed.

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Table 1

Participant Demographics

	Brenda	Donna	Erin	Connie	Carol	Sharon	Karen	Bonnie	Lucy
Gender	Female	Female	Female	Female	Female	Female	Female	Female	Female
Age	63	75	29	34	52	35	32	36	32
Language(s)	English	English	English and Spanish	English and Spanish	English	English	English	English and Spanish	English
Education	Master's	MD or PhD	Master's	Master's	Associate's	Associate's	Master's	Master's	MD or PhD
Occupation	Midwife/ Nurse	Advanced Registered Nurse Practitioner	Family Nurse Practitioner	Certified Nurse Midwife	LPN	LPN	Nurse Practitioner	Medical Family Therapist	MD
Employment Status	Full-Time	Part-Time	Part-Time	Part-Time	Full-Time	Full-Time	Full-Time	Full-Time	Part-Time
Length of Employment	20+ years	10-20 years	1-3 years	5-10 years	3-5 years	5-10 years	3-5 years	5-10 years	1-3 years
Ethnicity	Not Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino	Not Hispanic or Latino	Not Hispanic or Latino	Not Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino	Not Hispanic or Latino
Race	White	White	Multi- racial: White and Hispanic	White	White	Black or African American	White	Hispanic/ Latino	White
Location	West	North	North	West	Southeast	Southeast	Southeast	Southeast	Southeast

Table 2

Interview Guide

Category	Question
Grand Tour Question	How would you describe your experience caring for migrant and/or seasonal farmworking women patients who have experienced intimate partner violence?
Probing Questions	<p>In your experience, how prevalent is intimate partner violence among this population?</p> <p>At what point during the visit is intimate partner violence typically addressed? Who usually brings up the topic of intimate partner violence (the provider or the patient)?</p> <p>What screening methods do you use to detect intimate partner violence and how do you introduce them to your migrant and/or seasonal farmworking patient population?</p> <p>What protocols do you follow for determining who and when to screen?</p> <p>How comfortable do you feel with recognizing and effectively responding to intimate partner violence? Is there anything that might increase your comfortability in this matter?</p> <p>What has been the most challenging in your experiences screening for and/or addressing intimate partner violence with migrant and/or seasonal farmworking women?</p> <p>In your opinion, what are the ethical implications of asking about intimate partner violence?</p> <p>Are there any special considerations you keep in mind when working with migrant and/or seasonal farmworking women compared to other cultural groups? If so, what are they?</p> <p>Is there anything else that you would like to share about these experiences? If so, what?</p>

Table 3

Application of Colaizzi's procedural steps of analysis (1978) to this study

- Each verbatim transcript was read to acquire a thorough understanding
 - Significant statements were extracted from the transcripts that together form the whole meaning of the experience.
 - Formulated meanings were assigned to each significant statement extracted from the text.
 - The formulated meanings were grouped into thematic clusters and the PI referred back to the original transcripts for validation.
 - The thematic clusters were grouped to form four emergent themes shared among participants.
 - The results were integrated into an exhaustive description – a detailed summary of the overall experiences of the participants. The PI returned to the participants a summary of their interview with verbatim quotes from their interviews included and were invited to participate in a second interview. No participants elected to do so.
-

Table 4

Application of Lincoln & Guba's Framework

Criteria	Definition	Application to this Study
Credibility	Ensuring that the findings of the study truly reflect the participants' experiences, similar to the concept of "validity" in quantitative research.	Member checking was used to determine that the findings and meaning of participants' lived experiences were confirmed.
Dependability	Establishing reliability of data over time.	An audit trail was established and maintained throughout this study.
Confirmability	Establishing similarity between two independent reviewers of data and analyses.	Two independent researchers reviewed transcripts, extracted statements, formulated meanings, thematic clusters, and emergent themes. Member checking confirmed the accuracy of findings.
Transferability	Providing sufficient information for future researchers to explore the findings of this study by applying it to another time and place.	Data saturation was achieved with nine interviews. Member checking ensured saturation had been achieved.

Note. Adapted from "Naturalistic Inquiry," by Y. S. Lincoln & E. G. Guba, 1985, Sage Publications.

Table 5

Emergent Themes & Thematic Clusters

Emergent Themes	Thematic Clusters
Provider-Centered Factors	Healthcare providers use various IPV screening protocols with MSFW patients.
	Healthcare providers respond to patient disclosures of IPV in various methods.
	Healthcare providers experience barriers to screening for and addressing IPV with MSFW patients.
	Healthcare providers believe change is needed to improve MSFW patient care.
	Healthcare providers are confronted with the partners of their patients.
Patient-Centered Factors	MSFW patients experience IPV in numerous forms.
	MSFW patients respond to IPV perpetration in various ways.
	MSFW patients experience barriers to disclosing IPV and seeking resources suggested by providers.
Clinic-Centered Factors	Some clinics have protocol/resources in place to address IPV with patients.
	Some clinics unintentionally create barriers to effectively address IPV with patients.
Community-Centered Factors	IPV in the MSFW community is a multifaceted problem.
	Unique cultural factors within the MSFW community may exacerbate IPV.
	Communities provide resources to aid MSFW women experiencing IPV.
	Outcomes for IPV victims and perpetrators vary within the MSFW community.

Table 6

Selected Examples of Narratives and Emergent Theme Formation

Significant Statements	Formulated Meanings	Thematic Clusters	Emergent Themes
“I would definitely address it if the answer was yes or if the patient brought it up to me. If I suspected it I would address it, but I wouldn’t go fishing for it...”	Provider specifies the time of and/or frequency of IPV screening.	Healthcare providers use various IPV screening protocols with MSFW patients.	Provider-Centered Factors
“I don’t have any facts but... a lot of our patients are undocumented, so calling the police and sending their spouse to jail where there’s the possible deportation or on the other side where [our patients] might get deported. That’s a huge thing for people”	Immigration status of patients (including fear of deportation) is a barrier for patient disclosures of IPV.	MSFW patients experience barriers to disclosing IPV and seeking resources suggested by healthcare providers.	Patient-Centered Factors
125 “But I think when I first came here I did bring it up... and then I kind of backed off because I thought they’d think I’m crazy. Like, ‘Look at all the things we could be doing’”	Provider experienced resistance from employer regarding IPV screening/response protocol.	Some clinics unintentionally create barriers to effectively addressing IPV with patients.	Clinic-Centered Factors
“I hear other patients talking about how their husbands expect them to have food on the table and expect them to do this or that or the other with the children, which I don’t hear my non-migrant patients talking about...”	Traditional gender roles among the MSFW population (i.e. machismo) exacerbate IPV.	Unique cultural factors within the MSFW community may exacerbate IPV.	Community-Centered Factors

CHAPTER SIX: IMPLICATIONS FOR ADDRESSING INTIMATE PARTNER VIOLENCE AMONG WOMEN IN THE MIGRANT SEASONAL FARMWORKER WORKER POPULATION

The findings of this dissertation illustrate the severity of the problem of intimate partner violence (IPV) among the migrant and seasonal farmworker (MSFW) population. Chapter two, a policy brief, reviewed previous research related to IPV among MSFW women and recommended policies to improve the detection, intervention, resources, and available science with respect to the MSFW population. Chapter five presented a descriptive phenomenological study examining the essence of healthcare providers' experience screening for and treating IPV among MSFW women. The purpose of this chapter is to review the findings of the previous articles in this dissertation regarding screening MSFW women for IPV in healthcare settings, and to discuss the implications for clinical practice, research, policy, and Medical Family Therapy (MedFT).

Clinical Implications

As evidenced by the findings in article two, IPV prevalence rates among the MSFW population are proportionately higher than the general population. Specifically, MSFW women report a lifetime prevalence rate of 24.5% for physical violence and 20.9% for sexual coercion (Hazen & Soriano, 2007). Furthermore, awareness of available resources among MSFW women is low, around 22%, while most MSFW women (86%) desire to seek assistance from such resources if made available to them (Kugel et al., 2009). For healthcare providers working with MSFW patients, it is essential to routinely screen for IPV, preferably with all MSFW women patients. Routine screening for IPV in healthcare settings could identify women at risk and lead to interventions that reduce violence and improve health outcomes (Nelson et al., 2012).

Although the development of an IPV screening tool designed specifically for MSFW women has the potential to result in more accurate and culturally relevant screening protocols, the absence of such a screening tool does not justify eliminating IPV screenings in this population altogether. Healthcare providers should advocate for tool construction to occur immediately and resources made available at the local, state, and national levels for MSFW women who are experiencing IPV. Organizations like the Migrant Clinicians Network (www.migrantclinician.org) exist to provide healthcare professionals with essential support and resources in their work with the MSFW community. However, they cannot help if providers do not let them know what their needs are and what they are experiencing when attempting to care for this population. Studies like the one presented in chapter five are an entry point into opening up the conversation between providers and advocacy groups to initiate change at the clinical level.

Second, because many MSFW women who elect to seek safety from their abusive partners will have little to no support systems in place in their local communities, it is important for clinicians to be comfortable dealing with several systems at once and assisting patients and their families in navigating their relationships within these systems. Including caregivers, close friends, and other family members in the intervention process may be advantageous to the clinician and the families (Broderick & Smith, 1979). As was recommended by the participants in chapter 5, healthcare providers should seek input from other professionals (e.g., family therapists, social workers, etc.), and from trusted friends and family members who can provide assistance. The challenge with this recommendation is its time-consuming nature – assisting patients with establishing these relationships within the community takes time, and many healthcare providers have little time to devote to each patient in many environments. Adding a care coordinator could alleviate some of the burden from healthcare providers. Doing so would

enable the healthcare system as a whole to become more time and resource-efficient when encountering patients who have experienced IPV with increased exposure and practice. However, in order for patients to feel safe talking about IPV and providers to respond effectively, providers should be aware of the cultural factors (e.g., machismo; Humphreys & Campbell, 2004), financial barriers (e.g., due to low income or unemployment; Duke & Cunradi, 2011), bilingual and culturally-relevant IPV resources, and fears related to deportation (Lambert, 1995) that may be common to this population.

IPV is a multifaceted problem that impacts the individual and family on many levels. On an individual level, IPV causes physical, mental, and emotional injury to its victims (Campbell, 2002; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Furthermore, IPV has the potential to destroy the ability of a family to function, or even stay together. Based on the literature and data reported in chapters two and five, IPV could be more effectively addressed individually and systemically in a healthcare setting where behavioral health providers (such as medical family therapists [MedFT] are available on site. Previous researchers (e.g., Lambert, 1995) and participants in chapter five have indicated that MSFW women have little to no access to adequate mental health services. There are many different terms that are used interchangeably to describe collaborative behavioral healthcare, such as “collaborative, coordinated, co-located, care management, and integrated care” (Hunter, Goodie, Oordt, & Dobmeyer, 2010, p. 3). While each of these terms entails a different level of collaboration and integration among behavioral health and primary care, “integrated care” entails behavioral health and primary care providers working together in a shared system to create a single treatment plan with a shared medical record (Blount, 2003; Hunter et al., 2010). Approaching the problem of IPV from an integrated care approach would provide MSFW patients access to mental healthcare services at point of and

would relieve the primary care providers from feeling that they have to handle these incredibly time consuming, complex, and challenging patient encounters alone.

Finally, clinicians must be consumers of research to ensure the best treatments and interventions for IPV victims, especially when working with underserved and understudied populations such as the MSFW community. The literature from chapters two and three support that there are unique health disparities among the MSFW population (Denham et al., 2007; Duke & Cunradi, 2011; Lambert, 1995), and clinicians should remain aware of these differences to appropriately treat MSFW women experiencing IPV. Utilizing empirically-supported interventions appropriate for MSFW patients to help address IPV may help reduce unnecessary utilization of healthcare services, thus eliminating superfluous health care costs.

Research Implications

The findings from this dissertation project reveal a significant need for future research. Specifically, research implications in each of the three areas of the “Three-World View” (Peek & Heinrich, 1995) – clinical, operational, and financial – can be drawn from the results of this project.

Clinical Research

Generally speaking, the need for further clinical research of IPV among MSFW patients is great. As indicated in chapter two, no studies have been published regarding IPV screenings of MSFW women in healthcare settings. Researchers have examined screening practices in healthcare settings (e.g., Colarossi, Breitbart, & Betancourt, 2010; Macmillan et al., 2009; Nelson, Bougatsos, & Blazina, 2012), but none have focused on the screening of MSFW women exclusively. The results of chapter five highlight the similarities and differences among the experiences of healthcare providers who have screened for and addressed IPV among their

MSFW patients. These descriptions offer insight into the experiences of providers who encounter MSFW patients who have experienced IPV. However, by its nature, descriptive phenomenology is not designed to generalize to all members of a certain community – in this case, healthcare providers (Colaizzi, 1978). Therefore, the findings from this study should serve as a launching point for more extensive qualitative and quantitative studies that help to further elucidate and target the key indicators and variables influencing IPV screening and treatment for MSFW women who experience IPV.

First, research is needed to expand our understanding of the inconsistency in screening of providers for IPV with MSFW patients. Provider factors such as age, experience, race/ethnicity, relationship status, gender, and sexual orientation could all impact the experiences of these providers. Only one participant in the study discussed in chapter five indicated being *required* by her employer to routinely screen for IPV among her patients, most of whom were pregnant. Most participants were not required by their employers to screen for IPV, but chose to do so anyway on their own accord. Studies are needed to understand how healthcare providers make the decision to screen MSFW women, and how they prepare and equip themselves to screen and intervene effectively. Although previous researchers (Thackeray, Seltzer, Downs, & Miller, 2007) have documented the preferences of women in general regarding IPV screening (e.g., being screened in-person, verbally, and by female providers), no one has specifically studied the unique cultural and legal influences of screening and intervening with MSFW women who have experienced IPV. A grounded theory study examining the cultural/legal influences on the screening process could help providers better understand the IPV screening process for MSFW patients and articulate areas for improvement.

Future research is also needed to determine the effectiveness of culturally relevant IPV screening tool and intervention protocol for MSFW women. This study will need to be a collaborative multi-site study with data collected about variables such as: IPV screening outcomes, type of referrals, healthcare utilization, mental and behavioral health data (e.g., depression, anxiety, weight loss/gain, insomnia, etc.), and biometrics that are known to be a concern among those experiencing IPV (e.g., chronic pain, gastrointestinal disorders, migraine headaches, substance abuse, fractured bones, black or swollen eyes; see Campbell & Lewandowski, 1997; Coker, Smith, Bethea, King, & McKeown, 2000; Murdaugh, Hunt, Sowell, & Santana, 2004). Pre and post-intervention data will need to be collected to determine if the screening and interventional protocol is effective. This initial study should be comprised as a program evaluation rather than a comprehensive model for all clinics to implement.

Operational Research

Future research should also be done to examine operational aspects of screening for IPV among MSFW patients in healthcare settings as well. The operational world in healthcare settings aims to achieve efficient delivery of services to as many patients as possible (Peek & Heinrich, 1995). Chapter two results indicated that MSFW patients and the providers who care for them have low awareness of resources (e.g., shelter, clinic, church, legal services, counseling, police, and national domestic violence hotline). Specifically, Kugel et al (2009) indicated that only 22% of their sample of MSFW patients were aware of available resources, while 86% reported that they would seek help (i.e., be willing to act) if they witnessed or experienced IPV and were aware of available resources, such as women's shelters, legal services, and police. Additionally, to date, there appears to be no empirically validated screening tool designed for use with the MSFW population. Short and Rodriguez (2008) tested an IPV assessment measure (the

“Intimate Partner Violence Assessment Icon Form”) with MSFW women, but were unable to generate conclusive evidence of its usefulness. Such screening tools should display empirical validity and reliability with the MSFW population, or at least the migrant Latino population at large. Healthcare clinics should implement protocols using these empirically validated screening tools and interventions (when available) and provide adequate trainings for providers and staff about such methods.

Additionally, future researchers should examine the impact of screening tools, assessment/response protocols, and screening outcomes on workflow and clinic operations. In chapter five, one participant indicated an operational concern of “lack of time with patients” as being a barrier to screening for IPV. Additionally, another participant mentioned that it would be helpful to have a standardized IPV screening tool for MSFW patients to streamline the screening process. Future research studies should be done to find efficient solutions to these operational challenges. Specifically, future researchers should study different workflow patterns of providers with higher and lower IPV screening rates to determine differences and help identify methods to improve efficiency and quality of screens. Other studies should be conducted to examine various methods to delivering information about IPV resources to providers and patients, and determine which method(s) are most efficient and which provider types (e.g., primary care providers, nurses, behavioral health consultants) are more effective at it.

Financial Research

The “financial world” in healthcare settings aims to deliver cost-effective services to patients – that is, delivering valuable services at the right price (Peek & Heinrich, 1995). Chapter three indicated that women experiencing IPV use a disproportionate share of health care services, making more visits to emergency departments, primary care facilities, and mental

health agencies than women who have not experienced IPV (Coker et al., 2000). To date, no study has examined the financial repercussions of IPV among MSFW women specifically. Future researchers should examine the short and long term financial costs and benefits to screening and intervening for IPV among MSFW victims. For example, studies should examine differences in health care utilization of patients who were screened for IPV and treated as compared to their prior health care utilization. Because women experiencing IPV utilize more health care services than women who have not experienced IPV (Coker et al., 2000), it is possible that this does not apply to MSFW women. Studies examining pre and post-intervention data of healthcare utilization could begin to provide insight into the influence of IPV screening on healthcare utilization by MSFW patients experiencing IPV.

Policy Implications

Since the implementation of the Violence Against Women Act (VAWA, 1994), there have been increased governmental sanctions to provide relief for MSFW women experiencing IPV (e.g., free medical care, permission to work in the US and a green card without spousal assistance). However, as the results of chapter two indicate, many women are unaware of such protections (Kugel et al., 2009). Additionally, previous researchers have indicated, and the results of chapter five confirm, that there are not enough mental health care providers to meet the needs of rural citizens (Gamm, Stone, & Pittman, 2010). Policy changes are needed to help ensure that there are enough mental health providers available and trained to meet these needs in MSFW communities, especially the rural areas where recruiting healthcare providers may be difficult. Furthermore, policy changes are needed to support the development of improved IPV screening tools and protocols for healthcare facilities serving MSFW patients and their families.

Applying research done primarily with white, middle class women with U.S. citizenship to MSFW women is not only culturally irresponsible but can be inadequate and harmful.

Chapter two of this dissertation identified several large gaps in the current body of knowledge pertaining to IPV among MSFW women and IPV screenings in healthcare settings. For instance, no studies have been published regarding IPV screenings of MSFW women in healthcare settings and MSFW women are disturbingly unaware of available resources to aid women experiencing IPV (Kugel et al., 2009). Routine screening for IPV in healthcare settings is one vehicle to identify women at risk and intervene by providing them with resources to reduce violence and consequentially improve their health outcomes (Nelson et al., 2012). The Institute of Medicine (IOM; 2011), and several professional organizations (e.g., American Congress of Obstetricians and Gynecologists [ACOG], 2012), recommend universal IPV screenings for all women. Although progress has been made advocating for this action, neither a uniform screening protocol in healthcare settings, regardless of the cultural group, nor an endorsement by the IOM or ACOG for one exists currently (Elliott, Nerney, Jones, & Friedman, 2002; Erickson, Hill, & Siegel, 2001; Lapidus et al., 2002; Thackeray et al., 2007).

Chapter five of this dissertation illustrated the challenges faced by healthcare providers in screening for IPV among MSFW patients. Participants confirmed that their experiences have resembled what is already known in the literature (e.g., high prevalence of IPV among MSFW patients compared to the general population, low awareness of resources among MSFW women), but also presented information unique to their experiences that could be addressed by future policy writings. For instance, only one provider indicated being required by her employer to screen all patients (including MSFW patients) for IPV. Not only did the employers of the other participants not require IPV screening, but one participant indicated that her employer actually

discouraged her from screening for IPV unless reasonable suspicion was present due to limited time available to spend with each patient. Tying the implementation of evidence-based and effective protocols to certifications such as the Patient Centered Medical Home (Bolin, Gamm, Vest, Edwardson, & Miller, 2011) would be one way to ensure that clinics are held accountable to making this change.

In sum, based on the results of chapters two and five, policy changes are needed to equip healthcare providers with the knowledge and tools necessary to effectively screen for and treat IPV among their MSFW patients. The following recommendations are being extended to support the development of policies to advance the science, screening, and resources available to MSFW women who have experienced IPV.

1. Annual IPV Screenings for MSFW women - Policies should be written making it possible for MSFW women to be screened for IPV at least annually by their healthcare providers. These policies should include reimbursement for screenings to cover the costs and hire bilingual staff to assist where needed. Numerous researchers (e.g., Bradley, Smith, Long, & O'Dowd, 2002; Parkinson, Adams, & Emerling, 2001; Richardson et al., 2002; Thackeray et al., 2007) have indicated that universal screening for IPV significantly increases the number of identified victims. However, the screening tools available are not validated with the MSFW population. While annual screenings are the goal, concurrent work to further the science regarding the types of instruments used to detect IPV that are sensitive to the contextual factors of the MSFW population should be supported through healthcare policy.
2. Expansion of MSFW Advocacy Groups and Community Resources - Not only are MSFW women disproportionately victimized by IPV (Hazen & Soriano, 2007), and

constrained by numerous cultural factors (see Kamm & Rosenthal, 1999), but most (86% according to Kugel et al., 1999) would seek help if they were aware of what resources were available to them. However, in order for providers to effectively respond to positive screenings for IPV among their MSFW patients, they should be aware of the cultural factors, financial barriers, bilingual and culturally-relevant IPV resources, and respect any fears related to issues such as deportation (depending on legal status) that may be common to this population. Providers who work with MSFW women will benefit from using the available resources of the National Center for Farmworker Health (NCFH; www.ncfh.org), a private, not-for-profit agency dedicated to improving the health of farmworker families by providing information and training products to health centers that work with migrant farmworkers across the U.S. Additionally, the Migrant Clinicians Network (www.migrantclinician.org), an organization that serves healthcare providers who provide services to MSFW and their families, can equip providers with helpful education resources and networking opportunities to collaborate with others serving the MSFW population. Expansion of these agencies to include more resources available to screening, intervening, and studying IPV in the MSFW populations is needed through policy and advocacy efforts that funnel more funds specific to this effort in their direction.

3. Education and Training on IPV in the MSFW Community - The development of face-to-face and/or web-based educational opportunities to increase awareness and prepare providers effectively for the culturally unique needs of this population should be prioritized among policy writers. Additionally, given that many of the IPV stories told by the MSFW women will be powerful and emotionally challenging to hear,

education and training curriculum to help healthcare providers debrief the gravity of this work should also be funded. By debriefing and educating providers about the specific circumstances in which MSFW women live, and how to respond to IPV when working with MSFW women patients, providers will be much more prepared to provide assistance.

4. Research-Informed Advancements in Detecting IPV in the MSFW Community – As noted above, the primary recommendation is for researchers, in collaboration with the MSFW community (providers, patients, and advocacy groups), to develop culturally relevant screening tools for IPV specifically designed for MSFW women. Such screening tools should display empirical validity and reliability with the MSFW population, or at least the migrant Latino population at large. Additionally, future researchers should examine the impact of screening tools, assessment/response protocols, and screening environments on the comfort of MSFW women victims. Although previous researchers (Thackeray et al., 2007) have documented the preferences of women in general regarding IPV screening (e.g., being screened in-person, verbally, and by female providers) no one has specifically considered the unique cultural and legal influences of screening and identification on the MSFW population. Providers are encouraged to build upon the recommendations of Thackeray et al. (2007) by specifically attending to the unique needs of MSFW women until more studies are available that may influence provider training, community resource, and healthcare policy changes.

Medical Family Therapy Implications

Medical family therapy is founded upon the tenets of agency and communion (Doherty, McDaniel, & Hepworth, 1994). Agency refers to the patient's involvement and commitment to his or her own health care needs, and the ability to make choices about personal health issues (Doherty et al., 1994). Communion refers to the overall sense of connection to and collaboration with healthcare providers, staff, friends, and family (Doherty et al., 1994). In order to work effectively with staff and providers in an integrated care setting, MedFTs must understand the role that illness plays in families, and how the medical system operates (Ruddy & McDaniel, 2003). They need to conduct research to further the field (Tyndall, Hodgson, Lamson, Knight, & White, 2012a; 2012b) using the biopsychosocial model (BPS; Engel, 1977, 1980) to further the field and establish the effectiveness and efficacy of MedFT interventions (Mendenhall, Pratt, Phelps, & Baird, 2012).

IPV is a multifaceted problem that impacts the individual and family on many levels. On an individual level, IPV causes physical, mental, and emotional injury to its victims (Campbell & Lewandowski, 1997; Coker et al., 2000; Murdaugh et al., 2004). Furthermore, IPV has the potential to destroy the ability of a family to function, or even stay together (McCord-Duncan, Floyd, Kemp, Bailey, & Lang, 2006; Steinmetz, 1987). It is my argument that IPV could be more effectively addressed individually and systemically within an integrated care setting, particularly one with a MedFT available on site. Previous researchers (e.g., Lambert, 1995) and participants within this study have indicated that MSFW women have little to no access to adequate mental health services. Approaching the problem of IPV from an integrated care and relational approach would not only provide MSFW patients access to mental healthcare services,

but it would also combat the problem of IPV among MSFW patients in a more systemic and hopefully more effective manner.

Furthermore, MedFTs are capable of working within an integrated care medical setting by conducting research studies about IPV (and other topics pertaining to integrated care) from within the healthcare system. Doctoral-level MedFTs are skilled in their abilities to design and conduct research studies and interventions with couple and family units, and can use this knowledge and training to implement studies addressing the research implications mentioned above. Additionally, MedFTs are trained to be culturally knowledgeable and sensitive, traits that are essential in conducting research with underserved populations (e.g., MSFW population). Finally, MedFTs are trained to stay informed of policies such as the VAWA and how it impacts MSFW patients, families, and the healthcare system. MedFTs are capable of recognizing the devastation of IPV on MSFW women and their families through a BPS lens, and are able to advocate for policy changes accordingly. Staying abreast of current policy movements pertinent to MedFT and the healthcare system as a whole such as reimbursement for services, and provisions of services to underserved populations in rural communities will empower MedFTs to appropriately lobby for change as needed for MSFW patients, and other underserved rural populations.

Conclusion

The articles in this dissertation indicate a need for increased attention to screening for IPV among MSFW women in healthcare settings, expansion of MSFW advocacy groups and community resources, education and training on IPV within the MSFW community, and research-informed advancements for detecting IPV within the MSFW community. Several

recommendations were made in this chapter for clinicians, researchers, policy makers, and MedFTs based on the findings from this dissertation.

As research findings (such as those presented in this dissertation) are used to further demonstrate the need for empirically-based interventions addressing IPV among MSFW patients and their families, several steps need to be taken. First, medical and behavioral healthcare providers who serve MSFW patients and their families must advocate for the needs of these patients (especially in regard to IPV) within their professional organizations, at a national level for grant funding, and in some cases, to their employers. Next, behavioral health researcher and other experts in integrated care (e.g., MedFTs) should acquire grant funding to develop and research treatments and screening tools that are effective, efficient (e.g., brief), and appropriate for use with MSFW patients. Finally, clinicians, researchers, and policy makers must be willing to collaborate to implement these interventions in healthcare settings that serve MSFW patients and their families.

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APPENDIX A: UMCIRB APPROVAL FORM



EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
4N-70 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · www.ecu.edu/irb

Notification of Initial Approval: Expedited

From: Social/Behavioral IRB
To: [Jonathan Wilson](#)
CC: [Damon Rappleyea](#)
Date: 7/15/2013
Re: [UMCIRB 13-001324](#)
Healthcare Providers' Experiences with Screening for Intimate Partner Violence Among Migrant and Seasonal Farmworking Women: A Phenomenological Exploration

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) is for the period of 7/14/2013 to 7/13/2014. The research study is eligible for review under expedited category #6, 7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The Investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Name	Description
Demographic Questionnaire	Data Collection Sheet
Informed Consent - Low Risk	Consent Forms
Interview Guide	Interview/Focus Group Scripts/Questions
Letter of Introduction	Recruitment Documents/Scripts
MCN DV Monograph	Additional Items
Method	Study Protocol or Grant Application
Resources for Providers	Additional Items

APPENDIX B: MCN IRB APPROVAL FORM

1



NOTICE OF APPROVAL

Institutional Review Board (Assurance # FWA00014695)

Date: 09/06/2013

Principal Investigator Jonathan B Wilson

Mailing Address Oklahoma Baptist University, 500 W University Street, Shawnee, OK 74804

Dear PI: Jonathon Wilson

Re: IRB Protocol # 009-2013 (name of project) Healthcare Providers' Experiences with Screening for Intimate Partner Violence among Migrant and Seasonal Farmworker Women: A Phenomenological Study

This protocol was approved as submitted on (Date 09/05/2013) for:

☐ Standard review

☒ Expedited review: Research on individual or group behavior or characteristic of individuals, such as studies or perception, cognition, game theory, or test development, where investigator does not manipulate subjects' behavior and the research will not involve risk to subjects.

☐ Approval to waive the requirement to obtain informed consent is given under DHHS regulation 46.117(c)(1).

☒ This approval will be endorsed by the full Board and recorded in the minutes at the next convened IRB meeting on DATE: September 10, 2013

RESPONSIBILITIES OF PRINCIPAL INVESTIGATOR:

- (1) report immediately to the IRB all deaths of subjects, regardless of cause;
- (2) report immediately to the IRB any severe adverse reaction or serious problem, whether anticipated or unanticipated;
- (3) report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to take part;
- (4) insure that only formally designated investigators (as approved by the IRB) enroll subjects;
- (5) submit for review and approval by the IRB all modifications to the protocol or consent form(s) prior to the implementation of the change;
- (6) submit a **Review and Progress Report** for continuing review by the IRB. Federal regulations require IRB review of on-going projects no less than once a year (a Progress Report will be sent to you in 10 months); and
- (7) notify the IRB when the study has been completed and prepare a final report.

NEXT IRB REVIEW: (DATE) 09/04/2013

A handwritten signature in black ink, reading 'Loretta Heuer'.

Signature of MCN IRB Chairperson



IRB form

NOTICE OF APPROVAL

Date of approval – 09/22/05

APPENDIX C: INTERVIEW GUIDE

Thank you for being willing to speak with me about your personal experiences. I really want to understand more about your experience of working with migrant and seasonal farmworking women who have experienced intimate partner violence. There are no right or wrong answers and I encourage you to share any information that comes to mind during the interview, so please be as open and honest as possible. As we discussed earlier, you have the right to stop this interview at any point, or you can choose to skip any questions that you prefer not to answer. If you need me to clarify any questions please let me know. Do you have any questions before we begin?

Grand Tour Question:

How would you describe your experience caring for migrant and/or seasonal farmworking women patients who have experienced intimate partner violence?

Probes:

- In your experience, how prevalent is intimate partner violence among this population?
- At what point during the visit is intimate partner violence typically addressed? Who usually brings up the topic of intimate partner violence (the provider or the patient)?
- What screening methods do you use to detect intimate partner violence and how do you introduce them to your migrant and/or seasonal farmworking patient population?
- What protocols do you follow for determining who and when to screen?
- How comfortable do you feel with recognizing and effectively responding to intimate partner violence? Is there anything that might increase your comfortability in this matter?
- What has been the most challenging in your experiences screening for and/or addressing intimate partner violence with migrant and/or seasonal farmworking women?
- In your opinion, what are the ethical implications of asking about intimate partner violence?
- Are there any special considerations you keep in mind when working with migrant and/or seasonal farmworking women compared to other cultural groups? If so, what are they?
- Is there anything else that you would like to share about these experiences? If so, what?

APPENDIX D: LETTER OF INTRODUCTION

Dear Healthcare Provider,

My name is Jonathan Wilson and I am conducting interviews for a dissertation study on healthcare providers' experiences screening for and addressing intimate partner violence among migrant and seasonal farmworking women. You were identified as a provider who works in and/or for a health center that serves the needs of migrant and seasonal farmworking women. I am particularly interested in gathering information pertaining to your experiences serving patients who have been exposed to intimate partner violence. As you are well aware, the migrant and seasonal farmworker population faces many health disparities and challenges that other patients do not typically encounter. Intimate partner violence illustrates one example of these challenges. Previous researchers have indicated that significantly more migrant and seasonal farmworker women are exposed to intimate partner violence than other women in the United States. Because of this, I am trying to gain a better understanding of any healthcare providers' experiences of screening for and/or addressing intimate partner violence with these women.

Chances are you have treated at least one woman who had been exposed to intimate partner violence, or whom you believe was exposed to intimate partner violence. If this is true, I need your help. To determine your eligibility for this study, answer the following questions:

- A. Are you a clinically-active healthcare provider who extends healthcare services to the MSFW community and their families? (You do not have to provide services *exclusively* to this patient group).
- B. Are you bilingual (Spanish & English)? If not, are you fluent in English and have access to a nurse (or other medical provider) who translates into Spanish during patient care?
- C. Have you encountered one or more female patients that you believe has experienced IPV?
- D. Are you 18 years of age or older?

If you answered "yes" to every question, you are eligible to participate in this study! If you agree to participate in my study, I will be asking to meet with you either in person, by telephone or via Skype. During this meeting, I will be asking you some basic demographic questions and will discuss the details of the interview with you. I anticipate the meeting will take approximately 35-45 minutes of your time. The focus of the interview will be on your experiences with screening for and/or addressing intimate partner violence with your migrant and/or seasonal farmworking women patients. If you would be willing to participate, please contact me as soon as possible. A \$10 donation will be made in appreciation for your participation to the National Domestic Violence Hotline. Additionally, if you know of anyone else who may be willing to talk to me, please feel free to pass along my contact information.

Your attention to this opportunity is greatly appreciated. I truly believe the results of this research will empower our abilities as healthcare providers to serve these patients. Thank you in advance for your support in this request.

Sincerely,

Jonathan B. Wilson, M.S., LMFTA, CFLE
612 E. 10th Street, Greenville, NC
wilsonjon11@students.ecu.edu
(405) 334-6533

Research Advisors

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APPENDIX E: INFORMED CONSENT

East Carolina University



Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research: Healthcare Providers' Experiences with Screening for Intimate Partner Violence Among Migrant and Seasonal Farmworking Women: A Phenomenological Study

Principal Investigator: Jonathan B. Wilson, M.S.

Research Advisors: Damon Rappleyea, Ph.D. & Jennifer Hodgson, Ph.D.

Institution/Department or Division: East Carolina University/Child Development & Family Relations

Address: 612 E. 10th Street

Telephone #: (405) 334-6533

Researchers at East Carolina University (ECU) study problems in society, health problems, environmental problems, behavior problems and the human condition. Our goal is to try to find ways to improve the lives of you and others. To do this, we need the help of volunteers who are willing to take part in research.

Why is this research being done?

The purpose of this research is to examine the experiences of healthcare providers who have served migrant and seasonal farmworking patients. Specifically, we are interested in providers' experiences of screening for intimate partner violence among these patients. The decision to take part in this research is yours to make. By doing this research, we hope to develop a better understanding of these experiences and create knowledge about how to better equip other healthcare providers in similar situations to effectively screen and respond to intimate partner violence.

Why am I being invited to take part in this research?

You are being invited to take part in this research because: (a) you are a clinically active healthcare provider who provides healthcare services for the migrant and seasonal farmworkers and their families; (b) you are either bilingual (Spanish and English) *or* you have access to a nurse (or other medical provider) who translates Spanish; (c) you have encountered at least one female patient from the migrant/seasonal farmworker community who you believe has experienced intimate partner violence; and (d) you are 18 years of age or older. If you volunteer to take part in this research, you will be one of about 20 people to do so.

Are there reasons I should not take part in this research?

You should not take part in this research if you have no experience in screening for or responding to intimate partner violence detected among your patients.

What other choices do I have if I do not take part in this research?

You can choose not to participate.

Where is the research going to take place and how long will it last?

The research procedures will be conducted either in person at your work site, via telephone, or via teleconference using Skype. The total amount of time you will be asked to volunteer for this research is 45 minutes over the next 30 days.

What will I be asked to do?

You are being asked to do the following:

- Meet or connect with Jonathan B. Wilson once - either in person, via telephone, or teleconference via Skype.
- Complete a demographic questionnaire
- Participate in one individual interview that will last approximately 45 minutes.
- Answer questions about your personal experiences as a healthcare provider pertaining to screening for (or addressing) intimate partner violence among migrant and seasonal farmworkers and their families
- Allow your interview to be audio-recorded for research purposes

What possible harms or discomforts might I experience if I take part in the research?

It has been determined that the risks associated with this research are no more than what you would experience in everyday life.

What are the possible benefits I may experience from taking part in this research?

We do not know if you will get any personal benefits by taking part in this research but anticipate professional benefits to you and others who treat this population may be possible. This research might help us: (a) learn more about how to better respond to intimate partner violence among migrant and seasonal farmworking women in healthcare settings; and (b) better understand how healthcare providers can help migrant and seasonal farmworking women who have experienced intimate partner violence.

Will I be paid for taking part in this research?

We will not be able to pay you for the time you volunteer while being in this research. However, a \$10 donation will be made in appreciation for your participation to the National Domestic Violence Hotline. Verification of this donation will be sent to you via the primary researcher.

What will it cost me to take part in this research?

It will not cost you any money to be part of the research.

Who will know that I took part in this research and learn personal information about me?

To do this research, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- Any agency of the federal, state, or local government that regulates human research. This includes the Department of Health and Human Services (DHHS), the North Carolina Department of Health, and the Office for Human Research Protections.
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who have responsibility for overseeing your welfare during this research, and other ECU staff who oversee this research.

How will you keep the information you collect about me secure? How long will you keep it?

The interviews will be audio-recorded and later transcribed. Audio-recordings will be numerically labeled and digitally stored on a secure primary hard-drive and backed up to a secure secondary external hard drive. All audio-recordings will be password protected to ensure security, and only Jonathan B. Wilson and his research advisors will have access to the recordings. If names are mentioned in the interviews, they will be deleted from the typed transcripts. All data will be kept for 3 years and then deleted from both primary and backup hard drives.

What if I decide I do not want to continue in this research?

If you decide you no longer want to be in this research after it has already started, you may stop at any time. You will not be penalized or criticized for stopping. You will not lose any benefits that you should normally receive.

Who should I contact if I have questions?

The people conducting this research will be available to answer any questions concerning this research, now or in the future. You may contact the Principal Investigator, Jonathan B. Wilson, at (405) 334-6533 (Mon-Fri, 8:00am – 5:00pm Eastern Standard Time), or wilsonjon11@students.ecu.edu. You may also contact Damon L. Rappleyea at (252) 737-2416, or rappleyead@ecu.edu, or Jennifer L. Hodgson at (252) 258-4224, or hodgsonj@ecu.edu.

If you have questions about your rights as someone taking part in research, you may call the Office for Human Research Integrity (OHRI) at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research, you may call the Director of the OHRI, at 252-744-1971.

Is there anything else I should know?

The primary investigator, Jonathan B. Wilson, was a graduate assistant employed to provide clinical services in the same clinic from which potential participants may volunteer for this research. However, his research advisors, Drs. Damon Rappleyea and Jennifer Hodgson, will be overseeing that the recruitment, data collection, and data analysis processes are all consistent with what is outlined in the IRB approved methodology. Additionally, no additional requests for participation will be made that take advantage of a pre-existing relationship, be perceived as coercive, or bias the study's outcomes.

I have decided I want to take part in this research. What should I do now?

The person obtaining your informed consent will ask you to read the following and if you agree, you should sign this form:

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this research at any time.
- By signing this informed consent form, I am not giving up any of my rights.
- I have been given a copy of this consent document, and it is mine to keep.

Participant's Name (PRINT)	Signature	Date
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Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person's questions about the research.

Person Obtaining Consent (PRINT)	Signature	Date
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Principal Investigator (PRINT) (If other than person obtaining informed consent)	Signature	Date
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APPENDIX F: DEMOGRAPHIC QUESTIONNAIRE

ID _____

The purpose of this questionnaire is to allow me to describe my sample. Please read and answer each of the following items. Check all boxes that apply to you. Please do not include your name on this document. Please ask any questions that you may have.

What is your gender?

- ☐ 1. Male
- ☐ 2. Female

What is your current age? _____ years

What languages do you speak fluently (e.g., English, Spanish, German)?:

What is the your highest level of completed education?

- ☐ 1. Completed trade school
- ☐ 2. Completed Associates degree
- ☐ 3. Completed Bachelor's degree
- ☐ 4. Completed some graduate coursework
- ☐ 5. Completed Master's degree
- ☐ 6. Completed Doctorate/Professional degree (e.g., MD, PhD)

Major area of study: _____

What is your current job description? _____

What is your religious preference?

- ☐ 1. Catholic
- ☐ 2. Protestant
- ☐ 3. Non-denominational
- ☐ 4. Latter-Day Saint (Mormon)
- ☐ 5. Jewish
- ☐ 6. None
- ☐ 7. Other (specify): _____

What is your employment status?

- ☐ 1. Employed full-time
- ☐ 2. Employed part-time

How long have you been employed in your current position?

- ☐ 1. Less than 1 year
- ☐ 2. 1 to 3 years
- ☐ 3. 3 to 5 years
- ☐ 4. 5 to 10 years
- ☐ 5. 10 to 20 years
- ☐ 6. More than 20 years

What is your ethnicity?

- ☐ 1. Hispanic or Latino
- ☐ 2. Not Hispanic or Latino

What is your race?

- ☐ 1. American Indian or Alaska Native
- ☐ 2. Asian
- ☐ 3. Black or African American
- ☐ 4. Native Hawaiian or Other Pacific Islander
- ☐ 5. White
- ☐ 6. Multi-racial
- ☐ 7. Other (specify): _____

APPENDIX G: RESOURCES FOR PROVIDERS

Thank you so much for your participation in my project. Here are a few resources that you may contact or disseminate to your patients if you feel a need to.

Resources for Immediate Assistance

National Domestic Violence Hotline

www.thehotline.org (English)

<http://www.thehotline.org/en-la-linea-nacional-sobre-la-violencia-domestica/> (Español)
(800-799-7233)

Open 24 hours a day, 365 days a year, hotline advocates are available for victims and anyone calling on their behalf to provide crisis intervention, safety planning, information and referrals to agencies in all 50 states, Puerto Rico and the U.S. Virgin Islands. Assistance is available in English and Spanish with access to more than 170 languages through interpreter services.

National Domestic Violence Hotline: Information for Immigrants

<http://www.thehotline.org/is-this-abuse/information-for-immigrants/>

Information specifically for immigrants or refugees in abusive relationships, this link addresses unique issues that make it particularly difficult for migrant and seasonal farmworking women to reach out for help.

VINE

www.vinelink.com (English)

<https://www.vinelink.com/vinelink/initMap.do?lang=es> (En Español)

Active in 47 states, VineLink.com allows women to search for an offender in custody by name or identification number, then register to be alerted if the offender has been released or transferred, or has escaped. (States excluded: Kansas, Maine, and South Dakota)

Women's Law

<http://www.womenslaw.org> (English)

<http://www.womenslaw.org/index.php?lang=es> (Español)

This site provides state-specific legal information and resources for victims, in addition to advice on how to leave an abusive situation, gather evidence of abuse, and prepare for court.

Financial and Medical Resources

National Network to End Domestic Violence (NNEDV) Projects

<http://www.nnedv.org/projects>

NNEDS projects address the complex causes and far-reaching consequences of domestic violence at the state, national, and international levels. This site provides an overview of the many projects being completed to combat the negative effects of domestic violence.

FACE TO FACE: The National Domestic Violence Project

<http://www.facetofacesurgery.org/domestic/>; (800-842-4546)

The AAFPRS Foundation is the first surgical group to take a firm stand and become involved in assisting individuals of domestic violence to break the cycle of violence, enhance their self-esteem and rebuild their lives. Many victims of domestic violence receive facial injuries and are not financially able to have these injuries adequately repaired. We offer consultation and surgery, pro-bono, to eligible individuals through FACE TO FACE: The National Domestic Violence Project.

Give Back a Smile Program

<http://www.aacd.com/index.php?module=cms&page=610>

The Give Back a Smile Program provides restorative and cosmetic dentistry at no cost to qualified survivors of domestic violence.

APPENDIX H: EXTRACTED SIGNIFICANT STATEMENTS

Extracted Significant Statements

Significant Statements	Transcript No.	Page No.	Lines No.
“Not frequently, ... we do screen for it at every new O.B.”	1	4	117-119
“So it’s something we are screening for and... actually patients are asked the same question twice once by the midwife at the new O.B. and once before that at intake with the health educator.”	1	4	123-126
“Patients are asked the same question twice, once by the midwife at the new O.B. and once before that at intake with the health educator”	1	4	124-126
“At intake with the health educator who does the initial intake and ... we have a model where we have a health educator that meets the first with the patient and has some questions and then works out a care plan for the patient for the duration of the pregnancy, and the midwife is part of our medical history also.”	1	4	134-139
“Actually it is three times because they also do a written medical history before they get to us and that question is there too so yeah it is, it is three times, so they have, there is opportunity three times to disclose”	1	4	143-146
“It’s often said ‘It used to happen to me but I’m no longer with that person’.”	1	4	148-149
“You get more than ‘Yes I am getting abused’ ... that’s very rare.”	1	4	153-154
“We would ask them right ...at the point of disclosure.”	1	5	168-169
“If I remember correctly it says ‘Have you ever experienced trauma or violence in your life?’”	1	5	184-186
“And then the one of the health educators used to say, ‘Have you ever been hit, kicked, slapped...?’”	1	5	190-192
“‘Have you ever been hit, kicked, slapped called names?’ ... it’s very, very specific.”	1	6	206-207
“Everybody is screened. Yes 100%.”	1	6	213
“... [the patients] have to go through the screening process to establish medical prenatal care.”	1	6	217-219
“...If someone reports violence, we call the police.”	1	6	225-226
“It’s more than that...then ongoing support, we have a social worker on staff and we would refer to her for community resources if the patient is in danger and needs... to leave the situation. If she’s not ready to leave the situation then we talk	1	6	230-235

about and reinforce an exit strategy for her.”			
“But if we see bruising we have to call the police.	1	6	243
“Yeah, we’re mandated reporting.”	1	7	255
“I’m very comfortable.”	1	7	270
“Yeah, yeah I mean I’ve been around for thirty years and I’ve seen it... be good for the patient...”	1	7	280-281
“...and for the children, if there are any.”	1	8	294
“They can be, not necessarily are, but can be so dependent on that income, that male income that they... you know stay in situations that may be dangerous to them.”	1	8	302-305
“Just their own powerlessness and I can’t even argue with it.”	1	8	309-310
“You know, they’re here, they’re not documented most of them that we take care of and they’re really stuck.”	1	8	314-316
“Their isolation and then also this... how do I say it? This hesitancy to reach out.”	1	8	325-326
“It seems very real to me. There’s this, I’m not part of the culture so I don’t really know what goes on, but it... from what I’ve seen in my thirty years is that there’s a real circling of the wagons that ‘we will take care of our own problems.’”	1	8	330-334
“And also because our patients often are here not legally... They do not want legal action. They do not want to be disclosed. So... there’s a resistance... yeah there’s a resistance.”	1	8-9	338-341
“[Their undocumented status is] just something they’re...that’s just something they’re concerned about, for absolutely everything.”	1	9	361-363
“Hmm, ethical... No I don’t... I mean, you need to let people know...as a reporter what you’re going to do with the information.”	1	10	386-388
“Very very unaware. Yeah. Very very unaware. I think they think it’s either they get the guy arrested or nothing.”	1	11	435-436
“No, I think they would approach it differently.”	1	11	462
“We have connections with the safe houses in the area.”	1	11	468-469
“We have uh, a whole behavioral health component of our clinic so they can get free counseling services.”	1	11	473-474
“We have connections with the churches...”	1	11	474-475
“We have our own social worker that specializes... in prenatal and perinatal issues.”	1	11	475-477
“We’re well connected with the community and therefore we can connect our patients with their community resources...”	1	12	481-483
“I feel like we’re... pretty equipped to deal with, or to refer”	1	12	494-496
“I don’t feel like we’re lacking in resources in this arena...”	1	12	496-497

“... I don’t feel like, “Oh my gosh. Where am I going to refer this woman to?” You know that kind of... I have that feeling about other things... like specialty medical care.”	1	12	501-504
“I feel like our community...now, offers good resources and it... it’s not dependent on having a social security number”	1	12	511-513
“I mean it’s something that... we’ve really focused on for I don’t know... thirty years we’ve been asking the questions. We’ve been screening so when you ask the question, then you get answers, right?”	1	13	541-545
“We’ve had to develop...we’ve had to develop responses to the answers over the last thirty years.”	1	13	549-550
“I do in-services for our staff maybe once every two years and bring someone in from ... the Safe House or I have the social worker come to talk about intimate partner violence.”	1	13	555-559
“...in this community at this time there are functional places for people to go.”	1	13	563-564
“...if they can’t go... or don’t want to go... then we do work with them on...the cycle of violence, and also just like ‘ok... make yourself a getaway plan. How are you going to save money that he doesn’t know you have?’ And ‘what are you going to do? What’s your plan?’”	1	13-14	564-570
“It’s interesting...many women have a plan. Many women have a plan. Not always, but... but many do.”	1	14	570-572
“And I have noticed sort of the younger women are much more likely to call the police. That I’ve noticed in thirty years, a change. They are calling the police themselves.”	1	14	572-575
“That’s what I’ve seen over the years. Now I work with a young population... but I’m old with the young population right, so I’ve seen it over thirty years.”	1	14	579-582
“When I started when women were very hesitant to kind of blow the whistle on that. And now I’m seeing more and more women will say, ‘Well, uh... you know that used to happen but I, I called the police and he did jail time and now he’s quit drinking.’ ”	1	14	586-590
“Women will say, ‘Well, uh... you know that used to happen but I, I called the police and he did jail time...’ ”	1	14	588-589
““...he did jail time and now he’s quit drinking’... which is at the basis of a lot of it.”	1	14	589-590
“It’s alcohol and substance abuse... it’s almost like it goes hand-in-hand. I mean, maybe not 100% but you know...”	1	14	594-596
“Then they’ll say, ‘Well then he went... he went to jail, he quit drinking, and life has been okay since then.’ ”	1	14	601-602
“That you don’t have to be... And maybe the women feel a bit more empowered.”	1	15	633-634
“Very receptive of having us calling the police on their behalf. Very receptive. It’s sort of like...they want to do it...but for	1	15	647-654

whatever they're afraid... and are relieved that we do it and then they can say 'Well they had to... you know I didn't have any choice. They, they didn't...' You know what I mean?"			
"I've never had anybody say, 'No, don't call.'"	1	15	658-659
"If they're telling us they want something done and they're... they're...they don't have the self-confidence or whatever to do it."	1	16	668-670
"Once a long time ago I [had an interaction with a patient's abusive partner]. A long time ago. I think he knew he was kind of blowing it too."	1	16	679-681
"Well... we had a guy that just never... He hovered, which was a big red flag for us."	1	16	690-691
"We had to work hard to ask her the question. Which we did. And he wasn't really... He wasn't hitting her yet... But he was gonna."	1	16	700-702
"They often start... actually the abuse during pregnancy... it's a big deal."	1	17	707-708
"What I've noticed this big connection between alcohol/substance abuse... and violence."	1	17	719-720
"...at one of the camps we offered an HIV discussion and, proper use of condoms for the women ..."	3	4	117-118
"the women said no to the condom use... many of them... because they said only street walkers, 'putas', used condoms"	3	4	122-124
"So they were saying they were reluctant... to use them. And also during those discussions there were women who said, 'I don't like to take part in this kind of discussion because many of the others who attend here are my cousins or aunts or at least have a family connection and they are going to tell my partner what I have been talking about'."	3	4	128-133
"there was concern that they would be ratted out, if you will, about what their activities were which is a shame ..."	3	4	139-141
"We concluded: we need to do this on an individual basis rather than a group discussion and, efficiency be darned, we need to... if it's going to be effective it needs to be private."	3	5	164-167
"we also developed... and you probably have too... a handout, a tiny handout that can't be more than 2 by 4... that they could tuck, you could tuck in a bra... that gave the line, the phone number for the domestic violence..."	3	5	171-175
"We had some in Spanish and some in English."	3	5	179-180
"There was a family who came to the clinic... a mom and six children... and the mother had been assaulted by the husband who was in jail but it was a small city in Iowa and we knew that he was probably not going to be there more than 2 or 3 days"	3	5	193-197
"We had the capacity to just load up that family and bring them	3	6	202-

back to Des Moines, Iowa, about 150 miles from the small city, which we did.”			204
“We settled them in a shelter”	3	6	208
“That mom was very resourceful, she was a hard worker but she was not documented and four of the six kids were not documented... So you know the problems there. There were not services available ...	3	6	208-212
“...but [agency] did what we could medically and we settled them in”	3	6	216-217
“This woman was really very frightened of the husband”	3	6	217-218
“and as it happens... he was sent to jail”	3	6	218-219
“I do some work at the homeless shelter as well as migrant camps, and... and our regular clinic...the perpetrator was back out and he found them again.”	3	6	224-226
“Because as you probably know very well, there’s... a wonderful tradition of...sharing space and food and so forth and that family took him back.”	3	6	230-232
“I do not know then later, if there were specific incidents of violence between the mother and the father	3	6	236-238
“About a year after... his return... one of the girls who was a teen, about 14, got pregnant and had a baby... I never have established who the father is on this young lady then the final contact I had with that family... the mother, the daughter, the grandbaby, and still three younger children were still living together...”	3	6	238-244
“They came to a clinic for services and it was just regular immunizations and coughs and colds and so forth and so on, and I never have determined where the rest of the family is at this point.”	3	7	248-251
“it’s certainly a case of family strife then jail then reformation of the family”	3	7	255-256
“I am afraid that might be fairly typical... and if the spouse isn’t jailed for violence we have a lot of men particularly being jailed just because of the non-documented status.”	3	7	257-260
“I have had women report to me that their spouses say, ‘You are undocumented. If you leave me I will have you deported.’ And I think that’s fairly common knowledge that that has occurred with lots of...the population.”	3	8	293-297
“I am afraid that [IPV among this population] is very high”	3	8	324-325
“Part of it is unemployment for some...”	3	8	329
“...those normal family stresses...”	3	8	329-330
“...unplanned pregnancies of course figure in”	3	8	330

“...or an unplanned pregnancy in a child...which is devastating to all families.”	3	8	331-332
“We ask...everyone.”	3	9	353
“Verbally. Verbally we ask everyone...it’s part of the history...upfront.”	3	9	357-358
“And that’s then part of our inquiry to patients for a lot of times because they’re all, almost all, uninsured... transient, a lot of them”	3	9	371-373
“...almost all uninsured...transient, a lot of them, as I said, part of my work is at a homeless shelter so there’s a high rate of all races...there’s a high rate of assault, and intimate partner problem at the homeless shelter. It sleeps about 150 people, and there’s just a huge problem. So it’s not just Hispanic there. With XXXXXX, it’s almost all Hispanic families.”	3	9	372-379
“We don’t have a measure but we do have... if a patient responds positively to the domestic violence question, our next question is, ‘Do you need a number to call for immediate help?’”	3	10	387-390
“And then we do give them the number that I described to you, the little handout that they can tuck away in a bra...”	3	10	394-396
“If there is sufficient reason we do call the police. If there is visible bruising”	3	10	396-397
“The patient asks for help we do call the police.”	3	10	398
“Another difficulty...is some partners insist on coming into the exam room with their partner...and we do ask the patient if they wish to be interviewed alone. ... That’s very difficult sometimes...the patient herself will not boot the partner from the room.”	3	10	414-420
“We do ask the patient...if they wish to be interviewed alone.”	3	10	416-418
“We do respect the... because we know that the follow up for that might be violence after they leave the clinic.”	3	10	425-427
“But in our women’s restroom we also have these cards with the number on it for domestic violence to call for help.	3	11	432-434
“We are mandatory reporters. If any children are involved, or an elderly person, we are mandatory reporters for those cases. But, people in between, 19 or 18, over 18 and up through 60 or 65, we have to handle that in a little bit different way.”	3	11	448-452
“I’m very comfortable. I’m a white headed woman. I’m not big... I’m kind of like a grandmother in, in many respects and...my approach is often... ‘You know there is help available if you are in a situation that’s dangerous,’ and it kind of starts that way. And so often, the person’s response is, ‘Oh I don’t think it’s dangerous... It’s only if I don’t cook on time...’ Those kinds of responses. But then in exploring that a little further, I can make clear that that is not acceptable... that someone pounds you because you didn’t cook the right frijoles. That is	3	11-12	467-480

generally my approach...from very broad question down to some more specific..."			
"So often, the person's response is, 'Oh I don't think it's dangerous... It's only if I don't cook on time...' Those kinds of responses."	3	11	472-474
" 'I can make clear that that is not acceptable... that someone pounds you because you didn't cook the right frijoles.' "	3	11-12	475-477
"I wish my Spanish were adequate to really explore this one on one. But I do call in an interpreter in most instances because I'm not 100% sure I'm getting all the information"	3	12	491-494
"That third person in the room is a little hard."	3	12	498-499
"If you want to admit to problems, you might not want more than one person in the room."	3	12	510-511
"I think that [using interpreters] is a tiny bit of a barrier. However, we have almost exclusively female interpreters. And that helps."	3	12	517-519
"When we listen to a patient and we think we know what they should do, I think in describing what's available to them, we might emphasize one decision or another. And that's not right. We need to remain objective. And that's difficult for me at times. When I say 'ugh... it's clear you need to get out of this...' but I don't. One can't do that..."	3	13	531-538
"Well... if there's discovery of a problem, is there an acceptable action?"	3	13	554-555
"Ethically, do we allow a person to walk back in to a dangerous situation? So... it's that, being protective and the preventive side... and if these are adults, ethically we have to just describe. And then let them decide."	3	13	560-564
"Women who are may be in the United States, especially for the first time, and who are not documented, tend to be quite submissive to the male partner. I think they have trouble believing that they can make some decisions or stop the partner... stop the partner's actions. So this being is kind of a characteristic. After they've been here for a while, it's great to see them kind of blossom a little and begin to make some decisions for themselves or speak out and say, 'No, that's not right.' But at first... that first year that they're here, they tend to say it's a male dominant or respond as though male domination is okay."	3	14	574-586
"In general, this population is so gentle with children. I see both men and women being very gentle with children for the most part, at least very little children, 5 and under let's say. The females continue to be very gentle with discipline and so forth. The men tend not to be quite so gentle as the kids get bigger, but certainly as they're babies and little kids they tend to be gentle."	3	14	595-602

“There’s still that problem of unplanned pregnancies where there’s some assault on the pregnant women.”	3	14	602-604
“But generally the culture is so sweet to children and rarely do we see a dirty child. Those children are so nice and clean.”	3	14	604-607
“This country must do something about the citizenship... uh, the immigration problem. I’m afraid... the climate is looking sort of bad for getting anything done now quickly but...I sure push for that.”	3	15	638-641
“We can’t just say men have no problems because being undocumented and being badly treated. It’s the old story of going home and kicking the dog when you are upset at work. We can’t say to these men, ‘You have no right to react.’ But nonetheless, the type of reaction in my experience seems to be ... take it out on the partner, usually female.”	3	15-16	651-658
“I need to work on the Spanish skills but I’m getting a little old to learn too much more of the language, but I keep trying.”	3	16	666-668
“It’s a national shame that we treat these folks like we do. And that makes me all the more intent on giving them good physical and mental health care.”	3	16	672-675
“It’s difficult to get the right mental health services. For these folks that are in crisis and with all their pressures, why wouldn’t they be in mental health crises perhaps at a greater rate than the general population? Because they’ve got that stigma of, ‘I may get caught every time I step outside my door.’ And so, again, it’s difficult for us here in XXXX to find resources for mental health consultation. A few places we have now. But not many.”	3	16	679-687
“I feel like my experience hasn’t been that great and... I think it can improve a lot.... I feel like there is some uncertainty both on the part of me as a provider and...with resources that are lacking”	4	4	119-122
“...so I feel like overall it’s been... super fragmented honestly and...it just needs a lot of improvement”	4	4	122-123
“It’s a hard subject I think and I feel like... I’m uncertain about it sometimes and how to approach it”	4	4	124-125
“I’m uncertain about [addressing IPV] sometimes and how to approach it always and what resources I have or what’s out there”	4	4	125-126
“I don’t hear about [IPV] a lot or I don’t deal with it a lot... I think I can count on my one hand...how many times ...we talked about it specifically like, ‘Yes this has occurred and yes this is affecting you’ but I think it happens a lot more than we talk about it. I feel like I know it does.”	4	4	144-148
“We ask it on our health histories actually to everybody. We ask, ‘Do you feel safe in your home.’”	4	5	159-160
“I would definitely address it if the answer was yes or if the patient brought it up to me.”	4	5	160-161

“If I suspected it I would address it... but I wouldn’t go fishing for it...”	4	5	161-162
“‘Do you feel safe’ is actually the question.”	4	5	166
“We ask, ‘Do you feel safe?’ and we ask men... everybody.”	4	5	172
“The history is something that gets filled out like once a year and so it’s actually not re-asked which is a good point now that I’m thinking about it. It’s not re-asked every visit it’s just that one visit.”	4	5	176-178
“Well just questions like, ‘What happened?’”	4	5	187
“A lot of times the patient will say, “In the past...” ...they’ll answer it that way so that’s a little different.”	4	5	187-189
“If they don’t feel safe definitely that’s the first thing I’ll address. Like, ‘Why don’t you feel safe?’, ‘Who is making you feel unsafe?’ ... just find out what their situation is and what’s going on.”	4	5	189-192
“Are they in immediate danger or is this something that... emergencies... and that kind of thing.”	4	5	192-193
“Yeah I don’t have any screening that we have here that we use”	4	5	199
“After the questionnaire, during the physical exam... if something catches your eye you look for ...and I haven’t encountered any... at least that I’ve discovered.”	4	6	204-206
“Especially if...there’s something that shouldn’t be there. ‘Hmm, how did you get this?’ or something... it isn’t on the front line of my thinking. If it isn’t something that we were immediately talking about when I’m doing my exam... it’s not always in my differentials right away”	4	6	210-214
“I feel like I am comfortable about talking about the issue and asking the questions and listening and like kind of setting a plan...”	4	6	230-231
“I just wish I had like more... knowledge about it or better ways to go about it ... I feel like I haven’t had any real training on it so I’m just doing the best I... know how to and...I think I’ve read bits and pieces here and there... about it in school and then things that might come up through emails or domestic violence awareness days and things like that”	4	6	232-237
“Yeah what I really like...when we... for example depression, those PHQ9 screening tools ...I think it’s a really nice thing and something that might be beneficial for me because it’s...clear cut questions, it gives you an open door to talk and to really divide out what they’re going through, so... that would be helpful...”	4	7	249-253
“... just some kind of standard tool to use and then go from there and... Maybe like... an outline of steps, what to address first and... obviously you want to make sure they’re safe but this is an ongoing... this is not going to be something that’s going to be resolved in one visit.”	4	7	273-277

“Something that I try to do is... develop a plan... often times especially with migrant and seasonal workers you’re only seeing them one time... or maybe twice, and then you’re not sure where they’re going to be going next and so... you know there’s a lot of uncertainty, so ... once you know that they are safe, just developing some goals and a plan... like, ‘What are you going to do if you are unsafe’ or ‘who are you going to call?’”	4	7	281-286
“I’m a newer provider so maybe ten years down the line I won’t need it, but just make sure I cover all the areas... just guide me a little bit in... making sure I’m giving good quality care...evidence based”	4	8	299-301
“I’m doing what we know is best at the moment like for counseling and treatment”	4	8	306-307
“Different women are different so some people are really open about talking about it and some aren’t so, what if you get somebody that you can’t get answers out or stops talking”	4	8	315-317
“Maybe you’re not just going to have one standard plan or protocol, it’s going to be varied to how the conversation’s going or the situation”	4	8	317-319
“I feel like in-person is the best training in the majority of situations, especially like role playing... I attended this like interpersonal therapy... type of therapy conference for a day, it was two days and we did a lot of role playing and I felt like that was helpful ...like practicing. But... the reality is a lot of people are busy. So Webinars are good and just like pamphlets... they’re definitely not as effective, but...”	4	8	327-332
“I have to admit like I don’t have a really great idea of my local resources... we cover the whole state of Iowa and often times and you’re seeing these workers and you’re... you go to them... or we at least go to them... so you’re in a place... you’re in a county that’s unfamiliar to you... and just knowing what’s available to them...”	4	9	341-345
“I think a lot of times like my fear of like... going that route, you know, talking about it is that what am I going to do, you know... what for them?”	4	9	345-347
“I won’t have... anything for them. I’m not going to be able to help them, so... maybe just being aware of resources out there ...a line they can call or somewhere they can go.”	4	9	347-349
“We have a couple migrant camps, so they’re there living and definitely, we hang some things up like posters... that might be helpful... places they can call”	4	9	354-356
“The one case that I remember the most that I addressed is... she was seasonal so she didn’t live in the area so... it was something ... we could follow up and help so...and then the issue of following up is really hard when they’re migrating to state to state.”	4	9	360-363

“I don’t even know...what resources [MCN] have so... I should look into that”	4	9	372-373
“I know [MCN] have lots of amazing resources but I just haven’t talked to them all yet.”	4	9	379-380
“A lot of times when we go see patients we’re in an area... we don’t have an exam room so we set up in barns or community centers and so there’s not a lot of privacy so that’s a barrier”	4	10	394-396
“Like communal... the husband’s waiting...he may be across the community center or something along the way and... it can be hard to talk about those issues or get really what’s going on in the situation, so privacy and... it’s just another barrier.”	4	10	400-403
“Language... for me it’s not [a barrier] because all of our patients speak Spanish and so...I’m able to overcome that barrier.”	4	10	407-408
“Probably fear... fear in the patient’s perspective like, “What’s going to happen?”, “Am I going to get in trouble... for telling somebody?”...and then just like, ‘What if I go home and they find out?’”	4	10	412-414
“I don’t have any facts but... a lot of our patients are undocumented, so calling the police and sending their spouse to jail where there’s the possible deportation or on the other side where they might get deported. That’s a huge thing for people.”	4	10	415-418
“Time is a huge barrier for us because we often see the patient once or twice and we’re dealing with all of these other things like diabetes and hypertension and obesity”	4	10-11	427-429
“And I know I can fix these and [IPV] I am not sure, so... time is a big barrier with addressing...issues.”	4	11	435-436
“There’s like 10 problems and you...don’t have a lot of privacy and then you have lots of patients and not a lot of time...so those things get pushed off to the side.”	4	11	440-442
“I think I have a responsibility to address it... I feel like if somebody tells me they’re not safe and I put it to the side...ethically I need to address it in some way or another. So, it’s hard in that way.”	4	11	458-461
“If a patient tells me they don’t feel safe at home or this is going on ethically I feel like I should address it. I feel like it’s my responsibility, I mean I’m not saying I have to solve it”	4	11	466-468
“With a lot of people in the Latino population where the man is seen as the decision maker in the house, where there’s this Machismo kind of outlook where they work and they make the money and they make the decisions and so...breaking down some of those cultural barriers or educating about the difference between something that’s cultural and something that’s not safe and hurting you... can be challenging.”	4	12	479-484
“Educating about the difference between something that’s cultural and something that’s not safe and hurting you... can be	4	12	483-484

challenging.”			
“When you’re traveling from state to state and you’re living maybe in not the greatest conditions and don’t have resources available or... like the necessary food and clothes I think that just adds to the situation.”	4	12	510-512
“One could say, drinking among... the population ...which I don’t know if it’s actually more prevalent actually among Hispanics but, you’re away from your family or you’re traveling and you’re... stressed out and I think that drinking can play a part ... alcoholism... if that’s going on.”	4	12	512-516
“you’re away from your family or you’re traveling and you’re... stressed out”	4	12	514-515
“Or like...poor housing...I just feel like... less resources and...maybe to get out of the situation or... they’re living in houses and renting and... moving from house to house sometimes...”	4	13	525-537
“Education also probably plays a role... Just not knowing... this is wrong or knowing there’s other options out there.”	4	13	541-543
“Oh and transportation. That’s a huge issue for this population... if the person who is hitting you is the one taking you to the counselor or to your provider... that can be an issue.”	4	13	556-558
“Just the way we set up and things... in order to address [IPV] fully, you have to have a relationship with your patient and it’s really hard with this population because... a lot of... my farmworkers, they live in Texas for 6 months out of the year and then they’re here for...8 months and then here for 4 and so... where I get to see them... like with any disease like diabetes and then they go back and there kind of lost... I don’t know what happens and what’s going on and they kind of get lost in the loop and then they come back and I’m like, ‘Well, you know, what’s going on?’ Like, ‘Have you planned for follow-up?’”	4	14	582-591
“So it’s just really fragmented. And, a lot of people, they have families and they have kids so, maybe the abuse is not a top priority for them and they’re thinking about everyday things and it moves to the back burner a little bit.”	4	14	591-594
“Most of my patients are not... some of them are farmworkers they go back and forth like they go up to northern California and then they come back to the city... there’s off-season. But most of them are not. Most of them are immigrant and migrant as in like they move around a lot based on where the work is.”	5	4	113-137
“I have ladies who sometimes will work in the fields in northern California and then, when it's off season they'll come south and they'll work in the garment industry in downtown L.A. sewing.”	5	4	142-144
“Well, [prevalence is] hard to know because people often deny it... even when it’s pretty obvious.”	5	4	154-155
“I think it’s pretty prevalent but it’s hard to know... and then	5	4	159-

people ... sometimes won't want to admit it even when it's so obvious so...it's pretty prevalent but I can't come up with a number..."			162
"Where I am... you know most women coming are pregnant, or they're coming for family planning. You know we have some that come for GYN woman exams."	5	5	171-173
"I'd say 70% of the women I see are pregnant so it's even more of a big secret to hide it...because they're under all this family stress, they're having a baby."	5	5	174-175
"I actually had to go to court a couple years ago for a woman who was raped during her pregnancy...and, it didn't come out until later. But she was my patient the whole time and she never saw any other provider her whole entire pregnancy, she only saw me. And she never... never, never once said anything about it... it actually wasn't her partner it was her landlord. But she was hiding it from her partner because what if he left her, and here she was having a baby."	5	5	176-182
"And then I had... oh my gosh, this is terrible... one of our... medical assistants in the clinic, her daughter was pregnant... a teenager like 15 or 16. And was coming to me for all her care and then when she was in the hospital having her baby I just happened to be there that day so I took care of her... after a while I realized that she was acting kind of funny... because she was always holding her head only one way which is very unusual for a women in labor... women in labor move around a lot. So the deal was finally I realized I had to ask her to move her hair...she had this long thick hair that she had wrapped all around her. And I had to lure her boyfriend out of the room... and anyways ... here she is 9 months pregnant having a baby and he had tried to kill her. He had tried to strangle her. She had these horrible bruise marks all over her neck and her chest. Oh my god it was horrible. And she was only 15 or 16 and... we got social work involved and he was older, he was like 20 or 21 which doesn't really make the... or maybe he was 19... it didn't make the criteria for statutory rape. The age difference wasn't great enough but he was ... an adult and she was a minor..."	5	5	186-197
"Finally I realized I had to ask her to move her hair...She had this long thick hair that she had wrapped all around her. And I had to lure her boyfriend out of the room..."	5	5	193-195
"Oh my god it was horrible. And she was only 15 or 16 and...we got social work involved"	5	5	197-198
"And then the interesting thing is the mother... So then it all came out that mother pretty much knew that this was going on the whole time. So her mother who was charged with taking care of a minor knew she was being abused by the boyfriend."	5	6	210-216

But the boyfriend was a gang guy. So everyone was terrified of him. So the mother was scared... to do anything about it and then, there's this 15 year old having a baby whose terrified of him."			
"I wasn't terrified of him, although when the... cops came to talk to her they told me ...he was from some particularly horrible group of gang people... and they told me that I should have security escort back and forth from my car for a few months."	5	6	216-219
"But that's the interesting thing about where I work it's kind of a mixture of all different kinds of underserved people...So there's ...the inner city like never been to the beach 20 miles away kind of group of people...and then there's like really recent immigrants, and then there's...migrant workers that kind of go back and forth wherever the work is."	5	6	231-235
"We routinely screen... So...with prenatal care the way it works is usually the first visit is a big long visit. It's like an hour and a half or 2 hour visit, where we get their medical history and ask them all the psychosocial questions...like drug use, violence in the home, all that kind of stuff. So usually... we ask it the first visit... and then, they have... every trimester an in-take with like a nurse where they kind of review that stuff. But not with the... that's not usually with the provider. It wouldn't be... The first time would be with me but usually then I don't ask that question anymore. We do these quickie like 10 minute prenatal visits."	5	7	247-254
"Then in the hospital when ladies have their babies...the hospital screens them again. But they... always answer no and then they've got a big old bruise... and then... I mean what can you do? All you can do is ask people..."	5	7	258-261
"We also have a fair share of ladies whose partners are incarcerated...for various reasons. Sometimes because of... usually something they did... usually it was for stealing a car or whatever."	5	7	265-267
"I've had a good share of women whose husbands or whatever, baby daddies, are in...jail for things [the patient] did to [the perpetrator]. You know, I mean restraining orders."	5	7	267-269
"Most of the ladies never 'fess up to it, but... we have these really long waits in our clinic because that's just how it goes. So...they get there, they sign in, and then they wait... and then they get their vitals taken and then they wait... and ... it's really frustrating for everybody."	5	7	274-278
"We do have the issue of...they're on their cell phone with their boyfriend, who is in the waiting room, talking about, 'Well they just called me... no, no I swear I didn't go anywhere. I was in here. I'm here with the nurse. Do you want to come in the room?' And I'm always like oh my god I don't want him in	5	7	282-286

here!”			
“And they’re controlling. You ask a woman a question and she looks at her partner before she answers the question to get the like ‘Yes, it’s ok to answer that question.’”	5	7	290-292
“And then those ladies who I’m worried about... Usually I just bring it up. As healthcare providers... I don’t think we’re well trained for that kind of thing.”	5	8	297-299
“But I just say, ‘I’m worried about you. It seems like, you know it seems like your boyfriend is kind of controlling and it seems like you’re looking to him before answering your questions... Can you tell me about that?’ ‘Oh, no. no. I’m just checking in with him. He’s not feeling well today.’”	5	8	299-303
“I usually just bring it up. I’m usually just out in the open about it.”	5	8	313-314
“If I get a chance to get them alone... and then usually I try to finagle a way with them away for her to get an appointment when he is unavailable.”	5	8	315-316
“A lot of those guys like if they can’t control 100% they’ll send in a proxy. So he’ll send his brother to drive her.... Or he’ll send... someone who can give him the report of exactly what happened.”	5	8	317-320
“Like he’ll send his... ‘I can’t go but I’ll make sure my sister’s there with you.’ And it’s like... he’s putting on an act like he wants someone to be with her to protect her but really it’s someone to report back to him.”	5	8	329-331
“But what happens a lot of times if there’s a stand in, usually I can manipulate it enough to get them to not come in the room for the exam. Like I’ll say, ‘Well, we’re going to do a pelvic exam so you probably don’t want to see her vagina and I don’t think she’s comfortable with that... So you know, as soon as we’re done with that part we’ll come grab you, you know. It will just be 5 minutes.’ So then I have 5 minutes to like kind of talk to women about [IPV].”	5	8-9	336-341
“I’ve had...over the years maybe 10 or 15 women who’ve... admitted to what was going on but...couldn’t do anything about and didn’t want to do anything about it and weren’t willing to accept any kind of help. So... if a woman’s not a minor... say she’s 23, she’s got 2 babies, here she’s having number 3... ‘Yeah he does hit me but he doesn’t hit the kids and, you know, my parents are in Mexico and the only person I have here is my sister and she’s in the same situation in Bakersfield and how... I don’t have a car, I don’t have a job and I rely on him for all of my financial security so what am I going to do?’”	5	9	342-349
“Right exactly. So it’s up to her.”	5	9	353
“So all I do is say, “Well I’m really worried about you,” and I talk to you about during pregnancy it’s much more, likely that	5	9	358-362

the violence will escalate and I talk to women about like the number one cause of death in pregnancy is not bleeding to death when you have a baby it's getting murdered. And I talk to people about that and I talk to them about a safety plan.			
"I actually did have a lady once...when I was a brand new midwife and I was all energetic and stuff... and she did say she wanted to leave her guy. And she came to the clinic and the idea was that she was going to leave straight from the clinic to the safe house. And she did that, but then she was back a couple weeks later with the guy... so it didn't work out."	5	9	362-367
"Well, if I figure out or if I have a suspicion I bring it up...But I don't know how good I am at it because... I think I'm very suspicious of it you know and I am always on the lookout but sometimes you bring it up and you ask and they, and they say 'No,' so then I don't know... is it really no or are they just saying no to cover it up?"	5	9	373-376
"I don't know what the actual prevalence is."	5	9	377
"I always ask at that first visit... at well women GYN visits I always ask especially the ladies who seem depressed, somaticizing... they have all these very general health complaints but there's not actually anything medically wrong with them that I can find... 40 [year old] women who are dizzy and feel weak and tired and I always talk to them about depression. Are you... somaticizing your depression, your sadness? But then I always ask them also about domestic violence..."	5	9-10	378-385
"But, I don't know how good I am at detecting it. I always ask like I'm supposed to."	5	10	389-390
"So it's not like it's a big secret and we have really great resources."	5	10	401-402
"In my experience private practice doctors, private practice midwives really are the least likely to ask because they figure their clientele is kind of more affluent and if they wanted to get out they could. And there are no resources... once you identify the person has a problem, all you have in your office is you, the doctor, the midwife, and the nurse...and that's it."	5	10	402-406
"But where I am, because it's a Federal Qualified Health Center, and we have lots of resources."	5	10	406-407
"We have IBH, which is called Integrated Behavioral Health, so most days of the week there's someone there who we can do a warm hand-off. If I'm talking to someone and I'm suspecting they have a problem, I don't have to actually deal with it myself. I just identify it, I talk to them a little bit about it, and then I say, 'Ok, I would really like you to talk to Sarah, she's...a counselor that we have that works here that... has really great experience..."	5	10	408-414

<p>“They call them IBH; they’re really social work interns. We also have... a full-time M.S.W. but mostly the warm hand-offs go to ... these ...in social work school. ...We also have a real psychiatrists and then a couple psychologists... But they’re very part-time and they work based on grants, so...it’s just whatever the grant money is for. So, they’ll send out emails, ‘For the next 6 months we have grant money for depressed women between the ages of 15 and 25 with one or more children’... and nobody else qualifies...”</p>	5	10	418-425
<p>“And our social workers are great. They really help get people to good resources. And they would be the ones who facilitate for reporting. I don’t have to do the reporting myself. She’ll fill out the report, if it’s a reporting situation, she’ll fill out the report, she’ll take care of the whole thing, I just have to sign my name to it. Which makes it really easy on us...”</p>	5	11	429-433
<p>“I can still go see my other 25 patients that I’ve got booked for the day. It doesn’t take up my whole day.”</p>	5	11	437-438
<p>“Oh my gosh. I could always use more education. Like... how to... talk to people. I think midwives are really good about just talking to people like they’re really people... like not being so critical. But...that would be great. Any kind of training would be great.”</p>	5	11	452-455
<p>“When the guy’s there. We don’t ask... if at the initial visit the guy is there, I usually... don’t ask the questions I normally would ask. I usually would say, ‘Are you smoking, are you drinking, are you this and this... do you feel safe at home,’ which is a very general question... I feel like it’s ok to ask that in front of the guy, because it could mean, do you have rats in your apartment? ...Because some people take it that way. Some people are like “Well, yeah I feel safe but what about bedbugs?” ...like they take it that way. But it kind of plants the seed in her mind that...she could come talk to me about it later if she needed to... And then a lot of times on the problem list in the chart I’ll write ‘screen for DV when FOB is not present, when the father of the baby is not present...’ so that if she comes to another visit with even if it’s with someone else, not me, they’ll ask.”</p>	5	11	460-471
<p>“But if the woman never comes without the guy then how do you...it’s really hard.”</p>	5	12	475-476
<p>“Yes. Yes, we always ask [the partner to leave during a pelvic exam] and the nurse is, the... our protocol in where we are is... that when they do the initial like vital signs with the lady, because our volume is so much, they usually bring her in and then no one is allowed to come in with her. So that sometimes makes it really obvious who’s having a problem. Because most people are very reasonable and they say, ‘Oh ok, I understand.’</p>	5	12	482-492

You know, and you're like, 'Whoa, I've got 20 ladies... look, look at all the people over there. It gets... we can't, you know... we'll call you in for the real visit,' And most people are very reasonable and they're like, 'Oh ok. I see.' So the guys who are like, "No way, this is my baby and I'm not waiting out here, I don't know what you're doing to her in there," those are the people... that kind of make it a little obvious."			
"Sometimes they're afraid of dealing with the police because of their undocumented status but I always explain to them that... the police can't hand you over to immigration. That's against the law and I explain that to people sometimes and I don't know if they believe me or not but... I've never seen anyone have a problem in the cross-over."	5	12	509-514
"I think the fear is that... if they get rid of the boyfriend or if they try to leave him... well then what's their other choice? They can't make enough money on their own, then they have to go to back to their home family in Mexico who will look at them like a failure...like 'The whole family pooled all our money to send you to the U.S. You can't put up with a little...oh your boyfriend was mean to you. You can't put up with that? You know, you're supposed to send us money'..."	5	13	523-530
"We do occasionally have them where they've been raped or beaten or abused in some way. A lot of times they sometimes are here in relationships that are abusive but what I've seen is a lot of times it's when they're being transported. We had a girl that was pretty young... attractive girl and she had been raped actually leaving Mexico going to Texas to get here."	6	4	132-139
"She was... by several men... and beaten. ... She still had several scars and bruises on her when... she got here. She was hospitalized."	6	4	143-145
"I think hers was by random men because I had to actually go in and talk to her along with the doctor."	6	4	150-151
"We have [women who have experienced IPV] a lot."	6	5	157
"I mean I hate to say a lot but we have [women who have experienced IPV] frequently."	6	5	161-162
"So they come in and they're very upset. They want to be tested for STDs, because they have been raped by someone that they know. Maybe that has been a previous boyfriend or maybe even in a relationship that they were in at that time. But they were not a willing participant."	6	5	162-167
"In that culture some of the men think that the women are supposed to [_____], and no doesn't mean no."	6	5	171-173
"Well. On a scale from 0-10 I would say maybe a 4 or 5."	6	5	184
"There's also some great [MSFW men] that are family oriented."	6	5	188-189
"The ones who come [to the U.S.] with their families I don't	6	5-6	199-

really see it as much. It's the ones that come that either they had to leave their spouses behind, and family behind, or they're just single all the way around."			202
"Sometimes [patients will] tell us as soon as they hit the door, when we're getting Triage, when they're getting their vitals. Sometimes, they probably bring it up to the therapist when they talk to them prior to the doctor going in and sometimes, they break down and tell the doctor."	6	6	213-218
"It was obvious that she had been beaten. She was afraid, but that's why she came. Because she felt that she didn't get... actually it's not that she didn't really get the treatment that she needed in Texas but she left before she could complete it."	6	6	219-224
"Not that I know of. At the hospital we did. That was one question we always had to ask them when we did the interview on them... Is, 'Do you feel... have you ever been kicked, punched, hit, threatened in your home?' But ... on any of our screens here I don't see that. We have substance abuse, we have all kinds of other stuff...but I've never seen that one. That might be a good thing for us to get. I actually haven't thought about it."	6	6	235-243
"That's what we would do. We would ask them... 'Have they...' Because somebody would say yes, immediately... Bam. Like, 'Don't ask me nothing else.' So we would always say, 'Have you ever been kicked, punched, threatened, slapped?'"	6	7	251-255
"I guess the provider [is the first one to ask about IPV]."	6	7	268
"But sometimes, while we triage them they'll...in conversation like, 'How are you?'... or in questioning conversation, they might say something that will key you in, and then we try to let the provider know so they can ask more."	6	7	280-284
"A lot of times people won't tell you while other... there might be two of us in triage, or people might be coming in or out. We try to keep it to one person in there with them so they'll be more open and honest with us. But a lot of times it won't be until they're actually with their provider. The door is shut and they feel like they can actually tell everything then."	6	8	288-294
"Frequently, we would have couples or family members come together now and want to go in one room. Even though we would see them at the same time we do try to...break them up so they have the opportunity if they want to tell anything."	6	8	300-304
"Not on the nursing standpoint. And...that could be an easy remedy because we do a nursing history...And those ask things like, 'Do you exercise, do you wear your seatbelt, do you smoke, do you have a healthcare power of attorney?' and that...would be a very easy one to slide in and not be so abrasive to them is, 'Do you feel safe in your home?'"	6	8	318-325
"I would be fine with [discussing violence with patients]."	6	9	332
"I did work in a hospital for twenty-nine and one half years so	6	9	341-

that's one of the things that we did... We knew exactly... who to put them in contact with, number to give them, you know like Safe House."			348
"We actually had people in the hospital that that was their job. You could call them and they would come talk to that person for you."	6	9	345-347
"You could call them and they would come talk to that person for you. Which, we don't have those things here."	6	9	346-348
"Yeah I had actually brought that up when I first came and said that... we needed to have [IPV resources]... because we could put it in the waiting room if nothing else, a little pamphlet or something and they could just pick it up."	6	9	366-370
"I'm fine with [dealing with violence], but I feel like here, same thing... and I hate to keep comparing it, but at the hospital we had in-services on different things all the time."	6	10	382-384
"[Training] is not an option... it's not that it's not an option but that is not available here."	6	10	388-389
"Let me take that back. We don't have an in-service department but we do, on the computer, a yearly training and it does address violence there. It addresses violence, sexual discrimination... so we do get a little bit of [training]."	6	10	394-399
"I think the main thing is people don't know the resources to give people."	6	10	399-400
"But I think when I first came here I did bring it up... and then I kind of backed off because I thought they'd think I'm crazy. Like, 'Look at all the things we could be doing.'"	6	10	420-423
"A lot of [the challenge with screening and addressing IPV], they're reluctant to give you any information."	6	11	430-431
"Because they're going home to that very same person that abused them."	6	11	435-436
"And they're usually here with no family and really no place to go."	6	11	436-438
"And a lot of them are not legal so they're not going to go to a lot of places because they're afraid."	6	11	438-440
"[Their undocumented status], and probably finances... and they're away from their home. It's not like they have a family support system right here. They're hundreds and hundreds of miles away."	6	11	449-452
"I think that probably, like all women for some reason, they probably blame themselves. Why we do that, I can't tell you."	6	13	532-534
"But one thing, I think they are so dependent on their partner that they're afraid. Like I said, mainly the finances."	6	13	538-539
"I'm sure that the men convince them that somehow it was their fault."	6	13	540-541
"I think if [an IPV question] was on that little nursing interview screen... nobody would miss it."	6	13	552-554

“And just privacy. Because up here, our little triage area is just a curtain. And people might be passing outside the hallway. Even though you have the curtain pulled and they don’t see who you’re talking to... That’s why they feel better when they go into a room and the door is shut and they talk to the provider. But if we suspected it we could definitely go ahead and put them in a room and speak to them before the provider comes in.”	6	14	569-577
“But, if we suspected [IPV] we could definitely go ahead and put them in a room and speak to them before the provider comes in.”	6	14	605-612
“You probably see [the Pandora’s box scenario] more in a private practice but here in a community health center, I don’t think it’s a problem because hopefully everybody here knows that you’re here to help people who are not as fortunate. They’re ... I hate to say indigent. But... we’re hopefully trying to be more helpful than just doing your job.”	6	15	619-625
“The females a lot of times might not want to speak with Dr. Utson because he’s a male. If they’re a walk-in and most of the time they don’t usually make an appointment for that. They would come in as a walk-in because it’s something that has just come up. And I would try to put them with a female.”	6	15	619-625
“Then I would... ask them if they feel comfortable talking to him and if they did not that it’s not a problem. We have three other females that can speak to them... and I would let him know that.”	6	15	633-636
“They come here mainly for testing for STDs because they’ve already received... the female treatment or pap smear somewhere else. Especially if they’ve been traveling through different states. So they would just come here for a follow up STD testing for HIV or AIDS...”	6	18	748-753
“I noticed that if the husbands come in with them, [the patients] don’t say anything. The husbands do all the talking for them a lot of times. And even when we get an interpreter, mostly he’s the one who speaks English and he’ll speak English for her. And sometimes what the doctors will do, they’ll... bring in an interpreter and even then the man doesn’t necessarily want to leave her. And she’s always very quiet and she just answers [her partner’s] questions and... she keeps a lot of eye contact with him.”	7	4	123-132
“I think [IPV] is pretty common with the migrant [population]”	7	4	153
“Because with [the MSFW population] ... the women have to depend on the men so much, and they don’t know English, and the men usually know English, so [women] have to be submissive with them. It seems like the... women who speak English, who go about their day, they’re more independent and they just come to the doctor by themselves and... they voice	7	5	157-175

their opinion. We have interpreters here so they usually just come and see the doctor and get an interpreter and that's it. ...It's those who... have limited English that have to depend on [their partners] to take them to the doctor. They don't have [a driver's] license so they have to depend on them to do everything."			
"Most of the time if the patient comes in for falls or injuries, the provider will ask them about...any violence or anything. Other than that, if they're not coming in for an injury or a fall appointment or a walk-in, then the doctor will usually discuss [IPV]... They may just bring it up in the physical appointment.	7	5	187-193
"We would ask them, 'Are you coming for, you know, whatever' or... in conversation like, 'Oh I haven't seen your arm move... What happened to...?'"	7	6	210-213
"'Oh I haven't seen your arm move... What happened to...?' And if they... don't say anything, like they were hurt, then that's as far as we would take it.	7	6	212-215
"I feel comfortable with it. But I would definitely notify the provider and... the medical family therapist...to intervene, so they could have somebody else to talk to.	7	6	243-247
"Well if I spoke Spanish that would help."	7	7	257
"I think with more people in the room... sometimes the...Spanish ladies are... reluctant to speak to you about things. Because, they have me and the interpreter, and more people definitely make it... Secondhand information sometimes, [such as] the interpreter may say it a different way than the way I ask it and that sort of thing. And I think that could be an issue."	7	7	261-268
"Maybe if we had little seminars or classes about [IPV] in the office. That would be helpful."	7	7	283-285
"I guess they might not know the true percentage of it because... depending on how many outreach patients we see here...like Rochelle... she has the outreach clinic in Washington. She may see more. And the ones who go to the actual camp, they may see more."	7	8	295-300
"Then I don't know if they get scared or they have second thoughts, [but] then they leave. And sometimes we don't see them again. So you don't know whether they're okay or they're not ok... and that bothers [me] sometimes."	7	8	331-335
"We have had cases like that... that we've had the provider ask them to leave or step out. And she would send [the partner] out front and then she would talk to the patient alone. And sometimes the patient would talk better with him out of the room because she couldn't say anything [while] he's there with her. And then sometimes she may not say anything still because she's got to go back out there with him."	7	9	356-363
"They've not been here in America and...they're used to that in	7	10	393-

Mexico and... until they know better... until they can speak English and interact more... they don't know that it doesn't have to be that way over here."			398
"They get over here and until they know better... until they can speak English and interact more... they don't know that it doesn't have to be that way over here. And once they learn that... that's when it changes."	7	10	395-399
"The migrant population has probably experienced a little bit more domestic violence than other populations that I... work with... Our migrant population does tend to be Hispanic... Our other populations tend to be Caucasian or African American... non-Latino. Our Hispanic migrant population tends to experience a little bit more domestic violence..... than our other... populations."	8	4	110-119
"If I see any signs or symptoms... like bruising or some nonverbal cues like very poor eye-contact..."	8	4	134-136
"Or the male is not willing to leave the room... some of those... those nonverbal cues... then I'll bring up [IPV]."	8	4	136-138
"During the annual physical that's one of the questions that I always ask... I always screen for [IPV] during my questionnaires so, there are a couple different times that... it would be brought up."	8	4	138-142
"It's a screening question so I always screen for [IPV] during my questionnaires so, there are a couple different times that... it would be brought up."	8	4	140-142
"I guess the fourth time would be... pretty frequently when our medical family therapist comes in the room... to talk about anxiety or depression... if it gets brought up during that time."	8	4	147-150
"The medical family therapist will come and talk to me about it and we'll... do a joint visit."	8	5	155-156
"Probably [patients] bring it up to me most often, because if they're at the point of being willing to talk about it, or if they're coming in to talk about anxiety or depression then... that's pretty frequent."	8	5	163-170
"[Patient initiative for disclosure] is the most often when they're coming in to talk about anxiety or depression, because then they'll bring up why they're depressed or why they're anxious and... then they'll get into the reason for their anxiety or depression. And... their family life situation will come up and then we'll get further into it and... they might not be willing to talk about it initially, but once we start getting into it then they're more willing... to discuss their life situation."	8	5	170-179
"If they're coming in for their annual physical then... I'm going to go do my normal screening of tobacco use, alcohol use, substance use ... and, 'Do you have partner violence?'"	8	6	202-208
"And... 'Do you have anxiety?' I usually go with anxiety and	8	6	213-

depression first...and do my own little PHQ2 and then if that's positive... I always do the partner violence as well, then we talk about partner violence."			217
"And then...the other time it comes up is when I do their establishment of care... one of the questions is, 'Is there any domestic violence?' That's another time that it would come up is when I do their establishment of care or update their medical records."	8	6	221-226
"I think it's ...the company protocol."	8	6	236
"It's verbal. 'Is there any domestic violence in your home?' So that covers whether you're having domestic violence, whether your children are having domestic violence, whether you're perpetrating any violence..."	8	6	242-246
"Occasionally they'll look at me... because a lot of times it has to be interpreted, and if it's interpreted and they give me that questioning look, I can ask, 'Do you feel safe in your home? Do you experience any, emotional, verbal abuse? Any physical abuse?' And things of that nature. I can break it down even further. But they usually do understand domestic violence. But if I get that... questioning look like, 'I don't understand the question' when my interpreter gives them the question, we'll break it down even further."	8	7	259-269
"I screen all women and men and children."	8	7	279
"If [IPV] comes up, or if we're talking about anxiety or depression."	8	8	297-298
"Because I'm asking about risk factors for their anxiety and depression. So I'm going to go ahead and screen for situational things, for substance abuse, for domestic violence, for work situations, for...all of the common... for some of the risk factors that are going on."	8	8	313-318
"I feel moderately comfortable. Moderate to high comfort. If I don't feel comfortable then I bring in help."	8	8	331-333
"I know when I... start to feel out of my comfort zone... I know who to call, I know resources to turn to."	8	9	337-339
"I call the suicide helpline , I get my medical family therapist, I have a little card in my office that has a list of resources...that one of the medical family therapists gave me. So, if ever I need assistance I have several numbers to call. I'd have to look at it to tell you."	8	9	343-348
"I have had to call I think twice... when it's starting to get... out of my comfort zone."	8	9	352-354
"If there's a MedFT available onsite I always bring in the MedFT. I think there's always resources that I don't have...I think a group approach is always more helpful than a...singular provider approach. Unless that patient for some reason doesn't feel comfortable say, with a male provider in the room... or	8	9	365-375

doesn't want her or his story shared with a certain male or female or...more people. If they're okay, I always think having a group approach is a more productive approach."			
"Well anytime that we have an annual updated training on, 'Ok, here are the North Carolina state rules and regulations' because a lot of times things change or providers don't know what the... state laws are. 'Okay, for children it's a mandated report.' Well who do you report to? Who do you have to call? Okay, with adults it's not mandated but here's who you can call, or okay here's a card that has all of your resources that you can call. Some kind of annual training, like for CPR for providers or nurse practitioners and doctors and such. We have to do a CPR training. It would be helpful if something was offered that here is a lunch-and-learn where you can learn about domestic violence and your options in the area for your domestic violence resources."	8	10-11	420-435
"Something like that would be very helpful. Just as a reminder... as a refresher...possibly... we have new providers coming in all the time...who don't know what the resources are, who don't know where to send patients in the area. If there's not an MFT on site what do they do with these patients who they suspect, or they know have domestic violence if they don't know what the resources are in the area?"	8	11	437-444
"They might know what to do with domestic violence but they might not know the resources in the area and if they're the only provider on site... they're up a creek."	8	11	448-450
"Probably getting patients to come back in to see me [is the most challenging aspect]."	8	12	482
"Or getting...their husbands and their partners out of the room...when we're talking about the situation to begin with. ...If it's during a physical and we're talking about it then I can... get the...husband or the partner out of the room to speak about the issue. But when [the partners] come...if I can get [the patient] back in to see me and fake about their blood pressure or something else, then the partner might not be willing to leave the room to talk... so that I can follow-up...and talk about the partner violence."	8	12	483-492
"or get the MFT to get in there to talk about the violence"	8	12	492
"Or they're not... able to follow-up because they've moved on or they're not able to keep their appointment or...they just don't keep their appointment and I don't have... a working phone number or an address...in order to follow-up. So I don't know... I'm not able to follow-up and I don't know what's going on, if they're okay, or if they need further assistance. I can't keep in contact with them because they're migrant. So either they've moved on or they don't have working contact	8	12	493-503

information.”			
“And I don’t have... a working phone number or an address... in order to follow-up. So I don’t know... I’m not able to follow-up and I don’t know what’s going on, if they’re okay, or if they need further assistance. I can’t keep in contact with them because they’re migrant. So either they’ve moved on or they don’t have working contact information.”	8	12	496-503
“I think that’s pretty common across the board. I think that’s... common to domestic violence populations. I do think...it’s common across the board but it’s a little bit more common in Hispanic populations.”	8	12	516-520
“There’s a little bit of that Machismo going on where the Hispanic male wants to control his...partner’s health care in all aspects... whereas a Caucasian male...if there’s domestic violence in the home, he might be willing to let her go in and have her blood pressure checked and have her doctor’s appointment by herself a little bit more so. ...When Hispanic families come to the doctor’s office...because there’s only one car a lot of times or there’s no transportation, very little transportation...the father’s going to come, the mother’s going to come, the aunt or uncle might come, and all the kids are going to come... and they all come back to the room together. So it’s a little bit more difficult to have an appointment with just the female or just whoever is having the problem with domestic violence.”	8	13	533-549
“[IPV] is common across the board but in this population it’s a little bit more specific because of the dynamics of the Hispanic population, the migrant population.”	8	13	553-556
“A lot of times they’ll all come... the husband might come for his appointment and the wife and the children might all come for their appointments on the same day.”	8	13	560-563
“He is trying to tell me what’s going on with the female and he won’t let her talk. He’ll say, ‘she’s having very bad menstrual cramps,’ or ‘she’s having headaches.’...He will tell me what’s going on with her... especially, when I have a question of whether domestic violence is going on...in the relationship. And it’s difficult sometimes to get either get him out of the room or to let her talk to tell me what’s going on with her.”	8	14	580-588
“Of course I worry that...if I address this with them... that there’s going to be a negative impact when they get home. If I address this now and I try to help them and...if they receive help and it doesn’t go as planned, that [the patient] is going to get abused more at home.”	8	14	602-608
“Especially because they’re migrant... if they move away from their partner they’re not going to have that funding source.”	8	14-15	609-613
“...further abused. Because she’s bringing it up.”	8	15	621

<p>“If they’re a non-migrant population I can usually follow-up a little better, and get the police involved if she wants me to. I can help her find the resources within the community so if she wants to move out and move into a homeless shelter or whatever, I can help her find those resources. But because this is a migrant population, if she’s moving with the migrant population I can’t help her find those resources. If she’s moving next to Florida, I can’t help her find those resources necessarily in Florida, if she’s moving to pick oranges or to pick cotton, or to do something else at her next station. So... you always have to kind of be mindful of where they’re going next.”</p>	8	15	629-642
<p>“If she’s moving with a group of...migrant workers and he’s in that group of migrant workers, that might be their only income... her only income source. Either she stays here, which, if she’s on his visa, she might not be able to do that.”</p>	8	15	642-647
<p>“And then, of course, they’re not usually willing to report anything to the police because she’s afraid of being deported.”</p>	8	15	651-653
<p>“Of course I’m considering if...there’s domestic violence going on with the partner, if there is going to be domestic violence going on with the children as well... That makes it...an easier end road for reporting and for getting the process started because if there is [domestic violence] ... it’s not necessarily a reportable offense for an adult but it is a reportable offense for a child. So... if the child is there and I can bring the child in and...get the process started with the child, then that is a reportable offense.”</p>	8	16	677-687
<p>“But I’m also trying to keep my patient’s trust. I don’t want her to feel like I’m ratting her out. If she’s coming to me and she’s saying, “I’m having some abuse at home...but I don’t want to get my husband in trouble,” I don’t want her to feel like I am betraying her trust by turning...by turning her partner in to the police. So it’s a...fine line.”</p>	8	17	702-709
<p>“The only other thing I can think of is that the language barrier...would be one of the...biggest barriers, for me. ...A lot of times it’s very difficult to get the complete story and to get the patient to open up completely when they don’t always feel like you understand what they’re saying or when you’re having to go through a third party to interpret what they’re saying. They might not feel as open with, say, me as they would feel with Yolanda.”</p>	8	18	756-763
<p>“So that tends to be a very large barrier, the language barrier. It doesn’t mean that they’re not going to open up and talk to me. It just means that it’s going to be a little bit more difficult.”</p>	8	18	777-781
<p>“The other one is that when I had a male medical assistant, I felt that patients were less likely to speak to me about partner violence than now that I have a female medical assistant. She</p>	8	18-19	789-797

speaks fluent Spanish, and he spoke a little bit more broken Spanish. And I feel like my patients are much more talkative about certain things because she is a female and they feel more comfortable speaking to a female.”			
“Let’s say I’ve met with someone during a medical visit... often times that topic would not come up in...the first time I’m meeting them. Whether, it’s not something that gets brought up... a lot of times it takes time, ...even if it’s a couple or three times after they’ve seen me here...because it builds trust. So, there’s a huge trust component as far as how much they are willing to share and open up.”	9	4	140-150
“A lot of times [IPV] is in the past. Or they could still be living together with that partner, but the violence has either currently stopped or within the last few months or since they moved. A lot of times if they’re from Mexico or from Central America, then the violence ... sometimes it either stops or it...gets reduced a lot when they move into the U.S.”	9	4-5	153-160
“A lot of [the discussion we have about violence] is that sort of post-trauma... especially talking about stress and if they do mention the marriage or just the relationship with their spouse or their partner as being one of the main stressors, it usually still takes a little bit of time. After I’ve seen them a couple of times, they sort of go into the history of their relationship, in terms of dealing with the domestic violence. It’s not usually something that comes out right away.”	9	5	169-179
“I notice a big change when they see me and they’re like, ‘Ok this is ...an English speaking therapist...or she’s maybe American, who happens to speak English,’ versus when they specifically start asking me, ‘Where are you from?’ and then I say, ‘Well, I’m from Colombia.’ And they’re like, ‘Oh.’ They’re more willing to almost open up because then they realize we’re a lot closer in the culture. We’re both Hispanic. All of a sudden there’s a big shift in trust. There’s more trust, there’s more openness and more willingness to share. So there’s a huge cultural component as well.”	9	5-6	190-204
“I say, ‘Well, I’m from Colombia.’ And they’re like, ‘Oh.’ They’re more willing to almost open up because then they realize we’re a lot closer in the culture. We’re both Hispanic. All of a sudden there’s a big shift in trust. There’s more trust, there’s more openness and more willingness to share. ”	9	5-6	197-203
“...they’re not sure, but once they find out [we’re closer in culture] then they’re a lot more...comfortable, and they share more.”	9	6	214-216
“Not just Caucasian. I would say any other culture. Basically... any non-Hispanic I would say.”	9	6	223-225
“More often. A lot more often. Yeah. I would say like... at least	9	6	238-

in the 80%... 80-85.”			239
“I usually start with the level of stress. If they say it’s high or they give me 8 out of 10, then I usually try to find out where the biggest sources of stress are. And often times that’s usually where [IPV] comes out. If they’re like, ‘Well, you know, work’ or ‘my family is far away’ or different things like that, that’s when I’ll say, ‘Are you married or are you living with someone?’ ... and if they say, ‘yeah,’ I may say ‘Is that relationship a source of stress also?’ I don’t directly say, ‘Okay how is the relationship?’, ‘good’, ‘oh, ok. Is there any violence in the home?’”	9	7	258-272
“... if I don’t know them very well, if they don’t know me, [and] there’s [no] trust... it’s going to be too forward. Instead of being honest, instead of giving them the opportunity, or if it’s too soon, they may lie.”	9	7	273-277
“If they begin to talk about... a lot of conflict, a lot of arguing, a lot of fighting or sometimes they say... the words ‘bad temper’... or something similar to ‘aggressive’... [the patients] are not necessarily saying [bad temper or aggressive] with them... If they say... ‘anger,’ ‘can’t control his anger,’ then that’s when I specifically ask, ‘what do you mean?’ Like, ‘What is that?’ ‘What does anger look like? How does he show it?’ And then they sort of begin to tell a little more. Then sometimes they’ll say, ‘he’s never really... beat me up.’”	9	7-8	284-301
“And so I said, ‘Well he’s never beat you up but have you been hit you before?’ or then I start giving examples: hit, or scratched or pushed, because a lot of times they’re like, ‘Well I... don’t get beat up.’ So I have to sometimes be specific because they don’t see a push or a strong hold of a hand or something aggressive, that type of violence. ... Because it’s not beating up, they don’t see it as violence. And so sometimes I have to... start getting specific about the aggressiveness or the anger and how it’s shown.”	9	8	305-317
“Sometimes they will specifically say, ‘No, he is very angry with... he will kick a door or throw something at the window or whatever but it’s never toward me... he’s never laid hands on me,’”	9	8	317-321
“Usually [bringing up IPV] comes more from... assessing for stress and the relationship and then it goes from there.”	9	8	322-325
“Sometimes a part of the initial questionnaire that the clinic does ... is, ‘Are you currently or have you ever suffered any kind of trauma or violence in the home?’ Depending on how they answer that question, and what the provider finds out, then sometimes I will be asked to go in there ... especially if it sounds kind of vague. Then I can be more direct at that point, because they’ve expressed that there has been or some sort of	9	8-9	332-344

violence in the home.”			
“They may be afraid or [say], ‘Oh, I’m not going to go’ or ‘They’re asking too many questions.’”	9	9	372-373
“I could be seeing the kids, [while] mom is in the room and we’re actually talking about the kid’s behavior, the kid’s aggression. ‘They’re just really violent...’ So when we begin to talk about what the home environment is like, depending on what examples she gives me of [what] the kids are doing, depending on some level of aggressiveness from the kids themselves, I’m [thinking], ‘Hmm... that sounds...’” Or if the kids are hitting mom... I start digging in a little deeper. ...For some reason I noticed if they’re males... more boys will have a tendency... to hit more their mom if that’s something that the dad does. ...I haven’t seen a daughter do that...with mom, but a little boy, if he’s seen dad do that. So a lot of times if the boys are aggressive, not just... among siblings or at school, but if it’s something towards mom I start digging a little deeper. Often times, even when I’m asking the child or...I ask mom, if they have watched or observed or seen that behavior, if they’re around it anywhere. And they’ll sometimes say, ‘well... sometimes they’ll see that from their dad.’ And that’s...how it comes out.”	9	9-10	376-404
“Sometimes there could be more...out there, new programs or new things that I may not either hear about or be familiar with. So I guess... just being up to date with resources.”	9	10	420-424
“Because we do have, thankfully, the medical family therapist... [providers] might have the interest but I don’t know that they... would have the time to necessarily keep up with [resources].”	9	11	434-440
“[My employer] could offer something... Maybe once a year, if...[my employer] wanted to bring in someone to bring up the latest resources and the latest things that are available. Even if they wanted to have someone talk about how to refer, how they help, what new things they’re...currently doing and how they’re helping, and how they can work with [my employer] so that the providers know what to do, who to go to, where to send them, who can qualify, what will they be receiving, or just the contact information to give or to call.”	9	11	443-455
“Probably the biggest challenge is just being able to even get patients to share, to open up about it, to talk. And a lot of that is because sometimes, culturally speaking... [IPV] can be widely seen as normal. Normal in the sense of, ‘Oh, this is what happened to my great-grandma, my grandma, my mom and this is what kind of how...well, this is what’s supposed to happen.’ ...The problem is so widespread that sometimes it’s seen as normalized.”	9	11-12	469-480
“So the biggest challenge sometimes is...educating	9	12	484-

and...making sure that they understand this is a safe environment for them to share.”			487
“It’s educating and...making sure that they understand this is a safe environment for them to share ... but also, giving them...the resources and the information like, ‘Hey, if you share, this is...part of your protection or your rights even if you are not...a citizen of the U.S.’ Because a lot of times it’s a feeling that [MSFW women] don’t know what [their] rights are. [They] don’t know how much [they] will be protected ... or [their] children... or what resources...if they’re fully dependent on their husband, who is the breadwinner, the provider... there is language barrier so it’s not really easy for them just to pick up and leave...if they’ve never worked. ... Yeah, sure, you can say, ‘this is a safe place for you to open up and share,’ but once it’s shared... then [patients] may sort of feel like, ‘Well what was the point of sharing if...I’m stuck. I’m stuck in this situation. I can’t go here. I can’t go there. I can’t live on my own. I can’t work. I can’t speak English. What am I going to do? So, I either put up with this and I know my kids are taken care of or I’m out on the street somewhere. Then what am I going to do to provide for my kids?’”	9	12	485-513
“The only thing I can think of... [is] just that cultural sensitivity.”	9	13	537-539
“You’re educating and you’re offering, but you’re not judging, the fact that in a way they’ve accepted [IPV] as normal.”	9	13	546-548
“For various reasons they may not [only] choose to stay in the situation, but they may see it as... ‘This is normal’ or ‘This is okay, and I’m fine.’”	9	13	550-553
“Just being careful with the questions or even trying to offer support, if somehow the partner finds out, that you’re not putting [patients] at greater risk for more violence. Be careful...that the partner doesn’t pick up that at this clinic where they’re being treated for X, Y, and Z, they’re talking to them about [IPV] because if they find out...[the partners] just stop bringing them to the doctor. And so you have to also be careful that you’re not in a way sort of... making a bigger problem for them...”	9	14	579-591
“Being very aware and careful with even who is there and who is present and making sure that it is okay to even ask some questions or talk, depending on who is present in the room.”	9	14	595-599
“That’s another cultural thing. A lot of times the partner is present, because he’s the one paying, he’s the transportation, he’s the one that sometimes speaks more English than she does. So, being careful because even you’re asking him to step out it may already send red flags to him as far as, ‘Why am I being asked to step out? What did they talk about?’ And...that could cause a lot more problems for her because now she’s going to be	9	14-15	606-620

questioned. You just have to be really careful. Even asking him to step out already puts her at danger, because he's going to want to know exactly what was being asked and why..."			
"He may not be upset here at the clinic but it's what's going to happen afterwards as far as what she's going to say they talked about. ...[Be] careful...asking them to step out. ...Now of course this is different ...there's a lot of pregnant women...that come with their partner and sometimes [the partner is] asked to step out, not because they are getting suspicious about domestic violence. It's just more because, maybe they have two other kids and literally in the room there's absolutely no room. And so sometimes they're asked to step out but that's not for questioning... just because there's no room...but that's different."	9	15	624-638
"So I guess just being culturally sensitive but also sensitive overall as far as, we're here to help and to try to assess and get some information. But even how we assess and even how we go about finding our information, we have to be careful with it. And then in the process of [assessing], that we didn't create...potentially... putting them more at risk."	9	15	638-645
"I haven't actually checked some of the patient bathrooms lately but sometimes at the women's clinic they'll have, in the women's bathroom, the family violence program. You can rip off the paper. They will have them in the women's bathroom because they know it's the only place that the men can't go. So it gives [patients] a chance to... I don't think we have those set in place here, where they can just rip the number off and keep it somewhere. But a lot of times that's how discrete some women's clinics have to be. It has to be that discrete and private just because [providers] don't want to put the woman at higher risk for more violence after she comes to the doctor."	9	15-16	650-664
"So that's why I've seen those little...pieces of paper that you just rip them and they're small so they...hide them... somewhere on their body...easier than coming out with a pamphlet or something that's just too big."	9	16	674-678
"So, being really aware, really sensitive, really careful even in the assessment process. And obviously if [the patient and the partner] are together and they're answering the questions normally, but...it seems that you kind of hit an area where all of a sudden she gets really quiet and he's there... especially if you're [talking about] conflict or something among them, you can sense that it just gets really uncomfortable there, just [be] careful how you proceed. If she gets quiet, and it's in front of him, it's for a reason. So, that doesn't mean you stop assessing. Obviously that's when you want to make sure that everything's okay, but just [make] sure you're careful how you proceed."	9	16	680-694

“Depending on the cases, it’s not many, but I would say there are some that end up being partner to partner violence, where it’s not just...the male hitting the woman, but sometimes it can be the other way around. And depending on how it gets, it can be ... it’s different but it will still be... I guess it’s good to keep in mind that sometimes [mutual IPV] is going on and it’s just a vicious cycle.”	9	17	713-722
“She reported her husband, and he was deported for the domestic violence. She continued to feel threatened because his family still lived in her neighborhood here, and he was deported back to the neighborhood in her home country where her mother and other family members lived. So, when I met her, she had already gotten out of the situation of domestic violence by her husband, but she continued to feel danger because of being around his family members, who she said would threaten her in her neighborhood.”	10	3	93-103
“He had threatened to do harm to her family back in her home country.”	10	3	104-105
“Her husband was deported. She remained here.”	10	4	116
“[His family] had not done anything physically to her, she said to me, but she did fear them. They had made verbal threats to her, and that was not a comfortable situation for her.”	10	4	132-135
“The other patient that comes to mind is a woman in her mid- to late-thirties that I met in night clinic last summer who came in to night clinic complaining of shortness of breath. And when I went into the exam room to speak with her, her husband was in the room with us. She was kind of explaining the shortness of breath to me and she was certainly worried about this shortness of breath. But as I examined her and spoke with her, I got the sense that the shortness of breath was due to anxiety, and I got the sense that there was something going on in this relationship just based on the husband’s demeanor in the room.”	10	4	140-151
“And I got the sense that there was something going on in this relationship just based on the husband’s demeanor in the room.”	10	4	149-151
“At some point I asked her to step out and give us a urine sample.”	10	4	152-154
“I asked our interpreter to screen the patient very briefly and secretly for domestic violence. And when the interpreter asked the patient outside of the room while the husband waiting inside the exam room, the patient became tearful and said, ‘Yes’ that there were problems, and that, ‘Yes’ [IPV] was an issue.”	10	5	156-161
“With him right there it was kind of tricky to figure out what to do to help this patient who was in this situation. And we basically ended up scheduling her a very quick follow-up for a false diagnosis. We kind of said, “Well we think you have asthma. We think that’s what this shortness of breath is caused	10	5	165-172

by. We need you to come back soon to do more testing.”			
“Somehow we figured out a way to keep the husband in the waiting room and got the patient back to the exam room by herself. The interpreter and I spent a good amount of time asking her about the situation and finding out just what her resources were, just what was going on and tried to give her some telephone numbers that she could use to get some help.”	10	5	176-183
“And that was tricky because obviously this patient didn’t speak English.”	10	5	187-188
“We tried to find resources in the area that could accommodate Hispanic patients and we did eventually did find some that could help her with the language barrier. But then the next issue we faced was finding a shelter that could accommodate her teenage son. Because shelters don’t take in children who are male once they reach a certain age, and at least one of her sons was above the cutoff.”	10	5	188-196
“We made an arrangement for her to be contacted by one of our medical family therapists the next day at a time when her husband would not be in the home, and that contact was never made. She never answered and obviously you can’t leave a message, so I don’t know whatever happened with her.”	10	6	202-207
“If I remember correctly, it would not have been an issue if her children had been female. It was specifically because they were male that they were not welcome.”	10	6	230-232
“I’ve heard that domestic violence is more prevalent in migrant farmworker populations but I don’t know data. I may have known data at some point but all I know now is that my understanding is that it’s more prevalent.”	10	7	247-251
“I feel like gender roles in general are maybe more delineated among my patient population who are migrant farmworkers just in terms of my female patients think about getting up super early to cook breakfast for their husband and prepare their lunches for them to take to work. And you just don’t hear a lot of non-migrant patients thinking about having to do those types of traditional gender tasks, those specific tasks. So I can say it seems like there’s still a role for the wife that’s more traditional among my migrant patients.”	10	7	270-281
“I hear other patients talking about how their husbands expect them to have food on the table and expect them to do this or that or the other with the children, which I don’t hear my non-migrant patients talking about...”	10	7	286-290
“I don’t know if we have a protocol in place. Our medical assistants do certain screenings when patients are checked in but I never noticed that domestic violence was one of the things that they screen for. I know they screen for substance abuse, but I’ve never been aware of a screening for domestic violence. I think in	10	8	304-312

general, the others of us who are providers at Cherry Hill medical center kind of do our own thing.”			
“I generally include a screening for domestic violence in my female physicals but it’s not a 100% across the board question that I ask. I’m sitting on the computer and I’m going question-by-question on my physicals template and I’ll see it and remember. But I don’t always go through the template and if I don’t go through the template often times I forget. If I’m not following the template I try to include it in the portion of my questions for patients during a physical exam when I’m asking, ‘Do you have any problems with feeling nervous or any trouble with moods? Any trouble with insomnia? Do you feel safe in your relationship?’ But there are certainly many times when I forget to ask that specific question.	10	8	314-330
““Do you have any problems with feeling nervous or any trouble with moods? Any trouble with insomnia? Um, do you feel safe in your relationship?’ but there are certainly, um, many times when I forget to ask that specific question.”	10		
“One of the problems with that question is, ‘Safe’ is a subjective term. And it probably would be better to say, ‘Does your partner hit you?’ But for the same reason that I ask patients if they ‘Eat well’ and they say, ‘Sure, I eat plenty.’ They don’t understand that I’m asking, ‘Do you eat healthy food?’”	10	9	369-375
“It depends I guess just by the nature of the fact that I ask, ‘Do you feel safe?’ and I only ask it part of the time, I’m obviously not as comfortable as I ought to be. I would like to feel more comfortable asking patients if they’re in a violent relationship and feeling like I’m asking in a way that’s not offensive or belittling. So yes, I would certainly like to feel more comfortable.”	10	10	391-398
“If my patient and I have a conversation about being a victim of domestic violence, I feel perfectly comfortable talking with them about it. I have no trouble having the conversation about what’s going on with them. Now, I do not feel perfectly comfortable figuring out what to do about it. I feel very comfortable talking with somebody about it, and I feel like I can offer a great listening ear and I can provide some decent therapy.”	10	10	404-412
“When it comes time to figure out, ‘Okay well what are we going to do about this?’ That’s where I feel like I’m not equipped. Just like that situation with that patient at night clinic, I really had to scramble to figure out what my resources were and then we were not successful in following through with the situation she is in. So that’s where I do not feel equipped. I feel equipped to talk but not equipped to act.”	10	10	412-420
“If I don’t have a good rapport with my patients before I start asking such serious questions, I do worry that I’m not going to	10	11	438-447

be as helpful as I could. We do a lot of physicals on new patients or patients who are new to us and ...I don't screen because I feel like the patient's not going to trust me when they just met me."			
"And I don't know why exactly I feel that way. I mean I have serious conversations with patients very often who I've just met. They certainly are quick to confide in me about a death in the family or financial hardship. I feel like patients cry with me in the room with me at least once a week, and I only work two days a week. So I don't know why I feel like I've got to be touchier with [IPV]."	10	11	455-463
"I think another challenge is taking it to another level with the kids involved. It's a different situation when there's abuse towards children and then knowing what to do about that as well. Or not only knowing how to help...a female in a situation of domestic violence but knowing how to find out what type of situation the children are in and knowing what to do about that."	10	11-12	472-480
"She said that her sons were not victims of abuse by the husband or anyone else, but she told me that the oldest son was already starting to have...anger issues or speaking to her in a derogatory way, that she feels was because of experiences he had."	10	12	502-508

APPENDIX I: FORMULATED MEANINGS

Formulated Meanings

Formulated Meanings	Significant Statements
<p>Provider administers verbal screenings for IPV.</p>	<p>“If I remember correctly it says ‘Have you ever experienced trauma or violence in your life?’” (Transcript 1, page 5, lines 184-186).</p> <p>“And then the one of the health educators used to say, ‘Have you ever been hit, kicked, slapped...?’” (Transcript 1, page 5, lines 190-192).</p> <p>“‘Have you ever been hit, kicked, slapped called names?’ ... it’s very, very specific” (Transcript 1, page 6, lines 206-207).</p> <p>“We ask it on our health histories actually to everybody. We ask, ‘Do you feel safe in your home?’” (Transcript 4, page 5, lines 159-160).</p> <p>“‘Do you feel safe?’ is actually the question” (Transcript 4, page 5, line 166).</p> <p>“We ask, ‘Do you feel safe?’ and we ask men... everybody” (Transcript 4, page 5, line 172).</p> <p>“If...there’s something that shouldn’t be there, ‘Hmm, how did you get this?’ or something...” (Transcript 4, page 6, lines 210-211).</p> <p>“But I just say, ‘I’m worried about you. It seems like your boyfriend is kind of controlling and it seems like you’re looking to him before answering your questions... Can you tell me about that?’ ‘Oh, no. no. I’m just checking in with him. He’s not feeling well today’” (Transcript 5, page 8, lines 299-303).</p> <p>“Not that I know of. At the hospital we did. That was one question we always had to ask them when we did the interview on them... Is, ‘Have you ever been kicked, punched, hit, threatened in your home?’ But ... on any of our screens here I don’t see that” (Transcript 6, page 6, lines 235-240).</p> <p>“That’s what we would do. We would ask them ‘Have they...’ Because somebody would say yes, immediately... Bam. Like, ‘Don’t ask me anything else.’ So we would always say, ‘Have</p>

	<p>you ever been kicked, punched, threatened, slapped?” (Transcript 6, page 7, lines 251-255).</p> <p>“We would ask them, ‘Are you coming for... whatever’ or in conversation like, ‘Oh I haven’t seen your arm move... What happened to...?’” (Transcript 7, page 6, lines 212-215).</p> <p>“During the annual physical that’s one of the questions that I always ask. I always screen for [IPV] during my questionnaires so, there are a couple different times that...it would be brought up” (Transcript 8, page 4, lines 138-142).</p> <p>“If they’re coming in for their annual physical then... I’m going to go do my normal screening of tobacco use, alcohol use, substance use ... and, ‘Do you have partner violence?’” (Transcript 8, page 6, lines 202-208).</p> <p>“And then...the other time it comes up is when I do their establishment of care. One of the questions is, ‘Is there any domestic violence?’ That’s another time that it would come up is when I do their establishment of care or update their medical records” (Transcript 8, page 6, lines 221-226).</p> <p>“It’s verbal. ‘Is there any domestic violence in your home?’ So that covers whether you’re having domestic violence, whether your children are having domestic violence, whether you’re perpetrating any violence...” (Transcript 8, page 6, lines 242-246).</p> <p>“I usually start with the level of stress. If they say it’s high or they give me 8 out of 10, then I usually try to find out where the biggest sources of stress are. And often times that’s usually where [IPV] comes out. If they’re like, ‘Well, you know, work’ or ‘my family is far away’ or different things like that, that’s when I’ll say, ‘Are you married or are you living with someone?’ ... and if they say, ‘yeah,’ I may say ‘Is that relationship a source of stress also?’ I don’t directly say, ‘Okay how is the relationship?’, ‘good’, ‘oh, ok. Is there any violence in the home?’” (Transcript 9, page 7, lines 258-272).</p> <p>“If they say... ‘anger,’ ‘can’t control his anger,’ then that’s when I specifically ask, ‘what do you mean?’ Like, ‘What is that?’ ‘What does anger look like? How does he show it?’ And then they sort of begin to tell a little more. Then sometimes they’ll say, ‘he’s never really...beat me up’” (Transcript 9, page 7-8, lines 291-301).</p>
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	<p>“And so I said, ‘Well he’s never beat you up but have you been hit you before?’ or then I start giving examples: hit, or scratched or pushed, because a lot of times they’re like, ‘Well I...don’t get beat up.’ So I have to sometimes be specific because they don’t see a push or a strong hold of a hand or something aggressive, that type of violence. ...Because it’s not beating up, they don’t see it as violence. And so sometimes I have to... start getting specific about the aggressiveness or the anger and how it’s shown” (Transcript 9, page 8, lines 305-317).</p> <p>“I generally include a screening for domestic violence in my female physicals but it’s not a 100% across the board question that I ask. I’m sitting on the computer and I’m going question-by-question on my physicals template and I’ll see it and remember. But I don’t always go through the template and if I don’t go through the template often times I forget. If I’m not following the template I try to include it in the portion of my questions for patients during a physical exam when I’m asking, ‘Do you have any problems with feeling nervous or any trouble with moods? Any trouble with insomnia? Do you feel safe in your relationship?’ But there are certainly many times when I forget to ask that specific question” (Transcript 10, page 8, lines 314-330).</p> <p>“One of the problems with that question is, ‘Safe’ is a subjective term. And it probably would be better to say, ‘Does your partner hit you?’ But for the same reason that I ask patients if they ‘Eat well’ and they say, ‘Sure, I eat plenty.’ They don’t understand that I’m asking, ‘Do you eat healthy food?’” (Transcript 10, page 8, lines 326-330).</p>
Provider specifies the time of and/or frequency of IPV screening.	<p>“Not frequently, we do screen for it at every new O.B.” (Transcript 1, page 4, lines 117-119).</p> <p>“So it’s something we are screening for and actually patients are asked the same question twice once by the midwife at the new O.B. and once before that at intake with the health educator.” (Transcript 1, page 4, lines 123-126).</p> <p>“At intake with the health educator, who does the initial intake, we have a model where we have a health educator that meets first with the patient has some questions and then works out a care plan for the patient for the duration of the pregnancy, and the midwife is part of our medical history also” (Transcript 1, page 4, lines 134-139).</p> <p>“Actually it is three times because they also do a written medical</p>

	<p>history before they get to us and that question is there too so yeah it is, it is three times, so they have, there is opportunity three times to disclose” (Transcript 1, page 4, lines 143-146).</p> <p>“Everybody is screened. Yes 100%” (Transcript 1, page 6, lines 213).</p> <p>“[The patients] have to go through the screening process to establish medical prenatal care” (Transcript 1, page 6, lines 217-219).</p> <p>“I mean it’s something that we’ve really focused on, for thirty years we’ve been asking the questions. We’ve been screening so when you ask the question, then you get answers, right?” (Transcript 1, page 13, lines 541-545).</p> <p>“We ask...everyone” (Transcript 3, page 9, lines 353).</p> <p>“I would definitely address it if the answer was yes or if the patient brought it up to me. If I suspected it I would address it, but I wouldn’t go fishing for it...” (Transcript 4, page 5, lines 160-162).</p> <p>“The history is something that gets filled out like once a year and so it’s actually not re-asked which is a good point now that I’m thinking about it. It’s not re-asked every visit it’s just that one visit” (Transcript 4, page 5, lines 176-178).</p> <p>“We routinely screen... So...with prenatal care the way it works is usually the first visit is a big long visit. It’s an hour and a half or 2 hour visit, where we get their medical history and ask them all the psychosocial questions...like drug use, violence in the home, all that kind of stuff. So usually... we ask it the first visit... and then, they have... every trimester an in-take with a nurse where they kind of review that stuff. But... that’s not usually with the provider. The first time would be with me but usually then I don’t ask that question anymore. We do these quickie like 10 minute prenatal visits” (Transcript 5, page 7, lines 247-254).</p> <p>“I usually just bring it up. I’m usually just out in the open about it” (Transcript 5, page 8, lines 313-314).</p> <p>“I always ask at that first visit... at well women GYN visits I always ask especially the ladies who seem depressed, somaticizing... they have all these very general health complaints but there’s not actually anything medically wrong with them that</p>
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	<p>I can find... 40 [year old] women who are dizzy and feel weak and tired and I always talk to them about depression. Are you... somaticizing your depression, your sadness? But then I always ask them also about domestic violence..." (Transcript 5, page 9-10, lines 378-385).</p> <p>"Most of the time if the patient comes in for falls or injuries, the provider will ask them about...any violence or anything. Other than that, if they're not coming in for an injury or a fall appointment or a walk-in, then the doctor will usually discuss [IPV]... They may just bring it up in the physical appointment." (Transcript 7, page 5, lines 187-193).</p> <p>"It's a screening question so I always screen for [IPV] during my questionnaires so, there are a couple different times that...it would be brought up" (Transcript 8, page 4, lines 140-142).</p>
<p>Provider initiates conversation about IPV.</p>	<p>"So it's something we are screening for, and actually patients are asked the same question twice, once by the midwife at the new O.B. and once before that at intake with the health educator." (Transcript 1, page 4, lines 123-126).</p> <p>"At intake with the health educator, who does the initial intake, we have a model where we have a health educator that meets first with the patient and has some questions and then works out a care plan for the patient for the duration of the pregnancy, and the midwife is part of our medical history also." (Transcript 1, page 4, lines 134-139).</p> <p>"We routinely screen... So...with prenatal care the way it works is usually the first visit is a big long visit. It's an hour and a half or 2 hour visit, where we get their medical history and ask them all the psychosocial questions...like drug use, violence in the home, all that kind of stuff. So usually... we ask it the first visit... and then, they have... every trimester an in-take with a nurse where they kind of review that stuff. But... that's not usually with the provider. The first time would be with me but usually then I don't ask that question anymore. We do these quickie like 10 minute prenatal visits" (Transcript 5, page 7, lines 247-254).</p> <p>"I guess the provider [is the first one to ask about IPV]" (Transcript 6, page 7, lines 268).</p> <p>"Most of the time if the patient comes in for falls or injuries, the provider will ask them about any violence or anything. Other than that, if they're not coming in for an injury or a fall appointment or a walk-in, then the doctor will usually discuss [IPV]... They may</p>

	<p>just bring it up in the physical appointment” (Transcript 7, page 5, lines 187-193).</p> <p>“I screen all women and men and children” (Transcript 8, page 7, line 279).</p>
Provider administers IPV screening if physical evidence of violence is present.	<p>“During the physical exam... if something catches your eye ...and I haven’t encountered any... at least that I’ve discovered” (Transcript 4, page 6, lines 204-20666).</p> <p>“Especially if...there’s something that shouldn’t be there. ‘Hmm, how did you get this?’ It isn’t on the front line of my thinking. If it isn’t something that we were immediately talking about when I’m doing my exam... it’s not always in my differentials right away” (Transcript 4, page 6, lines 210-214).</p> <p>“It was obvious that she had been beaten. She was afraid, but that’s why she came. Because she felt that she didn’t get... actually it’s not that she didn’t really get the treatment that she needed in Texas but she left before she could complete it.” (Transcript 6, page 6, lines 219-224).</p> <p>““Oh I haven’t seen your arm move... What happened to...?’ And if they... don’t say anything, like they were hurt, then that’s as far as we would take it” (Transcript 7, page 6, lines 212-215).</p> <p>“If I see any signs or symptoms... like bruising or some nonverbal cues like very poor eye-contact...” (Transcript 8, page 4, lines 134-136).</p>
Provider administers written screenings for IPV.	<p>“Actually it is three times because they also do a written medical history before they get to us and that question is there too so yeah it is, it is three times, so they have, there is opportunity three times to disclose” (Transcript 1, page 4, lines 143-146).</p> <p>“We ask it on our health histories actually to everybody. We ask, ‘Do you feel safe in your home?’” (Transcript 4, page 4, lines 144-148).</p> <p>“Sometimes a part of the initial questionnaire...one of the basic questions is, ‘Are you currently or have you ever suffered any kind of trauma or violence in the home?’ Depending on how they answer that question, and what the provider finds out, then sometimes I will be asked to go in there ... especially if it sounds kind of vague. Then I can be more direct at that point, because they’ve expressed that there has been or some sort of violence in the home” (Transcript 9, page 8-9, lines 332-344).</p>
Provider screens for IPV	<p>“I always ask at that first visit... at well women GYN visits I</p>

<p>when patient is depressed or stressed.</p>	<p>always ask especially the ladies who seem depressed, somaticizing... they have all these very general health complaints but there's not actually anything medically wrong with them that I can find... 40 [year old] women who are dizzy and feel weak and tired and I always talk to them about depression. Are you... somaticizing your depression, your sadness? But then I always ask them also about domestic violence..." (Transcript 5, page 9-10, lines 378-385).</p> <p>"I guess the fourth [screen] would be... pretty frequently when our medical family therapist comes in the room to talk about anxiety or depression... if it gets brought up during that time" (Transcript 8, page 4, lines 140-142).</p> <p>"Probably [patients] bring it up to me most often, because if they're at the point of being willing to talk about it, or if they're coming in to talk about anxiety or depression then...that's pretty frequent." (Transcript 8, page 5, lines 163-170).</p> <p>"[Patient initiative for disclosure] is the most often when they're coming in to talk about anxiety or depression, because then they'll bring up why they're depressed or why they're anxious and... then they'll get into the reason for their anxiety or depression. And... their family life situation will come up and then we'll get further into it and... they might not be willing to talk about it initially, but once we start getting into it then they're more willing... to discuss their life situation" (Transcript 8, page 5, lines 170-179).</p> <p>"And... 'Do you have anxiety?' I usually go with anxiety and depression first...and do my own little PHQ2 and then if that's positive... I always do the partner violence as well, then we talk about partner violence" (Transcript 8, page 6, lines 213-217).</p> <p>"If [IPV] comes up, or if we're talking about anxiety or depression" (Transcript 8, page 8, lines 297-298).</p> <p>"Because I'm asking about risk factors for their anxiety and depression. So I'm going to go ahead and screen for situational things, for substance abuse, for domestic violence, for work situations, for...all of the common... for some of the risk factors that are going on" (Transcript 8, page 8, lines 313-318).</p> <p>"I usually start with the level of stress. If they say it's high or they give me 8 out of 10, then I usually try to find out where the biggest sources of stress are. And often times that's usually where</p>
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	<p>[IPV] comes out. If they're like, 'Well, you know, work' or 'my family is far away' or different things like that, that's when I'll say, 'Are you married or are you living with someone?' ... and if they say, 'yeah,' I may say 'Is that relationship a source of stress also?' I don't directly say, 'Okay how is the relationship?', 'good', 'oh, ok. Is there any violence in the home?'" (Transcript 9, page 7, lines 258-272).</p> <p>"Usually [bringing up IPV] comes more from...assessing for stress and the relationship and then it goes from there" (Transcript 9, page 8, lines 322-325).</p> <p>"The other patient that comes to mind is a woman in her mid- to late-thirties that I met in night clinic last summer who came in to night clinic complaining of shortness of breath. And when I went into the exam room to speak with her, her husband was in the room with us. She was kind of explaining the shortness of breath to me and she was certainly worried about this shortness of breath. But as I examined her and spoke with her, I got the sense that the shortness of breath was due to anxiety, and I got the sense that there was something going on in this relationship just based on the husband's demeanor in the room" (Transcript 10, page 4, lines 140-151).</p>
Provider determines who gets screened (e.g., everyone, only females, only MSFW women, etc.).	<p>"We ask it on our health histories actually to everybody. We ask, 'Do you feel safe in your home?'" (Transcript 4, page 5, lines 159-160).</p> <p>"We ask, 'Do you feel safe?' and we ask men... everybody" (Transcript 4, page 5, line 172).</p> <p>"I screen all women and men and children" (Transcript 8, page 7, lines 279).</p>
Provider discusses sex, HIV, contraception, etc. with patients.	<p>"...at one of the camps we offered an HIV discussion and proper use of condoms for the women..." (Transcript 3, page 4, lines 117-118).</p> <p>"The women said no to the condom use... many of them... because they said only street walkers, 'putas', used condoms" (Transcript 3, page 4, lines 122-124).</p> <p>"So they were saying they were reluctant... to use them. And also during those discussions there were women who said, 'I don't like to take part in this kind of discussion because many of the others who attend here are my cousins or aunts or at least have a family connection and they are going to tell my partner what I have been talking about'" (Transcript 3, page 4, lines 128-133).</p>

	<p>“So they come in and they’re very upset. They want to be tested for STDs, because they have been raped by someone that they know. Maybe that has been a previous boyfriend or maybe even in a relationship that they were in at that time. But they were not a willing participant” (Transcript 6, page 5, lines 162-167).</p> <p>“They come here mainly for testing for STDs because they’ve already received... the female treatment or pap smear somewhere else. Especially if they’ve been traveling through different states. So they would just come here for a follow up STD testing for HIV or AIDS...” (Transcript 6, page 18, lines 748-753).</p>
Patient initiates conversation about IPV.	<p>“But sometimes, while we triage them they’ll...in conversation like, “How are you?”... or in questioning conversation, they might say something that will key you in, and then we try to let the provider know so they can ask more” (Transcript 6, page 7, lines 280-284).</p> <p>“Probably [patients] bring it up to me most often, because if they’re at the point of being willing to talk about it, or if they’re coming in to talk about anxiety or depression then...that’s pretty frequent” (Transcript 8, page 5, lines 163-170).</p>
Provider determines whether to screen patients individually or as a family/group.	<p>“We concluded: we need to do this on an individual basis rather than a group discussion and, efficiency be darned, we need to... if it’s going to be effective it needs to be private” (Transcript 3, page 5, lines 164-167).</p> <p>“We do ask the patient...if they wish to be interviewed alone” (Transcript 3, page 10, lines 416-418).</p> <p>“That third person in the room is a little hard” (Transcript 3, page 12, lines 498-499).</p> <p>“If you want to admit to problems, you might not want more than one person in the room” (Transcript 3, page 12, lines 510-511).</p>
Provider discovers IPV while patient is in labor/delivering child.	<p>“And then I had... oh my gosh, this is terrible. One of our medical assistants in the clinic, her daughter was pregnant, a teenager like 15 or 16. And was coming to me for all her care and then when she was in the hospital having her baby I just happened to be there that day so I took care of her... after a while I realized that she was acting kind of funny... because she was always holding her head only one way which is very unusual for a women in labor... women in labor move around a lot. So the deal was finally I realized I had to ask her to move her hair...she had this long thick hair that she had wrapped all around her. And I had to lure her boyfriend out of the room... and anyways ...</p>

	<p>here she is 9 months pregnant having a baby and he had tried to kill her. He had tried to strangulate her. She had these horrible bruise marks all over her neck and her chest. Oh my god it was horrible. And she was only 15 or 16 and... we got social work involved and he was older, he was like 20 or 21 which doesn't really make the... or maybe he was 19... it didn't make the criteria for statutory rape. The age difference wasn't great enough but he was ... an adult and she was a minor..." (Transcript 5, page 5, lines 186-197).</p>
<p>Provider expresses confidence and/or comfortability in screening for and responding to IPV.</p>	<p>"I'm very comfortable" (Transcript 1, page 7, lines 270).</p> <p>"Yeah, I mean I've been around for thirty years and I've seen it... be good for the patient..." (Transcript 1, page 7, lines 280-281).</p> <p>"I feel like we're... pretty equipped to deal with or to refer" (Transcript 1, page 12, lines 494-496).</p> <p>"I don't feel like, "Oh my gosh. Where am I going to refer this woman to?" ...I have that feeling about other things...like specialty medical care." (Transcript 1, page 12, lines 501-504).</p> <p>"I'm very comfortable. I'm a white headed woman. I'm not big... I'm kind of like a grandmother in, in many respects and...my approach is often... 'You know there is help available if you are in a situation that's dangerous,' and it kind of starts that way. And so often, the person's response is, 'Oh I don't think it's dangerous... It's only if I don't cook on time...' Those kinds of responses. But then in exploring that a little further, I can make clear that that is not acceptable... that someone pounds you because you didn't cook the right frijoles. That is generally my approach...from very broad question down to some more specific..." (Transcript 3, page 11-12, lines 467-480).</p> <p>"Well... if there's discovery of a problem, is there an acceptable action?" (Transcript 3, page 13, lines 554-555).</p> <p>"I feel like my experience hasn't been that great and... I think it can improve a lot.... I feel like there is some uncertainty both on the part of me as a provider and...with resources that are lacking" (Transcript 4, page 4, lines 119-122).</p> <p>"It's a hard subject I think and I feel like... I'm uncertain about it sometimes and how to approach it" (Transcript 4, page 4, lines 124-125).</p> <p>"I feel like I am comfortable about talking about the issue and</p>

	<p>asking the questions and listening and like kind of setting a plan..." (Transcript 4, page 6, lines 230-231).</p> <p>"I think a lot of times like my fear of like... going that route, you know, talking about it is that what am I going to do, you know... what for them?" (Transcript 4, page 9, lines 345-347).</p> <p>"And I know I can fix these and [IPV] I am not sure, so... time is a big barrier with addressing...issues" (Transcript 4, page 11, lines 435-436).</p> <p>"Well, if I figure out or if I have a suspicion I bring it up...But I don't know how good I am at it because... I think I'm very suspicious of it and I am always on the lookout but sometimes you bring it up and you ask, and they say 'No,' so then I don't know... is it really no or are they just saying no to cover it up?" (Transcript 5, page 9, lines 373-376).</p> <p>"But, I don't know how good I am at detecting it. I always ask like I'm supposed to" (Transcript 5, page 10, lines 389-390).</p> <p>"I would be fine with [discussing violence with patients]" (Transcript 6, page 9, lines 332).</p> <p>"I feel comfortable with it. But I would definitely notify the provider and... the medical family therapist...to intervene, so they could have somebody else to talk to" (Transcript 7, page 6, lines 243-247).</p> <p>"I feel moderately comfortable. Moderate to high comfort. If I don't feel comfortable then I bring in help" (Transcript 8, page 8, lines 331-333).</p> <p>"It depends. I guess just by the nature of the fact that I ask, 'Do you feel safe?' and I only ask it part of the time, I'm obviously not as comfortable as I ought to be. I would like to feel more comfortable asking patients if they're in a violent relationship and feeling like I'm asking in a way that's not offensive or belittling. So yes, I would certainly like to feel more comfortable" (Transcript 10, page 10, lines 391-398).</p> <p>"If my patient and I have a conversation about being a victim of domestic violence, I feel perfectly comfortable talking with them about it. I have no trouble having the conversation about what's going on with them. Now, I do not feel perfectly comfortable figuring out what to do about it. I feel very comfortable talking</p>
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	<p>with somebody about it, and I feel like I can offer a great listening ear and I can provide some decent therapy” (Transcript 10, page 10, lines 404-412).</p>
<p>Provider encourages patients to advocate for themselves.</p>	<p>“So often, the person’s response is, ‘Oh I don’t think it’s dangerous... It’s only if I don’t cook on time...’ Those kinds of responses... I can make clear that that is not acceptable ‘that someone pounds you because you didn’t cook the right frijoles’” (Transcript 3, page 11-12, lines 472-477).</p> <p>“Educating about the difference between something that’s cultural and something that’s not safe and hurting you can be challenging” (Transcript 4, page 12, lines 483-484).</p> <p>“They get over here and until they know better... until they can speak English and interact more... they don’t know that it doesn’t have to be that way over here. And once they learn that... that’s when it changes” (Transcript 7, page 10, lines 395).</p> <p>“It’s educating and...making sure that they understand this is a safe environment for them to share ... but also, giving them...the resources and the information like, ‘Hey, if you share, this is...part of your protection or your rights even if you are not...a citizen of the U.S.’ Because a lot of times it’s a feeling that [MSFW women] don’t know what [their] rights are. [They] don’t know how much [they] will be protected ... or [their] children... or what resources...if they’re fully dependent on their husband, who is the breadwinner, the provider... there is language barrier so it’s not really easy for them just to pick up and leave...if they’ve never worked. ...Yeah, sure, you can say, ‘this is a safe place for you to open up and share,’ but once it’s shared... then [patients] may sort of feel like, ‘Well what was the point of sharing if...I’m stuck. I’m stuck in this situation. I can’t go here. I can’t go there. I can’t live on my own. I can’t work. I can’t speak English. What am I going to do? So, I either put up with this and I know my kids are taken care of or I’m out on the street somewhere. Then what am I going to do to provide for my kids?’” (Transcript 9, page 12, lines 485-513).</p> <p>“You’re educating and you’re offering, but you’re not judging, the fact that in a way they’ve accepted [IPV] as normal” (Transcript 9, page 13, lines 546-548).</p>
<p>Provider extends verbal support in response to patient disclosure of IPV.</p>	<p>“...if they can’t go... or don’t want to go... then we do work with them on...the cycle of violence, and also, ‘Ok... make yourself a getaway plan. How are you going to save money that he doesn’t know you have?’ And ‘what are you going to do? What’s your plan?’” (Transcript 1, page 13-14, lines 564-570).</p>

	<p>“We don’t have a measure but... if a patient responds positively to the domestic violence question, our next question is, ‘Do you need a number to call for immediate help?’” (Transcript 3, page 10, lines 387-390).</p> <p>“I can make clear that that is not acceptable... ‘that someone pounds you because you didn’t cook the right frijoles’” (Transcript 3, page 11-12, lines 475-477).</p> <p>“Well just questions like, ‘What happened?’ If they don’t feel safe definitely that’s the first thing I’ll address. Like, ‘Why don’t you feel safe?’, ‘Who is making you feel unsafe?’...find out what their situation is and what’s going on” (Transcript 4, page 5, lines 187-192).</p> <p>“‘What are you going to do if you are unsafe’ or ‘Who are you going to call?’” (Transcript 4, page 7, lines 285-286).</p> <p>“So all I do is say, “Well I’m really worried about you,” and I talk to you about during pregnancy it’s much more likely that the violence will escalate and I talk to women about the number one cause of death in pregnancy is not bleeding to death when you have a baby it’s getting murdered. And I talk to people about that and I talk to them about a safety plan” (Transcript 5, page 9, lines 358-362).</p> <p>“We have IBH, which is called Integrated Behavioral Health, so most days of the week there’s someone there who we can do a warm hand-off. If I’m talking to someone and I’m suspecting they have a problem, I don’t have to actually deal with it myself. I just identify it, I talk to them a little bit about it, and then I say, ‘Ok, I would really like you to talk to Sarah, she’s...a counselor that we have that works here that... has really great experience...’” (Transcript 5, page 10, lines 408-414).</p>
Provider develops safety plan with patient.	<p>“If she’s not ready to leave the situation then we talk about and reinforce an exit strategy for her” (Transcript 1, page 6, lines 233-235).</p> <p>“...if they can’t go... or don’t want to go... then we do work with them on...the cycle of violence, and also, ‘ok... make yourself a getaway plan. How are you going to save money that he doesn’t know you have?’ And ‘what are you going to do? What’s your plan?’” (Transcript 1, page 13-14, lines 564-570).</p> <p>“Something that I try to do is... develop a plan... often times</p>

	<p>especially with migrant and seasonal workers you're only seeing them one time... or maybe twice, and then you're not sure where they're going to be going next and so... you know there's a lot of uncertainty, so ... once you know that they are safe, just developing some goals and a plan... like, 'What are you going to do if you are unsafe' or 'who are you going to call?'" (Transcript 4, page 7, lines 281-286).</p> <p>"So all I do is say, "Well I'm really worried about you," and I talk to you about during pregnancy it's much more, likely that the violence will escalate and I talk to women about like the number one cause of death in pregnancy is not bleeding to death when you have a baby it's getting murdered. And I talk to people about that and I talk to them about a safety plan" (Transcript 5, page 9, lines 358-362).</p>
Provider allows patient to make informed decision without imposing his/her own values/opinions.	<p>"When we listen to a patient and we think we know what they should do, I think in describing what's available to them, we might emphasize one decision or another. And that's not right. We need to remain objective. And that's difficult for me at times. When I say 'ugh... it's clear you need to get out of this...' but I don't. One can't do that..." (Transcript 3, page 13, lines 531-538).</p> <p>"Ethically, do we allow a person to walk back in to a dangerous situation? So... it's that, being protective and the preventive side... and if these are adults, ethically we have to just describe. And then let them decide" (Transcript 3, page 13, lines 560-564).</p> <p>"Right exactly. So it's up to her" (Transcript 5, page 9, lines 353).</p>
Provider reports IPV to police.	<p>"...If someone reports violence, we call the police" (Transcript 1, page 6, lines 225-226).</p> <p>"But if we see bruising we have to call the police" (Transcript 1, page 6, lines 243).</p> <p>"Yeah, we're mandated reporting" (Transcript 1, page 7, lines 255).</p> <p>"Hmm, ethical...you need to let people know, as a reporter, what you're going to do with the information" (Transcript 1, page 10, lines 386-388).</p> <p>"If there is sufficient reason we do call the police. If there is visible bruising..." (Transcript 3, page 10, lines 396-397).</p> <p>"We are mandatory reporters. If any children are involved, or an</p>

	elderly person, we are mandatory reporters for those cases. But, people in between, 19 or 18, over 18 and up through 60 or 65, we have to handle that in a little bit different way” (Transcript 3, page 11, lines 448-452).
IPV is addressed by provider if reasonable suspicion/belief is present.	“I would definitely address it if the answer was yes or if the patient brought it up to me” (Transcript 4, page 5, lines 160-161).
Provider evaluates the severity of the situation and safety of the patient.	“Are they in immediate danger or is this something that... emergencies... and that kind of thing” (Transcript 4, page 5, lines 192-193).
Provider indicates a lack of resources (or awareness of resources) available to provide patients.	<p>“I won’t have... anything for them. I’m not going to be able to help them, so... maybe just being aware of resources out there ...a line they can call or somewhere they can go” (Transcript 4, page 9, lines 347-349).</p> <p>“I know [MCN] has lots of amazing resources but I just haven’t talked to them all yet” (Transcript 4, page 9, lines 379-380).</p> <p>“I feel like my experience hasn’t been that great and... I think it can improve a lot.... I feel like there is some uncertainty both on the part of me as a provider and...with resources that are lacking” (Transcript 4, page 4, lines 119-122).</p> <p>“I’m uncertain about [addressing IPV] sometimes and how to approach it always and what resources I have or what’s out there” (Transcript 4, page 4, lines 125-126).</p> <p>“You could call them and they would come talk to that person for you. Which, we don’t have those things here” (Transcript 6, page 9, lines 346-348).</p> <p>“I think the main thing is people don’t know the resources to give people” (Transcript 6, page 10, lines 399-400).</p> <p>“They might know what to do with domestic violence but they might not know the resources in the area and if they’re the only provider on site... they’re up a creek” (Transcript 8, page 11, lines 448-450).</p> <p>“If they’re a non-migrant population I can usually follow-up a little better, and get the police involved if she wants me to. I can help her find the resources within the community so if she wants to move out and move into a homeless shelter or whatever, I can help her find those resources. But because this is a migrant population, if she’s moving with the migrant population I can’t help her find those resources. If she’s moving next to Florida, I</p>

	<p>can't help her find those resources necessarily in Florida, if she's moving to pick oranges or to pick cotton, or to do something else at her next station. So... you always have to kind of be mindful of where they're going next" (Transcript 8, page 15, lines 629-642).</p> <p>"Sometimes there could be more...out there, new programs or new things that I may not either hear about or be familiar with. So I guess... just being up to date with resources" (Transcript 9, page 10, lines 420-424).</p> <p>"When it comes time to figure out, 'Okay well what are we going to do about this?' That's where I feel like I'm not equipped. Just like that situation with that patient at night clinic, I really had to scramble to figure out what my resources were and then we were not successful in following through with the situation she is in. So that's where I do not feel equipped. I feel equipped to talk but not equipped to act" (Transcript 10, page 10, lines 412-420).</p>
Establishing and keeping patients' trust is a barrier for providers to addressing IPV effectively.	<p>"But I'm also trying to keep my patient's trust. I don't want her to feel like I'm ratting her out. If she's coming to me and she's saying, 'I'm having some abuse at home...but I don't want to get my husband in trouble,' I don't want her to feel like I am betraying her trust by turning...by turning her partner in to the police. So it's a...fine line" (Transcript 8, page 17, lines 702-709).</p> <p>"Let's say I've met with someone during a medical visit... often times that topic would not come up in...the first time I'm meeting them. Whether, it's not something that gets brought up... a lot of times it takes time, ...even if it's a couple or three times after they've seen me here...because it builds trust. So, there's a huge trust component as far as how much they are willing to share and open up" (Transcript 9, page 4, lines 140-150).</p> <p>"A lot of [the discussion we have about violence] is that sort of post-trauma... especially talking about stress and if they do mention the marriage or just the relationship with their spouse or their partner as being one of the main stressors, it usually still takes a little bit of time. After I've seen them a couple of times, they sort of go into the history of their relationship, in terms of dealing with the domestic violence. It's not usually something that comes out right away" (Transcript 9, page 5, lines 169-179).</p> <p>"I say, 'Well, I'm from Colombia.' And they're like, 'Oh.' They're more willing to almost open up because then they realize we're a lot closer in the culture. We're both Hispanic. All of a</p>

	<p>sudden there's a big shift in trust. There's more trust, there's more openness and more willingness to share" (Transcript 9, page 5-6, lines 197-203).</p> <p>"If I don't know them very well, if they don't know me, [and] there's [no] trust... it's going to be too forward. Instead of being honest, instead of giving them the opportunity, or if it's too soon, they may lie" (Transcript 9, page 7-8, lines 284-301).</p> <p>"So the biggest challenge sometimes is...educating and...making sure that they understand this is a safe environment for them to share" (Transcript 9, page 12, lines 484-487).</p> <p>"If I don't have a good rapport with my patients before I start asking such serious questions, I do worry that I'm not going to be as helpful as I could. We do a lot of physicals on new patients or patients who are new to us and ...I don't screen because I feel like the patient's not going to trust me when they just met me" (Transcript 10, page 11, lines 438-447).</p> <p>"And I don't know why exactly I feel that way. I mean I have serious conversations with patients very often who I've just met. They certainly are quick to confide in me about a death in the family or financial hardship. I feel like patients cry with me in the room with me at least once a week, and I only work two days a week. So I don't know why I feel like I've got to be touchier with [IPV]" (Transcript 10, page 11, lines 455-463).</p>
Provider's inability to speak Spanish is a barrier to effective IPV screening.	<p>"I wish my Spanish were adequate to really explore this one on one. But I do call in an interpreter in most instances because I'm not 100% sure I'm getting all the information" (Transcript 3, page 12, lines 491-494).</p> <p>"I need to work on the Spanish skills but I'm getting a little old to learn too much more of the language, but I keep trying" (Transcript 3, page 16, lines 666-668).</p> <p>"Language... for me it's not [a barrier] because all of our patients speak Spanish and so...I'm able to overcome that barrier" (Transcript 4, page 10, lines 407-408).</p> <p>"Well if I spoke Spanish that would help" (Transcript 7, page 7, lines 257).</p>
Using an interpreter to screen for IPV can be a barrier for providers.	<p>"I think that [using interpreters] is a tiny bit of a barrier. However, we have almost exclusively female interpreters. And that helps" (Transcript 3, page 12, lines 517-519).</p>

	<p>“I think with more people in the room... sometimes the...Spanish ladies are... reluctant to speak to you about things. Because, they have me and the interpreter, and more people definitely make it... Secondhand information sometimes, [such as] the interpreter may say it a different way than the way I ask it and that sort of thing, I think that could be an issue” (Transcript 7, page 7, lines 261-268).</p> <p>“Occasionally they’ll look at me... because a lot of times it has to be interpreted, and if it’s interpreted and they give me that questioning look. I can ask, ‘Do you feel safe in your home? Do you experience any, emotional, verbal abuse? Any physical abuse?’ And things of that nature. I can break it down even further. But they usually do understand domestic violence. But if I get that... questioning look like, ‘I don’t understand the question’ when my interpreter gives them the question, we’ll break it down even further” (Transcript 8, page 7, lines 259-269).</p> <p>“The only other thing I can think of is that the language barrier...would be one of the...biggest barriers, for me. ...A lot of times it’s very difficult to get the complete story and to get the patient to open up completely when they don’t always feel like you understand what they’re saying or when you’re having to go through a third party to interpret what they’re saying. They might not feel as open with, say, me as they would feel with Yolanda” (Transcript 8, page 18, lines 756-763).</p>
Patient accessibility can be a barrier for providers (e.g., living in camps, migrant status) to delivering healthcare services.	<p>“Their isolation and then also this... how do I say it? This hesitancy to reach out” (Transcript 1, page 8, lines 314-316).</p> <p>“The one case that I remember the most that I addressed is... she was seasonal so she didn’t live in the area so... it was something ... we could follow up and help so...and then the issue of following up is really hard when they’re migrating to state to state” (Transcript 4, page 9, lines 360-363).</p> <p>“Just the way we set up and things... in order to address [IPV] fully, you have to have a relationship with your patient and it’s really hard with this population because... a lot of... my farmworkers, they live in Texas for 6 months out of the year and then they’re here for...8 months and then here for 4 and so... where I get to see them... like with any disease like diabetes and then they go back and there kind of lost... I don’t know what happens and what’s going on and they kind of get lost in the loop and then they come back and I’m like, ‘Well, you know, what’s going on?’ Like, ‘Have you planned for follow-up?’” (Transcript 4, page 14, lines 582-591).</p>

	<p>“Probably getting patients to come back in to see me [is the most challenging aspect]” (Transcript 8, page 12, line 482).</p> <p>“Or they’re not... able to follow-up because they’ve moved on or they’re not able to keep their appointment or...they just don’t keep their appointment and I don’t have... a working phone number or an address...in order to follow-up. So I don’t know... I’m not able to follow-up and I don’t know what’s going on, if they’re okay, or if they need further assistance. I can’t keep in contact with them because they’re migrant. So either they’ve moved on or they don’t have working contact information” (Transcript 8, page 12, line 493-503).</p> <p>“If they’re a non-migrant population I can usually follow-up a little better, and get the police involved if she wants me to. I can help her find the resources within the community so if she wants to move out and move into a homeless shelter or whatever, I can help her find those resources. But because this is a migrant population, if she’s moving with the migrant population I can’t help her find those resources. If she’s moving next to Florida, I can’t help her find those resources necessarily in Florida, if she’s moving to pick oranges or to pick cotton, or to do something else at her next station. So... you always have to kind of be mindful of where they’re going next” (Transcript 8, page 15, lines 629-642).</p>
Priority of IPV screening is a barrier for providers.	<p>“Especially if...there’s something that shouldn’t be there. ‘Hmm, how did you get this?’ or something... it isn’t on the front line of my thinking. If it isn’t something that we were immediately talking about when I’m doing my exam... it’s not always in my differentials right away” (Transcript 4, page 6, lines 210-214).</p> <p>“There’s like 10 problems and you...don’t have a lot of privacy and then you have lots of patients and not a lot of time...so those things get pushed off to the side” (Transcript 4, page 11, lines 440-442).</p>
Lack of time with patient is a barrier for providers.	<p>“Time is a huge barrier for us because we often see the patient once or twice and we’re dealing with all of these other things like diabetes and hypertension and obesity” (Transcript 4, page 10-11, lines 427-429).</p> <p>“And I know I can fix these and [IPV] I am not sure, so... time is a big barrier with addressing...issues” (Transcript 4, page 11, lines 435-436).</p> <p>“There’s like 10 problems and you...don’t have a lot of privacy</p>

	and then you have lots of patients and not a lot of time...so those things get pushed off to the side” (Transcript 4, page 11, lines 440-442).
Provider believes patients are less likely to trust non-Hispanic providers than Hispanic providers.	“Not just Caucasian. I would say any other culture. Basically... any non-Hispanic I would say” (Transcript 9, page 6, lines 223-225).
Provider indicates general (unspecified) resources available to provide patients.	<p>“I don’t feel like we’re lacking in resources in this arena...” (Transcript 1, page 12, lines 496-497).</p> <p>“I don’t feel like, “Oh my gosh. Where am I going to refer this woman to?” You know that kind of... I have that feeling about other things... like specialty medical care” (Transcript 1, page 12, lines 501-504).</p> <p>“I feel like our community...now, offers good resources and it... it’s not dependent on having a social security number” (Transcript 1, page 12, lines 511-513).</p> <p>“...in this community at this time there are functional places for people to go” (Transcript 1, page 13, lines 563-564).</p> <p>“So it’s not like it’s a big secret and we have really great resources” (Transcript 5, page 10, lines 401-402).</p> <p>“But where I am, because it’s a Federal Qualified Health Center, and we have lots of resources” (Transcript 5, page 10, lines 406-407).</p> <p>“I know when I... start to feel out of my comfort zone... I know who to call. I know resources to turn to.” (Transcript 8, page 9, lines 337-339).</p>
Provider believes additional professionals (e.g., social worker, therapist) can be helpful in addressing IPV with patients.	<p>“It’s more than that...then ongoing support, we have a social worker on staff and we would refer to her for community resources if the patient is in danger and needs... to leave the situation. If she’s not ready to leave the situation then we talk about and reinforce an exit strategy for her” (Transcript 1, page 6, lines 230-235).</p> <p>“We have uh, a whole behavioral health component of our clinic so they can get free counseling services” (Transcript 1, page 11, lines 473-474).</p> <p>“We have our own social worker that specializes... in prenatal and perinatal issues” (Transcript 1, page 11, lines 475-477).</p>

	<p>“Oh my god it was horrible. And she was only 15 or 16 and...we got social work involved” (Transcript 5, page 5, lines 197-198).</p> <p>“We have IBH, which is called Integrated Behavioral Health, so most days of the week there’s someone there who we can do a warm hand-off. If I’m talking to someone and I’m suspecting they have a problem, I don’t have to actually deal with it myself. I just identify it, I talk to them a little bit about it, and then I say, ‘Ok, I would really like you to talk to Sarah, she’s...a counselor that we have that works here that... has really great experience...’” (Transcript 5, page 10, lines 408-414).</p> <p>“They call them IBH; they’re really social work interns. We also have... a full-time M.S.W. but mostly the warm hand-offs go to ... these ...in social work school. ...We also have a real psychiatrists and then a couple psychologists... But they’re very part-time and they work based on grants, so...it’s just whatever the grant money is for. So, they’ll send out emails, ‘For the next 6 months we have grant money for depressed women between the ages of 15 and 25 with one or more children’... and nobody else qualifies...” (Transcript 5, page 10, lines 418-425).</p> <p>“And our social workers are great. They really help get people to good resources. And they would be the ones who facilitate for reporting. I don’t have to do the reporting myself. She’ll fill out the report, if it’s a reporting situation, she’ll fill out the report, she’ll take care of the whole thing, I just have to sign my name to it. Which makes it really easy on us” (Transcript 5, page 11, lines 429-433).</p> <p>“I can still go see my other 25 patients that I’ve got booked for the day. It doesn’t take up my whole day” (Transcript 5, page 11, lines 437-438).</p>
<p>Provider gives contact information of resources (e.g., IPV hotline, local agencies) to patient.</p>	<p>“We also developed...a tiny handout that can’t be more than 2 by 4... that they could tuck in a bra... that gave the phone number for the domestic violence” (Transcript 3, page 5, lines 171-175).</p> <p>“We had [contact cards] in Spanish and some in English” (Transcript 3, page 5, lines 179-180).</p> <p>“And then we do give them the number that I described to you, the little handout that they can tuck away in a bra...” (Transcript 3, page 10, lines 394-396).</p> <p>“But in our women’s restroom we also have these cards with the number on it for domestic violence to call for help” (Transcript 3,</p>

	<p>page 11, lines 432-434).</p> <p>“I haven’t actually checked some of the patient bathrooms lately but sometimes at the women’s clinic they’ll have, in the women’s bathroom, the family violence program. You can rip off the paper. They will have them in the women’s bathroom because they know it’s the only place that the men can’t go. So it gives [patients] a chance to... I don’t think we have those set in place here, where they can just rip the number off and keep it somewhere. But a lot of times that’s how discrete some women’s clinics have to be. It has to be that discrete and private just because [providers] don’t want to put the woman at higher risk for more violence after she comes to the doctor” (Transcript 9, page 15-16, lines 650-664).</p> <p>“So that’s why I’ve seen those little...pieces of paper that you just rip them and they’re small so they...hide them... somewhere on their body...easier than coming out with a pamphlet or something that’s just too big” (Transcript 9, page 16, lines 674-678).</p>
Provider believes resources for patients should be readily available for providers to give.	<p>“Yeah I had actually brought that up when I first came and said that...we needed to have [IPV resources]... because we could put it in the waiting room if nothing else, a little pamphlet or something and they could just pick it up” (Transcript 6, page 9, lines 366-370).</p>
Provider indicates phone resources (e.g., national hotlines) for patients to call for assistance.	<p>“I call the suicide helpline, I get my medical family therapist, I have a little card in my office that has a list of resources...that one of the medical family therapists gave me. So, if ever I need assistance I have several numbers to call. I’d have to look at it to tell you” (Transcript 8, page 9, lines 343-348).</p> <p>“I have had to call I think twice... when it’s starting to get... out of my comfort zone” (Transcript 8, page 9, lines 337-339).</p>
Provider trainings regarding IPV can be helpful and are (or should be) available.	<p>“I do in-services for our staff maybe once every two years and bring someone in from...the Safe House or I have the social worker come to talk about intimate partner violence” (Transcript 1, page 13, lines 555-559).</p> <p>“I just wish I had more... knowledge about it or better ways to go about it ...I feel like I haven’t had any real training on it so I’m just doing the best I... know how to and...I think I’ve read bits and pieces here and there... about it in school and then things that might come up through emails or domestic violence awareness days and things like that” (Transcript 4, page 6, lines 232-237).</p> <p>“I feel like in-person is the best training in the majority of</p>

	<p>situations, especially like role playing... I attended this like interpersonal therapy... type of therapy conference for a day, it was two days and we did a lot of role playing and I felt like that was helpful ...like practicing. But... the reality is a lot of people are busy. So Webinars are good and just like pamphlets... they're definitely not as effective, but..." (Transcript 4, page 8, lines 327-332).</p> <p>"Oh my gosh. I could always use more education. Like... how to... talk to people. I think midwives are really good about just talking to people like they're really people... like not being so critical. But...that would be great. Any kind of training would be great" (Transcript 5, page 11, lines 452-455).</p> <p>"I'm fine with [dealing with violence], but I feel like here, same thing... and I hate to keep comparing it, but at the hospital we had in-services on different things all the time" (Transcript 6, page 10, lines 383-384).</p> <p>"[Training] is not an option... it's not that it's not an option but that is not available here" (Transcript 6, page 10, lines 388-389).</p> <p>"Let me take that back. We don't have an in-service department but we do, on the computer, a yearly training and it does address violence there. It addresses violence, sexual discrimination... so we do get a little bit of [training]" (Transcript 6, page 10, lines 394-399).</p> <p>"Maybe if we had little seminars or classes about [IPV] in the office. That would be helpful" (Transcript 7, page 7, lines 283-285).</p> <p>"Well anytime that we have an annual updated training on, 'Ok, here are the North Carolina state rules and regulations' because a lot of times things change or providers don't know what the... state laws are. 'Okay, for children it's a mandated report.' Well who do you report to? Who do you have to call? Okay, with adults it's not mandated but here's who you can call, or okay here's a card that has all of your resources that you can call. Some kind of annual training, like for CPR for providers or nurse practitioners and doctors and such. We have to do a CPR training. It would be helpful if something was offered that here is a lunch-and-learn where you can learn about domestic violence and your options in the area for your domestic violence resources" (Transcript 8, page 10-11, lines 420-435).</p>
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	<p>“Something like that would be very helpful. Just as a reminder... as a refresher...possibly... we have new providers coming in all the time...who don’t know what the resources are, who don’t know where to send patients in the area. If there’s not an MFT on site what do they do with these patients who they suspect, or they know have domestic violence if they don’t know what the resources are in the area?” (Transcript 8, page 11, lines 437-444).</p> <p>“[My employer] could offer something... Maybe once a year, if...[my employer] wanted to bring in someone to bring up the latest resources and the latest things that are available. Even if they wanted to have someone talk about how to refer, how they help, what new things they’re...currently doing and how they’re helping, and how they can work with [my employer] so that the providers know what to do, who to go to, where to send them, who can qualify, what will they be receiving, or just the contact information to give or to call” (Transcript 9, page 11, lines 443-455).</p>
Provider believes there is a need for addressing/screening for IPV among MSFW patients.	<p>“It’s a national shame that we treat these folks like we do. And that makes me all the more intent on giving them good physical and mental health care” (Transcript 3, page 16, lines 672-675).</p> <p>“I think I have a responsibility to address it... I feel like if somebody tells me they’re not safe and I put it to the side...ethically I need to address it in some way or another. So, it’s hard in that way” (Transcript 4, page 11, lines 458-461).</p> <p>“If a patient tells me they don’t feel safe at home or this is going on ethically I feel like I should address it. I feel like it’s my responsibility, I mean I’m not saying I have to solve it” (Transcript 4, page 11, lines 466-468).</p>
Provider believes IPV screening tools should be available for providers.	<p>“Yeah what I really like...when we... for example depression, those PHQ9 screening tools ...I think it’s a really nice thing and something that might be beneficial for me because it’s...clear cut questions, it gives you an open door to talk and to really divide out what they’re going through, so... that would be helpful...” (Transcript 4, page 7, lines 249-253).</p> <p>“I think if [an IPV question] was on that little nursing interview screen...nobody would miss it” (Transcript 6, page 13, lines 552-554).</p>
Provider desires to help/serve MSFW population due to their lack of resources, ways to get help, etc.	<p>“It’s a national shame that we treat these folks like we do. And that makes me all the more intent on giving them good physical and mental health care” (Transcript 3, page 16, lines 672-675).</p> <p>“You probably see [the Pandora’s box scenario] more in a private</p>

	<p>practice but here in a community health center, I don't think it's a problem because hopefully everybody here knows that you're here to help people who are not as fortunate. They're ...I hate to say indigent. But... we're hopefully trying to be more helpful than just doing your job" (Transcript 6, page 14, lines 605-611).</p>
<p>Provider feels powerless to help patients who are experiencing IPV.</p>	<p>"Just their own powerlessness and I can't even argue with it" (Transcript 1, page 8, lines 309-310).</p> <p>"That you don't have to be... And maybe the women feel a bit more empowered" (Transcript 1, page 15, lines 633-634).</p> <p>"If they're telling us they want something done and they don't have the self-confidence to do it..." (Transcript 1, page 16, lines 668-670).</p>
<p>Provider believes patient care and provider response to IPV needs improvement.</p>	<p>"...so I feel like overall it's been... super fragmented honestly and...it just needs a lot of improvement" (Transcript 4, page 4, lines 122-123).</p> <p>"I just wish I had like more...knowledge about it or better ways to go about it...I feel like I haven't had any real training on it so I'm just doing the best I...know how to and...I think I've read bits and pieces here and there... about it in school and then things that might come up through emails or domestic violence awareness days and things like that" (Transcript 4, page 6, lines 232-237).</p> <p>"So it's just really fragmented. And, a lot of people, they have families and they have kids so, maybe the abuse is not a top priority for them and they're thinking about everyday things and it moves to the back burner a little bit" (Transcript 4, page 14, lines 591-594).</p>
<p>Provider believes IPV response protocol needs to be adaptable to the demands of the situation.</p>	<p>"Maybe you're not just going to have one standard plan or protocol, it's going to be varied to how the conversation's going or the situation" (Transcript 4, page 8, lines 317-319).</p>
<p>Provider is uncertain about further violence, or denial of medical care from partner after visit with patient if IPV is addressed.</p>	<p>"I do not know then later, if there were specific incidents of violence between the mother and the father" (Transcript 3, page 6, lines 236-238).</p> <p>"They came to a clinic for services and it was just regular immunizations and coughs and colds and so forth and so on, and I never have determined where the rest of the family is at this point" (Transcript 3, page 7, lines 248-251).</p> <p>"We do respect the [patient's requests]... because we know that the follow up for that might be violence after they leave the</p>

	<p>clinic” (Transcript 3, page 10, lines 425-427).</p> <p>“Then I don’t know if they get scared or they have second thoughts, [but] then they leave. And sometimes we don’t see them again. So you don’t know whether they’re okay or they’re not ok... and that bothers [me] sometimes” (Transcript 7, page 8, lines 331-335).</p> <p>“And I don’t have... a working phone number or an address... in order to follow-up. So I don’t know... I’m not able to follow-up and I don’t know what’s going on, if they’re okay, or if they need further assistance. I can’t keep in contact with them because they’re migrant. So either they’ve moved on or they don’t have working contact information” (Transcript 8, page 12, lines 496-503).</p> <p>“Of course I worry that...if I address this with them... that there’s going to be a negative impact when they get home. If I address this now and I try to help them and...if they receive help and it doesn’t go as planned, that [the patient] is going to get abused more at home” (Transcript 8, page 14, lines 602-608).</p> <p>“...further abused. Because she’s bringing it up” (Transcript 8, page 15, line 621).</p> <p>“Just being careful with the questions or even trying to offer support, if somehow the partner finds out, that you’re not putting [patients] at greater risk for more violence. Be careful...that the partner doesn’t pick up that at this clinic where they’re being treated for X, Y, and Z, they’re talking to them about [IPV] because if they find out...[the partners] just stop bringing them to the doctor. And so you have to also be careful that you’re not in a way sort of... making a bigger problem for them...” (Transcript 9, page 14, lines 579-591).</p> <p>“That’s another cultural thing. A lot of times the partner is present, because he’s the one paying, he’s the transportation, he’s the one that sometimes speaks more English than she does. So, being careful because even you’re asking him to step out it may already send red flags to him as far as, ‘Why am I being asked to step out? What did they talk about?’ And...that could cause a lot more problems for her because now she’s going to be questioned. You just have to be really careful. Even asking him to step out already puts her at danger, because he’s going to want to know exactly what was being asked and why...” (Transcript 9, page 14-15, lines 606-620).</p>
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	<p>“So I guess just being culturally sensitive but also sensitive overall as far as, we’re here to help and to try to assess and get some information. But even how we assess and even how we go about finding our information, we have to be careful with it. And then in the process of [assessing], that we didn’t create...potentially... putting them more at risk” (Transcript 9, page 15, lines 638-645).</p> <p>“We made an arrangement for her to be contacted by one of our medical family therapists the next day at a time when her husband would not be in the home, and that contact was never made. She never answered and obviously you can’t leave a message, so I don’t know whatever happened with her” (Transcript 10, page 6, lines 202-207).</p>
Provider interacts with abusive partners of patients.	<p>“Once a long time ago I [had an interaction with a patient’s abusive partner]. A long time ago. I think he knew he was kind of blowing it too” (Transcript 1, page 16, lines 679-681).</p> <p>“We had a guy that...hovered, which was a big red flag for us” (Transcript 1, page 16, lines 679-681).</p> <p>“We had to work hard to ask her the question. Which we did. And he wasn’t hitting her yet... But he was gonna” (Transcript 1, page 16, lines 700-702).</p> <p>“Yes. Yes, we always ask [the partner to leave during a pelvic exam] and the nurse is, the... our protocol in where we are is... that when they do the initial like vital signs with the lady, because our volume is so much, they usually bring her in and then no one is allowed to come in with her. So that sometimes makes it really obvious who’s having a problem. Because most people are very reasonable and they say, ‘Oh ok, I understand.’ You know, and you’re like, ‘Whoa, I’ve got 20 ladies... look, look at all the people over there. It gets... we can’t, you know... we’ll call you in for the real visit,’ And most people are very reasonable and they’re like, ‘Oh ok. I see.’ So the guys who are like, “No way, this is my baby and I’m not waiting out here, I don’t know what you’re doing to her in there,” those are the people... that kind of make it a little obvious” (Transcript 5, page 12, lines 482-492).</p>
Provider attempts to separate patient from partner (or partner's proxy) to administer IPV screen	<p>“If I get a chance to get them alone... and then usually I try to finagle a way with them away for her to get an appointment when he is unavailable” (Transcript 5, page 8, lines 315-316).</p> <p>“But what happens a lot of times if there’s a stand in, usually I can manipulate it enough to get them to not come in the room for</p>

	<p>the exam. Like I'll say, 'Well, we're going to do a pelvic exam so you probably don't want to see her vagina and I don't think she's comfortable with that... So you know, as soon as we're done with that part we'll come grab you, you know. It will just be 5 minutes.' So then I have 5 minutes to like kind of talk to women about [IPV]" (Transcript 5, page 8-9, lines 336-341).</p> <p>"Yes. Yes, we always ask [the partner to leave during a pelvic exam] and the nurse is, the... our protocol in where we are is... that when they do the initial like vital signs with the lady, because our volume is so much, they usually bring her in and then no one is allowed to come in with her. So that sometimes makes it really obvious who's having a problem. Because most people are very reasonable and they say, 'Oh ok, I understand.' You know, and you're like, 'Whoa, I've got 20 ladies... look, look at all the people over there. It gets... we can't, you know... we'll call you in for the real visit,' And most people are very reasonable and they're like, 'Oh ok. I see.' So the guys who are like, "No way, this is my baby and I'm not waiting out here, I don't know what you're doing to her in there," those are the people... that kind of make it a little obvious" (Transcript 5, page 12, lines 482-492).</p> <p>"At some point I asked her to step out and give us a urine sample" (Transcript 10, page 4, lines 152-154).</p> <p>"Somehow we figured out a way to keep the husband in the waiting room and got the patient back to the exam room by herself. The interpreter and I spent a good amount of time asking her about the situation and finding out just what her resources were, just what was going on and tried to give her some telephone numbers that she could use to get some help" (Transcript 10, page 5, lines 176-183).</p>
Protective measures are put in place to protect provider from abusive partner (i.e., IPV perpetrator).	<p>"I wasn't terrified of him, although when the... cops came to talk to her they told me...he was from some particularly horrible group of gang people...and they told me that I should have security escort back and forth from my car for a few months" (Transcript 5, page 6, lines 216-219).</p>
Partners of patients will send friend/family member with patient to visit.	<p>"A lot of those guys like if they can't control 100% they'll send in a proxy. So he'll send his brother to drive her....Or he'll send... someone who can give him the report of exactly what happened" (Transcript 5, page 8, lines 317-320).</p> <p>"Like he'll send his... 'I can't go but I'll make sure my sister's there with you.' And it's like... he's putting on an act like he wants someone to be with her to protect her but really it's someone to report back to him" (Transcript 5, page 8, lines 329-</p>

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IPV often occurs during pregnancy among the MSFW community.	<p>“They often start... actually the abuse during pregnancy... it’s a big deal” (Transcript 1, page 17, lines 707-708).</p> <p>“...unplanned pregnancies of course figure in or an unplanned pregnancy in a child, which is devastating to all families” (Transcript 3, page 8, lines 332).</p> <p>“There’s still that problem of unplanned pregnancies where there’s some assault on the pregnant women” (Transcript 3, page 14, lines 602-604).</p> <p>“I’d say 70% of the women I see are pregnant so it’s even more of a big secret to hide it...because they’re under all this family stress, they’re having a baby” (Transcript 5, page 5, lines 174-175).</p> <p>“And then I had... oh my gosh, this is terrible. One of our medical assistants in the clinic, her daughter was pregnant, a teenager like 15 or 16. And was coming to me for all her care and then when she was in the hospital having her baby I just happened to be there that day so I took care of her... after a while I realized that she was acting kind of funny... because she was always holding her head only one way which is very unusual for a women in labor... women in labor move around a lot. So the deal was finally I realized I had to ask her to move her hair...she had this long thick hair that she had wrapped all around her. And I had to lure her boyfriend out of the room... and anyways ... here she is 9 months pregnant having a baby and he had tried to kill her. He had tried to strangulate her. She had these horrible bruise marks all over her neck and her chest. Oh my god it was horrible. And she was only 15 or 16 and... we got social work involved and he was older, he was like 20 or 21 which doesn’t really make the... or maybe he was 19... it didn’t make the criteria for statutory rape. The age difference wasn’t great enough but he was ... an adult and she was a minor...” (Transcript 5, page 5, lines 186-197).</p> <p>“So all I do is say, “Well I’m really worried about you,” and I talk to you about during pregnancy it’s much more likely that the violence will escalate and I talk to women about the number one cause of death in pregnancy is not bleeding to death when you have a baby it’s getting murdered. And I talk to people about that and I talk to them about a safety plan” (Transcript 5, page 9, lines 358-362).</p>
Violence, including physical	“I actually had to go to court a couple years ago for a woman who

abuse and rape, is sometimes perpetrated by someone other than partner.	<p>was raped during her pregnancy... and, it didn't come out until later. But she was my patient the whole time and she never saw any other provider her whole entire pregnancy, she only saw me. And she never... never, never once said anything about it... it actually wasn't her partner it was her landlord. But she was hiding it from her partner because what if he left her, and here she was having a baby" (Transcript 5, page 5, lines 176-182).</p> <p>"We do occasionally have them where they've been raped or beaten or abused in some way. A lot of times they sometimes are here in relationships that are abusive but what I've seen is a lot of times it's when they're being transported. We had a girl that was pretty young... attractive girl and she had been raped actually leaving Mexico going to Texas to get here" (Transcript 6, page 4, lines 132-139).</p> <p>"She was [raped]... by several men... and beaten. ... She still had several scars and bruises on her when... she got here. She was hospitalized" (Transcript 6, page 4, lines 143-145).</p>
MSFW women are occasionally raped by their partners.	"So they come in and they're very upset. They want to be tested for STDs, because they have been raped by someone that they know. Maybe that has been a previous boyfriend or maybe even in a relationship that they were in at that time. But they were not a willing participant" (Transcript 6, page 5, lines 162-167).
Family members of partner threatens patient with violence.	<p>"She reported her husband, and he was deported for the domestic violence. She continued to feel threatened because his family still lived in her neighborhood here, and he was deported back to the neighborhood in her home country where her mother and other family members lived. So, when I met her, she had already gotten out of the situation of domestic violence by her husband, but she continued to feel danger because of being around his family members, who she said would threaten her in her neighborhood" (Transcript 10, page 3, lines 93-103).</p> <p>"[His family] had not done anything physically to her, she said to me, but she did fear them. They had made verbal threats to her, and that was not a comfortable situation for her" (Transcript 10, page 4, lines 132-135).</p>
Mutual violence between partners sometimes occurs.	"Depending on the cases, it's not many, but I would say there are some that end up being partner to partner violence, where it's not just... the male hitting the woman, but sometimes it can be the other way around. And depending on how it gets, it can be ... it's different but it will still be... I guess it's good to keep in mind that sometimes [mutual IPV] is going on and it's just a vicious cycle" (Transcript 9, page 17, lines 713-722).
Violence occurring during	"I actually had to go to court a couple years ago for a woman who

pregnancy is sometimes perpetrated by someone other than partner.	was raped during her pregnancy... and, it didn't come out until later. But she was my patient the whole time and she never saw any other provider her whole entire pregnancy, she only saw me. And she never... never, never once said anything about it... it actually wasn't her partner it was her landlord. But she was hiding it from her partner because what if he left her, and here she was having a baby" (Transcript 5, page 5, lines 176-182).
Abusive partner threatens patient's family of origin with violence.	"He had threatened to do harm to her family back in her home country" (Transcript 10, page 3, lines 104-105).
Patient verbally responds to provider addressing IPV.	<p>"It's often said, 'It used to happen to me but I'm no longer with that person'" (Transcript 1, page 4, lines 148-149).</p> <p>"You get more than 'Yes I am getting abused'... that's very rare" (Transcript 1, page 4, lines 153-154).</p> <p>"When I started when women were very hesitant to kind of blow the whistle on that. And now I'm seeing more and more women will say, 'Well, uh... you know that used to happen but I, I called the police and he did jail time and now he's quit drinking'" (Transcript 1, page 14, lines 586-590).</p> <p>"So often, the person's response is, 'Oh I don't think it's dangerous... It's only if I don't cook on time...' Those kinds of responses" (Transcript 3, page 11, lines 472-474).</p> <p>"A lot of times the patient will say, 'In the past...' ...they'll answer it that way so that's a little different" (Transcript 4, page 5, lines 187-189).</p> <p>"I've had...over the years maybe 10 or 15 women who've... admitted to what was going on but...couldn't do anything about and didn't want to do anything about it and weren't willing to accept any kind of help. So... if a woman's not a minor... say she's 23, she's got 2 babies, here she's having number 3... 'Yeah he does hit me but he doesn't hit the kids and, you know, my parents are in Mexico and the only person I have here is my sister and she's in the same situation in Bakersfield and how... I don't have a car, I don't have a job and I rely on him for all of my financial security so what am I going to do?'" (Transcript 5, page 9, lines 342-349).</p> <p>"If they begin to talk about...a lot of conflict, a lot of arguing, a lot of fighting or sometimes they say...the words 'bad temper'...or something similar to 'aggressive'... [the patients] are not necessarily saying [bad temper or aggressive] with</p>

	<p>them... If they say... ‘anger,’ ‘can’t control his anger,’ then that’s when I specifically ask, ‘what do you mean?’ Like, ‘What is that?’ ‘What does anger look like? How does he show it?’ And then they sort of begin to tell a little more. Then sometimes they’ll say, ‘he’s never really...beat me up’” (Transcript 9, page 7-8, lines 284-301).</p> <p>“And so I said, ‘Well he’s never beat you up but have you been hit you before?’ or then I start giving examples: hit, or scratched or pushed, because a lot of times they’re like, ‘Well I...don’t get beat up.’ So I have to sometimes be specific because they don’t see a push or a strong hold of a hand or something aggressive, that type of violence. ...Because it’s not beating up, they don’t see it as violence. And so sometimes I have to... start getting specific about the aggressiveness or the anger and how it’s shown” (Transcript 9, page 8, lines 305-317).</p>
Patients' partners are sometimes incarcerated (for reasons other than IPV perpetration).	<p>“I am afraid that might be fairly typical... and if the spouse isn’t jailed for violence we have a lot of men particularly being jailed just because of the non-documented status” (Transcript 3, page 7, lines 257-260).</p> <p>“We also have a fair share of ladies whose partners are incarcerated...for various reasons. Sometimes because of... usually something they did... usually it was for stealing a car or whatever” (Transcript 5, page 7, lines 265-267).</p>
Patient asks provider to contact police.	<p>“Very receptive of having us calling the police on their behalf. Very receptive. It’s sort of like...they want to do it...but for whatever [reason] they’re afraid... and are relieved that we do it and then they can say, ‘Well they had to... I didn’t have any choice...’” (Transcript 1, page 15, lines 647-654).</p> <p>“The patient asks for help we do call the police” (Transcript 3, page 10, lines 398).</p>
Patient is hesitant to disclose information pertaining to IPV.	<p>“A lot of [the challenge with screening and addressing IPV], they’re reluctant to give you any information” (Transcript 6, page 11, lines 430-431).</p> <p>“Because they’re going home to that very same person that abused them” (Transcript 6, page 11, lines 435-436).</p> <p>“I think with more people in the room... sometimes the...Spanish ladies are... reluctant to speak to you about things. Because, they have me and the interpreter, and more people definitely make it... Secondhand information sometimes, [such as] the interpreter may say it a different way than the way I ask it and that sort of thing, I think that could be an issue” (Transcript 7, page 7, lines 261-</p>

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Variability is evident as to when patients disclose IPV.	“Sometimes [patients will] tell us as soon as they hit the door, when we’re getting Triage, when they’re getting their vitals. Sometimes, they probably bring it up to the therapist when they talk to them prior to the doctor going in and sometimes, they break down and tell the doctor” (Transcript 6, page 6, lines 213-218).
Patient has safety plan in place.	“It’s interesting...many women have a plan. Many women have a plan. Not always, but many do” (Transcript 1, page 14, lines 570-572).
Patient will call police, if necessary.	<p>“And I have noticed sort of the younger women are much more likely to call the police. That I’ve noticed in thirty years, a change. They are calling the police themselves” (Transcript 1, page 14, lines 572-575).</p> <p>“When I started when women were very hesitant to kind of blow the whistle on that. And now I’m seeing more and more women will say, ‘Well, uh... you know that used to happen but I, I called the police and he did jail time and now he’s quit drinking’” (Transcript 1, page 14, lines 586-590).</p>
Patient blames herself for her partner's violent behaviors.	<p>“I think that probably, like all women for some reason, they probably blame themselves. Why we do that, I can’t tell you.” (Transcript 6, page 13, lines 532-534).</p> <p>“I’m sure that the men convince them that somehow it was their fault” (Transcript 6, page 13, lines 540-541).</p>
Patient denies help attempts/resources from provider.	“I’ve had...over the years maybe 10 or 15 women who’ve... admitted to what was going on but...couldn’t do anything about and didn’t want to do anything about it and weren’t willing to accept any kind of help. So... if a woman’s not a minor... say she’s 23, she’s got 2 babies, here she’s having number 3... ‘Yeah he does hit me but he doesn’t hit the kids and, you know, my parents are in Mexico and the only person I have here is my sister and she’s in the same situation in Bakersfield and how... I don’t have a car, I don’t have a job and I rely on him for all of my financial security so what am I going to do?’” (Transcript 5, page 9, lines 342-349).
Patient is afraid of IPV perpetrator.	“This woman was really very frightened of the husband” (Transcript 3, page 6, lines 217-218).
Presence of partners of patients either in the exam room or nearby is a barrier to IPV disclosure.	<p>“Another difficulty...is some partners insist on coming into the exam room with their partner...and we do ask the patient if they wish to be interviewed alone. ... That’s very difficult sometimes...the patient herself will not boot the partner from the room” (Transcript 3, page 10, lines 414-420).</p> <p>“We do respect the [patient’s requests]... because we know that</p>

	<p>the follow up for that might be violence after they leave the clinic” (Transcript 3, page 10, lines 425-427).</p> <p>“Like communal... the husband’s waiting...he may be across the community center or something along the way and... it can be hard to talk about those issues or get really what’s going on in the situation, so privacy and... it’s just another barrier” (Transcript 4, page 10, lines 400-403).</p> <p>“So the deal was finally I realized I had to ask her to move her hair...she had this long thick hair that she had wrapped all around her. And I had to lure her boyfriend out of the room... and anyways ... here she is 9 months pregnant having a baby and he had tried to kill her. He had tried to strangle her. She had these horrible bruise marks all over her neck and her chest. Oh my god it was horrible” (Transcript 5, page 5, lines 194-197).</p> <p>“We do have the issue of...they’re on their cell phone with their boyfriend, who is in the waiting room, talking about, ‘Well they just called me... no, no I swear I didn’t go anywhere. I was in here. I’m here with the nurse. Do you want to come in the room?’ And I’m always like oh my god I don’t want him in here!” (Transcript 5, page 7, lines 282-286).</p> <p>“And they’re controlling. You ask a woman a question and she looks at her partner before she answers the question to get the like ‘Yes, it’s ok to answer that question’” (Transcript 5, page 7, lines 290-292).</p> <p>“When the guy’s there. We don’t ask... if at the initial visit the guy is there, I usually... don’t ask the questions I normally would ask. I usually would say, ‘Are you smoking, are you drinking, are you this and this... do you feel safe at home,’ which is a very general question... I feel like it’s ok to ask that in front of the guy, because it could mean, do you have rats in your apartment? ...Because some people take it that way. Some people are like “Well, yeah I feel safe but what about bedbugs?” ...like they take it that way. But it kind of plants the seed in her mind that...she could come talk to me about it later if she needed to... And then a lot of times on the problem list in the chart I’ll write ‘screen for DV when FOB is not present, when the father of the baby is not present...’ so that if she comes to another visit with even if it’s with someone else, not me, they’ll ask” (Transcript 5, page 11, lines 460-471).</p> <p>“But if the woman never comes without the guy then how do</p>
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	<p>you...it's really hard" (Transcript 5, page 12, lines 475-476).</p> <p>"Frequently, we would have couples or family members come together now and want to go in one room. Even though we would see them at the same time we do try to...break them up so they have the opportunity if they want to tell anything" (Transcript 6, page 8, lines 300-304).</p> <p>"I noticed that if the husbands come in with them, [the patients] don't say anything. The husbands do all the talking for them a lot of times. And even when we get an interpreter, mostly he's the one who speaks English and he'll speak English for her. And sometimes what the doctors will do, they'll... bring in an interpreter and even then the man doesn't necessarily want to leave her. And she's always very quiet and she just answers [her partner's] questions and... she keeps a lot of eye contact with him" (Transcript 7, page 4, lines 123-132).</p> <p>"We have had cases like that... that we've had the provider ask them to leave or step out. And she would send [the partner] out front and then she would talk to the patient alone. And sometimes the patient would talk better with him out of the room because she couldn't say anything [while] he's there with her. And then sometimes she may not say anything still because she's got to go back out there with him" (Transcript 7, page 9, lines 356-363).</p> <p>"Or the male is not willing to leave the room... some of those... those nonverbal cues...then I'll bring up [IPV]" (Transcript 8, page 4, lines 136-138).</p> <p>"Or getting...their husbands and their partners out of the room...when we're talking about the situation to begin with. ...If it's during a physical and we're talking about it then I can... get the...husband or the partner out of the room to speak about the issue. But when [the partners] come...if I can get [the patient] back in to see me and fake about their blood pressure or something else, then the partner might not be willing to leave the room to talk... so that I can follow-up...and talk about the partner violence" (Transcript 8, page 12, lines 483-492).</p> <p>"I think [difficulty getting partners out of the room] is pretty common across the board. I think that's... common to domestic violence populations. I do think...it's common across the board but it's a little bit more common in Hispanic populations" (Transcript 8, page 12, lines 516-520).</p>
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	<p>“A lot of times they’ll all come... the husband might come for his appointment and the wife and the children might all come for their appointments on the same day” (Transcript 8, page 13, lines 560-563).</p> <p>“He is trying to tell me what’s going on with the female and he won’t let her talk. He’ll say, ‘she’s having very bad menstrual cramps,’ or ‘she’s having headaches.’...He will tell me what’s going on with her... especially, when I have a question of whether domestic violence is going on...in the relationship. And it’s difficult sometimes to get either get him out of the room or to let her talk to tell me what’s going on with her” (Transcript 8, page 14, lines 580-588).</p> <p>“Being very aware and careful with even who is there and who is present and making sure that it is okay to even ask some questions or talk, depending on who is present in the room” (Transcript 9, page 14, lines 595-599).</p> <p>“That’s another cultural thing. A lot of times the partner is present, because he’s the one paying, he’s the transportation, he’s the one that sometimes speaks more English than she does. So, being careful because even you’re asking him to step out it may already send red flags to him as far as, ‘Why am I being asked to step out? What did they talk about?’ And...that could cause a lot more problems for her because now she’s going to be questioned. You just have to be really careful. Even asking him to step out already puts her at danger, because he’s going to want to know exactly what was being asked and why...” (Transcript 9, page 14-15, lines 606-620).</p> <p>“He may not be upset here at the clinic but it’s what’s going to happen afterwards as far as what she’s going to say they talked about. ...[Be] careful...asking them to step out. ...Now of course this is different ...there’s a lot of pregnant women...that come with their partner and sometimes [the partner is] asked to step out, not because they are getting suspicious about domestic violence. It’s just more because, maybe they have two other kids and literally in the room there’s absolutely no room. And so sometimes they’re asked to step out but that’s not for questioning... just because there’s no room...but that’s different” (Transcript 9, page 15, lines 624-638).</p> <p>“So, being really aware, really sensitive, really careful even in the assessment process. And obviously if [the patient and the partner] are together and they’re answering the questions normally,</p>
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	<p>but...it seems that you kind of hit an area where all of a sudden she gets really quiet and he's there... especially if you're [talking about] conflict or something among them, you can sense that it just gets really uncomfortable there, just [be] careful how you proceed. If she gets quiet, and it's in front of him, it's for a reason. So, that doesn't mean you stop assessing. Obviously that's when you want to make sure that everything's okay, but just [make] sure you're careful how you proceed" (Transcript 9, page 16, lines 680-694).</p> <p>"And I got the sense that there was something going on in this relationship just based on the husband's demeanor in the room" (Transcript 10, page 4, lines 149-151).</p> <p>"With him right there it was kind of tricky to figure out what to do to help this patient who was in this situation. And we basically ended up scheduling her a very quick follow-up for a false diagnosis. We kind of said, "Well we think you have asthma. We think that's what this shortness of breath is caused by. We need you to come back soon to do more testing" (Transcript 10, page 5, lines 165).</p>
Immigration status of patients (including fear of deportation) is a barrier for patient disclosures of IPV.	<p>"You know, they're here, they're not documented most of them that we take care of and they're really stuck" (Transcript 1, page 8, lines 314-316).</p> <p>"And also because our patients often are here not legally... They do not want legal action. They do not want to be disclosed. So... there's a resistance" (Transcript 1, page 8-9, lines 338-341).</p> <p>"[Their undocumented status is] just something they're...that's just something they're concerned about, for absolutely everything" (Transcript 1, page 9, lines 361-363).</p> <p>"That mom was very resourceful, she was a hard worker but she was not documented and four of the six kids were not documented... So you know the problems there. There were not services available" (Transcript 3, page 6, lines 208-212).</p> <p>"I have had women report to me that their spouses say, 'You are undocumented. If you leave me I will have you deported.' And I think that's fairly common knowledge that that has occurred with lots of...the population" (Transcript 3, page 8, lines 293-297).</p> <p>"This country must do something about the immigration problem. I'm afraid... the climate is looking sort of bad for getting anything done now quickly but...I sure push for that" (Transcript</p>

	<p>3, page 15, lines 638-641).</p> <p>“I don’t have any facts but... a lot of our patients are undocumented, so calling the police and sending their spouse to jail where there’s the possible deportation or on the other side where [our patients] might get deported. That’s a huge thing for people” (Transcript 4, page 10, lines 415-418).</p> <p>“Sometimes they’re afraid of dealing with the police because of their undocumented status but I always explain to them that... the police can’t hand you over to immigration. That’s against the law and I explain that to people sometimes and I don’t know if they believe me or not but... I’ve never seen anyone have a problem in the cross-over” (Transcript 5, page 12, lines 509-514).</p> <p>“I think the fear is that... if they get rid of the boyfriend or if they try to leave him... well then what’s their other choice? They can’t make enough money on their own, then they have to go back to their home family in Mexico who will look at them like a failure...like ‘The whole family pooled all our money to send you to the U.S. You can’t put up with a little...oh your boyfriend was mean to you. You can’t put up with that? You know, you’re supposed to send us money’” (Transcript 5, page 13, lines 523-530).</p> <p>“And a lot of them are not legal so they’re not going to go to a lot of places because they’re afraid” (Transcript 6, page 11, lines 438-440).</p> <p>“And then, of course, they’re not usually willing to report anything to the police because she’s afraid of being deported” (Transcript 8, page 15, lines 651-653).</p> <p>“It’s educating and...making sure that they understand this is a safe environment for them to share ... but also, giving them...the resources and the information like, ‘Hey, if you share, this is...part of your protection or your rights even if you are not...a citizen of the U.S.’ Because a lot of times it’s a feeling that [MSFW women] don’t know what [their] rights are. [They] don’t know how much [they] will be protected ... or [their] children... or what resources...if they’re fully dependent on their husband, who is the breadwinner, the provider... there is language barrier so it’s not really easy for them just to pick up and leave...if they’ve never worked. ...Yeah, sure, you can say, ‘this is a safe place for you to open up and share,’ but once it’s shared... then [patients] may sort of feel like, ‘Well what was the point of</p>
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	<p>sharing if...I'm stuck. I'm stuck in this situation. I can't go here. I can't go there. I can't live on my own. I can't work. I can't speak English. What am I going to do? So, I either put up with this and I know my kids are taken care of or I'm out on the street somewhere. Then what am I going to do to provide for my kids?" (Transcript 9, page 12, lines 485-513).</p>
<p>Patients depend on spousal income, which is a barrier to disclosing/responding to IPV.</p>	<p>"They can be, not necessarily are, so dependent on that income, that male income that they...stay in situations that may be dangerous to them" (Transcript 1, page 8, lines 302-305).</p> <p>"I think the fear is that... if they get rid of the boyfriend or if they try to leave him... well then what's their other choice? They can't make enough money on their own, then they have to go back to their home family in Mexico who will look at them like a failure...like 'The whole family pooled all our money to send you to the U.S. You can't put up with a little...oh your boyfriend was mean to you. You can't put up with that? You know, you're supposed to send us money'" (Transcript 5, page 13, lines 523-530).</p> <p>"[Their undocumented status], and probably finances...and they're away from their home. It's not like they have a family support system right here. They're hundreds and hundreds of miles away" (Transcript 6, page 11, lines 449-452).</p> <p>"But one thing, I think they are so dependent on their partner that they're afraid. Like I said, mainly the finances" (Transcript 6, page 13, lines 538-539).</p> <p>"Especially because they're migrant... if they move away from their partner they're not going to have that funding source" (Transcript 8, page 14-15, lines 609-613).</p> <p>"If she's moving with a group of...migrant workers and he's in that group of migrant workers, that might be their only income... her only income source. Either she stays here, which, if she's on his visa, she might not be able to do that" (Transcript 8, page 15, lines 642-647).</p> <p>"A lot of times it's a feeling that [MSFW women] don't know what [their] rights are. [They] don't know how much [they] will be protected ... or [their] children... or what resources...if they're fully dependent on their husband, who is the breadwinner, the provider... there is language barrier so it's not really easy for them just to pick up and leave...if they've never worked. ... Yeah, sure, you can say, 'this is a safe place for you to open up and</p>

	<p>share,’ but once it’s shared... then [patients] may sort of feel like, ‘Well what was the point of sharing if...I’m stuck. I’m stuck in this situation. I can’t go here. I can’t go there. I can’t live on my own. I can’t work. I can’t speak English. What am I going to do? So, I either put up with this and I know my kids are taken care of or I’m out on the street somewhere. Then what am I going to do to provide for my kids?’” (Transcript 9, page 12, lines 496-513).</p>
<p>Presence of nearby family members (e.g., in the exam room) is a barrier to patient IPV disclosure.</p>	<p>“So they were saying they were reluctant... to use them. And also during those discussions there were women who said, ‘I don’t like to take part in this kind of discussion because many of the others who attend here are my cousins or aunts or at least have a family connection and they are going to tell my partner what I have been talking about’” (Transcript 3, page 4, lines 128-133).</p> <p>“There was concern that they would be ratted out, if you will, about what their activities were which is a shame” (Transcript 3, page 4, lines 139-141).</p> <p>“Frequently, we would have couples or family members come together now and want to go in one room. Even though we would see them at the same time we do try to...break them up so they have the opportunity if they want to tell anything.” (Transcript 6, page 8, lines 300-304).</p> <p>“A lot of times they’ll all come... the husband might come for his appointment and the wife and the children might all come for their appointments on the same day” (Transcript 8, page 13, lines 560-563).</p> <p>“Being very aware and careful with even who is there and who is present and making sure that it is okay to even ask some questions or talk, depending on who is present in the room” (Transcript 9, page 14, lines 595-599).</p>
<p>Lack of transportation for patients is a barrier to disclosing IPV with provider.</p>	<p>“Oh and transportation. That’s a huge issue for this population... if the person who is hitting you is the one taking you to the counselor or to your provider... that can be an issue” (Transcript 4, page 13, lines 556-558).</p> <p>“It’s those who... have limited English that have to depend on [their partners] to take them to the doctor. They don’t have [a driver’s] license so they have to depend on them to do everything” (Transcript 7, page 5, lines 157-175).</p> <p>“When Hispanic families come to the doctor’s office...because there’s only one car a lot of times or there’s no transportation, very little transportation...the father’s going to come, the</p>

	<p>mother's going to come, the aunt or uncle might come, and all the kids are going to come... and they all come back to the room together" (Transcript 8, page 13, lines 540-546).</p> <p>"That's another cultural thing. A lot of times the partner is present, because he's the one paying, he's the transportation, he's the one that sometimes speaks more English than she does" (Transcript 9, page 14, lines 606-610).</p>
Inability to speak English serves as a barrier to disclosure of IPV or ability to seek resources.	<p>"Because with [the MSFW population] ... the women have to depend on the men so much, and they don't know English, and the men usually know English, so [women] have to be submissive with them. It seems like the...women who speak English, who go about their day, they're more independent and they just come to the doctor by themselves and... they voice their opinion. We have interpreters here so they usually just come and see the doctor and get an interpreter and that's it. ...It's those who... have limited English that have to depend on [their partners] to take them to the doctor. They don't have [a driver's] license so they have to depend on them to do everything" (Transcript 7, page 5, lines 157-175).</p> <p>"The only other thing I can think of is that the language barrier...would be one of the...biggest barriers, for me. ...A lot of times it's very difficult to get the complete story and to get the patient to open up completely when they don't always feel like you understand what they're saying or when you're having to go through a third party to interpret what they're saying. They might not feel as open with, say, me as they would feel with Yolanda" (Transcript 8, page 18, lines 756-763).</p> <p>"So that tends to be a very large barrier, the language barrier. It doesn't mean that they're not going to open up and talk to me. It just means that it's going to be a little bit more difficult" (Transcript 8, page 18, lines 777-781).</p> <p>"Yeah, sure, you can say, 'this is a safe place for you to open up and share,' but once it's shared... then [patients] may sort of feel like, 'Well what was the point of sharing if...I'm stuck. I'm stuck in this situation. I can't go here. I can't go there. I can't live on my own. I can't work. I can't speak English. What am I going to do? So, I either put up with this and I know my kids are taken care of or I'm out on the street somewhere. Then what am I going to do to provide for my kids?'" (Transcript 9, page 12, lines 502-513).</p> <p>"And that was tricky because obviously this patient didn't speak</p>

	English” (Transcript 10, page 5, lines 187-188).
Patient awareness of available resources tends to be low.	<p>“Very, very unaware. Yeah. Very, very unaware. I think they think it’s either they get the guy arrested or nothing” (Transcript 1, page 11, lines 435-436).</p> <p>“No, I think they would approach [responding to IPV] differently” (Transcript 1, page 11, lines 462).</p> <p>“Education also probably plays a role... [Patients] not knowing... this is wrong or knowing there’s other options out there” (Transcript 4, page 13, lines 541-543).</p> <p>“It was obvious that she had been beaten. She was afraid, but that’s why she came. Because she felt that she didn’t get... actually it’s not that she didn’t really get the treatment that she needed in Texas but she left before she could complete it” (Transcript 6, page 6, lines 219-224).</p>
Some resources are unavailable to patients due to their migrant status.	<p>“When you’re traveling from state to state and you’re living maybe in not the greatest conditions and don’t have resources available or... like the necessary food and clothes I think that just adds to the situation” (Transcript 4, page 12, lines 510-512).</p> <p>“Or like...poor housing...I just feel like... less resources and...maybe to get out of the situation or... they’re living in houses and renting and... moving from house to house sometimes...” (Transcript 4, page 13, lines 525-537).</p> <p>“It was obvious that she had been beaten. She was afraid, but that’s why she came. Because she felt that she didn’t get... actually it’s not that she didn’t really get the treatment that she needed in Texas but she left before she could complete it” (Transcript 6, page 6, lines 219-224).</p> <p>“You could call them and they would come talk to that person for you. Which, we don’t have those things here.” (Transcript 6, page 9, lines 346-348).</p> <p>“It’s educating and...making sure that they understand this is a safe environment for them to share ... but also, giving them...the resources and the information like, ‘Hey, if you share, this is...part of your protection or your rights even if you are not...a citizen of the U.S.’ Because a lot of times it’s a feeling that [MSFW women] don’t know what [their] rights are. [They] don’t know how much [they] will be protected ... or [their] children... or what resources...if they’re fully dependent on their husband, who is the breadwinner, the provider... there is language barrier</p>

	<p>so it's not really easy for them just to pick up and leave...if they've never worked. ...Yeah, sure, you can say, 'this is a safe place for you to open up and share,' but once it's shared... then [patients] may sort of feel like, 'Well what was the point of sharing if...I'm stuck. I'm stuck in this situation. I can't go here. I can't go there. I can't live on my own. I can't work. I can't speak English. What am I going to do? So, I either put up with this and I know my kids are taken care of or I'm out on the street somewhere. Then what am I going to do to provide for my kids?'" (Transcript 9, page 12, lines 485-513).</p>
Confidentiality/privacy due to location of screening/medical visit (e.g., at migrant camps) is a barrier to IPV disclosure.	<p>"A lot of times when we go see patients we're in an area... we don't have an exam room so we set up in barns or community centers and so there's not a lot of privacy so that's a barrier" (Transcript 4, page 10, lines 394-396).</p> <p>"Like communal... the husband's waiting...he may be across the community center or something along the way and... it can be hard to talk about those issues or get really what's going on in the situation, so privacy and... it's just another barrier" (Transcript 4, page 10, lines 400-403).</p> <p>"There's like 10 problems and you...don't have a lot of privacy and then you have lots of patients and not a lot of time...so those things get pushed off to the side" (Transcript 4, page 11, lines 440-442).</p> <p>"A lot of times people won't tell you while other... there might be two of us in triage, or people might be coming in or out. We try to keep it to one person in there with them so they'll be more open and honest with us. But a lot of times it won't be until they're actually with their provider. The door is shut and they feel like they can actually tell everything then" (Transcript 6, page 8, lines 288-294).</p> <p>"And just privacy. Because up here, our little triage area is just a curtain. And people might be passing outside the hallway. Even though you have the curtain pulled and they don't see who you're talking to...That's why they feel better when they go into a room and the door is shut and they talk to the provider. But if we suspected it we could definitely go ahead and put them in a room and speak to them before the provider comes in" (Transcript 6, page 14, lines 569-577).</p>
Gender of provider may be a barrier to patient disclosure of IPV.	<p>"The females a lot of times might not want to speak with Dr. Utson because he's a male. If they're a walk-in and most of the time they don't usually make an appointment for that. They</p>

	<p>would come in as a walk-in because it's something that has just come up. And I would try to put them with a female" (Transcript 6, page 15, lines 619-625).</p> <p>"Then I would... ask them if they feel comfortable talking to him and if they did not that it's not a problem. We have three other females that can speak to them... and I would let him know that" (Transcript 6, page 15, lines 633-636).</p> <p>"If there's a MedFT available onsite I always bring in the MedFT. I think there's always resources that I don't have... I think a group approach is always more helpful than a...singular provider approach. Unless that patient for some reason doesn't feel comfortable say, with a male provider in the room... or doesn't want her or his story shared with a certain male or female or...more people. If they're okay, I always think having a group approach is a more productive approach" (Transcript 8, page 9, lines 365-375).</p> <p>"The other one is that when I had a male medical assistant, I felt that patients were less likely to speak to me about partner violence than now that I have a female medical assistant. She speaks fluent Spanish, and he spoke a little bit more broken Spanish. And I feel like my patients are much more talkative about certain things because she is a female and they feel more comfortable speaking to a female" (Transcript 8, page 18-19, lines 789-797).</p>
Unidentifiable/unspecified barriers exist for patients to discuss IPV with provider.	<p>"Different women are different so some people are really open about talking about it and some aren't so, what if you get somebody that you can't get answers out or stops talking" (Transcript 4, page 8, lines 315-317).</p> <p>"Then in the hospital when ladies have their babies...the hospital screens them again. But they... always answer no and then they've got a big old bruise... and then... I mean what can you do? All you can do is ask people..." (Transcript 5, page 7, lines 258-261).</p>
Patient role as family caregiver is a barrier to IPV disclosure.	<p>"So it's just really fragmented. And, a lot of people, they have families and they have kids so, maybe the abuse is not a top priority for them and they're thinking about everyday things and it moves to the back burner a little bit" (Transcript 4, page 14, lines 591-594).</p>
Lack of health insurance for patients is a barrier to disclosing IPV with provider.	<p>"And that's then part of our inquiry to patients for a lot of times because they're all, almost all, uninsured...transient, a lot of them" (Transcript 3, page 9, lines 371-373).</p>
Family fear of IPV	<p>"And then the interesting thing is the mother... So then it all</p>

perpetrator is a barrier to IPV disclosure/response.	came out that mother pretty much knew that this was going on the whole time. So her mother who was charged with taking care of a minor knew she was being abused by the boyfriend. But the boyfriend was a gang guy. So everyone was terrified of him. So the mother was scared... to do anything about it and then, there's this 15 year old having a baby whose terrified of him" (Transcript 5, page 6, lines 210-216).
Mental health services are not readily available to MSFW patients.	"It's difficult to get the right mental health services. For these folks that are in crisis and with all their pressures, why wouldn't they be in mental health crises perhaps at a greater rate than the general population? Because they've got that stigma of, 'I may get caught every time I step outside my door.' And so, again, it's difficult for us here in XXXX to find resources for mental health consultation. A few places we have now. But not many" (Transcript 3, page 16, lines 679-687).
Patients are more willing to open up to and trust providers who speak Spanish and understand their culture.	<p>"I notice a big change when they see me and they're like, 'Ok this is ...an English speaking therapist...or she's maybe American, who happens to speak English,' versus when they specifically start asking me, 'Where are you from?' and then I say, 'Well, I'm from Colombia.' And they're like, 'Oh.' They're more willing to almost open up because then they realize we're a lot closer in the culture. We're both Hispanic. All of a sudden there's a big shift in trust. There's more trust, there's more openness and more willingness to share. So there's a huge cultural component as well" (Transcript 9, page 5-6, lines 190-204).</p> <p>"...they're not sure, but once they find out [we're closer in culture] then they're a lot more...comfortable, and they share more" (Transcript 9, page 6, lines 214-216).</p> <p>"The only thing I can think of... [is] just that cultural sensitivity" (Transcript 9, page 13, lines 537-539).</p>
Provider refers patient to on-site social worker, therapist, etc. if IPV is disclosed or if they feel uncomfortable addressing IPV.	<p>"It's more than that...then ongoing support, we have a social worker on staff and we would refer to her for community resources if the patient is in danger and needs... to leave the situation. If she's not ready to leave the situation then we talk about and reinforce an exit strategy for her" (Transcript 1, page 6, lines 230-235).</p> <p>"We have a whole behavioral health component of our clinic so they can get free counseling services" (Transcript 1, page 11, lines 473-474).</p> <p>"We have our own social worker that specializes... in prenatal and perinatal issues" (Transcript 1, page 11, lines 475-477).</p>

	<p>“We actually had people in the hospital that that was their job. You could call them and they would come talk to that person for you” (Transcript 6, page 9, lines 345-347).</p> <p>“I feel comfortable with it. But I would definitely notify the provider and... the medical family therapist...to intervene, so they could have somebody else to talk to” (Transcript 7, page 6, lines 243-247).</p> <p>“I feel moderately comfortable. Moderate to high comfort. If I don’t feel comfortable then I bring in help” (Transcript 8, page 8, lines 331-333).</p> <p>“I call the suicide helpline, I get my medical family therapist, I have a little card in my office that has a list of resources...that one of the medical family therapists gave me. So, if ever I need assistance I have several numbers to call. I’d have to look at it to tell you” (Transcript 8, page 9, lines 343-348).</p> <p>“If there’s a MedFT available onsite I always bring in the MedFT. I think there’s always resources that I don’t have...I think a group approach is always more helpful than a...singular provider approach. Unless that patient for some reason doesn’t feel comfortable say, with a male provider in the room... or doesn’t want her or his story shared with a certain male or female or...more people. If they’re okay, I always think having a group approach is a more productive approach” (Transcript 8, page 9, lines 365-375).</p> <p>“Or get the MFT to get in there to talk about the violence” (Transcript 8, page 12, line 492).</p> <p>“Because we do have, thankfully, the medical family therapist... [providers] might have the interest but I don’t know that they... would have the time to necessarily keep up with [resources]” (Transcript 9, page 11, lines 434-440).</p> <p>“We made an arrangement for her to be contacted by one of our medical family therapists the next day at a time when her husband would not be in the home, and that contact was never made. She never answered and obviously you can’t leave a message, so I don’t know whatever happened with her” (Transcript 10, page 6, lines 202-207).</p>
Interpreters enable providers to administer IPV screenings to MSFW women who do not	<p>“I wish my Spanish were adequate to really explore this one on one. But I do call in an interpreter in most instances because I’m not 100% sure I’m getting all the information” (Transcript 3, page</p>

<p>speak English.</p>	<p>12, lines 491-494).</p> <p>“I noticed that if the husbands come in with them, [the patients] don’t say anything. The husbands do all the talking for them a lot of times. And even when we get an interpreter, mostly he’s the one who speaks English and he’ll speak English for her. And sometimes what the doctors will do, they’ll... bring in an interpreter and even then the man doesn’t necessarily want to leave her. And she’s always very quiet and she just answers [her partner’s] questions and... she keeps a lot of eye contact with him” (Transcript 7, page 4, lines 123-132).</p> <p>“Because with [the MSFW population] ... the women have to depend on the men so much, and they don’t know English, and the men usually know English, so [women] have to be submissive with them. It seems like the...women who speak English, who go about their day, they’re more independent and they just come to the doctor by themselves and... they voice their opinion. We have interpreters here so they usually just come and see the doctor and get an interpreter and that’s it. ...It’s those who... have limited English that have to depend on [their partners] to take them to the doctor. They don’t have [a driver’s] license so they have to depend on them to do everything” (Transcript 7, page 5, lines 157-175).</p> <p>“I asked our interpreter to screen the patient very briefly and secretly for domestic violence. And when the interpreter asked the patient outside of the room while the husband waiting inside the exam room, the patient became tearful and said, ‘Yes’ that there were problems, and that, ‘Yes’ [IPV] was an issue” (Transcript 10, page 5, lines 165-172).</p>
<p>Provider indicates required IPV screening protocol used in their practice.</p>	<p>“I think it’s ...the company protocol” (Transcript 8, page 6, lines 236).</p>
<p>Provider indicates a lack of required IPV screening protocol used in their practice.</p>	<p>“Yeah I don’t have any screening that we have here that we use” (Transcript 4, page 5, lines 199).</p> <p>“I just wish I had more... knowledge about it or better ways to go about it ...I feel like I haven’t had any real training on it so I’m just doing the best I... know how to and...I think I’ve read bits and pieces here and there... about it in school and then things that might come up through emails or domestic violence awareness days and things like that, but there’s no protocol or anything like that” (Transcript 4, page 6, lines 232-237).</p> <p>“Not that I know of. At the hospital we did. That was one</p>

	<p>question we always had to ask them when we did the interview on them... Is, 'Do you feel... have you ever been kicked, punched, hit, threatened in your home?' But ... on any of our screens here I don't see that. We have substance abuse, we have all kinds of other stuff...but I've never seen that one. That might be a good thing for us to get. I actually haven't thought about it." (Transcript 6, page 6, lines 235-243).</p> <p>"Not on the nursing standpoint. And...that could be an easy remedy because we do a nursing history...And those ask things like, 'Do you exercise, do you wear your seatbelt, do you smoke, do you have a healthcare power of attorney?' and that...would be a very easy one to slide in and not be so abrasive to them is, 'Do you feel safe in your home?'" (Transcript 6, page 8, lines 318-325).</p> <p>"I don't know if we have a protocol in place. Our medical assistants do certain screenings when patients are checked in but I never noticed that domestic violence was one of the things that they screen for. I know they screen for substance abuse, but I've never been aware of a screening for domestic violence. I think in general, the others of us who are providers at Cherry Hill medical center kind of do our own thing" (Transcript 10, page 8, lines 304-312).</p>
Provider experienced resistance from employer regarding IPV screening/response protocol.	<p>"But I think when I first came here I did bring it up... and then I kind of backed off because I thought they'd think I'm crazy. Like, 'Look at all the things we could be doing'" (Transcript 6, page 10, lines 420-423).</p>
Provider indicates clinic general protocol (e.g., what happens during intake) getting in the way of addressing IPV.	<p>"Most of the ladies never 'fess up to it, but... we have these really long waits in our clinic because that's just how it goes. So...they get there, they sign in, and then they wait... and then they get their vitals taken and then they wait... and ... it's really frustrating for everybody" (Transcript 5, page 7, lines 274-278).</p>
Prevalence of IPV among the MSFW population is substantial.	<p>"You get more than, 'Yes I am getting abused'... that's very rare" (Transcript 1, page 4, lines 153-154).</p> <p>"I am afraid that [IPV among this population] is very high" (Transcript 3, page 8, lines 324-325).</p> <p>"I don't hear about [IPV] a lot or I don't deal with it a lot... I think I can count on my one hand...how many times ...we talked about it specifically like, 'Yes this has occurred and yes this is affecting you' but I think it happens a lot more than we talk about it. I feel like I know it does" (Transcript 4, page 4, lines 144-148).</p>

	<p>“A lot of times the patient will say, “In the past...” ...they’ll answer it that way so that’s a little different” (Transcript 4, page 5, lines 187-189).</p> <p>“Well, [prevalence is] hard to know because people often deny it... even when it’s pretty obvious” (Transcript 5, page 4, lines 154-155).</p> <p>“I think it’s pretty prevalent but it’s hard to know... and then people ... sometimes won’t want to admit it even when it’s so obvious so...it’s pretty prevalent but I can’t come up with a number...” (Transcript 5, page 4, lines 159-162).</p> <p>“I don’t know what the actual prevalence is” (Transcript 5, page 9, lines 377).</p> <p>“We have [women who have experienced IPV] a lot” (Transcript 6, page 5, lines 157).</p> <p>“I mean I hate to say a lot but we have [women who have experienced IPV] frequently” (Transcript 6, page 5, lines 161-162).</p> <p>“Well. On a scale from 0-10 I would say maybe a 4 or 5” (Transcript 6, page 5, lines 184).</p> <p>“I think [IPV] is pretty common with the migrant [population]” (Transcript 7, page 4, lines 153).</p> <p>“I guess they might not know the true percentage of it because... depending on how many outreach patients we see here...like Rochelle... she has the outreach clinic in Washington. She may see more. And the ones who go to the actual camp, they may see more” (Transcript 7, page 8, lines 295-300).</p> <p>“The migrant population has probably experienced a little bit more domestic violence than other populations that I... work with... Our migrant population does tend to be Hispanic...Our other populations tend to be Caucasian or African American... non-Latino. Our Hispanic migrant population tends to experience a little bit more domestic violence..... than our other...populations” (Transcript 8, page 4, lines 110-119).</p> <p>“[IPV] is common across the board but in this population it’s a little bit more specific because of the dynamics of the Hispanic population, the migrant population.” (Transcript 8, page 13, lines</p>
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	<p>553-556).</p> <p>“More often. A lot more often. Yeah. I would say like... at least in the 80%... 80-85” (Transcript 9, page 6, lines 238-239).</p> <p>“I’ve heard that domestic violence is more prevalent in migrant farmworker populations but I don’t know data. I may have known data at some point but all I know now is that my understanding is that it’s more prevalent” (Transcript 10, page 7, lines 247-251).</p>
IPV is very prevalent at homeless shelters.	<p>“...almost all uninsured...transient, a lot of them, as I said, part of my work is at a homeless shelter so there’s a high rate of all races...there’s a high rate of assault, and intimate partner problem at the homeless shelter. It sleeps about 150 people, and there’s just a huge problem. So it’s not just Hispanic there. With XXXXXX, it’s almost all Hispanic families” (Transcript 3, page 9, lines 372-379).</p>
Prevalence of IPV decreases when family moves to United States.	<p>“A lot of times [IPV] is in the past. Or they could still be living together with that partner, but the violence has either currently stopped or within the last few months or since they moved. A lot of times if they’re from Mexico or from Central America, then the violence ... sometimes it either stops or it...gets reduced a lot when they move into the U.S.” (Transcript 9, page 4-5, lines 153-160).</p>
Traditional gender roles among the MSFW population (i.e. machismo) exacerbate IPV.	<p>“I think it’s out in the culture a little bit more now... That you don’t have to be... And maybe the women feel a bit more empowered” (Transcript 1, page 15, lines 629-634).</p> <p>“Women who are may be in the United States, especially for the first time, and who are not documented, tend to be quite submissive to the male partner. I think they have trouble believing that they can make some decisions or stop the partner... stop the partner’s actions. So this being is kind of a characteristic. After they’ve been here for a while, it’s great to see them kind of blossom a little and begin to make some decisions for themselves or speak out and say, ‘No, that’s not right.’ But at first... that first year that they’re here, they tend to say it’s a male dominant or respond as though male domination is okay” (Transcript 3, page 14, lines 574-586).</p> <p>“With a lot of people in the Latino population where the man is seen as the decision maker in the house, where there’s this Machismo kind of outlook, they work and they make the money, and they make the decisions and so...breaking down some of those cultural barriers or educating about the difference between something that’s cultural and something that’s not safe and hurting you... can be challenging” (Transcript 4, page 12, lines</p>

	<p>479-484).</p> <p>“In that culture some of the men think that the women are supposed to [consent] and no doesn’t mean no” (Transcript 6, page 5, lines 171-173).</p> <p>“They’ve not been here in America and...they’re used to that in Mexico and... until they know better... until they can speak English and interact more... they don’t know that it doesn’t have to be that way over here” (Transcript 7, page 10, lines 393-398).</p> <p>“There’s a little bit of that Machismo going on where the Hispanic male wants to control his...partner’s health care in all aspects... whereas a Caucasian male...if there’s domestic violence in the home, he might be willing to let her go in and have her blood pressure checked and have her doctor’s appointment by herself a little bit more so. ...When Hispanic families come to the doctor’s office...because there’s only one car a lot of times or there’s no transportation, very little transportation...the father’s going to come, the mother’s going to come, the aunt or uncle might come, and all the kids are going to come... and they all come back to the room together. So it’s a little bit more difficult to have an appointment with just the female or just whoever is having the problem with domestic violence” (Transcript 8, page 13, lines 533-549).</p> <p>“I feel like gender roles in general are maybe more delineated among my patient population who are migrant farmworkers just in terms of my female patients think about getting up super early to cook breakfast for their husband and prepare their lunches for them to take to work. And you just don’t hear a lot of non-migrant patients thinking about having to do those types of traditional gender tasks, those specific tasks. So I can say it seems like there’s still a role for the wife that’s more traditional among my migrant patients” (Transcript 10, page 7, lines 270-281).</p> <p>“I hear other patients talking about how their husbands expect them to have food on the table and expect them to do this or that or the other with the children, which I don’t hear my non-migrant patients talking about...” (Transcript 10, page 7, lines 286-290).</p>
Presence of children (or other vulnerable persons) increases provider sensitivity to IPV.	<p>“Yeah, I mean I’ve been around for thirty years and I’ve seen it... be good for the patient... and for the children, if there are any.” (Transcript 1, page 7-8, lines 280-294).</p> <p>“Of course I’m considering if...there’s domestic violence going</p>

	<p>on with the partner, if there is going to be domestic violence going on with the children as well... That makes it...an easier end road for reporting and for getting the process started because if there is [domestic violence] ... it's not necessarily a reportable offense for an adult but it is a reportable offense for a child. So... if the child is there and I can bring the child in and...get the process started with the child, then that is a reportable offense” (Transcript 8, page 16, lines 677-687).</p> <p>“I think another challenge is taking it to another level with the kids involved. It's a different situation when there's abuse towards children and then knowing what to do about that as well. Or not only knowing how to help...a female in a situation of domestic violence but knowing how to find out what type of situation the children are in and knowing what to do about that” (Transcript 10, page 12, lines 502-508).</p>
Stressors associated with being away from family may exacerbate IPV.	<p>“You're away from your family or you're traveling and you're... stressed out” (Transcript 4, page 12, lines 514-515).</p> <p>“The ones who come [to the U.S.] with their families I don't really see it as much. It's the ones that come that either they had to leave their spouses behind, and family behind, or they're just single all the way around” (Transcript 6, page 5-6, lines 199-202).</p> <p>“And they're usually here with no family and really no place to go” (Transcript 6, page 11, lines 436-438).</p> <p>“[Their undocumented status], and probably finances...and they're away from their home. It's not like they have a family support system right here. They're hundreds and hundreds of miles away” (Transcript 6, page 11, lines 449-452).</p>
Drug and/or alcohol abuse is common among IPV perpetrators in the MSFW community.	<p>“When I started when women were very hesitant to kind of blow the whistle on that. And now I'm seeing more and more women will say, ‘Well, uh... you know that used to happen but I, I called the police and he did jail time and now he's quit drinking’” (Transcript 1, page 14, lines 586-590).</p> <p>“It's alcohol and substance abuse... it's almost like it goes hand-in-hand. I mean, maybe not 100% but you know...” (Transcript 1, page 14, lines 594-596).</p> <p>“Then they'll say, ‘Well then he went... he went to jail, he quit drinking, and life has been okay since then’” (Transcript 1, page 14, lines 601-602).</p> <p>“What I've noticed this big connection between alcohol/substance</p>

	<p>abuse... and violence” (Transcript 1, page 17, lines 719-720).</p> <p>“One could say, drinking among... the population ...which I don’t know if it’s actually more prevalent actually among Hispanics but, you’re away from your family or you’re traveling and you’re... stressed out and I think that drinking can play a part ... alcoholism... if that’s going on” (Transcript 4, page 12, lines 512-516).</p>
Patients and their families often take the IPV perpetrator (partner) back.	<p>“Because as you probably know very well, there’s... a wonderful tradition of...sharing space and food and so forth and that family took him back” (Transcript 3, page 6, lines 230-232).</p> <p>“About a year after... his return... one of the girls who was a teen, about 14, got pregnant and had a baby... I never have established who the father is on this young lady then the final contact I had with that family... the mother, the daughter, the grandbaby, and still three younger children were still living together...” (Transcript 3, page 6, lines 238-244).</p> <p>“I actually did have a lady once...when I was a brand new midwife and I was all energetic and stuff... and she did say she wanted to leave her guy. And she came to the clinic and the idea was that she was going to leave straight from the clinic to the safe house. And she did that, but then she was back a couple weeks later with the guy... so it didn’t work out” (Transcript 5, page 9, lines 362-367).</p>
Patients within the MSFW community may normalize IPV as a part of life.	<p>“Probably the biggest challenge is just being able to even get patients to share, to open up about it, to talk. And a lot of that is because sometimes, culturally speaking... [IPV] can be widely seen as normal. Normal in the sense of, ‘Oh, this is what happened to my great-grandma, my grandma, my mom and this is what kind of how...well, this is what’s supposed to happen.’ ...The problem is so widespread that sometimes it’s seen as normalized” (Transcript 9, page 11-12, lines 469-480).</p> <p>“For various reasons they may not [only] choose to stay in the situation, but they may see it as... ‘This is normal’ or ‘This is okay, and I’m fine’” (Transcript 9, page 13, lines 550-553).</p>
The MSFW community maintains a cultural independence from mainstream society.	<p>“It seems very real to me. There’s this, I’m not part of the culture so I don’t really know what goes on, but it... from what I’ve seen in my thirty years is that there’s a real circling of the wagons that ‘we will take care of our own problems’” (Transcript 1, page 8, lines 330-334).</p>
Stressors associated with immigration status may exacerbate IPV.	<p>“Women who are may be in the United States, especially for the first time, and who are not documented, tend to be quite submissive to the male partner. I think they have trouble</p>

	<p>believing that they can make some decisions or stop the partner... stop the partner's actions. So this being is kind of a characteristic. After they've been here for a while, it's great to see them kind of blossom a little and begin to make some decisions for themselves or speak out and say, 'No, that's not right.' But at first... that first year that they're here, they tend to say it's a male dominant or respond as though male domination is okay" (Transcript 3, page 14, lines 574-586).</p> <p>"We can't just say men have no problems because being undocumented and being badly treated. It's the old story of going home and kicking the dog when you are upset at work. We can't say to these men, 'You have no right to react.' But nonetheless, the type of reaction in my experience seems to be ... take it out on the partner, usually female" (Transcript 3, page 15-16, lines 651-658).</p> <p>"It's difficult to get the right mental health services. For these folks that are in crisis and with all their pressures, why wouldn't they be in mental health crises perhaps at a greater rate than the general population? Because they've got that stigma of, 'I may get caught every time I step outside my door.' And so, again, it's difficult for us here in XXXX to find resources for mental health consultation. A few places we have now. But not many" (Transcript 3, page 16, lines 679-687).</p>
Occupational (i.e., work-related) stressors among IPV perpetrators may exacerbate IPV.	<p>"Part of [the problem] is unemployment for some..." (Transcript 3, page 8, lines 329).</p> <p>"We can't just say men have no problems because being undocumented and being badly treated. It's the old story of going home and kicking the dog when you are upset at work. We can't say to these men, 'You have no right to react.' But nonetheless, the type of reaction in my experience seems to be ... take it out on the partner, usually female" (Transcript 3, page 15-16, lines 651-658).</p>
Family values are evident in the MSFW culture.	<p>"There's also some great [MSFW men] that are family oriented" (Transcript 6, page 5, lines 188-189).</p>
MSFW patients and their families migrate around the country to maintain work.	<p>"Most of my patients are not... some of them are farmworkers they go back and forth like they go up to northern California and then they come back to the city... there's off-season. But most of them are not. Most of them are immigrant and migrant as in like they move around a lot based on where the work is" (Transcript 5, page 4, lines 113-137).</p> <p>"I have ladies who sometimes will work in the fields in northern California and then, when it's off season they'll come south and</p>

	they'll work in the garment industry in downtown L.A. sewing" (Transcript 5, page 4, lines 142-144).
Provider is concerned that violence extends beyond just the partner relationship within the family.	"I could be seeing the kids, [while] mom is in the room and we're actually talking about the kid's behavior, the kid's aggression. 'They're just really violent...' So when we begin to talk about what the home environment is like, depending on what examples she gives me of [what] the kids are doing, depending on some level of aggressiveness from the kids themselves, I'm [thinking], 'Hmm... that sounds...' Or if the kids are hitting mom... I start digging in a little deeper. ...For some reason I noticed if they're males... more boys will have a tendency... to hit more their mom if that's something that the dad does. ...I haven't seen a daughter do that...with mom, but a little boy, if he's seen dad do that. So a lot of times if the boys are aggressive, not just... among siblings or at school, but if it's something towards mom I start digging a little deeper. Often times, even when I'm asking the child or... I ask mom, if they have watched or observed or seen that behavior, if they're around it anywhere. And they'll sometimes say, 'well... sometimes they'll see that from their dad.' And that's...how it comes out" (Transcript 9, page 9-10, lines 376-404).
Diversity exists among underserved populations.	"But that's the interesting thing about where I work it's kind of a mixture of all different kinds of underserved people...So there's ...the inner city like never been to the beach 20 miles away kind of group of people...and then there's like really recent immigrants, and then there's...migrant workers that kind of go back and forth wherever the work is" (Transcript 5, page 6, lines 231-235).
MSFW culture values gentle interaction with children.	"In general, this population is so gentle with children. I see both men and women being very gentle with children for the most part, at least very little children, 5 and under let's say. The females continue to be very gentle with discipline and so forth. The men tend not to be quite so gentle as the kids get bigger, but certainly as they're babies and little kids they tend to be gentle" (Transcript 3, page 14, lines 595-602).
Provider identifies connections with shelters, safe houses, etc. as resources for patients.	<p>"We have connections with the safe houses in the area" (Transcript 1, page 11, lines 468-469).</p> <p>"We settled them in a shelter" (Transcript 3, page 6, line 208).</p> <p>"...but [agency] did what we could medically and we settled them in" (Transcript 3, page 6, lines 216-217).</p> <p>"I did work in a hospital for twenty-nine and one half years so that's one of the things that we did... We knew exactly... who to put them in contact with, number to give them, you know like Safe House" (Transcript 6, page 9, lines 341-348).</p>

IPV materials are distributed at migrant camps (not direct patient interaction).	“We have a couple migrant camps, so they’re there living and definitely, we hang some things up like posters... that might be helpful... places they can call” (Transcript 4, page 9, lines 354-356).
Provider indicates connections with churches as resources for patients.	“We have connections with the churches...” (Transcript 1, page 11, lines 474-475).
Provider indicates connections with community resources.	“We’re well connected with the community and therefore we can connect our patients with their community resources...” (Transcript 1, page 12, lines 481-483).
Provider transports patient to shelter, safe house, etc.	“We had the capacity to just load up that family and bring them back to Des Moines, Iowa, about 150 miles from the small city, which we did” (Transcript 3, page 6, lines 202-204).
IPV perpetrators must serve jail time in some instances.	<p>“Very, very unaware. Yeah. Very, very unaware. I think they think it’s either they get the guy arrested or nothing” (Transcript 1, page 11, lines 435-436).</p> <p>“When I started when women were very hesitant to kind of blow the whistle on that. And now I’m seeing more and more women will say, ‘Well, uh... you know that used to happen but I, I called the police and he did jail time and now he’s quit drinking” (Transcript 1, page 14, lines 586-590).</p> <p>“Then they’ll say, ‘Well then he went... he went to jail, he quit drinking, and life has been okay since then” (Transcript 1, page 14, lines 601-602).</p> <p>“There was a family who came to the clinic... a mom and six children... and the mother had been assaulted by the husband who was in jail but it was a small city in Iowa and we knew that he was probably not going to be there more than 2 or 3 days” (Transcript 3, page 5, lines 193-197).</p> <p>“This woman was really very frightened of the husband... and as it happens... he was sent to jail” (Transcript 3, page 6, lines 217-219).</p> <p>“I do some work at the homeless shelter as well as migrant camps, and... and our regular clinic...the perpetrator was back out and he found them again” (Transcript 3, page 6, lines 224-226).</p> <p>“It’s certainly a case of family strife then jail then reformation of the family. I am afraid that might be fairly typical... and if the spouse isn’t jailed for violence we have a lot of men particularly being jailed just because of the non-documented status””</p>

	<p>(Transcript 3, page 7, lines 255-260).</p> <p>“I don’t have any facts but... a lot of our patients are undocumented, so calling the police and sending their spouse to jail where there’s the possible deportation or on the other side where they might get deported. That’s a huge thing for people” (Transcript 4, page 10, lines 415-418).</p> <p>“I’ve had a good share of women whose husbands or whatever, baby daddies, are in...jail for things [the patient] did to [the perpetrator]. You know, I mean restraining orders” (Transcript 5, page 7, lines 267-269).</p>
Abusive partner is deported after patient reports IPV.	<p>“She reported her husband, and he was deported for the domestic violence. She continued to feel threatened because his family still lived in her neighborhood here, and he was deported back to the neighborhood in her home country where her mother and other family members lived. So, when I met her, she had already gotten out of the situation of domestic violence by her husband, but she continued to feel danger because of being around his family members, who she said would threaten her in her neighborhood” (Transcript 10, page 3, lines 93-103).</p> <p>“Her husband was deported. She remained here” (Transcript 10, page 4, lines 116).</p>
Some women's shelters will not accept teenage sons of patients.	<p>“We tried to find resources in the area that could accommodate Hispanic patients and we did eventually did find some that could help her with the language barrier. But then the next issue we faced was finding a shelter that could accommodate her teenage son. Because shelters don’t take in children who are male once they reach a certain age, and at least one of her sons was above the cutoff” (Transcript 10, page 5, lines 188-196).</p> <p>“If I remember correctly, it would not have been an issue if her children had been female. It was specifically because they were male that they were not welcome” (Transcript 10, page 6, lines 230-232).</p>

APPENDIX J: STATEMENT OF BIAS

Violence has always been an interesting subject for me on many levels. Even as a child, I was fascinated by aggressive behavior as evidenced by my involvement in martial arts throughout most of my childhood and adolescence. As an avid sports fan, I tend to prefer the contact sports (e.g., football, mixed martial arts, basketball) to no-contact sports (e.g., tennis, swimming, golf). Throughout my collegiate education, my research interests have been centered on issues of human aggression and violence. Despite these interests, I have never personally experienced nor witnessed intimate partner violence (IPV) in any relationship in which I have been involved or closely associated with. Nevertheless, I have a number of biases and assumptions about IPV that I must recognize. Furthermore, as a heterosexual, white, Christian male in the southern United States, I must recognize and account for my biases and assumptions that may be present as a result of my many un-earned privileges. Finally, as a behavioral health provider working in multiple medical settings, I also have biases and assumptions about healthcare providers and their attitudes, beliefs, and practices about IPV. These assumptions and biases include the following:

- I believe IPV among MSFW women could arguably be equated with other types of violence against those who cannot advocate for or defend themselves (e.g., child or elder abuse).
- I assume many medical providers choose not to screen for or address IPV with their patients due to their self-perceived incompetence about addressing IPV or inability to effectively lend aid.
- I assume many medical providers are unaware of how prevalent IPV is among their migrant and seasonal farmworker (MSFW) patients.

- I assume many medical providers do not fully understand the influence of cultural factors among MSFW patients in regard to IPV.
- I believe that many medical providers believe the liability risks of patients disclosing IPV are too great to screen for or address IPV unless absolutely necessary.
- I believe that, through this proposed study, I may find that most healthcare providers will have addressed IPV with their patients only if a patient presented with physical symptoms (e.g., unusual bruises, frequent broken bones, black eyes, etc.) indicative of IPV.
- I believe that, through this proposed study, I may find that healthcare providers will not have had more than a few hours of training regarding IPV, with possibly none of these hours pertaining to the influence of culture on IPV.

APPENDIX K: TRIANGULATED RESEARCHER STATEMENT OF BIAS

Violence has been a topic of interest for me since my first church missions trip in junior high. I worked with children in rural South Texas who had experienced domestic violence. In my mind, the only justification I could rationalize violence was due to the abuse of alcohol, which I had been informed was a prevalent component of the Hispanic culture. I soon developed a strong desire to work with families and children who had experienced violence related to alcoholism. After further education and encounters with victims of intimate partner violence, I began to realize that violence exists outside the context of alcohol alone. Moreover, I intend to devote my life to social work, in which I will advocate for the rights of the underserved, underprivileged, underrepresented populations of my community. Nonetheless, I recognize that I, as a white, Christian, heterosexual, middle-class citizen, have been granted a number of financial and social privileges that could very well elicit unintentional beliefs or assumptions. My education thus far in the field of social work also holds great sway on my beliefs about intimate partner violence. For example, my beliefs on race relations and cultural differences have been defined by statistics more than by experience. Also, I hold to the methods of responding to IPV disclosures as I have been instructed in class, though I have never had to use them to report or address anyone. Although I have experienced a minor degree of IPV, I have received thorough counseling and believe this experience will not hinder my ability to be an objective researcher. Additionally, though I have no experience working in a healthcare setting as a provider, I addressed my own issues with IPV with a healthcare provider. Finally, as a woman with some personal experience with IPV, I recognize some assumptions and beliefs about healthcare providers and their ability to effectively address IPV. These biases and assumptions include the following:

- I assume many healthcare providers choose not to screen patients for IPV due to a belief of inadequate training or resources to assist.
- I assume many medical providers do not assume responsibility for assessing IPV.
- I believe some medical providers may not be fully equipped to effectively respond to IPV.
- I assume many medical providers only have limited resources with which to address IPV victims.

APPENDIX L: EMERGENT THEMES

I. Provider-Centered Factors

- a. Healthcare providers use various IPV screening protocols with MSFW patients.
 - i. Provider administers verbal screenings for IPV. (8)
 - ii. Provider specifies the time of and/or frequency of IPV screening. (6)
 - iii. Provider initiates conversation about IPV. (5)
 - iv. Provider administers IPV screening if physical evidence of violence is present. (4)
 - v. Provider administers written screenings for IPV. (3)
 - vi. Provider screens for IPV when patient is depressed or stressed. (3)
 - vii. Provider determines who gets screened (e.g., everyone, only females, only MSFW women, etc.). (2)
 - viii. Provider discusses sex, HIV, contraception, etc. with patients. (2)
 - ix. Patient initiates conversation about IPV. (2)
 - x. Provider determines whether to screen patients individually or as a family/group. (1)
 - xi. Provider discovers IPV while patient is in labor/delivering child. (1)
- b. Healthcare providers respond to patient disclosures of IPV in various methods.
 - i. Provider expresses confidence and/or comfortability in screening for and responding to IPV. (9)
 - ii. Provider encourages patients to advocate for themselves. (4)
 - iii. Provider extends verbal support in response to patient disclosure of IPV. (4)
 - iv. Provider develops safety plan with patient. (3)
 - v. Provider allows patient to make informed decision without imposing his/her own values/opinions. (2)
 - vi. Provider reports IPV to police. (2)
 - vii. IPV is addressed by provider if reasonable suspicion/belief is present. (1)
 - viii. Provider evaluates the severity of the situation and safety of the patient. (1)
- c. Healthcare providers experience barriers to screening for and addressing IPV with MSFW patients.
 - i. Provider indicates a lack of resources (or awareness of resources) available to provide patients. (5)
 - ii. Establishing and keeping patients' trust is a barrier for providers to addressing IPV effectively. (3)
 - iii. Provider's inability to speak Spanish is a barrier to effective IPV screening. (3)
 - iv. Using an interpreter to screen for IPV can be a barrier for providers. (3)
 - v. Patient accessibility can be a barrier for providers (e.g., living in camps, migrant status) to delivering healthcare services. (3)
 - vi. Priority of IPV screening is a barrier for providers. (1)
 - vii. Lack of time with patient is a barrier for providers. (1)
 - viii. Provider believes patients are less likely to trust non-Hispanic providers than Hispanic providers. (1)

- d. Healthcare providers have access to resources on site and in the community to assist IPV victims.
 - i. Provider indicates general (unspecified) resources available to provide patients. (3)
 - ii. Provider believes additional professionals (e.g., social worker, therapist) can be helpful in addressing IPV with patients. (2)
 - iii. Provider gives contact information of resources (e.g., IPV hotline, local agencies) to patient. (2)
 - iv. Provider believes resources for patients should be readily available for providers to give. (1)
 - v. Provider indicates phone resources (e.g., national hotlines) for patients to call for assistance. (1)
- e. Healthcare providers believe change is needed to improve MSFW patient care.
 - i. Provider trainings regarding IPV can be helpful and are (or should be) available. (7)
 - ii. Provider believes there is a need for addressing/screening for IPV among MSFW patients. (2)
 - iii. Provider believes IPV screening tools should be available for providers. (2)
 - iv. Provider desires to help/serve MSFW population due to their lack of resources, ways to get help, etc. (2)
 - v. Provider feels powerless to help patients who are experiencing IPV. (1)
 - vi. Provider believes patient care and provider response to IPV needs improvement. (1)
 - vii. Provider believes IPV response protocol needs to be adaptable to the demands of the situation. (1)
- f. Healthcare providers are confronted with the partners of their patients.
 - i. Provider is uncertain about further violence, or denial of medical care from partner after visit with patient if IPV is addressed. (5)
 - ii. Provider interacts with abusive partners of patients. (2)
 - iii. Provider attempts to separate patient from partner (or partner's proxy) to administer IPV screen. (2)
 - iv. Protective measures are put in place to protect provider from abusive partner (i.e., IPV perpetrator). (1)
 - v. Partners of patients will send friend/family member with patient to visit. (1)

II. Patient-Centered Factors

- a. MSFW patients experience IPV in numerous forms.
 - i. IPV often occurs during pregnancy among the MSFW community. (3)
 - ii. Violence, including physical abuse and rape, is sometimes perpetrated by someone other than partner. (2)
 - iii. MSFW women are occasionally raped by their partners. (1)
 - iv. Family members of partner threatens patient with violence. (1)
 - v. Mutual violence between partners sometimes occurs. (1)
 - vi. Violence occurring during pregnancy is sometimes perpetrated by someone other than partner. (1)

- vii. Abusive partner threatens patient's family of origin with violence. (1)
- b. MSFW patients respond to IPV perpetration in various ways.
 - i. Patient verbally responds to provider addressing IPV. (5)
 - ii. Patients' partners are sometimes incarcerated (for reasons other than IPV perpetration). (2)
 - iii. Patient asks provider to contact police. (2)
 - iv. Patient is hesitant to disclose information pertaining to IPV. (2)
 - v. Variability is evident as to when patients disclose IPV. (1)
 - vi. Patient has safety plan in place. (1)
 - vii. Patient will call police, if necessary. (1)
 - viii. Patient blames herself for her partner's violent behaviors. (1)
 - ix. Patient denies help attempts/resources from provider. (1)
 - x. Patient is afraid of IPV perpetrator. (1)
- c. MSFW patients experience barriers to disclosing IPV and seeking resources suggested by healthcare providers.
 - i. Presence of partners of patients either in the exam room or nearby is a barrier to IPV disclosure. (8)
 - ii. Immigration status of patients (including fear of deportation) is a barrier for patient disclosures of IPV. (7)
 - iii. Patients depend on spousal income, which is a barrier to disclosing/responding to IPV. (5)
 - iv. Presence of nearby family members (e.g., in the exam room) is a barrier to patient IPV disclosure. (4)
 - v. Lack of transportation for patients is a barrier to disclosing IPV with provider. (4)
 - vi. Inability to speak English serves as a barrier to disclosure of IPV or ability to seek resources. (4)
 - vii. Patient awareness of available resources tends to be low. (3)
 - viii. Some resources are unavailable to patients due to their migrant status. (3)
 - ix. Confidentiality/privacy due to location of screening/medical visit (e.g., at migrant camps) is a barrier to IPV disclosure. (2)
 - x. Gender of provider may be a barrier to patient disclosure of IPV. (2)
 - xi. Unidentifiable/unspecified barriers exist for patients to discuss IPV with provider. (2)
 - xii. Patient role as family caregiver is a barrier to IPV disclosure. (1)
 - xiii. Lack of health insurance for patients is a barrier to disclosing IPV with provider. (1)
 - xiv. Family fear of IPV perpetrator is a barrier to IPV disclosure/response. (1)
 - xv. Mental health services are not readily available to MSFW patients. (1)
 - xvi. Patients are more willing to open up to and trust providers who speak Spanish and understand their culture. (1)

III. Clinic-Centered Factors

- a. Some clinics have protocol/resources in place to address IPV with patients.
 - i. Provider refers patient to on-site social worker, therapist, etc. if IPV is disclosed or if they feel uncomfortable addressing IPV. (6)

- ii. Interpreters enable providers to administer IPV screenings to MSFW women who do not speak English. (3)
 - iii. Provider indicates required IPV screening protocol used in their practice. (1)
- b. Some clinics unintentionally create barriers to effectively addressing IPV with patients.
 - i. Provider indicates a lack of required IPV screening protocol used in their practice. (3)
 - ii. Provider experienced resistance from employer regarding IPV screening/response protocol. (1)
 - iii. Provider indicates clinic general protocol (e.g., what happens during intake) getting in the way of addressing IPV. (1)

IV. Community-Centered Factors

- a. IPV in the MSFW community is a considerable problem.
 - i. Prevalence of IPV among the MSFW population is substantial. (9)
 - ii. IPV is very prevalent at homeless shelters. (1)
 - iii. Prevalence of IPV decreases when family moves to United States. (1)
- b. Unique cultural factors within the MSFW community may exacerbate IPV.
 - i. Traditional gender roles among the MSFW population (i.e. machismo) exacerbate IPV. (7)
 - ii. Presence of children (or other vulnerable persons) increases provider sensitivity to IPV. (3)
 - iii. Stressors associated with being away from family may exacerbate IPV. (2)
 - iv. Drug and/or alcohol abuse is common among IPV perpetrators in the MSFW community. (2)
 - v. Patients and their families often take the IPV perpetrator (partner) back. (2)
 - vi. Patients within the MSFW community may normalize IPV as a part of life. (1)
 - vii. The MSFW community maintains a cultural independence from mainstream society. (1)
 - viii. Stressors associated with immigration status may exacerbate IPV. (1)
 - ix. Occupational (i.e., work-related) stressors among IPV perpetrators may exacerbate IPV. (1)
 - x. Family values are evident in the MSFW culture. (1)
 - xi. MSFW patients and their families migrate around the country to maintain work. (1)
 - xii. Provider is concerned that violence extends beyond just the partner relationship within the family. (1)
 - xiii. Diversity exists among underserved populations. (1)
 - xiv. MSFW culture values gentle interaction with children. (1)
- c. Local communities provide resources to aid MSFW women experiencing IPV.
 - i. Provider identifies connections with shelters, safe houses, etc. as resources for patients. (3)
 - ii. IPV materials are distributed at migrant camps (not direct patient interaction). (1)

- iii. Provider indicates connections with churches as resources for patients. (1)
- iv. Provider indicates connections with community resources. (1)
- v. Provider transports patient to shelter, safe house, etc. (1)
- d. Outcomes for IPV victims and perpetrators vary within the MSFW community.
 - i. IPV perpetrators must serve jail time in some instances. (4)
 - ii. Abusive partner is deported after patient reports IPV. (1)
 - iii. Some women's shelters will not accept teenage sons of patients. (1)